ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672
9427 HOUSE STATE AFFAIRS

requirements the State can impose as a precondition to a minor's abortion decision. The Supreme Court has long recognized that the status of minors under the law is unique in many respects. As Justice Frankfurter aptly put it: "[C]hildren have a very special place in life which law should reflect. Legal theories and their phrasing in other cases readily lead to fallacious reasoning if uncritically transferred to determination of a state's duty towards children." May v. Anderson, 345 U.S. 528, 536, 73 S. Ct. 840, 844 (1953) (concurring opinion). Also, as Justice Powell put it in Bellotti, "[t]he unique role in our society of the family, the institution by which we inculcate and pass down many of our most cherished values, moral and cultural, . . . requires that constitutional principles be applied with sensitivity and flexibility to the special needs of parents and children." 443 U.S. at 634, 99 S. Ct. at 3035, quoting, Moore v. East Cleveland, 431 U.S. 494, 503-504, 97 S. Ct. 1932, 1938, 1977 (plurality opinion). Specifically, the Court has recognized three reasons which justify the conclusion that the constitutional rights of children cannot be equated with those of adults: The peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner, and the importance of the parental role in child rearing. Bellotti, 443 U.S. at 644, 99 S. Ct. at 3043. "[P]arent notice and consent are qualifications that typically may be imposed by the State on a minor's right to make important decisions. As immature minors often lack the ability to make fully informed choices that take account of both immediate and long-range consequences, a State reasonably may determine that parental consultation often is desirable and in the best interest of a minor." Bellotti, 443 U.S. at 640, 99 S. Ct. at 3046.[1] Each of these reasons have amplified significance in the case of a minor woman considering the dramatic decision of whether to abort her unborn child. See Id.; Casey, __ U.S. at __, 112 S. Ct. at 2832. Accordingly, the State may determine, as a general proposition, that such consultation is particularly desirable with respect to the abortion decision, as it is one that for some people raises profound moral and religious concerns. Moreover, it is widely demonstrated that parental involvement in a minor's abortion decision, if compassionate and supported, is highly desirable. See Bellotti, 443 U.S. 642, n. 20, 99 S. Ct. at 3047, n. 20.[2]

---

[1] In Danforth, 428 U.S. at 75, 96 S. Ct. 2844, the Court emphasized that its holding "[d]id not suggest that every minor, regardless of age or maturity, may give effective consent for termination of her pregnancy."

[2] The State's interest in a one-parent consent statute, such as Alaska's, is clear: it is to protect children from their own immaturity as well as from the possibly deficient advise of those whose business it is to provide abortions at profit. Such statutes are plainly constitutional provided they contain adequate judicial bypass provisions. Casey, ___ U.S. at ____, 112 S. Ct. at 2832; Ashcroft, 462 U.S. 476, 103 S. Ct. 2517. Ohio v. Akron Center for Reproductive Health (Akron II), 497 U.S. 502, 520, 110 S. Ct. 2972, 2984 (1990). Justice Kennedy eloquently expressed the interest of the State and the Family in requiring parental consent as a precondition to a minor's abortion:

> It is both rational and fair for the State to conclude that, in most instances, the family will strive to give a lonely or even terrified minor advise that

In the abortion context, parental involvement statutes may be divided into four groups, in ascending order of the burden which they impose on the minor's exercise of her limited right to an abortion: One-parent notification statutes, two-parent notification statutes, one-parent consent statutes, and two-parent consent statutes. The Supreme Court upheld a one-parent notification statute in H.L. v. Matheson, 450 U.S. 398, 101 S. Ct. 1164 (1981). The Court upheld a two-parent notification statute that includes a judicial bypass provision in Hodgson v. Minnesota, 497 U.S. 417, 110 S. Ct. 2926 (1990) (Kennedy, J. plurality opinion).[3] Finally, as stated above, the Court upheld a one-parent consent statute with a judicial bypass in both Casey, __ U.S. at __, 112 S. Ct. at 2832; and Ashcroft, 462 U.S. 476, 103 S. Ct. 2517. The only unanswered question, which at least arguably was answered in Bellotti v. Baird, is whether a two-parent consent statute with a judicial bypass impermissibly crosses the line so as to impose an undue burden on a minor woman's right to an abortion. See Casey, ____ U.S., 112 S. Ct. 2791.

In analyzing parental consultation statutes, the Court scrutinizes consent statutes more closely than it does notification statutes, and two-parent laws more closely than one-parent laws (simply because parental consent is viewed as being a greater burden on the right to choose an abortion from parental notification). Thus, a two-parent consent statute arguably raises more serious questions than the other parental involvement statutes. In Bellotti v. Baird, 443 U.S. at 636, 99 S. Ct. at 3045, a fractured court struck down a state law that required minors to obtain the consent of both parents before an abortion could be performed. The plurality opinion struck the law down on the grounds that the statute's judicial bypass provision was constitutionally inadequate. Bellotti, 443 U.S. at 645, 99 S. Ct. at 3049. However, the opinion clearly stated: "We are not persuaded that, as a general rule, the requirement of obtaining both parents' consent unconstitutionally burdens a minor's right to seek an abortion." Id. at 649, S. Ct. at 3051. In outlining the constitutional requirements for such a statute, the Court said: We therefore conclude that if the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained." Id. at 643, 99 U.S. at 3048 (emphasis added). Thus, if the two-parent consent statute at issue in Bellotti had contained an adequate judicial bypass, the four members of the plurality opinion stood ready to uphold it. A fifth, Justice White, was prepared

---

> is both compassionate and mature. The statute in issue here is a rational way to further those ends. It would deny all dignity to the family to say that the State cannot take this reasonable step in regulating its affairs professions to insure that, in most cases, a young woman will receive guidance and understanding from a parent.

[3] In Akron II, decided in tandem with Hodgson, the Supreme Court left open the precise question of whether parental notification statutes even require alternative judicial bypass provisions. 497 U.S. 502, 110 S. Ct. 2972.

to uphold the two-parent consent statute in Bellotti, even without a judicial bypass. Id. at 657, 99 S. Ct. at 3055 (White J., dissenting).

Although the Court in Bellotti did not uphold the two-parent consent statute at issue, it did indicate that it would do so under different circumstances. The indication given in Bellotti, that even a two-parent consent statute with an appropriate judicial bypass would be constitutionally permissible, is particularly persuasive in light of Justice Kennedy's plurality opinion in Hodgson, 497 U.S. at 498, 110 S. Ct. at 2970. There, Justice Kennedy relied on Bellotti to uphold a two-parent notice requirement. Justice Kennedy argued that since Bellotti approved a two-parent consent statute with a judicial bypass, it follows that the less onerous two-parent notice statute must be constitutional. Id. at 498, 110 S. Ct. at 2970. (Bellotti "requires us to sustain this statute before us here"). Justice O'Connor, also citing Bellotti, joined the plurality in Hodgson on the broad grounds that a bypass provision tailors "a parental-consent provision so as to avoid unduly burdening the minor's limited right to obtain an abortion." Id. at 461, 110 S. Ct. at 2950. (O'Connor, J., concurring). Thus, in Hodgson five justices (Rehnquist, White, O'Connor, Scalia, and Kennedy) viewed Bellotti, as settling the question in favor of the constitutionality of the two-parent consent/judicial bypass statute. See e.g., Barns, 992 F.2d at 1338-39.

For purposes of analyzing the constitutionality of the legislation which you propose to introduce to the Alaska Legislature, however, even if Bellotti is not directly controlling to approve a two-parent consent/judicial bypass statute, a one-parent consent statute (such as Alaska's current statute, AS 18.16.010 et. seq.) with a judicial bypass is unquestionably constitutional. See Casey, __ U.S. at __, 112 S. Ct. at 2832. The reason that a one-parent consent provision, with an adequate judicial bypass provision, is constitutional is because (1) the state is viewed as having an important interest at stake in encouraging or requiring parental involvement in a minor's abortion decision, and (2) the consent requirement, with an alternative judicial bypass, does not place an undue burden on the woman's right to choose an abortion. See Casey, ____ U.S. at ____, 112 S. Ct. at 2832.

The United States Supreme Court, and lower federal appellate courts, have both routinely recognized that the State does have an important interest at stake in parental involvement statutes. The State's interest, in part, is insuring that someone other than the immature minor and the abortion provider has a hand in making an important decision that fundamentally affects the minor's health and welfare. The Supreme Court has recognized that "the guiding role of parents in the upbringing of their children justifies limitations on the freedom of minors. Bellotti, 443 U.S. at 637, 99 S. Ct. at 3045. The Supreme Court has described the "belief that the parental role implies a substantial measure of authority over ones children" as being "deeply rooted in our nation's history and tradition." Id. at 638, 99 S. Ct. at 3045. "Legal restrictions on minors especially those supported by the parental role, may be important to the child's chances for the full growth and maturity that make eventual participation in our free society meaningful and rewarding. Id. at 638-39, 99 S. Ct. at 3046. Parental consultation is particularly important on the abortion decision, "one that for some people raises profound moral and religious concerns." Id. at 640, 99 S. Ct. at 3047. The child herself may be too immature

to make the decision. And the abortion provider cannot be counted on to provide "adequate counsel and support . . . at an abortion clinic, where abortions for pregnant minors frequently take place." Id. at 641, 99 S. Ct. at 3047.

The remaining consideration involves a determination of what constitutes an adequate judicial bypass procedure. Bellotti establishes four criteria which must be satisfied in any judicial bypass procedure:

> 1. The procedure must allow the minor to show that she possesses the maturity and information to make her abortion decision, and in consultation with her physician, without regard to her parents' wishes;
>
> 2. The procedure must allow the minor to show that, even if she cannot make the abortion decision by herself, the desired abortion would be in her best interest;
>
> 3. The procedure must insure the minor's anonymity; and
>
> 4. The Courts must conduct a bypass procedure with expediency to allow the minor an effective opportunity to obtain an abortion.

443 U.S. at 643-44, 99 S. Ct. at 3048; accord Akron II, ___ U.S. ____, 110 S. Ct. at 2979-80.[4]

With respect to the first Bellotti requirement, the Supreme Court has ruled that every minor must have the opportunity, if she so desires, to go directly to a Court to request judicial approval of her abortion decision without first consulting or notifying her parents. If the minor satisfies the Court that she is mature and well enough informed to intelligently make the abortion decision on her own, the Court must authorize her to act without parent consultation or consent. If the minor fails to satisfy the Court that she is mature or competent enough to make the

---

[4] Justice Powell stated specifically in Bellotti that: "A pregnant minor is entitled in such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even is she is not able to make this decision independently, the desired abortion would be in her best interest. The proceeding in which this showing is made must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effect opportunity for an abortion to be obtained. In sum, the procedure must insure that the provision requiring parental consent does not in fact amount to the absolute, and possibly arbitrary, veto that was found impermissible in Danforth." 443 U.S. at 644, 99 S. Ct. at 3048.

abortion decision independently, she must be permitted to show that an abortion, nevertheless, would be in her best interest. This leads, in essence, to the second Bellotti requirement.

With respect to the second Bellotti requirement, the Supreme Court has recognized that there is an important State interest in encouraging a family rather than a judicial resolution of a minor's abortion decision. Furthermore, the Court has observed that parents naturally take an interest in the welfare of their children, an interest that is particularly strong where a normal family relationship exists and where the child is living with one or both of the parents. With respect to the second Bellotti criteria, the Court's independent determination of whether an abortion is in the best interest of the minor child regardless of her immaturity or lack of information, the Supreme Court has specifically ruled that it is proper for a Court to take into account the importance of family involvement in such an important decision for the minor. Under the second Bellotti criteria if, all things considered, the Court determines that an abortion is in the minor's best interest, she is entitled to Court authorization without any parental involvement." However, the Supreme Court has indicated that a Court may deny the abortion request of an immature minor in the absence of parental consultation if it concludes that her best interests would be served through parental consultation. It is also permissible, in such a case, for the Court to defer its decision until there is parental consultation in which the Court may participate. According to the Supreme Court in Bellotti, "this is the full extent in which parental involvement may be required." 443 U.S. at 648, 99 S. Ct. at 3051.

II. Alaska's Constitutional Right to Privacy.

In Breese v. Smith, 501 P.2d 159 (Alaska 1972), the Alaska Supreme Court stated the tests which are to be applied when a claim is made that state action encroaches upon an individual's constitution rights. In Breese, the Court had before it a "hairlength" regulation which encroached on what the Court determined to be the individual's fundamental right to determine his own personal appearance. In that case, the Court stated:

> Once a fundament right under the Constitution of Alaska has been shown to be involved and it has been further shown that this constitutionally protected right has been impaired by governmental action, then the government must come forward and meet its substantial burden of establishing that the abridgement in question was justified by a compelling government interest.

501 P.2d at 171.[5] This standard, established in Breese, is similar to the federal protection for the U.S. Constitutional Implied Right of Privacy existing prior to Casey, ____ U.S. ____ 112 S. Ct. at 2821.

---

[5] See also State v. [illegible] 516 P.2d 142 (Alaska 1973); State v. Van Dort, 502 P.2d 453 (Alaska 1972); [illegible] State, 525 P.2d 524, 527 (Alaska 1974); Gilbert v. State, 526 P.2d 1131, 1133 (Alaska 1974); State v. Adams, 522 P.2d 1125 (Alaska 1974).

In 1972, the Alaska Constitution was amended to add Article I, § 22, which states an express right of privacy to Alaska citizens. Article I, § 22 reads:

> The right of the people to privacy is recognized and shall not be infringed. The legislature shall implement this section.

In Ravin v. State, 537 P.2d 494 (Alaska 1975), the Alaska Supreme Court ruled that "[t]he effect of this amendment is to place privacy among the specifically enumerated rights in Alaska's Constitution." Accordingly, in Ravin, the Alaska Supreme Court determined that the right of privacy guaranteed by Article I, § 22 of the Alaska Constitution is a fundamental right which can only be infringed by the state upon a showing of a compelling government interest. Although in Ravin the Alaska Court determined that private marijuana use outside the home did not fall within the scope of the privacy interests protected by Article I, § 22, there is little doubt that the Alaska Supreme Court, consistent with the United States Supreme Court's decision in Roe v. Wade, would determine that the right of a woman to choose to have an abortion is a privacy right protected by Article I, § 22. As a result, there is little doubt that the Alaska Supreme Court would recognize a woman's right to choose to have an abortion as a fundamental right protected by the Alaska Constitution, principally Article I, § 22.

Since 1975, the Alaska Supreme Court has consistently ruled that the government must demonstrate a convincing and compelling interest, which the government must seek to implement through the least restrictive means available, in order to justify infringement upon the fundamental right to privacy guaranteed by Article I, § 22, of the Alaska Constitution. For example, In Matter of A.B., 791 P.2d 615 (Alaska 1990), the Alaska Court ruled as follows:

> Although neither federal nor state rights of privacy are absolute, it is part of the judicial function to insure the governmental infringements of privacy are supported by sufficient justification. Under federal precedent, it must be found that the privacy invasion is necessary to a compelling state interest, and that the government regulation does not sweep too broadly.
>
> See, e.g., Griswold, 381 U.S. at 485, 85 S. Ct. at 1682; Roe v. Wade, 410 U.S. 113, 155, 93 S. Ct. 705, 727, 35 L. Ed. 2d 147 (1973); Carey, 431 U.S. at 687, 97 S. Ct. at 2016. Under the Alaska Constitution, the required level of justification turns on the precise nature of the privacy interest involved. In absence of a suspect classification or impairment of a fundamental right, we have required that there be a fair and substantial relation between the means chosen for a legitimate governmental purpose. Issakson v. Rickey, 550 P.2d 359, 363 (Alaska 1976). Where fundamental rights are at stake, the State's interest invading privacy must be compelling. Id.. Thus, to determine the validity of the release work, we must consider both the nature and the extent of the privacy invasion, and the strength of the State interest or requiring disclosure. See

generally Falcon v. Alaska Public Offices Commission, 570 P.2d 469, 475 (Alaska 1977).

Id. at 621. Accord Luedtke v. Nabors Alaska Drilling, Inc., 768 P.2d 1123, 1129 (Alaska 1989).

Consistent with the United States Supreme Court precedent addressed above, it should be recognized by the Alaska Supreme Court that the State has a compelling interest to insure the protection of minor children in the context of their making important decisions, such as the decision to abort an unborn child. The key to guaranteeing the enforceability of a parental consent statute under Alaska's Constitutional Privacy Provision, therefore, would seem to be in drafting the parental consent provisions so as to implement the state's compelling interest in the least restrictive means possible to the minor woman's right to choose. Including within your proposed legislation, a judicial bypass procedure which is consistent with U.S. Supreme Court precedent as detailed above, would implement the State's compelling interest in the least restrictive means possible.

CONCLUSION

A one-parent consent requirement as a precondition to a minor's abortion is constitutionally permissible provided the statute contains an alternate judicial bypass procedure. To be constitutionally adequate, a judicial bypass procedure must allow the minor to obtain court approval of her abortion decision, independent of her parent's involvement, upon a showing that either (1) she is independently mature and informed enough to make her own abortion decision, or (2) that the abortion is otherwise in her best interests. The procedure must be conducted expediently and so as to preserve the minor's anonymity. Examples of statutes from other states are enclosed as is a redrafted proposed bill.

cc:Mail for: Barbara Cotting

Subject: Re: fiscal notes
From: Shari Kochman at Gov_Juneau_Capitol 02/15/1997 11:55 AM
To: Barbara Cotting at LAA_TRANS

HB 37

will request opa/pd/dhss.

you need to request courts directly from them

Reply Separator

Subject: Fiscal notes
Author: Barbara Cotting at GOV_LAA
Date: 2/15/97 11:07 AM

I need fiscal notes for a CS we just passed out of State Affairs:

CS HB 37 (STA).

The Senate Judiciary bill has 5 fiscal notes from:

Admin, Office of Public Advocacy
Admin, Public Defender Agency
DOC, Mat-Su Pre-Trial Facility
DHSS, Public Health &Soc Services
Alaska Court System, Trial Courts

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

4. *Migration*

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

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

---

[8] Stanley Henshaw suggested that there was migration to North Dakota based merely on the fact that a clinic opened up in Fargo in 1981. J.A. 99-101; Henshaw T. at 82. But he then chose to exclude North Dakota from his regional assessment of birth rates because of its parental consent law. Henshaw T. at 39-40.

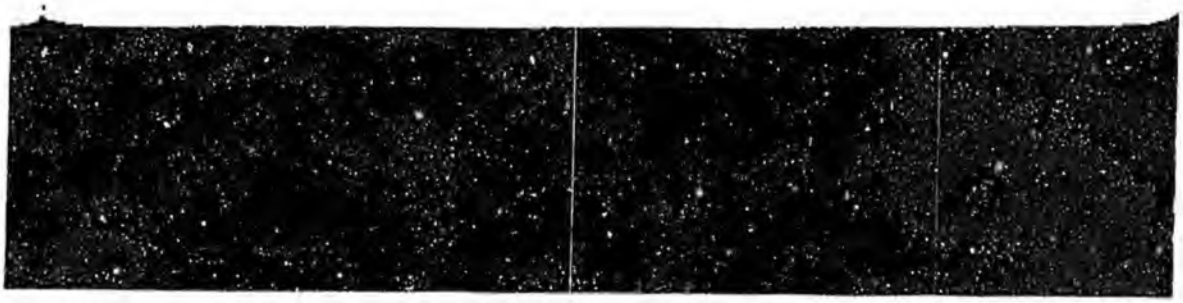
for teenagers, the solution to migration is not to abolish the public health standards of stricter states but to strengthen the standards in the more permissive states. *Cf. South Dakota v. Dole*, 107 S.Ct. 2793 (1987); 23 U.S.C. 158 (1982 ed. and Supp. III). Regardless of the Massachusetts scenario,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

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

Because raw figures do not take account of possible changes in Minnesota's population for a particular age group from year to year, rates for pregnancies, abortions, and births were also calculated based on the Department's data. Rates, in this study, equal the occurrence (incidence) of a phenomenon per 1000 females. *Cf.* T. 664-65. The numerator is the number reflecting the phenomenon for females in that age category; the denominator is the population number for females in that age category (in thousands). The data in this brief rely on the Department's data for the entire population of Minnesota, not just on a sample. Table 2 contains rates for abortion, births and pregnancy for the various age groups between 1975-1986.

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

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



Nos. 88-1125, 88-1309

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

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

v.

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

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

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

Of Counsel:
KENT MASTERSON BROWN
1114 First National Bldg.
167 West Main Street
Lexington, KY 40507
(606) 233-7879

CLARKE D. FORSYTHE *
LEANNE McCOY
AMERICANS UNITED FOR LIFE
LEGAL DEFENSE FUND (AUL)
343 S. Dearborn Street #1804
Chicago, IL 60604
(312) 786-9494
Counsel for Amicus Curiae

* Counsel of Record

October 10, 1989

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

:S—Continued

Page

ɔortion Statistics 5

serting Scientific nent and Adoles- ɔlogist 895 (June 8

American Women ı. Plan. Persp. 90 5

stics of Abortion '79-1980, 15 Fam. 5

: *Epidemiological lescent Abortion:*) (1986) 5

the Incidence of ed States, 74 Am. 7

)82-1987) 16

Done? A State by ouse Select Com- d Families, 99th 6, 7

linic Policies and nning and Abor- ersp. 284 (1980) .. 5

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

Nos. 88-1125, 88-1309

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

v.

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

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

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

INTEREST OF THE *AMICUS CURIAE* *

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

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

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

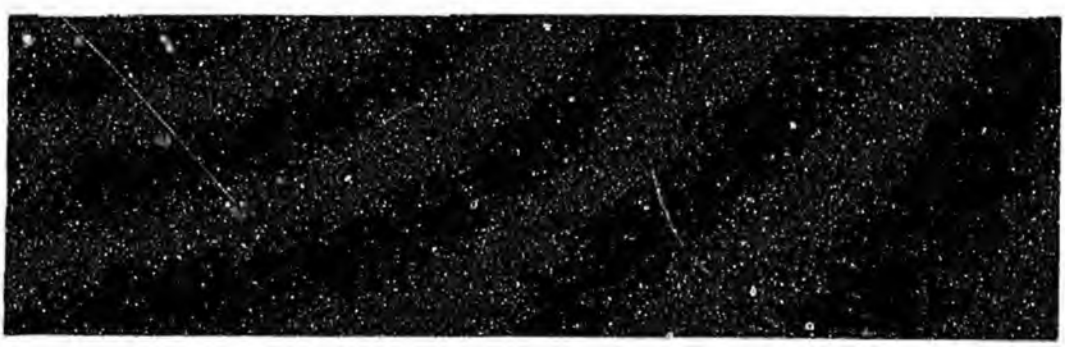
SUMMARY OF ARGUMENT

In this challenge to the Minnesota parental notice of abortion law, as applied, Minnesota abortion clinics and physicians have launched a selective attack to overturn this Court's decisions in *H.L. v. Matheson*, 450 U.S. 398 (1981), *Bellotti v. Baird*, 443 U.S. 622 (1979), and *Planned Parenthood v. Ashcroft*, 462 U.S. 476 (1983), as well as the constitutional principle that parents have fundamental rights to rear and raise their minor daughters in the area of abortion decision-making. The clinics' record in this case focuses exclusively on a minute subsection of Minnesota teens—those who sought elective abortions through judicial bypass—constituting only 25% of all pregnant teens and never more than .34% of the entire population of Minnesota teens aged 10-17. The clinics attempt to establish the unremarkable proposition that parents and teenagers do not always see eye to eye on teens' activities, that some parents may be abusive, that parents may react with grief, fear, or anger when they suddenly discover that their minor, unwed daughter is unexpectedly pregnant, and that this discovery may

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

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

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



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

ARGUMENT

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

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

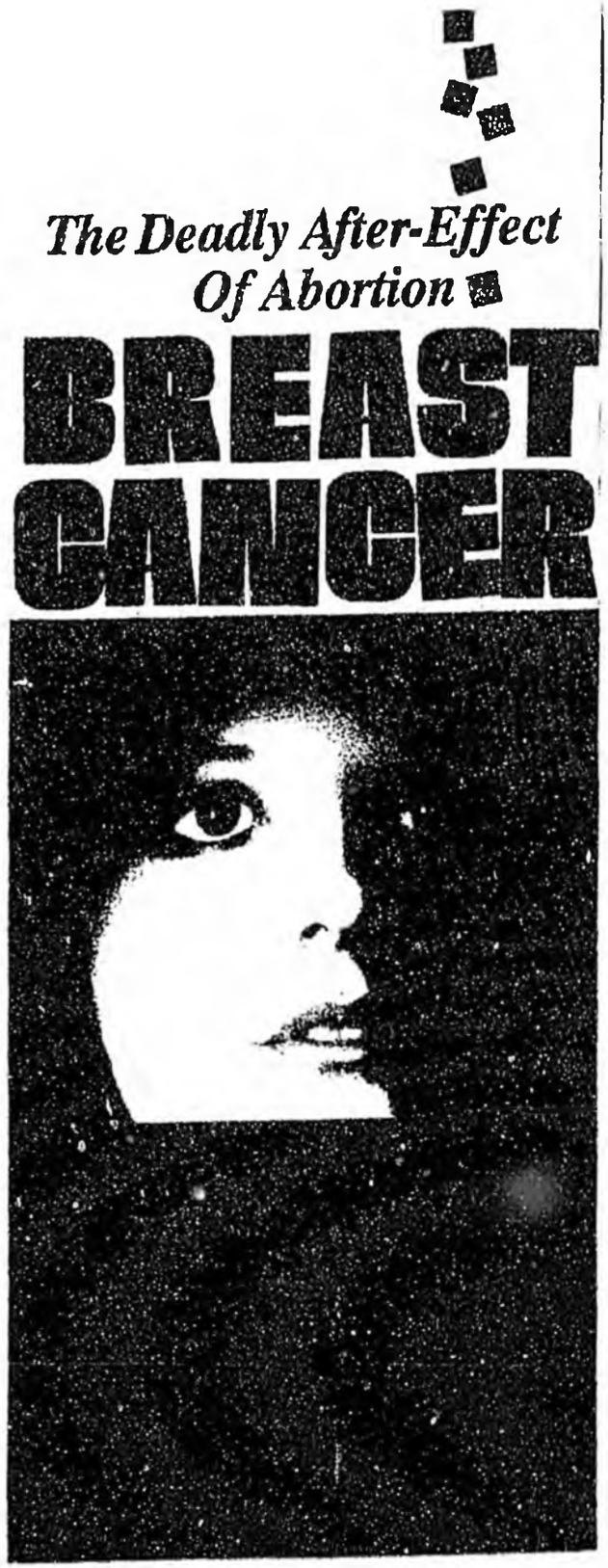
[11]B.-M.-Lindefors-Harris et al, Response Bias... abortions...two Swedish Studies, (1991) Am. J. Epidemiol. Vol 134, No 9, Pg 1003.

[12]TIME, Jan. 14, 1991

[13]JAMA, July 21, 1993

[14]N. Eng. J. Med., Jan. 1994

[15]Remennick, L. (1989) Int. J. Epidemiol.18:498-510.



Additional copies: One free with self-addressed stamped envelope; 50/$11.00 (plus post.); 100/$20.00 (plus post.); 500/$80.00 (plus post.); 1000/$150.00 (plus post.).

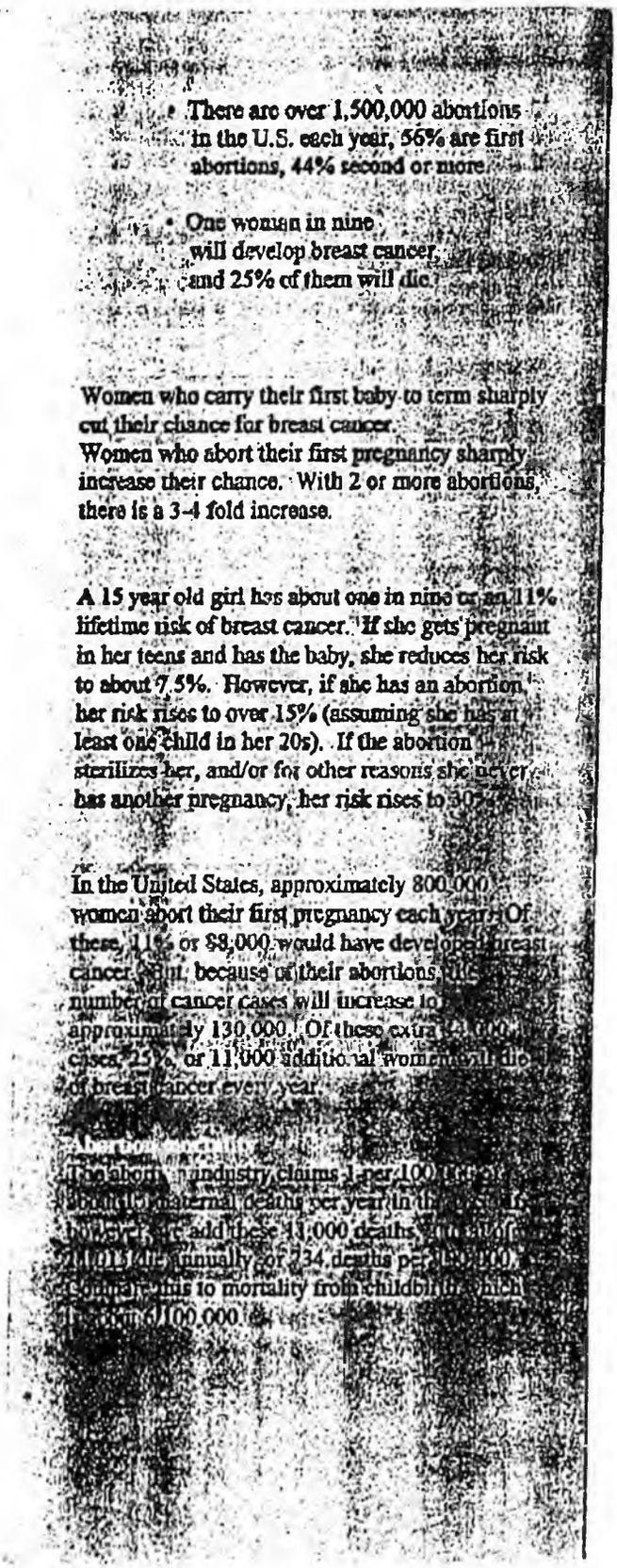
Hayes Publishing Co. Inc., 6304 Hamilton Avenue
Cincinnati, Ohio 45224
Ph: (513) 681-7559 Ph./Fax: (513) 681-9298

A first pregnancy permanently changes the structure of a woman's breasts. Before she is pregnant, her breasts cannot produce milk, as the gland cells are immature and underdeveloped. When she becomes pregnant, estrogen and other hormones flood her system. This results in rapid growth in size, while the internal structure undergoes dramatic change.

Cells, previously dormant, rapidly grow into a system of branching ducts and gland cells capable of producing milk. Once this growth, change and maturing is complete, there is no further significant change the rest of her life. Once mature, the chance of the breast developing cancer is much less.

When these cells are changing and transitional, they are less stable and have much greater potential of becoming cancerous. If she completes her first pregnancy, this unstable period passes and her gland cells mature and stabilize.

But — if she interrupts her pregnancy, in its early phase - 90% of abortions are done in the first trimester - she in effect stops the development of the cells at this unstable, transitional phase. It seems apparent that cancerous changes can and do occur more frequently among these transitional cells of a woman who has terminated her pregnancy. If she aborts more than once before completing a pregnancy, her chance for cancer increases even more. A subsequent full term pregnancy helps, but sadly never removes the sharply increased threat of cancer.



- There are over 1,500,000 abortions in the U.S. each year, 56% are first abortions, 44% second or more.
- One woman in nine will develop breast cancer, and 25% of them will die.

Women who carry their first baby to term sharply cut their chance for breast cancer.
Women who abort their first pregnancy sharply increase their chance. With 2 or more abortions, there is a 3-4 fold increase.

A 15 year old girl has about one in nine or an 11% lifetime risk of breast cancer. If she gets pregnant in her teens and has the baby, she reduces her risk to about 7.5%. However, if she has an abortion, her risk rises to over 15% (assuming she has at least one child in her 20s). If the abortion sterilizes her, and/or for other reasons she never has another pregnancy, her risk rises to 30%.

In the United States, approximately 800,000 women abort their first pregnancy each year. Of these, 11% or 88,000 would have developed breast cancer. But, because of their abortions, the number of cancer cases will increase to approximately 130,000. Of these extra 42,000 cases, 25%, or 11,000 additional women will die of breast cancer every year.

The abortion industry claims 1 per 100,000 abortion maternal deaths per year in the U.S. ... add these 11,000 deaths ... annually for 234 deaths per 100,000 ... annually ... to mortality from childbirth which ... 6/100,000 ...

Is Breast Cancer Increasing?
Yes, in 1962 there were 63,000 cases
in 1972 there were 90,000 cases
in 1982 there were 120,000 cases
in 1992 there were 180,000 cases

What increases a woman's risk?
Breast Cancer in close relatives; never having a baby; early onset and late cessation of menstruation; possessing certain genes; and induced abortion of first pregnancy are major risk factors.
Smoking, toxic chemicals, high fat diet, contraceptives and other drugs, alcohol, and electromagnetic fields are among other suspected risk factors.

What protects her?
Completing her first pregnancy by her early 20s. We must also counsel her to not abort her first pregnancy. A spontaneous miscarriage does not increase her risk.[1]

When was this first suspected?
Dr. M. Pike[2] at University of Southern California in 1981 did the first major study. He showed that aborting her first pregnancy increased her chance of developing Breast Cancer by a factor of 2.4 times.

There were other studies?
Yes. Dr. H. Howe[3], using New York State official Health Department records, found that aborting her first pregnancy had a 1.7 times increased risk of Breast Cancer under age 40. If she also aborted her 2nd or/and 3rd pregnancy, her risk was 4.0.

Dr. Janet Daling's[4] study in 1994 received worldwide publicity. She found:

- An induced abortion increased the risk of Breast Cancer before age 45 by 50%.
- If done before 18 years, it increased by 150%.
- If done after 30 years, it increased by 110%.
- If she had a family member with Breast Cancer and aborted after 30 years, her risk increased by 270%.
- All 12 women in the study, with such a family member who aborted before age 18, got Breast Cancer before age 45.

In Greece:[5] An overall increased risk of 51% was reported in 1995.

New scientific evidence shows that the increase in abortions worldwide has caused a sharp increase in breast cancer.
Over twenty studies indicate that women who abort their first pregnancy have a much higher risk of developing cancer.

In Paris:[6] Having at least two abortions is associated with an increased Breast Cancer risk of 2.1 times.

In USA:[7] An increased risk of 23% was shown. For those over 60 years the risk was 80%.

How about recurrences?
In 1983 H. Ownby[8] found among Breast Cancer patients whose disease had been in remission, a:
10% recurrence in women whose first pregnancy went to term.
20% recurrence in women whose first pregnancy was aborted.
30% recurrence in women who also aborted their second and/or third pregnancy.

And aggressiveness of the cancer?
Dr. H. Olsson[9] found, if she had aborted her first pregnancy, that the cancer was more aggressive, metastasized earlier and was lethal more quickly as compared to women who had completed their first pregnancy.

What about studies showing no risk?
With few exceptions these were flawed by: inappropriately crude age matching or adjusting of controls (the main problem); interpreting as statistically insignificant some retrospective case controls with low statistical power; minimizing the actual results obtained in their conclusions; and attributing results to patient's "recall bias" even though a close exam refutes such a claim.[10]
The Swedish Lindford Harris Study[11] is an example of an invalid study. It claimed "no overall risk after abortion in the first three months" — but it:

- combined those who aborted their first pregnancy with those who completed their first pregnancy.
- had no control group. It compared with the total population which includes those who aborted.
- claimed "recall bias" with no proof.

In its conclusion it did not mention that in its findings it showed that:

- Women, aborted after a term delivery, equaled 58% of average risk.
- Women, aborted before a term delivery equaled 109% of average risk.

What about Contraceptive Pills?
If a causative factor, the risk is greater if taken before age 20 and/or for 10 years or more.

Why is this not reported?
TIME[12] Magazine and both the AMA[13] and New England Journals[14], in reviewing pre-disposing factors, did not include abortion. Dr. Remennick[15] concluded "an initial attitude of researchers toward abortion usually determines the way they interpret results."

How many studies are there in the Medical Literature?
There are now over 50, and the vast majority of well done professional studies continue to point to a positive correlation between abortion and breast cancer

J.C. WILLKE, M.D.

FOOTNOTES

[1]MacMahon, B, et al (1970) Bull. Wld. Hlth. Org. 43:209-21.

[2]Pike MC, (1981) Brit. J. Cancer. 43:72-6.

[3]Howe HL (1989) Int. J. Epidemiol. 18:300-4

[4]Daling, J. et al, Risk of Br. Ca. Among Young Women, J. Nat Ca. Inst., Vol.86, No.21, Nov 2,'94, Pg. 1584.

[5]Lipworth, L, (April 1995) Int. J. Cancer.

[6]Andrieu, N. Role of Genetic and Repro.Factors (1994)

[7]Newcomb, P. et al,(1996) Preg.Termin. & Risk of Br. Ca. JAMA, Vol. 275, No. 4, Pg. 283.

[8]Ownby, H., Interrupted Preg...Poor Prognosis...in Br. Ca. (1983) Br. Ca. Res. Treat 3:339-344.

[9]Olsson, H. et al. (1991) Cancer 67:1285-90.

[10]Brind, Joel, Baruch College, numerous articles Natl. Right to Life News

AUL FAXLINE

TALKING POINTS re: the Danish abortion study by Melbye et al., published in the 1/9/97 New England Journal of Medicine (NEJM)

1. Study's enormity is exaggerated: Database is highly skewed

—Of the 1.5 million women studied, 1.2 million neither have had exposure to induced abortion nor have developed breast cancer.

—Of the 281,000 women who had induced abortions, most are too young to have developed breast cancer (Some are still teenagers).

—Of the 10,000 women who developed breast cancer, most are too old to have their abortion histories on record, since the abortion registry only goes back to 1973 (when the oldest women were 38).

—Of the 1338 women who had abortions and did develop breast cancer, over 81% had abortions recorded only at age 30 or over; 54% at age 35 or over.

2. Important data are omitted or de-emphasized

—Among the women who had abortions as teenagers the study actually found essentially the same increased risk (29%) as had been reported in Brind et al.'s Comprehensive Review and Meta-analysis of 23 worldwide studies (a statistically significant 30% overall elevated risk), published last October. However, Melbye et al.'s finding is not statistically significant, because their statistical power is too low.

—The Melbye study actually found a statistically significant trend of a 3% risk increase for each week of gestation before abortion, even within the first trimester: Women who had an abortion of an 11-12 week fetus showed a 12% higher breast cancer risk, with the risk increase rising to 89% for abortions after 18 weeks (but it wasn't in the study's "Conclusions").

—Much data was missing from the paper: No information was given on the independent effect of other variables that influence breast cancer risk, and we are shown only relative risk data after adjustment for these variables. Somehow, an unadjusted overall relative risk of 1.44 is adjusted down to 1.00.

3. Previous studies are attacked or misrepresented

—Melbye et al. attacked the validity of the meta-analysis and all case-control (interview-based data) on the basis of alleged response-bias, citing a 1991 Swedish study. However, the only significant evidence of response bias depends on the assumption that 7 Swedish breast cancer patients reported abortions that never took place (alleged "overreporting"). Response bias is the "Loch Ness Monster" of abortion-breast cancer research: No credible evidence of it has yet been produced.

—4 previous cohort studies are cited as reporting similar findings of no increased risk with induced abortion. But 2 of the studies are exclusively on spontaneous abortion (miscarriage), and one is mostly on spontaneous abortion and does not report any specific data on induced abortion.

AMERICANS UNITED FOR LIFE
343 S. Dearborn, Suite 1804
Chicago, IL 60604-3815
312. 786-9494
312. 786-8151, fax

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

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

Myth 1

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

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

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

Fact

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

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

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

Myth 2

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

Fact

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

Myth 3

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

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

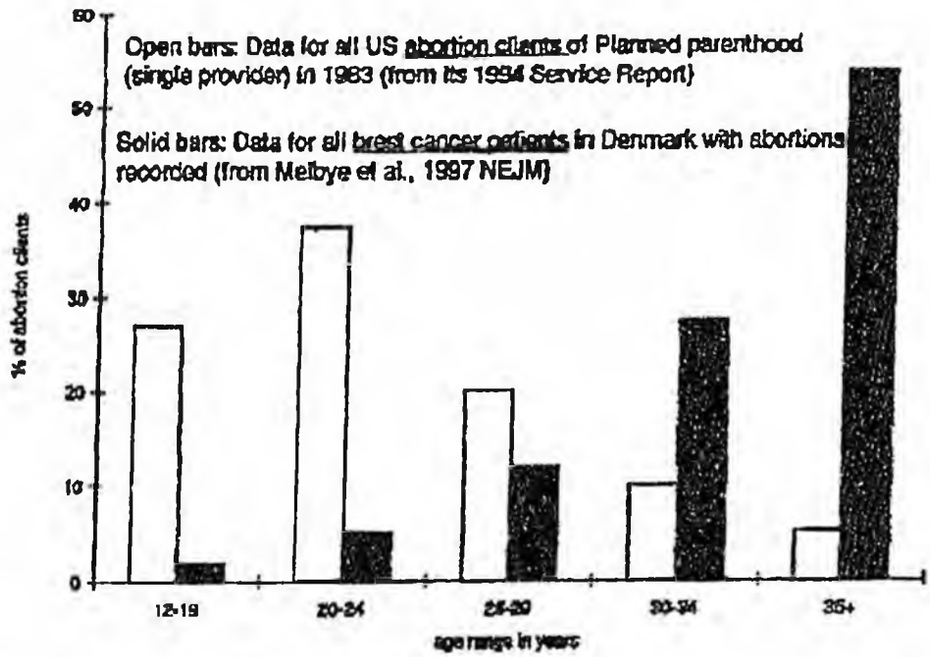
terminated pregnancies. By comparison, large case-control studies in the United States each have included 200 to 300 cases of breast cancer in women who had abortions."

Fact

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

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

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



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

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

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

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

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

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

Myth 4

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

Fact

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

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

Myth 5

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

Fact

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

Myth 6 (The "Loch Ness Monster")

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

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

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

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

Fact

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

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

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

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

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

Myth 7

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

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

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

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

Concluding Remarks

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

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

Finally, it must be acknowledged that computerized cohort data are generally of better quality than interview-based data, all other things being equal. The difficulty with computerized data on the risk of a disease like breast cancer is that it takes years—perhaps 5 to 50 years— for cancer to show up in exposed women. And abortion registries are not generally that old. Computerized registry data are most useful when the outcome in question does not require such a long follow up period. A perfect example is a 1996 study using the Finnish abortion registry. In this British Medical Journal paper, Dr. Mika Gissler et al. found a very reliable, almost sixfold (488%) increase in the rate of suicide by women who had had an induced abortion in the previous year, compared to women who had a baby.

CHAPTER 21

MATERNAL DEATHS AND LONG TERM COMPLICATIONS

— ABORTION – CHILDBIRTH —

It is claimed by abortion proponents that abortion is safer than childbirth. They claim 1 death per 100,000 abortions compared to 10 deaths per 100,000 deliveries . . .

Not True

What is the maternal mortality from childbirth?

Reported average maternal mortality 1979 through 1986 was 9.1 per 100,000 deliveries, having declined from 11 to 7.4.

Morbidity & Mortality Report, July 1991, Cent. Dis. Cont., Vol. 40, No. 55-1

If all causes of maternal death, other than those associated with live birth i.e., abortion, tubal pregnancy, molar pregnancy, etc., were excluded. . . . "the maternal mortality for 1985 would be 4.7 deaths per 100,000 live births."

"Induced Termination of Preg . . . ," Council on Scientific Affairs, AMA; *JAMA*, Dec. 9, '92, Vol. 268, No. 22, p. 3231

And the rate has dropped further since the above, but the U.S. Center for Disease Control (see Chapter 17) does not break down their figures. It continues to report a figure for "maternal mortality" that includes abortion and other deaths.

But some mothers do die?

In developed nations, almost never. The National Maternity Hospital in Dublin, Ireland, receives many complicated cases from around that nation and delivers 10% of all births in Ireland. In 10 years (1970-79) it delivered 74,317 births at more than 28 weeks gestation with only one woman dying from a cause related to her pregnancy.

J. Murphy et al., Therapeutic Ab.. The Medical Argument, *Irish Med. J.*, Aug. '82, Vol. 75, No. 8

Ed. note: And this report was from two decades ago. Since then medical care has improved substantially.

Abortion Deaths

These have been grossly under-reported. The exposé on this is detailed in *Lime 5* published by Life Dynamics. The author and his staff have verified 23 deaths from induced abortion in 1992-93. All were reported to state agencies. There is documentation from state health departments that 18 were reported to the Federal Center for Disease Control. However, the official report of the CDC listed only 2 deaths.

"At Life Dynamics we knew abortion complications were grotesquely under-reported, but attributed it to garden-variety bureaucratic incompetence." But after continuing research, they documented "that the flawed abortion data from the CDC was not from ineptitude but of dishonesty and manipulation" after finding that "a large percentage of CDC employees had direct ties to the abortion industry," they retitled the CDC to stand for "Center for Damage Control" — "The CDC doesn't oversee abortion, it justifies it."

M. Crutcher, *Lime 5-Exploited by Choice*, Genesis Pub., Chapter 4, "Cooking the Books," p. 135.

The claim that relevant statistics can be collected from the place where the abortion was performed "is little short of science fiction."

"Complications following abortions performed in free-standing clinics is one of the most frequent gynecologic emergencies . . . encountered. Even life-endangering complications rarely come to the attention of the physician who performed the abortion unless the incident entails litigation. The statistics presented by Cates represent substantial under- reporting and disregard women's reluctance to return to a clinic, where, in their mind, they received inadequate treatment."

L. Iffy, "Second Trimester Abortions," *JAMA*, vol. 249, no. 5, Feb. 4, 1983, p. 588.

What can cause her death?

The main causes are infection, hemorrhage and uterine perforation.

How often do women get infection as a consequence of induced abortion?

A study from one of the most prestigious medical centers in the world, John Hopkins University, reported:

"Occurrence of genital tract infection following elective abortion is a well-known complication." This institution reports rates up to 5.2% for first trimester abortions and up to 18.5% in midtrimester.

Burkman et al., "Culture and Treatment Results in Endometritis Following Elective Abortion," *Amer. Journ. OB/GYN*, vol. 128, no. 5, 1977, pp. 556-559.

For the local freestanding abortion facility in your

community, with far inferior quality of care, the number of such infections will be at least double that of such a medical center.

"One sequel to abortion can be a killer. This is pelvic abscess, almost always from a perforation of the uterus and sometimes also of the bowel," said two professors from UCLA, in reporting on four such cases.

C. Gassner & C. Ballard, Amer. Jour. *OB/GYN*, vol. 48, p. 716 as reported in *Emerg. Med. After Abortion-Abscess*, vol. 19, no. 4, Apr. 1977

In an underdeveloped country, complications are more frequent and treatment is usually less available and effective.

Can infection cause damage?

Infection in the womb and tubes often does permanent damage. The Fallopian tube is a fragile organ, a very tiny bore tube. If infection injures it, it often seals shut. The typical infection involving these organs is pelvic inflammatory disease (PID).

Patients with Chlamydia Trachomatous infection of the cervix (13% in this series) who get induced abortion "run a 23% risk of developing PID."

B. Quigstad et al., *British Jour of Venereal Disease*, June 1982, p. 11[illegible]

"Pelvic Inflammatory Disease (PID) is difficult to manage and often leads to infertility, even with prompt treatment . . . Approximately 10% of women will develop tubal adhesions leading to infertility after one episode of PID, 30% after two episodes, and more than 60% after three episodes."

M. Spence, "PID: Detection & Treatment," *Sexually Transmitted Disease Bulletin*, John Hopkins Univ., vol. 3, no. 1, [illegible]

"Acute inflammatory conditions occur in 5% of [illegible] cases, whereas permanent complications such [illegible]

chronic inflammatory conditions of the female organs, sterility, and ectopic [tubal] pregnancies are registered in 20-30% of all women . . . these are definitely higher in primigravidas [aborted for first pregnancy]."

A. Kodasek, "Artificial Termination of Pregnancy in Czechoslovakia," *Internat'l Jour. GYNAOB*, vol. 9, no. 3, 1971

Venereal disease, usually Gonorrhea or Chlamydia, causes PID. This, if present, vastly complicates an induced abortion.

"Chlamydia trachomatous was cultured from the cervix in 70 of 557 women admitted for therapeutic abortion. Among the 70, 22 developed acute PID postoperatively (4% of the total)."

E. Quigstad et al., "PID Associated with C. Trachomatous Infection, A Prospective Study," *British Jour of Venereal Disease*, vol. 59, no. 3, 1982, pp. 189-192

Another study revealed a 17% incidence of post-abortal Chlamydia infection.

Barbacel et al., "Post Abortal Endometritis and Chlamydia," *OB & GYN*, 68:686, 1986.

In a classic English study at a university hospital which reported on four years' experience, "there was a 27% complication rate from infection."

J.A. Stallworthy et al., "Legal Abortion: A Critical Assessment of Its Risks," *The Lancet*, Dec. 4, 1971

What of bleeding?

Bleeding is common. Most get by, but some need blood transfusions. The Stallworthy study (above) reported that 9.5% needed transfusions. Most recent studies are reporting smaller percentages.

Are blood transfusions a cause of death in abortions?

Yes, and these deaths are never associated directly nor reported as statistics related to abortions. Here is

how this works:

First, we must know how many women need blood transfusions after getting induced abortions. These figures are hard to come by. The only controlled studies are from university medical centers, which do only a small fraction of all abortions. Over 90% of abortions in the U.S. and varying percentages in other nations are done in free-standing abortion chambers where the medical care is only a faint shadow of the competence of those medical centers. Women who hemorrhage from these abortions are sent to "real" hospitals for transfusions and surgery. The percentage who need transfusions then must remain an estimate as these commercial establishments do not report this

How many then? Let's be conservative and say that one in every hundred needs a blood transfusion. If there are 1,600,000 abortions annually in the United States, this means that 1% or 16,000 women were transfused.

Viral hepatitis is transmitted in up to 10% of patients transfused. Ten percent of 16,000 is 1,600 women.

Amer. Assn. Blood Banks and Amer. Red Cross Circular Information, 1984, p. 6

An analysis of 300,000 cases of Hepatitis virus infection showed that deaths occurred from three causes: 322 from acute disease, 5100 from cirrhosis, and 1200 from liver cancer. This mortality rate is over 2%.

R. Voelker, Hepatitis B: Planned Standard, AMA Med. News, Oct. 13, '89, p.

Two percent of 1600 women means that ultimately deaths result annually from abortions for this reason.

AIDS is another threat. Two percent of AIDS has been acquired by blood transfusions. With recent careful screening techniques, this is now much less. Even so, 200-400 people in developed countries, per year are still being exposed via blood transfusions.

Noyes, "Transfusions Risk Despite Screening," *Family Practice News*, May 15, 1987.

In underdeveloped nations the AIDs threat ranges from seldom to common.

Are blood clots ever a problem?

Blood clots are one of the causes of death to mothers who deliver babies normally. They are also a cause of death in healthy young women who have abortions performed.

Embolism (floating objects in the blood that go to the lungs) is another problem. Childbirth is a normal process, and the body is well prepared for the birth of the child and the separation and expulsion of the placenta. Surgical abortion is an abnormal process, and slices the unripe placenta from the wall of the uterus into which its roots have grown. This sometimes causes the fluid around the baby, or other pieces of tissue or blood clots, to be forced into the mother's circulation. These then travel to her lungs, causing damage and occasional death. This is also a major cause of maternal deaths from the salt poisoning method of abortion.

For instance, pulmonary thromboembolism (blood clots to the lungs) was the cause of eight mothers dying from abortions, as reported to the U.S. Center for Disease Control.

W. Cates et al., *Amer. Jour. OB/GYN*, vol. 132, p. 169

And this can occur in those as young as 14 years old.

Pediatrics, vol. 68, no. 4, Oct. 1971

Also, amniotic fluid embolism has "emerged as an important cause of death from legally induced abortion." Of 15 cases, the risk seems to be greater after three months. Treatment is ineffective."

R. Gaidotti et al., Amer. Jour. OB/GYN, vol. 41, 1981, p. 257

And has an 80% mortality rate.

S. Clark, Amniotic Fluid Embolism, the Female Patient, vol. 14, Aug. '89, p. 50

What is Disseminated Intravascular Coagulation?

This is a sudden drop in blood clotting ability which causes extensive internal bleeding and sometimes death. The classic paper was on hypertonic saline (salt poisoning) abortions (see reference below).

H. Glueck et al., "Hypertonic Saline Abortion, Correlation with D.I.C.," *JAMA*, vol. 225, no. 1, July 2, 1973, pp. 28-29

"Saline-induced abortion is now the first or second most common cause of obstetric hypofibrinogenemia." [Same as D.I.C. above].

L. Talbert, Univ. of NC. "DIC More Common Threat with Use of Saline Abortion." *Family Practice News*, vol. 5, no. 19, Oct. 1975

In recent years this method has been seldom used. However, D.I.C. has also been caused by D&E and Prostaglandin abortions.

White et al., "D.I.C. Following Three Mid-Trimester Abortions," *Anaesthesiology*, vol. 58, 1983, pp. 99-100

Apart from deliberate mis-reporting to mask abortion death, are there others innocently missed?

Yes. For instance:

- Consider the mother who hemorrhaged, was transfused, got hepatitis, and died months later. Official cause of death, Hepatitis. Actual cause, abortion.
- A perforated uterus leads to pelvic abscess, septicemia (blood poisoning), and death. The official report of the cause of death may list pelvic abscess and septicemia. Abortion will not be listed.
- Abortion causes tubal pathology. She has an ectopic pregnancy years later and dies. The cause listed will be ectopic pregnancy. The actual cause, abortion.

- Deep depression and guilt following an abortion leads to suicide. The cause listed, suicide! Actual cause, abortion.

But many are mis-reported on the original death certificate and are not quite innocent.

- The kindhearted surgeon, unable to save the life of an abortion victim, feels that she and her family have been punished enough. He doesn't want to ruin her and her family's reputation in the community — so he forgets to mention abortion on the death certificate.
- If the abortionist does the follow-up care and the patient dies from the abortion, the abortionist doesn't want the reputation of being a butcher, so another cause is listed.
- Usually, however, a different doctor sees a patient who dies from the damage done from an abortion, but she and her family hotly deny the abortion. The abortion connection cannot be absolutely proven, and the new doctor fears a suit for malpractice or for defamation of character, and so he lists another cause.

You mean all maternal deaths from abortion are not reported?

That's exactly correct. The official reporting agency for the U.S. government is the Center for Disease Control in Atlanta, Georgia. Listen to this:

During the two-year stretch of 1991 and '92, the CDC officially reported only one mother each year dying from induced abortion. In fact, there are 20 documented deaths. Of these, 14 were reported directly to the CDC from state health agencies. The CDC only listed two of them. Mr. Crutcher's book, *Lime 5*, which accuses this agency of gross dishonesty and malfeasance in its reporting, is extremely convincing.

M. Crutcher, Life Dynamics, personal communication, July '90

Even so, the situation today is better than the "5,000 to 10,000 women who died annually in the U.S.A. from back-alley abortions," isn't it?

These figures, often cited by pro-abortionists, are simply false. During the debate on the floor of the U.S. Senate on the Hatch-Eagleton Pro-Life Amendment in 1983, the U.S. Bureau of Vital Statistics provided the data on such deaths.

Its reports showed that you must go back to the pre-Penicillin era to find more than 1,000 maternal deaths per year from illegal and legal abortions combined. The precipitous drop in maternal deaths in the 1950s and '60s occurred while abortions were still illegal. Before the first state legalized abortions in 1966, the total deaths were down to 120 per year. By 1972, before the Supreme Court legalized abortion in all 50 states, it was down to 39 per year in the entire U.S. Since legalization, the slow decline has continued, so that now the only difference is that more mothers are dying from legal, rather than illegal abortions.

U.S. BUREAU OF VITAL STATISTICS
CENTER FOR DISEASE CONTROL

YEAR	Reported Maternal Deaths from Illegal Abortion in U.S.
1940	1,679
1950	316
1960	289
1966	120 First State Legalized in 1967
1970	128
1972	39 Supreme Court Decision in 1973
1977	21
1981	8

Taken from U.S. Senate

What of pregnancy and abortion in teenagers?

Early on, it was thought that pregnancy in young teenagers was more risky than in older women. But recent studies have shown that teenage mothers have no more risks during pregnancy and labor, and their babies fare just as well as their more mature sisters' babies, if they have had good prenatal care.

"We have found that teenage mothers, given proper care, have the least complications in childbirth. The younger the mother, the better the birth. If there are more problems, society makes it so, not biology."

B. Sutton-Smith, *Jour. of Youth and Adolescence*
As reported in the *New York Times*, April 24, 1979

"No relationship between mother's physical growth and maturation and adverse pregnancy course or outcome was demonstrated.

Sukanich et al., "Physical Maturity and Pregnancy Outcome Under 16 Years," *Pediatrics*, vol. 78, no. 1, July 1986, p. 31

Dr. Jerome Johnson of John Hopkins University, and Dr. Felix Heald, Professor of Pediatrics, University of Maryland, agree that the fact that teenage mothers often have low birth weight babies is not due to "a pregnant teen-ager's biologic destiny." They pointed to the fact that the cause for this almost invariably is due to the lack of adequate prenatal care. "With optimal care, the outcome of an adolescent pregnancy can be as successful as the outcome of a non-adolescent pregnancy."

Family Practice News, Dec. 15, 1975

"The overall incidence of pregnancy complications among adolescents 16 years and younger is similar to that reported for older women."

E. Hopkins, "Pregnancy Complications Not Higher in Teens," *OB-GYN News*, vol. 15, no. 10, May 1980

"Obstetric and neonatal risks for teenagers over 15

are no greater than for women in their twenties, provided they receive adequate care."

There is evidence that in 15- to 17-year old women, pregnancy may even be healthier than in older ages.

E. McAnarney, "Pregnancy May Be Safer," *OB-GYN News*, Jan. 1978

Pediatrics, vol. 6, no. 2, Feb. 1978, pp. 199-205

F. Avey, Canada Col. Family Physicians, "Pregnant Teens . . ." *Family Practice News*, Jan. 15, 1987, p. 14

But the abortion picture is different, particularly in regard to cervical damage.

After years of legalized abortion experience, a pro-abortion professor of OB/GYN at the University of Newcastle-on-Tyne reported on his follow-up, ranging from two to twelve years, of 50 teenage mothers who had been aborted by him. He noted that "the cervix of the young teenager, pregnant for the first time, is invariably small and tightly closed and especially liable to damage on dilatation." He reported on the "rather dismal" results of their 53 subsequent pregnancies:

Six had another induced abortion.
Nineteen had spontaneous miscarriages.
One delivered a stillborn baby at 6 months.
Six babies died between birth and 2 years.
Twenty-one babies survived

J. Russell, "Sexual Activity and Its Consequences in the Teenager," *Clinics in OB, GYN*, vol. 1, no. 3, Dec. 1974, pp. 683-[illegible]

"Physical and emotional damage from abortion is greater in a young girl. Adolescent abortion candidates differ from their sexually mature counterparts; these differences contribute to high morbidity." They have immature cervixes and "run the risk of a difficult, potentially traumatic dilatation." The use of laminaria "in no way mitigates our present concern over the problems of abortion."

C. Cowell, *Problems of Adolescent Abortion*, Ortho Panel 14, Toronto General Hospital

"The younger the patient, the greater the gestation (age of the unborn), the higher the complication rate. . . . Some of the most catastrophic complications occur in teenagers."

"Eighty-seven percent (87%) of 486 obstetricians and gynecologists had to hospitalize at least one patient this year due to complications of legal abortions."

M. Bulfin, M.D., *OB-GYN Observer*, Oct.-Nov. 1975

Abortions May Be Legal But They Are Not Always Safe

Editorials

Abortion, Breast Cancer, and Epidemiology

In this issue of the *Journal*,[1] Melbye et al. present substantial epidemiologic evidence that induced abortions do not affect a woman's risk of having breast cancer. In a linkage study, they compared the abortion histories of women with and without breast cancer in Denmark. The use of data on abortion obtained from population registries rather than from interviews, the large size of the study, the inclusion of one country's entire population of women, and the adjustment for other aspects of reproductive history all strengthen the credibility of the findings. The study thus provides important new evidence to resolve a controversy that previous investigations have been unable to settle.

By relying on uniformly collected data on abortion in Danish registries, Melbye et al. avoided the major problem that has plagued case-control interview studies: differential reporting of abortions. For many issues, interviews of women with breast cancer (as case patients) and women from the same population (as controls) provide valid information, but they founder if the patients with breast cancer are either more or less likely than other women to recall or report their history accurately.

Induced abortion, even when legal, is an emotional and private matter and is often not reported in interviews.[2] Women whose recent diagnosis of breast cancer moves them to cooperate with researchers are more likely to report their abortions.[3] Thus, when several case-control studies based on interviews[4-6] reported a slightly elevated risk overall or in a subgroup of women, the interpretation was clouded by the unknown extent of the bias. For instance, in a case-control study involving personal interviews that was conducted in Seattle,[4] the investigators estimated an overall increase in risk of 50 percent. They judged that false reports of not having had an abortion could have inflated the estimate by 16 percent at most, but their estimate of the bias was arguably too low, since half of all abortions were denied in earlier U.S. surveys. In a later study, the investigators reported no overall difference in risk but noted a slightly higher risk among nulliparous women.[5]

In a study using telephone interviews,[6] the authors concluded that much if not all of an apparent 23 percent increase in risk could be attributed to inaccurate reports of the history of abortion. In a recent Dutch study, only 1 of 230 women in the control group from the heavily Roman Catholic region of the country reported having had an abortion, and the resulting apparent risk was very large.[7] The investigators doubted the validity of the association, however, since none appeared in the other region and since a comparison of prescriptions for oral contraceptives and interviews showed that control-group women in the Roman Catholic region were especially prone to understate their use of oral contraceptives.

With low estimated risks and a potentially large bias, it is ultimately impossible to tell how far off the mark these case-control interview studies could be. Meta-analysis of multiple case-control interview studies offers no insights into this critical issue, only adding apparent precision to an estimate that is systematically erroneous by an unknown amount. In short, record-based studies like the one by Melbye et al. are necessary.

The Danish study included data on the key reproductive factors that affect the risk of breast cancer and that may differ between women who have had abortions and other women. In this way, the potential effects of abortion could be distinguished from related reproductive characteristics, such as older age at the time of the first full-term pregnancy. One drawback of the study was that it lacked data on nonreproductive risk factors for breast cancer that could differ according to abortion history. Could such confounding have obscured a real overall association? If the women who had abortions had substantially fewer family members with breast cancer, were much older at menarche, or had other unmeasured characteristics that lowered their expected risk of breast cancer, some degree of risk associated with abortion could have been missed. Such a characterization could apply to small subgroups, but it seems unlikely that it would apply to all 18 percent of the women in the Danish cohort who had had an abortion.

The large size of the new study is also an advantage. It yields a very stable estimate of overall risk, and it provides information on specific risks according to when in the woman's life the abortion occurred. In this cohort of 1.5 million women, 1338 cases of breast cancer were diagnosed in women who had terminated pregnancies. By comparison, large case-control studies in the United States each have included 200 to 300 cases of breast cancer in women who had abortions. Among the women who had abortions, those who later had full-term pregnancies and those who never gave birth had the same risks as women in the corresponding groups who had not had abortions. Similarly, having had more than one abortion did not appear to alter the risk.

Even though the risk of breast cancer was unrelated to abortion overall, the length of gestation when the abortion was performed differed between the women with breast cancer and the controls. The overwhelming majority of the abortions in the Danish study took place at 7 to 14 weeks of gestation, as in the United States today, but the study included

a small number of women who had terminated their pregnancies in the fifth month or later and a small number who had abortions very early, at less than 7 weeks. Among the women with late terminations, there were 14 cancers — almost twice as many as expected. Slightly fewer cancers than expected were diagnosed in women whose abortions took place before seven weeks of gestation.

With such small numbers, a chance association is possible, but one also may wonder what else distinguishes women who have very late or very early abortions. Their diet, alcohol consumption, or social class may be different from that of other women. The overall trend toward a slightly decreased risk in association with very early abortion and an increased risk in association with late abortion could be the result of cause, chance, or confounding (that is, correlation with an unmeasured risk factor). Only epidemiologic studies that include both large numbers of women who have had these unusual abortions and detailed information about nonreproductive risk factors are likely to reveal which explanation is correct.

In short, a woman need not worry about the risk of breast cancer when facing the difficult decision of whether to terminate a pregnancy. For the scientist trying to elucidate how pregnancy sometimes impedes and sometimes enhances one or more steps in breast carcinogenesis, puzzles remain, and this large study highlights some of them. The possibility of an increased risk with very late abortion, a decreased risk with very early abortion, or both must be seen as one of those puzzles. Neither the clear central finding that there is no overall risk nor the unresolved peripheral issues ought to influence the continuing public debate about abortion itself — a debate that is ethical and political in its essence.

PATRICIA HARTGE, Sc.D.
National Cancer Institute
Bethesda, MD 20892

REFERENCES

1. Melbye M, Wohlfahrt J, Olsen JH, et al. Induced abortion and the risk of breast cancer. N Engl J Med 1997;336:81-5.
2. Jones EF, Forrest JD. Underreporting of abortion in surveys of U.S. women: 1976 to 1988. Demography 1992;29:113-26.
3. Lindefors-Harris BM, Eklund G, Adami HO, Meirik O. Response bias in a case-control study: analysis utilizing comparative data concerning legal abortions from two independent Swedish studies. Am J Epidemiol 1991; 134:1003-8.
4. Daling JR, Malone KE, Voigt LF, White E, Weiss NS. Risk of breast cancer among young women: relationship to induced abortion. J Natl Cancer Inst 1994;86:1584-92.
5. Daling JR, Brinton LA, Voigt LF, et al. Risk of breast cancer among white women following induced abortion. Am J Epidemiol 1996;144:373-80.
6. Newcomb PA, Storer BE, Longnecker MP, Mittendorf R, Greenberg ER, Willett WC. Pregnancy termination in relation to risk of breast cancer. JAMA 1996;275:283-7.
7. Rookus MA, vanLeeuwen FE. Induced abortion and risk of breast cancer: reporting (recall) bias in a Dutch case-control study. J Natl Cancer Inst 1996;88:1759-64.

A MALARIA VACCINE BASED ON A SPOROZOITE ANTIGEN

MALARIA was eliminated from many temperate-zone countries in the 1940s, and in the next decade its prevalence was drastically reduced in several tropical countries. However, in recent years, this infection has undergone a resurgence in most tropical regions. Currently, malaria occurs in over 90 countries, and according to World Health Organization estimates, it causes up to 500 million clinical cases and 2.7 million deaths per year. *Plasmodium falciparum* is the most prevalent of the four malaria parasites of humans and causes most of the severe and lethal infections affecting young children and nonimmune adults. The *P. vivax* species also causes considerable morbidity, particularly when it infects persons who have never been exposed to malaria. A sustained, effective program of control has been difficult to implement in areas in which the disease is endemic because of the rapid spread of drug resistance in *P. falciparum;* the development of resistance to insecticides by anopheles mosquitoes, which transmit the disease; and the deterioration of socioeconomic conditions in these areas. A reliable, highly protective malaria vaccine would certainly provide the most cost-effective means of control.

Sporozoites, the infective stage of the parasites, are inoculated into the host by the bite of infected mosquitoes. After reaching the bloodstream, they rapidly invade hepatocytes, undergoing profound changes and rapid multiplication, so that one sporozoite will produce tens of thousands of parasites in a few days. These events constitute the asymptomatic, pre-erythrocytic phase of malaria. Large numbers of parasites are released from hepatocytes and enter the circulation, rapidly invading erythrocytes, where they undergo further transformation and multiplication. This process constitutes the asexual, erythrocytic phase, which is responsible for the symptoms and pathologic characteristics of this disease. Some intraerythrocytic parasites are transformed into gametocytes (a sexual stage), which undergo further differentiation and multiplication, resulting in sporozoites that migrate to the insects' salivary glands.

The developmental stages of malaria parasites involve a number of potentially protective, stage-specific antigens, providing multiple targets for effective immune responses. They are the basis of three distinct approaches to vaccine development: vaccines targeted against sporozoites or the intrahepatocytic form of the parasite, vaccines targeted against selected antigens of asexual stages of the parasite, and transmission-blocking vaccines targeted against gametocytes, gametes, or later stages in mosquitoes. Only the first two types of vaccines attempt to pro-

The New England
Journal of Medicine

VOLUME 336 JANUARY 9, 1997 NUMBER 2

INDUCED ABORTION AND THE RISK OF BREAST CANCER

MADS MELBYE, M.D., JAN WOHLFAHRT, M.Sc., JØRGEN H. OLSEN, M.D., MORTEN FRISCH, M.D., TINE WESTERGAARD, M.D., KARIN HELWEG-LARSEN, M.D., AND PER KRAGH ANDERSEN, PH.D.

ABSTRACT

Background It has been hypothesized that an interrupted pregnancy might increase a woman's risk of breast cancer because breast cells could proliferate without the later protective effect of differentiation.

Methods We established a population-based cohort with information on parity and vital status consisting of all Danish women born from April 1, 1935, through March 31, 1978. Through linkage with the National Registry of Induced Abortions, information on the number and dates of induced abortions among those women was combined with information on the gestational age of each aborted fetus. All new cases of breast cancer were identified through linkage with the Danish Cancer Registry.

Results In the cohort of 1.5 million women (28.5 million person-years), we identified 370,715 induced abortions among 280,965 women (2.7 million person-years) and 10,246 women with breast cancer. After adjustment for known risk factors, induced abortion was not associated with an increased risk of breast cancer (relative risk, 1.00; 95 percent confidence interval, 0.94 to 1.06). No increases in risk were found in subgroups defined according to age at abortion, parity, time since abortion, or age at diagnosis of breast cancer. The relative risk of breast cancer increased with increasing gestational age of the fetus at the time of the most recent induced abortion: <7 weeks, 0.81 (95 percent confidence interval, 0.68 to 1.13); >12 weeks, 1.38 (1.00 to 1.90) (reference category, 9 to 10 weeks).

Conclusions Induced abortions have no overall effect on the risk of breast cancer. (N Engl J Med 1997; 336:81-5.)

A FULL-TERM pregnancy increases a woman's short-term risk of breast cancer, possibly as a result of the growth-enhancing properties of pregnancy-induced estrogen secretion. By contrast, such a pregnancy decreases the long-term risk of breast cancer, perhaps by inducing terminal differentiation of the susceptible mammary cells.[1-5] Studies in animals suggest that the potential for terminal differentiation of breast cells is lower for a pregnancy terminated by abortion than for a full-term pregnancy. On this basis Russo and Russo[3] have proposed that a full-term pregnancy allows complete differentiation of breast cells, thereby protecting against cancer, whereas an abortion forestalls the late protective effect of differentiation, thereby increasing the risk of breast cancer.

Epidemiologic studies of the association between abortion and the subsequent risk of breast cancer have yielded inconsistent results, with estimates of risk ranging from moderately elevated to significantly lowered.[6-24] In a recent case–control study, Daling et al. found evidence of an elevated risk in women who had an induced abortion between 9 and 12 weeks' gestation, but this finding was based on a very limited number of women.[7] In the present study, we took advantage of Denmark's mandatory reporting of all induced abortions, together with the week of gestation, to evaluate the hypothesis of Russo and Russo.[3]

METHODS

Population Registries

Before initiating this study, we obtained permission from Denmark's National Scientific Ethics Committee and Data Protection

From the Department of Epidemiology Research, Danish Epidemiology Science Center, Statens Serum Institut (M.M., J.W., M.F., T.W., P.K.A.), the Danish Cancer Registry (J.H.O.), and the National Board of Health (K.H.-L.) — all in Copenhagen, Denmark. Address reprint requests to Dr Melbye at the Department of Epidemiology Research, Danish Epidemiology Science Center, Statens Serum Institut, 5 Artillerivej, DK-2300 Copenhagen S, Denmark.

Board. For this investigation we linked data from the Civil Registration System (CRS) with data from the National Registry for Induced Abortions and the Danish Cancer Registry. Since April 1, 1968, the CRS has assigned a unique identification number to all Danish residents, which permits information from different registries to be linked. The CRS also keeps updated files on the dates of live births and documents demographic variables such as emigration and deaths.

The reporting of induced abortions to the National Board of Health has been mandatory since 1939. In 1973, the legal right to an induced abortion through 12 weeks' gestation was established for women with residence in Denmark. Induced abortions after week 12 were permitted under medical or other circumstances, such as rape, that could greatly interfere with the proper care of the newborn child. Since 1973, information on all induced abortions, including the date of the procedure and the week of gestation at the time, has been computerized in the national registry of induced abortions.[25] The induced abortions included in this analysis (those occurring between 1973 and 1992) were performed almost exclusively by surgical removal.

The Danish Cancer Registry contains information on all cases of cancer diagnosed in the country since 1943. It receives reports from clinicians, pathologists, clinics, radiotherapy units, and hospitals.[26]

Subjects

A research data base comprising all Danish women born between April 1, 1935, and March 31, 1978, and including information on any live-born children, was established on the basis of information from the CRS. The individually identifiable CRS numbers were used to form a link with the national registry of induced abortions, which supplied information on the date of any induced abortion and the gestational age of the aborted fetus. Subjects' CRS numbers were subsequently linked with the Danish Cancer Registry to identify the subjects with a diagnosis of invasive breast cancer.

Statistical Analysis

Follow-up for breast cancer for all the women began on April 1, 1968, or on their 12th birthday, whichever came later. The period at risk continued until a diagnosis of breast cancer, death, emigration, loss to follow-up, or December 31, 1992 (at which date the cancer registry was considered complete) — whichever occurred first. The possible effect of the duration of the pregnancies that ultimately ended in induced abortions was investigated in a log-linear Poisson regression model.[27] The numbers of person-years at risk were calculated for groups defined according to the week of gestation for induced abortions that took place at <7, 7 to 8, 9 to 10, 11 to 12, 13 to 14, 15 to 18, and >18 weeks' gestation. Women with more than one induced abortion were, in the period between the first and second abortion, considered at risk according to the week of gestation at the time of the first induced abortion; between the second and third abortions they were considered at risk according to the week of gestation at the time of the second induced abortion; and so on.

Adjustment was made for attained age in one-year intervals and for the calendar period in which the abortion occurred (1968–1972, 1973–1977, 1978–1982, 1983–1987, and 1988–1992), parity (0, 1, 2, 3, 4, 5, 6, and ≥7), and age at delivery of a first child (12 to 19, 20 to 24, 25 to 29, 30 to 34, and >34 years). In an exploratory analysis we also categorized the women according to calendar period and age at first delivery in one-year intervals, but this had no effect on the results — a finding that argues against residual confounding. For simplicity, the attained age of a woman is denoted as her "age at the time of diagnosis of breast cancer." "Calendar period" and "calendar period at time of diagnosis of breast cancer" are used synonymously. Tests for trend were performed with gestational age treated as a continuous variable and the mean gestational age used as the value for each group. Rate ratios for the incidence of breast cancer were estimated with the use of the SAS procedures software package PROC GENMOD.[28] These rate ratios are referred to as relative risks in this article.

RESULTS

Overall, 1,529,512 women were included in the cohort. Of these, 280,965 (18.4 percent) had a total of 370,715 induced abortions, distributed as follows: 215,902 women (76.8 percent) each had one induced abortion; 47,906 women (17.1 percent) each had two; and 17,157 women (6.1 percent) each had three or more. The distribution of the number of induced abortions according to gestational age was as follows: <7 weeks, 3.1 percent; 7 to 8 weeks, 37.1 percent; 9 to 10 weeks, 41.8 percent; 11 to 12 weeks, 15.7 percent; >12 weeks, 2.3 percent. Women without a history of induced abortion accounted for 25,850,000 person-years of follow-up. In this group, there were 8908 cases of breast cancer. In comparison, among women with a history of induced abortion, accounting for 2,697,000 person-years of follow-up, there were 1338 cases of breast cancer.

Overall, the risk of breast cancer in women with a history of induced abortion was not different from that in women without such a history, after potential confounding by age, parity, age at delivery of a first child, and calendar period was taken into account (relative risk, 1.00; 95 percent confidence interval, 0.94 to 1.06).

Table 1 presents the association between variables related to abortion history and the risk of breast cancer. We calculated both the relative risk adjusted for age, parity, calendar period, and age at first delivery and the further adjusted multivariate relative risk (adjusted also for the other variables shown in the table). The adjustment had little or no effect on any of the risk estimates. Age at the time of the induced abortion did not significantly influence the overall risk, but there was a tendency toward a higher risk of breast cancer among women in the lowest age category — between 12 and 19 years of age (relative risk, 1.29; 95 percent confidence interval, 0.80 to 2.08). Neither the number of induced abortions nor whether or not the woman had given birth to a live infant (i.e., whether the induced abortion occurred in a nulliparous woman or either before or after a live birth) significantly influenced the risk of breast cancer. We also examined the time interval between the induced abortion and the diagnosis of breast cancer but found no indication of a differential effect (<1 year, relative risk = 0.97; 1 to 4 years, relative risk = 0.99; ≥5 years, relative risk = 1 [reference category]) (Table 1).

There was no effect of induced abortion on the risk of breast cancer after adjustment for the ages of the women at the time of the diagnosis of breast cancer (12 to 34 years, relative risk = 0.95 [95 percent confidence interval, 0.78 to 1.14]; 35 to 39 years,

TABLE 1. ADJUSTED RELATIVE RISK OF BREAST CANCER IN WOMEN WITH A HISTORY OF INDUCED ABORTION.

ABORTION HISTORY	NO. OF CANCERS	PERSON-YEARS (THOUSANDS)	RELATIVE RISK (95% CI)*	MULTIVARIATE RELATIVE RISK (95% CI)†
Wk of gestation				
<7	30	82	0.81 (0.58–1.13)	0.81 (0.58–1.13)
7–8	526	1012	1.01 (0.89–1.14)	1.01 (0.89–1.14)
9–10‡	634	1118	1	1
11–12	205	422	1.12 (0.95–1.31)	1.12 (0.95–1.31)
13–14	6	14	1.13 (0.50–2.52)	1.13 (0.51–2.53)
15–18	17	35	1.24 (0.76–2.01)	1.23 (0.76–2.00)
>18	14	14	1.92 (1.13–3.26)	1.89 (1.11–3.22)
Age at induced abortion (yr)				
12–19	23	458	1.32 (0.82–2.12)	1.29 (0.80–2.08)
20–24‡	68	617	1	1
25–29	161	552	0.91 (0.68–1.20)	0.93 (0.69–1.25)
30–34	366	529	0.99 (0.76–1.29)	1.03 (0.77–1.38)
≥35	720	541	1.04 (0.81–1.34)	1.07 (0.80–1.43)
No. of induced abortions				
1‡	1105	2220	1	1
2	191	376	1.08 (0.92–1.26)	1.09 (0.94–1.28)
≥3	42	101	0.99 (0.73–1.35)	1.02 (0.75–1.40)
Time since induced abortion (yr)				
<1	63	339	0.97 (0.75–1.25)	0.97 (0.75–1.25)
1–4	315	1048	0.99 (0.87–1.12)	0.99 (0.87–1.13)
≥5‡	960	1310	1	1
Time of induced abortion and live-birth history				
Nulliparous women	95	694	1.04 (0.83–1.29)	1.04 (0.83–1.31)
Parous women				
Induced abortion before 1st live birth	77	850	1.08 (0.85–1.36)	1.08 (0.82–1.44)
Induced abortion after 1st live birth‡	1154	1582	1	1
Other§	12	71	0.76 (0.43–1.34)	0.74 (0.41–1.33)

*The relative risks were calculated separately for each of the five variables, with adjustment for women's age, calendar period, parity, and age at delivery of a first child. CI denotes confidence interval.

†Values were adjusted for women's age, calendar period, parity, age at delivery of a first child, and the other variables shown in the table.

‡The women with this characteristic served as the reference group.

§"Other" denotes induced abortion occurring after delivery of a first child in women who also had induced abortion before delivery of a first child.

relative risk = 0.99 [0.87 to 1.14]; 40 to 44 years, relative risk = 1.01 [0.91 to 1.12]; 45 to 49 years, relative risk = 1 [reference category]; ≥50 years, relative risk = 1.03 [0.88 to 1.21]; P for trend = 0.97). Also, neither the calendar period at the time of diagnosis of breast cancer (P = 0.17) nor the calendar period at the time of induced abortion (P = 0.83) modified the relation between induced abortion and the risk of breast cancer.

With each one-week increase in the gestational age of the fetus, however, there was a 3 percent increase in the risk of breast cancer. The relative risk increased from 0.81 (95 percent confidence interval, 0.58 to 1.13) among women whose most recent induced abortion was at less than 7 weeks of gestation to 1.38 (95 percent confidence interval, 1.00 to 1.90) among women whose most recent abortion was at more than 12 weeks of gestation. We acknowledge the small number of cases in the group with abortions later than 12 weeks, but we evaluated this period further and found the following relative risks: weeks 13 to 14, 1.13 (95 percent confidence interval, 0.51 to 2.53); weeks 15 to 18, 1.23 (0.76 to 2.00); weeks >18, 1.89 (1.11 to 3.22) (P for trend = 0.016, Table 1).

DISCUSSION

Our study of a population-based cohort uncovered no overall increased risk of breast cancer among women with a history of induced abortion. This result is very much in line with the results of previous retrospective cohort studies,[9,10,15,16] two of which actually suggested a decreased risk.[10,15] However, all previously published retrospective cohort studies lack detailed information on the week of gestation at the time of abortion. The results of case–control

studies have been inconsistent,[6,8,11-14,17-24] but several groups have reported an increased risk of breast cancer among women with a history of induced abortion.[7,8,18,21-24]

A recent meta-analysis found an overall increased risk of breast cancer among women with a history of induced abortion of 1.3 (95 percent confidence interval, 1.2 to 1.4).[24] The authors concluded that "such a broad base of statistical agreement rules out any reasonable possibility that the association is the result of bias or any other confounding variable." However, since almost all 23 studies included in the analysis were case–control studies, it is not unreasonable to assume that many of them were inherently biased, making the pooled conclusions biased as well. Furthermore, the authors based their results on a crude analysis of published odds ratios and relative risks with no attempt to incorporate the original raw data into a more sophisticated statistical analysis.

Almost inevitably, case–control studies arouse concern about the potential problem of differential misclassification. Even after its legalization, abortion remains a sensitive issue. It is possible that women with breast cancer might be more willing to report induced abortions than healthy women. A Swedish study that compared registry information with interview data regarding induced abortion attributed an increase in the risk of breast cancer of between 16 and 50 percent to differential misclassification in interview data.[7,25] The problem of misclassification based on reporting led Newcomb et al. to conclude that studies that do not rely on interviews with case and control subjects are necessary to resolve whether there is a link between induced abortion and breast cancer.[8] In our study, all the information on dates and the number of induced abortions, reproductive history, and cancer diagnosis was obtained from national registries, which are compiled through a system of mandatory reporting for the entire population. Follow-up included complete information on death and emigration and was performed through computerized linkage of registry information by means of individually identifiable registration numbers. These measures, we believe, allowed us to avoid some of the major methodologic problems of previous studies.

A limitation of our research data base was that information on induced abortions has been computerized only since 1973. Therefore, we might have obtained an incomplete history of induced abortions for some of the oldest women in the cohort. However, we found that the risk of breast cancer among women with a history of induced abortion was no different from that among women without such a history, nor did we find that the number of induced abortions influenced the risk of breast cancer. Therefore, it is unlikely that missing information about abortions before 1973 affected the results of our analysis.

Induced abortion had no overall effect on the risk of breast cancer, but we found a statistically significant increase in risk among women with a history of second-trimester abortion. The fact that such an increase did not affect the overall result clearly indicates that it is based on small numbers and therefore requires cautious interpretation. The increased risk among women who had had second-trimester abortions finds biologic support in experiments in rats and is in line with the hypothesis of Russo and Russo.[5]

We were concerned that women whose breast cancer was diagnosed during pregnancy might have been advised to have induced abortions, a situation that would not be equally distributed according to the week of gestation at the time of the abortion. Since the time at risk was calculated only up to the diagnosis of breast cancer, only late abortions that were misclassified as occurring before the diagnosis of cancer could represent a problem. However, a stratified analysis of the risk of breast cancer according to the length of time since an induced abortion showed no differential risk and, in particular, no increased risk within the first year after abortion. Abortions induced at gestational ages of more than 12 weeks were performed primarily for medical or social reasons. The women who had such abortions could have had a relatively high risk of breast cancer, but we could not identify any medical condition associated with both a high risk and late induced abortion. Women with drinking problems might delay the interruption of their unwanted pregnancies, but the association between alcohol and breast cancer is weak and inconsistent.[30]

We cannot explain why a very early induced abortion was associated with a slight, although insignificant, decrease in risk. Nulliparous women with a history of induced abortion did not differ from parous women in their risk of breast cancer. Among nulliparous women, the possible effects of lactation and later births are irrelevant. We are therefore confident that neither of these variables had any confounding effect on our overall result.

Supported by grants from the Danish Cancer Society, the Danish National Research Foundation, and the U.S. Department of Defense (DAMD17-96-1-6321). Dr. Melbye is a Medical Research Council professor and is supported by the Danish Medical Research Council.

The views expressed in this paper do not necessarily reflect the position or the policy of the U.S. government.

REFERENCES

1. Lambe M, Hsieh C-C, Trichopoulos D, Ekbom A, Pavia M, Adami H-O. Transient increase in the risk of breast cancer after giving birth. N Engl J Med 1994;331:5-9.
2. Albrektsen G, Heuch I, Kvale G. The short-term and long-term effect of a pregnancy on breast cancer risk: a prospective study of 802 457 parous Norwegian women. Br J Cancer 1995;72:480-4.

The Psychological Sequelae of Therapeutic Abortion—Denied and Completed

Paul K.B. Dagg, M.D.

Objective: *The purpose of this article is to review the available literature on the psychological sequelae of therapeutic abortion, addressing both the issue of the effects of the abortion on the woman involved and the effects on the woman and on the child born when abortion is denied.* *Method:* *Papers reviewed were initially selected by using a Medline search. This procedure resulted in 225 papers being reviewed, which were further selected by limiting the papers to those reporting original research. Finally, studies were assessed as to whether or not they used control groups or objective, validated symptom measures.* *Results:* *Adverse sequelae occur in a minority of women, and when such symptoms occur, they usually seem to be the continuation of symptoms that appeared before the abortion and are on the wane immediately after the abortion. Many women denied abortion show ongoing resentment that may last for years, while children born when the abortion is denied have numerous, broadly based difficulties in social, interpersonal, and occupational functions that last at least into early adulthood.* *Conclusions:* *With increasing pressure on access to abortion services in North America, nonpsychiatrist physicians and mental health professionals need to keep in mind the effects of both performing and denying therapeutic abortion. Increased research into these areas, focusing in particular on why some women are adversely affected by the procedure and clarifying the relationship issues involved, continues to be important.*

(Am J Psychiatry 1991; 148:578–585)

After a period of relative quiescence, therapeutic abortion services are once again attracting significant political and public attention in North America and elsewhere. Systematic evaluation of any medical procedure usually requires examination of both the effects of performing that procedure and the effects on the patient when nothing is done. Despite a great deal of concern about the psychological effects of therapeutic abortion in both the lay and scientific press, the research examining either side of this issue, particularly that looking at the effects of denying abortion on the parent and child, is sparse.

The last half century has seen a trend toward progressively more liberal laws with respect to access to abortion, particularly in developed nations. Currently in the United States approximately 1.5 million therapeutic abortions are performed annually, involving 27.4 of every 1,000 women betwen the ages of 15 and 44. Worldwide, an estimated 30–40 million legal abortions are performed annually, with perhaps another 20 million illegal abortions (1). Recently, in North America, as well as in some European countries, we have seen a trend toward reexamination of this liberalization and reinstitution of more restrictive laws. Moreover, in the developing countries highly restrictive laws often persist, a situation that is complicated by "right-to-life" groups in Western nations that ally themselves with conservative forces in some developing nations to try to strengthen restrictive abortion laws there (2).

This paper has broken down the existing literature in order to address the following essential questions. The first is the simplest to address, and hence the one that has generated the most research interest. What are the psychological sequelae of therapeutic abortion, both the immediate effects and the more subtle, long-lasting effects? When abortion is denied, the issues are more varied. What proportion of women go on to find abortion elsewhere? If the fetus is not aborted, how many of the infants are actually adopted away, the alternative most often offered? Most importantly, what are the effects on the mother and the child when abortion is denied? Obviously, these are questions not easily addressed scientifically. There can be no random

Presented at the 143rd annual meeting of the American Psychiatric Association, New York, May 12–17, 1990. Received April 13, 1990; revision received Sept. 27, 1990; accepted Oct. 16, 1990. From the Department of Psychiatry, Mount Sinai Hospital. Address reprint requests to Dr. Dagg, Department of Psychiatry, Mount Sinai Hospital, 600 University Ave., Toronto, Ont., Canada M5G 1X5.

assignment of pregnant women to a group granted abortion and to one denied abortion. Follow-up, particularly for women denied abortion services, is understandably difficult. Cultural, social, and legal variations from place to place make comparability of studies difficult.

PSYCHOLOGICAL SEQUELAE OF COMPLETED ABORTION

The first group to review systematically this particular side of the abortion issue was Simon and Senturia (3) in 1966; they commented on the wide range of results quoted by various studies, most of whose methodology they severely criticized. In 1981, Doane and Quigley (4) published an even more exhaustive review of the literature, also commenting on the large proportion of studies that were severely hampered by major methodologic flaws. They criticized in particular the lack of any control group and the fact that the majority of studies were impressionistic reports of a handful of cases. Other problems included short periods of follow-up, vague and poorly defined symptoms without objective measurement, low response rates, and unspecified indications for the abortion. The last problem is particularly significant in that it has been clearly demonstrated that medical or genetic indications for abortion increase the risk of adverse psychological sequelae in the mothers (5, 6).

Since those two reviews, research has continued in this area. The ongoing trend to liberalize abortion access laws toward the principle of abortion on demand has had an impact on research in this field. Early research tended to concentrate on psychiatric or medical complications of abortion, emphasizing a disease model, as some conception of disease was often required for abortion to be performed legally. The emphasis has now shifted toward a model in which research examines the psychological sequelae and antecedents that affect a woman who seeks an abortion. In examining past research that covers a variety of legal climates, one must differentiate between research on "therapeutic" abortion, which requires medical or psychiatric consultation in the decision-making process, and research on open abortion, in which the woman involved is the sole decision maker. A recent review by Adler et al. (7), which limited itself to U.S. studies in order to reduce the confounding variables of social, cultural, and legal differences, found that "legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for women" in the legal context of open abortion. None of the reviews mentioned there, however, address the issue of denied abortion.

Although many studies have examined the short-term consequences of therapeutic abortion, few have used either a comparison group or objective measure of symptoms. A few studies of open abortion do meet these criteria. Freeman et al. (8), in one of the more objective studies involving over 400 women, found that SCL-90 scores were elevated on several subscales in women before the procedure but decreased significantly toward normal quite rapidly after the abortion. Those scales on which the preabortion scores were highest, indicating the highest level of distress, had the greatest decrease after the abortion. In 1985 Major et al. (9) surveyed over 200 women before their abortion, 30 minutes afterward, and at the end of 3 weeks, using the Beck Depression Inventory and clinical interviews. They found the average score to be in the nondepressed range immediately after the abortion; 3 weeks after the abortion the women's mood had continued to improve, and there was less depression and less anticipation of negative consequences. Using the SCL-90 before and immediately after the procedure, Cohen and Roth (10) demonstrated a significant drop after the abortion in scores on the depression subscale, with similar drops in scores on the anxiety subscale of the SCL-90 and the Impact of Events Scale. Prospectively following hospital admissions in a study of therapeutic abortion in the United Kingdom, Brewer (11) found an admission rate of 0.3/1,000 for postabortion psychosis compared to a rate of 1.7/1,000 for postpartum psychosis in normal-term deliveries.

Other studies, using less objective measures and examining therapeutic abortions that required psychiatric or other medical consultation, still seem to point in the same direction when comparison groups are available. Ewing and Rouse (12) found depressive symptoms in 3% of women granted abortions for psychological indications and in 12% of those women with previous psychiatric contact. Mackenzie (13) commented that women were more likely to be depressed before the abortion than after and that 78% expressed predominant feelings of relief, while 33% reported some feelings of guilt, with 80% of the guilt rated as mild. Niswander and Patterson (14) found that most women report an improvement in emotional health. In their study, women who had abortions for medical reasons reported more "unfavourable reactions" than those who had abortions for psychogenic indications. In 1965 Jansson (15) reported the following rates of admission to psychiatric hospitals immediately after abortion or delivery: 0.70% after term delivery, 1.92% after legal abortion, and 0.27% after illegal abortion and spontaneous abortion. It was felt that the apparent difference in reaction to legal and illegal abortion was due to the much higher proportion of women in the legal abortion group (over 50%) with a previous psychiatric history. Unmarried women were also more likely to be hospitalized. Other short-term studies that lack such comparison groups are summarized in table 1 (3, 16–27).

When studies have examined the effects of abortion months or years after the procedure, similar trends continue. Brody et al. (28) and Niswander et al. (29), who used pregnant women with normal deliveries for control subjects in examining therapeutic abortion, showed that MMPI scores, which may be abnormal

TABLE 1. Studies of the Immediate Psychological Sequelae of Abortion

Study and Year	Number of Subjects	Results	
		Positive	Negative
Ekblad, 1955 (16)	479	—	2% had severe self-reproach
Simon and Senturia, 1966 (3)	—[a]	—	0%–41% felt guilty
Patt et al., 1969 (17)	35	—	40% had symptoms, all mild; in one-half, symptoms were present before abortion
Bacon, 1969 (18)	9	55% felt considerable relief	33% felt mild guilt lasting a few days
Walter, 1970 (19)	—[a]	—	0%–30% felt mild guilt
Osofsky and Osofsky, 1972 (20)[b]	250	65% were happy	14% were sad, 24% felt guilty
Lazarus, 1985 (21)[b]	292	76% felt relief	15% felt guilty and were depressed; 10% had overall negative symptoms
Pare and Raveo, 1970 (22)	128	Most experienced marked relief and improved relationships	A few felt mild guilt for 1–2 weeks
Marder, 1970 (23)	147	Most experienced marked relief of symptoms and improved relationships	—
Bracken et al., 1974 (24)	489	Positive reactions increased with more support	—
Adler, 1975 (25)[b]	95	Most had positive feelings	A few felt guilt and doubt
Spaulding and Cavenor, 1978 (26)[b]	2[c]	—	Two subjects developed psychosis, one organic
McAll and Wilson, 1987 (27)[b]	6[c]	—	Six subjects developed psychiatric symptoms

[a] Review study.
[b] Studies examined abortion on request. All other studies involved therapeutic abortion requiring some degree of psychiatric or other medical consultation.
[c] Case reports.

before the abortion, normalize within 6 months to a year after the abortion. The control subjects, who had less abnormal scores before delivery, showed no change in their scores after delivery. In the study by Brody et al., a group of women who were denied abortion continued to have quite abnormal scores after the delivery of the infant.

Studies of open abortion show similar results. Athanasiou et al. (30), who also used pregnant women with normal deliveries as control subjects and matched for socioeconomic status, found no difference in MMPI and SCL-90 scores between the two groups after delivery or abortion. A study by Jacobs et al. (31), who used women undergoing minor gynecologic surgery as control subjects, showed higher preabortion scores for the pregnant women on the Psychopathic Deviate, Schizophrenia, Hysteria, and Depression scales of the MMPI; these differences disappeared after the abortion. Using a different control group, Zabin et al. (32) examined a group of adolescents who presented initially for pregnancy testing and subsequently studied three groups—those who were pregnant and chose to abort the fetus, those who were pregnant and chose to complete the pregnancy, and those whose test results were negative. One and 2 years later they found that the abortion group showed no evidence of psychological distress compared to either control group and that, indeed, there was a nonsignificant trend toward better psychological health with less anxiety on the State-Trait Anxiety Inventory and more internal locus of control. In addition, the women who completed their pregnancy showed a significant economic deterioration afterward and were significantly more likely to discontinue school than the abortion group; this difference actually increased between the first and second years after delivery or abortion. In a study in Denmark (33) that tracked psychiatric hospitalization rates for 3 months after abortion or delivery, there was no difference between postpartum and postabortion rates in married and never married women. Higher postabortion rates of admission were found in separated, divorced, and widowed women, women who were more likely to be isolated and alone.

Among the older studies of therapeutic abortions with less rigorous methodology, Peck and Marcus (34) and Smith (35) found more symptoms of depression and negative feelings, up to 2 years afterward, in women for whom the abortion was performed for medical/genetic indications. Significant distress occurred in less than 10% of women who had abortion for psychosocial indications. Ewing and Rouse (12) found that approximately 95% of their study subjects reported improved emotional health as a result of the abortion at 2-year follow-up.

Table 2 presents data on other long-term studies (16, 17, 22, 36–47) that lacked comparison or control groups (thereby making interpretation difficult). All studies in this group involved therapeutic abortion in which psychiatric or other medical consultation was required before the abortion. Noteworthy, again, is the relative lack of significant negative responses in the women. The two studies that found relatively higher rates of negative responses are those of Wallerstein et al. (42) and Ashton (46). The low response rate (less

TABLE 2. Studies of the Long-Term Psychological Effects of Abortion[a]

Study and Year	Length of Follow-Up	Number of Subjects	Results	
			Positive	Negative
Ekblad, 1955 (16)	2 years	479	—	11% had self-reproach
Kretzschmar and Norris, 1967 (36)	1–5 years	24	—	—
Parr et al., 1969 (17)	2–6 months	35	74%	14%
Pare and Raven, 1970 (22)	3 months	321	—	13% felt guilty
Whittington, 1970 (37)	2–12 months	31	87%	6%
Ford et al., 1971 (38)	6 months	22	—	14%[b]
Margolis et al., 1971 (39)	3–6 months	43	67%	9%
Meyerowitz et al., 1971 (40)	1–84 months	114	78%	9%
Todd, 1972 (41)	1–3 years	83	91% had no adverse symptoms	—
Wallerstein et al., 1972 (42)	5–7 months	22	—	32%
Perez-Reyes and Falk, 1973 (43)	3 months	41	75%–90%	—
Lask, 1975 (44)	3 months	50	68%–89%	8%
Greer et al., 1976 (45)	18 months	217	—	7% felt guilty, 19% had other symptoms
Ashton, 1980 (46)	6 weeks	64	—	24% felt guilty, 31% felt worried
Schmidt, 1981 (47)	3–6 years	10	Normalization of scale scores[c]	—

[a]All studies involved therapeutic abortion requiring some degree of psychiatric or other medical consultation.
[b]According to the MMPI.
[c]On the Hostility and Direction of Hostility Questionnaire and the Symptom-Sign Inventory.

than 20%) to a mailed questionnaire in the first study and the minor nature of symptoms measured in the second may account for the difference.

Table 3 presents data on studies (12, 14, 17, 22, 36, 37, 39, 44, 45, 48) that queried subjects concerning the presence of regrets after the procedure (a measure of ambivalence about the abortion decision). This question is frequently posed, and yet despite the subjective nature of the question, the results are surprisingly uniform. They reveal that for the large majority of women, the decision about abortion, although undoubtedly difficult, is not one for which a great deal of conscious ambivalence exists.

In women undergoing induced abortion, several factors have been identified that correlate with higher rates of psychological distress after abortion. As previously mentioned, it has been clearly demonstrated that a medical or genetic indication for abortion increases the risk of a negative reaction (5, 6, 34, 35). Previous psychiatric contact has also been clearly shown to increase the likelihood of the woman having a negative emotional response to the abortion (12, 34, 38). The presence of support seems to be a more complex issue, with possibly contradictory results. Several studies have shown that a woman's perceived degree of support at the time of the abortion was positively correlated with a good psychological response afterward (20, 24, 33, 49, 50), but Major et al. (9) found that women whose partners accompanied them to the clinic for the procedure were more likely to feel depressed afterward and experienced more physical complaints. Similarly, Robbins (51) found that single women who maintained a strong relationship with their partners after the abortion were more likely to experience regrets at 1 year and had more negative scores on the MMPI at 6 months.

TABLE 3. Studies of the Prevalence of Regrets After Abortion[a]

Study and Year	Total Subjects	Subjects With Regrets
Greer et al., 1976 (45)	217	3% at 3 months, 3.7% at 18 months
Niswander and Patterson, 1967 (14)	116	3%
McCoy, 1968 (48)	62	32% had regrets of some degree at some time
Ewing and Rouse, 1973 (12)	126	3%
Margolis et al., 1971 (39)	43	4.4%
Parr et al., 1969 (17)	35	5.7%
Whittington, 1970 (37)	31	6.5%
Kretzschmar and Norris, 1967 (36)	24	12.5% had occasional regrets
Lask, 1975 (44)	50	16% had some regrets
Pare and Raven, 1970 (22)	321	1.6%

[a]All studies involved therapeutic abortion requiring some degree of psychiatric or other medical consultation.

The decision on whether to abort the fetus or to carry it to term is a complex one that has several effects on the psychological state of the woman. Not surprisingly, women undergoing mid-trimester abortions experienced more difficulty with the decision than those having first-trimester abortions (25), and they experienced greater ambivalence about the pregnancy (52). They also appeared more likely to experience negative reactions after the abortion (25, 30, 53), particularly if the late abortion required induction of labor and delivery (54). Adolescents who felt that they themselves made the decision to abort, regardless of the length of the pregnancy, without pressure from parents or oth-

TABLE 4. Studies of the Outcome of Pregnancy After Abortion Was Denied

Study and Year	Number of Subjects	Full-Term Pregnancy (%)	Abortion (%)	
			Induced	Spontaneous
Lindberg, 1948 (57)	344	—	14.5	—
Delcomyn, 1952 (58)	136	—	39	—
Hultgren, 1959 (59)	4,214	85.6	10	4.4
Hook, 1963 (60)	249	69	—	—
Peck and Marcus, 1966 (34)	9	—	56	—
Forssman and Thuwe, 1966 (61)	196	65.3	34.7	—
Pare and Raven, 1970 (22)	120	—	36	—
Meyerowitz et al., 1971 (40)	4	—	75	—
Hultin and Ortosson, 1971 (62)	1,008	81.2	—	—
Dytrych et al., 1975 (63)	439	72	10	18
Hunton, 1977 (64)	253	34.5	46.6	5
Drower and Nash, 1978 (65, 66)	69	55	—	—
Binkin et al., 1983 (67)	258	72	20	—

TABLE 5. Studies of the Adoption of Children Born After Abortion Was Denied

Study and Year	Number of Children Born	Children Adopted Away (%)
Malmfors, 1951 (68)	85	8
Aren and Amark, 1957 (69)	162	7.4
Forssman and Thuwe, 1966 (61)	120	6.7
Hook, 1963 (60)	204	7.4
Pare and Raven, 1970 (22)	73	19
Drower and Nash, 1978 (65, 66)	38	16

ers, were less likely to experience negative emotions after the abortion (24, 43).

Several studies have examined the effect of the woman's preabortion psychological status on her postabortion course. Spreckhard (55), in looking at women who reported significant postabortion distress, found that they used a great deal of denial and repression, as well as projection onto their partner or the medical staff, in dealing with the stress of their pregnancy and subsequent abortion. These women also described high degrees of boundary ambiguity with respect to the aborted fetus and maintained an ongoing, high level of attachment to the fetus, despite its loss. Athanasiou et al. (30) found that women who experienced the most distress after an abortion were more likely to have lower self-esteem, a higher sense of alienation, and less knowledge of contraceptives before the abortion. Bracken et al. (56) found that women with a relatively internal locus of control and high level of ego resiliency responded most favorably to the abortion.

PSYCHOLOGICAL SEQUELAE OF DENIED ABORTION

Even more difficult to determine, and hence even less often examined, is the issue of the effects of denying abortion on the mother and child. The studies that have been done are often older, since the access to abortion has improved in many countries.

Before an examination of the direct effects of the denied abortion, two issues need to be clarified. How many pregnancies will go on to completion if abortion is not performed as requested, and of those, how many women will eventually put their infants up for adoption? Table 4 presents data on studies (22, 34, 40, 57–67) that addressed the first question. Particularly in the more recent studies, a large proportion of women (over 40% in one large study [64]) will continue to seek abortion elsewhere and will succeed. Particularly alarming are the reported rates of "spontaneous" abortion in this population. Because women who request abortion are often past the first trimester (the stage at high risk for spontaneous abortion), truly spontaneous miscarriage should be rare. However, when these pregnancies are carried to term, studies (22, 60, 61, 65, 66, 68, 69) show that the proportion of children put up for adoption is quite small, ranging from 6.7% to 19.0% (table 5). From these studies it would seem that when an abortion request is denied, the result is often either an abortion obtained elsewhere or a mother raising an infant from an unwanted pregnancy in the situation that led her to request the abortion in the first place.

The few studies that have examined the effect of the denied abortion on the parents have focused on the effects on the mother. While the effects on the father have been reported occasionally in an anecdotal fashion, systematic studies are lacking. The earliest study (60) evaluated 249 women 7 years after the denied abortion. It found that 27% of the women had been able to cope fully with the pregnancy and the child, 22% still showed signs of mental illness and poor adjustment, and 51% had shown symptoms of mental disturbance and great emotional strain for a period of considerable length since the birth but seemed to have overcome these problems. Unfortunately, the study did not distinguish between women who aborted the fetus elsewhere, gave the child up for adoption, or raised the child themselves. Drower and Nash (65, 66) reported that those women denied abortion expressed greater

guilt and anxiety than women for whom an abortion had been performed. In the most compelling of these studies, Pare and Raven (22) looked at 73 women 1–3 years after their request for abortion was denied and found that 59% reported that they accepted the child and were glad that they had not aborted the fetus, while 34% reported that the child was a burden that they frequently resented. Admittedly quite subjective, these studies nonetheless show that although an unwanted pregnancy does not always result in an unwanted child, there is reason to be concerned that significant numbers of these women will continue to harbor quite negative feelings toward their children, feelings that are easily elicited by interviewers.

The final and most difficult question concerns the effects on the children themselves of being born after an abortion request is denied. In a study of the world literature on infanticide, Resnick (70) found that 83% of the newborns killed and 11% of the children killed by their mothers had been born of unwanted pregnancies. Studies by Blomberg (71) and Hultin and Ottosson (62) found no difference in the rate of pregnancy-related or perinatal complications in children born of unplanned pregnancies, while Nielsen (72) found a slightly above normal rate of physical abnormalities in newborns born in this situation.

In a classic study that continues to have relevance today, Forssman and Thuwe (61) compared, up to age 21 years, 120 children born of unwanted pregnancies with control subjects matched by date of birth. They found that the study group had a more insecure childhood, more psychiatric care, more childhood delinquency, and more early marriages and were more often young mothers; all of these findings were statistically significant. Even after socioeconomic class was controlled, fewer of the study subjects had more than secondary education and fewer were without defects of any kind, when all these problems were grouped together. A recent update (73) on the study group, then 35 years old, found that the differences were diminishing; however, the study subjects were still significantly more likely to appear on some kind of registry, indicating contact for psychiatric care, because of crime or delinquency, or for public assistance. Hook (cited in reference 74) studied 88 children born after abortion was denied, comparing them with a control group made up of the same-sex classmate of nearest age to each study individual. At age 18, the boys in the study group had a higher rate of conduct disorder, criminality, and unstable homes, with lower emotional maturity. At 23, more of the men in the study group were likely to require economic assistance, and the women in the study group began to show evidence of lower self-esteem and more depression. A study (75) with a more rigorous control group, which was matched for age, sex, number of siblings, and socioeconomic class at the time of the child's birth, evaluated the children until their 15th birthday. The study group had poorer school performance throughout this time, as well as more neurotic and psychosomatic symptoms recorded in the school health registry, and more likelihood of being registered with social welfare authorities.

Perhaps the most ambitious study to date is that of Matejcek et al. (63, 76–80), who compared a control group and a group of 220 children born in Prague in 1961–1963, after abortion was denied. The two groups were matched for socioeconomic class, sex, age, birth order, number of siblings, and parental marital status. Early findings in 1970 found that the study subjects were less likely to be breast fed, had more acute medical illness, were more likely to be reported as difficult when they were preschoolers, were more likely to be rejected by friends and teachers, had poorer school performance, and were less adaptive to frustration; boys were more likely to be affected. At ages 14–16 (79), 216 of the original 220 were still being studied. School performance in the study group continued to deteriorate, and various indicator scales showed that this group had more negative relationships with their mothers. Current studies (80) of the children in their early 20s show an ongoing propensity for social problems that remains markedly prevalent in this group. The study subjects had more job dissatisfaction and fewer friends and reported dissatisfaction with life (all significant findings) and less education, more criminality, and more registration by the authorities for drug and alcohol problems (trends).

DISCUSSION

In spite of the numerous difficulties facing researchers who attempt to address the issue of therapeutic abortion, the findings do appear to be remarkably uniform. Precise answers, unaffected by bias, are probably not possible, but the research examined here does highlight several things.

Immediately after abortion, symptoms of distress and dysphoria do occur in many women. However, these symptoms seem to be continuations of symptoms present before the abortion and more a result of the circumstances leading to the abortion than a result of the procedure itself. Indeed, many studies report significant positive feelings after the abortion. When the women are studied over the course of the episode, the dysphoria is found to be on the wane after the abortion. Longer-term studies, over months and years, show similar trends; the majority of women express positive reactions to the abortion, and only a small minority express any degree of regrets. Similarly, negative feelings present before the abortion disappear, with normalization of various scores.

Although it is difficult to generalize about factors that are more likely to be involved in women who experience a negative psychological response to abortion, and potentially misleading when dealing with an individual, several trends are evident. Abortion for medical or genetic indications, a history of psychiatric contact before the abortion, and mid-trimester abortions often result in more distress afterward. When

women experience significant ambivalence about the decision or when the decision is not freely made, the results are also more likely to be negative. The issue of support is a more complex one and is not easily measured; many studies indicate that support by the parent or partner can be positive, although apparently contradictory studies exist. Prior psychological coping styles and resiliency also appear to play an important role in the psychological sequelae of an abortion, in that certain defensive styles such as projection, repression, and denial may hinder a woman's working through and resolving the loss of a fetus, particularly when it is one that is ambivalently regarded.

When abortion is denied, a different picture seems to arise. Many women, up to 40% in some studies, have the abortions elsewhere, depending on availability. Relatively few of the children are put up for adoption, and the majority born of unwanted pregnancies are raised by their biological mother. A significant minority—about 30%—of the women examined in the few long-term studies continue to report negative feelings toward their child and difficulty adjusting.

Finally, the most disturbing part of the whole issue is the evidence of significant negative effect on the child. With the caveat that the unwanted pregnancy does not necessarily result in an unwanted child, the carefully designed and executed prospective studies of Matejcek et al., Hook, Blomberg, and Forssman and Thuwe reveal long-lasting, broadly based, negative effects of the denial of abortion on the children subsequently raised in the situation that the parents had tried so desperately to avoid.

While this paper has not addressed any of the ethical issues raised by therapeutic abortion, it has attempted to give a psychiatric perspective that has hitherto been unavailable in this debate. Further research on some of the questions examined is important, particularly if society moves toward more restrictive legislation on this issue, since the question of the effects on the mother and the child in particular has only begun to be explored.

REFERENCES

1. Tietze C, Henshaw SK: Induced Abortion: A World Review, 6th ed. New York, Alan Guttmacher Institute, 1986
2. Dixon-Mueller R: Abortion policy and women's health in developing countries. Int J Health Serv 1990; 20:297–314
3. Simon NM, Senturia AG: Psychiatric sequelae of abortion, review of the literature 1935–64. Arch Gen Psychiatry 1966; 15: 378–389
4. Doane BK, Quigley BG: Psychiatric aspects of therapeutic abortion. Can Med Assoc J 1981; 125:427–432
5. Blumberg BD, Golbus MS, Hanson KH: The psychological sequelae of abortion performed for a genetic indication. Am J Obstet Gynecol 1975; 122:799–808
6. Donnai P, Charles N, Harris R: Attitudes of patients after genetic termination of pregnancy. Br Med J 1981; 282:621–622
7. Adler NE, David HP, Major BN, et al: Psychological responses after abortion. Science 1990; 248:41–44
8. Freeman EW, Rickels K, Huggins GR, et al: Emotional distress patterns among women having first or repeat abortions. Obstet Gynecol 1980; 55:630–636
9. Major BN, Mueller P, Hildebrandt K: Attributions, expectations and coping with abortion. J Pers Soc Psychol 1985; 48: 585–599
10. Cohen L, Roth SH: Coping with abortion. J Hum Stress 1984; 10:140–145
11. Brewer C: Incidence of post-abortion psychosis: a prospective study. Br Med J 1977; 1:476–477
12. Ewing JA, Rouse BA: Therapeutic abortion and a prior psychiatric history. Am J Psychiatry 1973; 130:37–40
13. Mackenzie P: Before and after therapeutic abortion. Can Med Assoc J 1974; 111:667–671
14. Niswander KR, Patterson RJ: Psychological reaction to therapeutic abortion, I: subjective patient response. Obstet Gynecol 1967; 29:702–706
15. Jansson B: Mental disorder after abortion. Acta Psychiatr Scand 1965; 41:87–110
16. Ekblad M: Induced abortion on psychiatric grounds: a follow-up study of 479 women. Acta Psychiatr Neurol Scand (Suppl) 1955; 99:3–328
17. Patt SL, Rappaport RG, Barglow P: Follow-up of therapeutic abortion. Arch Gen Psychiatry 1969; 20:408–414
18. Bacon HM: Psychiatric aspects of therapeutic abortion. Can Ment Health 1969; 17:18–21
19. Walter GS: Psychological and emotional consequences of elective abortion: a review. Obstet Gynecol 1970; 36:482–491
20. Osofsky JD, Osofsky HJ: The psychological reaction of patients to legalized abortion. Am J Orthopsychiatry 1972; 42:48–60
21. Lazarus A: Psychiatric sequelae of legalized elective first trimester abortion. J Psychosom Obstet Gynecol 1985; 4(3):141–150
22. Pare CMB, Raven H: Psychiatric sequelae to therapeutic abortion: follow-up of patients referred for termination of pregnancy. Lancet 1970; 1:635–638
23. Marder L: Psychiatric experience with a liberalized therapeutic abortion law. Am J Psychiatry 1970; 126:1230–1236
24. Bracken MB, Hachamovitz M, Grossman G: The decision to abort and psychological sequelae. J Nerv Ment Dis 1974; 158: 154–162
25. Adler NE: Emotional responses of women following therapeutic abortion. Am J Orthopsychiatry 1975; 45:446–454
26. Spaulding JG, Cavenar JO: Psychoses following therapeutic abortion. Am J Psychiatry 1978; 135:364–365
27. McAll K, Wilson WP: Ritual mourning for unresolved grief after abortion. South Med J 1987; 80:817–821
28. Brody H, Meikle S, Gerritse R: Therapeutic abortion: a prospective study. Am J Obstet Gynecol 1971; 109:347–353
29. Niswander KR, Singer J, Singer M: Psychological reaction to therapeutic abortion, II: objective response. Am J Obstet Gynecol 1972; 114:29–33
30. Athanasiou R, Oppel WC, Michelson L, et al: Psychiatric sequelae to term birth and induced early and late abortion: a longitudinal study. Fam Plann Perspect 1973; 5:227–231
31. Jacobs D, Garcia C-R, Rickels K, et al: A prospective study on the psychological effects of therapeutic abortion. Compr Psychiatry 1974; 15:423–434
32. Zabin LS, Hirsch MB, Emerson MR: When urban adolescents choose abortion: effects on education, psychological status and subsequent pregnancy. Fam Plann Perspect 1989; 21:248–255
33. David HP: Post-abortion and post-partum psychiatric hospitalization. Ciba Found Symp 1985; 115:150–164
34. Peck A, Marcus H: Psychiatric sequelae of therapeutic interruption of pregnancy. J Nerv Ment Dis 1966; 143:417–425
35. Smith EM: A follow-up study of women who request abortion. Am J Orthopsychiatry 1973; 43:574–585
36. Kretzschmar RM, Norris AS: Psychiatric implications of therapeutic abortion. Am J Obstet Gynecol 1967; 98:368–373
37. Whittington HG: Evaluation of therapeutic abortion as an element of preventive psychiatry. Am J Psychiatry 1970; 126: 1224–1229
38. Ford CV, Castelnuovo-Tedesco P, Long KD: Abortion: is it a therapeutic procedure in psychiatry? JAMA 1971; 218:1173–1178
39. Margolis A, Davison LA, Hanson KH, et al: Therapeutic abor-

tion follow-up study. Am J Obstet Gynecol 1971; 110:243–249
40. Meyerowitz S, Satloff A, Romano J: Induced abortion for psychiatric indication. Am J Psychiatry 1971; 127:1153–1160
41. Todd NA: Follow-up of patients recommended for therapeutic abortion. Br J Psychiatry 1972; 120:645–646
42. Wallerstein JS, Kurtz P, Bar-Din M: Psychosocial sequelae of therapeutic abortion in young unmarried women. Arch Gen Psychiatry 1972; 27:828–832
43. Perez-Reyes MG, Falk R: Follow-up after therapeutic abortion in early adolescence. Arch Gen Psychiatry 1973; 28:120–126
44. Lask B: Short-term psychiatric sequelae to therapeutic termination of pregnancy. Br J Psychiatry 1975; 126:173–177
45. Greer HS, Lal S, Lewis SC: Psychosocial consequences of abortion. Br J Psychiatry 1976; 128:74–79
46. Ashton JR: The psychosocial outcome of induced abortion. Br J Obstet Gynaecol 1980; 87:1115–1122
47. Schmidt R: The effects of termination of pregnancy: a follow-up study of psychiatric referrals. Br J Med Psychol 1981; 54:267–276
48. McCoy D: The emotional reaction of women to therapeutic abortion and sterilization. J Obstet Gynecol Br Commonwealth 1968; 75:1054–1057
49. Shusterman LR: Predicting the psychological consequences of abortion. Soc Sci Med 1979; 13A:683–689
50. Moseley DT, Follingstad DR, Harley H, et al: Psychological factors that predict reaction to abortion. J Clin Psychol 1981; 37:276–279
51. Robbins JM: Out-of-wedlock abortion and delivery: the importance of the male partner. Soc Probl 1984; 31:334–350
52. Osofsky JD, Osofsky HJ, Rajan R, et al: Psychosocial aspects of abortion in the United States. Mt Sinai J Med 1975; 42:456–467
53. Kaltreider NB: Psychological factors in mid-trimester abortions. Psychol Med 1973; 4:129–134
54. Kaltreider NB, Goldsmith S, Margolis AJ: The impact of mid-trimester abortion techniques on patients and staff. Am J Obstet Gynecol 1979; 135:235–238
55. Spreckhard AC: The Psychosocial Aspects of Stress Following Abortion. Kansas City, Sheed and Ward, 1987
56. Bracken MB, Klerman LV, Bracken M: Coping with pregnancy resolution among never-married women. Am J Orthopsychiatry 1978; 48:320–334
57. Lindberg BJ: (What does the woman do when the psychiatrist says no to her application for abortion)? Svenska Lak-Tidn 1948; 45:1381–1391 (Swedish)
58. Delcomyn K: (Follow-up study of women whose application for therapeutic abortion was refused). Nord Med 1952; 48:980 (Swedish)
59. Hultgren G: (Refusal of request for legal abortion: statistical study on 4274 women whose applications for abortion were rejected by the Swedish Medical Board). Nord Med 1959; 62: 1182–1185 (Swedish)
60. Hook K: Refused abortion. A follow-up study of 249 women whose applications were refused by the National Board of Health in Sweden. Acta Psychiatr Scand (Suppl) 1963; 168:3–156
61. Forssman H, Thuwe I: One hundred and twenty children born after application for therapeutic abortion refused. Acta Psychiatr Scand 1966; 42:71–78
62. Hultin M, Ottosson JO: Perinatal conditions of unwanted children. Acta Psychiatr Scand (Suppl) 1971; 221:59–77
63. Dytrych Z, Matejcek Z, Schuller V, et al: Children born to women denied abortion. Fam Plann Perspect 1975; 7:165–171
64. Hunton RB: Patients denied abortion at a private early pregnancy termination service in Aukland, NZ Med J 1977; 85: 424–425
65. Drower SJ, Nash ES: Therapeutic abortion on psychiatric grounds, part I: a local study. S Afr Med J 1978; 54:604–608
66. Drower SJ, Nash ES: Therapeutic abortion on psychiatric grounds, part II: the continuing debate. S Afr J Med 1978; 54:643–647
67. Binkin N, Mhango C, Cates W Jr, et al: Women refused second trimester abortion: correlates of pregnancy outcome. Am J Obstet Gynecol 1983; 145:279–284
68. Malmfors K: (Problems of the woman seeking abortion). Svenska Lak-Tidn 1951; 48:2445–2468 (Swedish)
69. Aren P, Amark C: (Outcome in cases of authorized but not performed therapeutic abortion). Svenska Lak-Tidn 1957; 54: 3709–3784 (Swedish)
70. Resnick PJ: Murder of the newborn: a psychiatric review of neonaticide. Am J Psychiatry 1970; 126:1414–1420
71. Blomberg S: Influence of maternal distress during pregnancy on complications in pregnancy and delivery. Acta Psychiatr Scand 1980; 62:399–404
72. Nielsen JB: (Decisions by a maternity assistance board and a follow-up study). Ugeskr Laeger 1960; 120:330–335 (Danish)
73. Forssman H, Thuwe I: The Gotcborg cohort, 1939–77, in Born Unwanted: Developmental Effects of Denied Abortion. Edited by David HP, Dytrych Z, Matejcek Z, et al. New York, Springer, 1988
74. David HP: Additional studies from Sweden. Ibid
75. Blomberg S: Influence of maternal distress during pregnancy on postnatal development. Acta Psychiatr Scand 1980; 62:405–417
76. Matejcek Z, Dytrych Z, Schuller V: Children born from unwanted pregnancies. Acta Psychiatr Scand 1978; 57:67–90
77. Matejcek Z, Dytrych Z, Schuller V: The Prague study of children born from unwanted pregnancies. Int J Ment Health 1979; 7:63–77
78. David HP, Matejcek Z: Children born to women denied abortion. Fam Plann Perspect 1981; 7:165–171
79. Matejcek Z: Follow-up study of children born to women denied abortion. Ciba Found Symp 1985; 115:136–149
80. Dytrych Z, Matejcek Z, Schuller V: The Prague cohort: adolescence and early adulthood. In Born Unwanted: Developmental Effects of Denied Abortion. Edited by David HP, Dytrych Z, Matejcek Z, et al. New York, Springer, 1988

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

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

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

June 5, 1996

Testimony

western union **Telegram**

RESOLUTION 279 AND HOUSE BILL 3766 IMPACTING ON YOUR ACTIONS.

SINCERELY,

MARK JEROME SEIDENBERG

C.C.

GEORGE SCHULTZ
GEO SHEFFIELD
SEN STEVENS
SEN. MORKOWSKI
CONG. YOUNG
ADM. POINDEXTER
CONG SILJANDER
SEN. JESSE HELMS
CARL OLSON

2131 EST

IPMWGWK WSH

W.U. 1201-SF (R5-69)

[redacted]

RE: HB 37

There are five testifiers on bridge lines:

FIRST, please take Judith Koehler, with
Americans United for Life, from Chicago.
There will be questions from the committee for her.

LATER, at your convenience, others are:

Dr. Jan Whitefield, Anchorage,
Dr. Cynthia Brooke, Anchorage,
Dr. Bruce Chandler, Anchorage,
Janet Krepps (or designee) from Colorado.

Eve Gartner

303-839-1912

Atty "Center for Reproductive Law"

* Tell Jeanette *

Chicago - (Wanted 10 Minutes)?

Judith Koehler

Americans United for Life -

Ass't D.A.

312 - 786 - 9494

* 1 - 800 - 478 - 7612

She'll go First —

Ask Questions!!

Date: February 6, 1997

To: Barbara Cotting
Representative James' office

From: Patrick Flynn
Representative Berkowitz's office

Subject: Bridge line requests

Below is a list of witnesses wishing to testify during hearings on HB 37 and HB 65. Due to their busy schedules, it would be particularly helpful if they could dial in to bridge lines to provide their testimony and answer questions. Most will also supply written testimony which I will provide to you by noon on Monday, February 10. If I receive further requests for bridge lines I will forward them to you ASAP.

If you have any questions please give me a call at x4919. Thank you for your assistance in this matter.

Name	Phone number
Dr. Jan Whitefield	907.563.7228 x241
Dr. Cynthia Brooke	907.563.8588
Dr. Bruce Chandler	907.343 6718 mornings 907.257.4600 afternoons
Janet Krepps (or designee)	303.839.1912 1-800-478-7612

1-800-764-6202

I need info by 9:00 a.m. so I can have it in packets by noon, for the next day.

Barbara

Alaska State Legislature

Please enter into the record my testimony to the STATE AFFAIRS committee name

committee on HB-37 / (MINOR ABORTION) PARENTAL CONSENT, dated 02-11-97 .
bill/subject

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

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

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

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

ABORTION IS A VERY LONELY CALL TO MAKE - IT CAN CAUSE A QUIET DESPERATION DEEP WITHIN... PROTECT YOUR DAUGHTERS. SUPPORT HB-37

Signed: Debra Hendy
Testifier

Representing (Optional)

P.O. BOX 2975 SITKA AK 99835
Address

907-747-3561 (W) 907-966-2204 (H)
Phone No.

TESTIMONY ON HB 37
House State Affairs
February 6, 1997

Mr. Chairman and members of the Committee,

Thank you for the opportunity to testify on HB 37, a bill that would require parental consent before a minor's abortion.

My Name is Dr. Peter Nakamura.

I am the Director of the Division of Public Health within the Department of Health and Social Services. I am also a family practitioner and pediatrician. I have provided medical care or supervised health care programs in diverse International settings, on American Indian Reservations, Native American communities, and within the urban setting of Anchorage. I managed the health program for the Yukon Kuskokwim area from 1970 to 1972 and provided clinical care in several of the remote communities. I share this information to demonstrate that I have had the opportunity to experience the influence of small and culturally diverse communities on the behavior of their youth.

A State law that would mandate parental notification or consent for minor women who choose to have an abortion pose significant dilemmas for the minor and her chosen health care professional. The health care professional may be forced to delay care, abrogate patient confidentiality, and , in some cases expose the minor woman to actual physical and psychological harm.

Health care professionals routinely encourage their minor patients to consult with parents or guardians about health care treatment. A state law that mandates parental involvement in all circumstances, however, is impractical, unjustified, and possibly unwise. Health professionals agree that without confidentiality, many adolescents will not seek timely or appropriate care. The American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, and over 40 organizations with an interest or investment in health care have endorsed this position.

Basic principles of law and society hold that parents should be involved in and responsible for assuring appropriate medical care for their children, that parents ordinarily act in the best interest of their children, and the minors benefit from the advice and emotional support of their parents. Legislation mandating parental involvement in abortion are promoted on the basis of the theoretical benefits on strengthening family responsibility and communication.

Experience has shown that 61% of unmarried minors have informed one or both parents of their pregnancy. Over 20% of unmarried minors did not inform their parents but they did involved at least one responsible adult such as the clergy, another relative, teacher, counselor, or professional other then the principle physician. The most frequent reasons minors site for not informing their parents include the belief that the knowledge would damage their relationship, the fear that it would elevate conflict or coercion, and the desire to protect a vulnerable parent from stress and disappointment. One third of minors who do not inform parents already have experienced family violence and fear it will recur. Although parental involvement in many cases may be helpful, in others it may be punitive, coercive, or abusive.

Legislation that threatens a physician with a civil crime subjective to punitive damages for allowing his clinical judgment and practice to be guided by what is best for the individual patient is not at all supportive of the best practice of medicine. This may in many cases subject the young woman to increased risk to her health and well being. In a similar manner, legislation that preclude any consideration for psychological or emotional damage to the client is denying the serious consequences that can result from such omissions.

Provisions are made in the proposed bill to accommodate a judicial bypass procedure which is meant to allow a teenager to appear before a judge to request a waiver of the parental involvement. Young women often will avoid or delay access to this intimidating procedure because of the anticipated fear, anxiety, shame and concern for loss of confidentiality often associated with this action. In small rural communities it is almost impossible for a young adolescent to access medical care much less to appear in a judicial setting. If successful it would generally not be done without personal recognition. Access for young woman in the rural communities is often compromised by the lack of knowledge and by the great distance to a judicial system. There is no mechanism in most rural communities whereby confidentiality could be

preserved during the effort to identify the true parent, guardian, or legal custodian.

Further restricting access to professional guidance and safe medical procedures can only increase the risks to life and to the health of our children.

Juneau Coalition for Pro-Choice

February 8, 1997

Dear Members of the House State Affairs Committee:

The Juneau Coalition for Pro-Choice (JCPC) would like to go on record opposing the passage of HB 37 which would restrict a young woman's ability to act on her Constitutionally protected right to choose. JCPC strongly encourages all young women who become pregnant, and the putative fathers, to discuss options with their parents if they are able, but such communication cannot be achieved through passage of this bill. The majority of young women who do not involve their parents in making decisions about a pregnancy have problems with their family which precludes discussion about the issue. HB 37 only serves to put minors at risk.

Judicial bypass procedures are not the answer either, as this option is intimidating to a young woman and only results in delay which makes an abortion riskier if the minor gets approval from the judge for an abortion. As an appellate court in California stated "the judicial bypass procedure creates a substantial obstacle whose only effect is to hinder the minor from obtaining an abortion. Whether a minor is capable or giving informed consent to undergo an abortion is a question which can be more easily decided by a physician than a judge." The judicial bypass is particularly unworkable in Alaska where rural communities may not have access to a court, resulting in a law that unreasonably impacts rural Alaskans.

HB 37 does not protect young women who are at risk from physical or emotional abuse by their parents and unconstitutionally restricts a young woman's right to choose to terminate a pregnancy.

Sincerely,

SO'F

Shannon O'Fallon
President
Juneau Coalition for Pro-Choice

Alaska State Legislature

Please enter into the record my testimony to the House State Affairs committee name

committee on 2-11-97, ~~dated~~ P.M. HB 37.

I am strongly against HB 37, regarding parental consent for minor abortions. I believe you are putting the health of young women in jeopardy. I know a girl who, upon finding she was pregnant, smoke, drank and starved herself to the point of aborting because her parents are fundamentalists & she believed, would have kicked her out of the house.

Signe

Sincerely,

Julie Marquardt

JULIE MARQUARDT

Box 6071, Sitka 99835

Alaska State Legislature

Please enter into the record my testimony to the House State of Affairs Committee on HB 37. "Parental Consent before a minor receives an abortion with a judicial by pass option. dated February 11. 1997.

In every case that I worked with, I have seen family bonds strengthened when a minor told her parents she was pregnant. Most parents love and care for their children and any thing that weakens the bond between parents and child destroys the family bonds of trust. It is inconceivable to me why any one who is not receiving money or personal satisfaction from weaking the bonds between parent and child, would want to help a minor sneak behind her parents back and have such an intrusive surgical procedure as an abortion. Remember it is the parents who are the ones who are left with their child's emotional and physical problems after an abortion. One such problem is increased risk of breast cancer in women who terminated their first pregnancy with an abortion. Studies at the Fred Hutchinsons' Cancer Center have verified this sad fact.

Please pass HB 37. Thank You.

Signed Virginia C. Phillips T
Testifier

Self
Representing(Optional)

404 Lake St., #2-D SITKA, AK 99835
Address

907-747-8024
Phone Number

STATE OF ALASKA
HOUSE OF REPRESENTATIVES

STATE AFFAIRS COMMITTEE
Representative Jeannette James, Chair

Room 102, Capitol Building, Juneau

Phone 465-3743, FAX 465-2381

Monday, February 10, 1997

Please add the attached letters to your State Affairs notebook on House Bill 37,

Parental Consent Before Minor's Abortion.

February 3, 1997

Represenative Jeanette James
716 West 4th Avenue
Anchorage, Alaska 99501

Dear Representative James:

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

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

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

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

Sincerely,

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

Alaska Women's Lobby
P.O. Box 210685 Anchorage 99521
211 Fourth Street Juneau #108 99801
586-1107
fax: 586-1097

POSITION PAPER

HB 37: Parental Consent Before Minor's Abortion

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

The Alaska Women's Lobby opposes House Bill 37. We wholeheartedly encourage open and honest communication between parents and their children, and support efforts to prevent teenage pregnancy. We don't believe, however, that HB 37 will accomplish either of those goals.

HB 37 places an untenable judicial burden on young women who, by virtue of their situation, are already facing difficult decisions. By requiring a teenager to seek judicial redress, HB 37assumes that young women in these situations not only have the resources to seek but also the access to obtain such redress.

In its 1992 decision in Planned Parenthood of Southeastern Pennsylvania v. Casey, the U.S. Supreme Court made it clear that states may not veto a woman's decision to terminate her pregnancy, but that states could impose restrictions so long as those restrictions don't have the "purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion." By requiring young Alaskan women to obtain judicial approval in order to terminate a pregnancy, HB 37 creates just the kind of "substantial obstacle" the U.S. Supreme Court decision prohibits.

HB 37 will not reduce the rate of teenage pregnancy, encourage teens to talk to their parents, or transform dysfunctional families into stable ones. It will force teens to take unwanted pregnancies to term, to have illegal abortions, or face the results of exacerbating an already troubled or dangerous home life.

The thousands of Alaskans represented by the Alaska Women's Lobby oppose HB 37.

NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

525 Main Street, Juneau AK 99801
586-4438 1-800-478-6279 Fax: 586-4439
naswak@alaska.net

Testimony Regarding

HB 37 - PARENTAL CONSENT FOR ABORTION

Before the
STATE AFFAIRS COMMITTEE
ALASKA HOUSE OF REPRESENTATIVES
February 6, 1997

Presented by
Angela M. Salerno, ACSW
Executive Director,
National Association of Social Workers Alaska Chapter

NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

525 Main Street, Juneau AK 99801
586-4438 1-800-478-6279 Fax: 586-4439
naswak@alaska.net

The National Association of Social Workers (NASW) is the world's largest organization of professional social workers. NASW's 155,000 members nationwide and 460 in Alaska work in a wide range of settings at all levels in the public and private sectors. Professional social workers focus on vulnerable populations and promote state and federal policies which enhance the lives of the people we serve.

Thank you for the opportunity to address the Committee on HB 37 - Parental Consent for Abortion.

NASW opposes HB 37 and does not recommend its passage.
A pregnant woman's constitutional right to choose between childbirth and abortion was established in 1973 by the Supreme Court's landmark ruling in *Roe V. Wade.* All women, including those under 18, are entitled to a safe, legal abortion.

Of the more than one million teenage pregnancies that occur in the United States each year, over 80 percent are unintended. Nearly all pregnant teens are unwed, and some 40% of them choose abortion. The bill before you will require that young women seeking to terminate an unwanted pregnancy receive the permission of parents, guardians or the court before receiving a safe, legal abortion.

This proposal will not act to promote desirable parental consultation. Ideally, a teenager should be able to tell her parents about her pregnancy, obtain their love and support and arrive at critical decisions about her future through family discussions. In fact, the majority of pregnant teenagers do tell at least one parent about their pregnancies. Based on a national survey of more that 1,600 unmarried minors having abortions in states without parental consent laws, 61% discussed the decision to have an abortion with at least one of their parents. The younger the minor, the more likely she was to have voluntarily discussed the abortion with her parents.

Parental involvement laws do not strengthen family relationships. The need to reinforce family relationships is the reason most often cited to justify state laws requiring parental consent before abortion. But such laws are unnecessary for stable and supportive families, and they are ineffective and cruel for unstable, troubled families. Some teenagers cannot tell their parents. Some are victims of incest or other forms of family violence - one study showed that 14% of minors having abortions believed that, if forced to tell their parents about their pregnancies, they would face physical abuse, and 11% feared violence between their parents. Mandatory parental consent cannot transform abusive families into supportive ones.

Mandating parental involvement poses health risks to teenagers. Young women already are more likely than older women to have later abortions, and parental involvement laws only cause further delays either because of fears of telling their parents or because of the inevitable delays in going to court for a judicial bypass hearing. While abortion at all stages of pregnancy is safer than childbirth, the risk of major complications increases 15 - 30% per week. Statistics compiled by the Federal Centers for Disease Control indicate that the risk of death from childbirth is, on average, 24 times higher than the risk of death from abortion up to 12 weeks of pregnancy. Following enactment of Minnesota's parental notification laws, second-trimester abortions among minors increased by 18%. Minors who cannot obtain an abortion in their small towns or villages must travel to other sites to have the procedure, are forced to carry their pregnancies to term, or resort to illegal abortion. Under Minnesota notification statute, the birth rate in Minneapolis for 15 -17 year olds rose 38%. The American Medical Association has long recognized that parental notification and consent requirements deter minors from seeking necessary health care. The desire to maintain secrecy has been one of the leading reasons for illegal abortion deaths since the Supreme Court recognized the constitutional right to abortion in 1973. Further, the AMA believes some minors may be physically or emotionally harmed if required to involve a parent in the abortion decision.

Teenagers faced with the choice between childbirth and abortion can make a responsible decision without parents or courts. The American Psychological Association has found that minors are usually able to make intelligent, informed decisions about pregnancy. Even young women from severely troubled families often show great maturity and sensitivity when seeking confidential birth services.

A judicial bypass option is inadequate and discriminatory in Alaska. Young women using this procedure often experience fear, anxiety and shame as they are forced to reveal detail of their private lives to strangers in the courtroom. Mandatory representation by the currently overburdened Office of Public Advocacy will surely result in delays or inadequate representation. In rural Alaska, confidentiality will be severely compromised as a young woman will most likely be recognized by the judge or other court personnel.

In Alaska, the courts are moving toward assigning teenagers greater responsibility for their actions, not imposing further restrictions. During the last legislative session lawmakers were successful in passing laws to treat certain juvenile offenders as adults. In the 20th Legislature, bills have been introduced to remove the protections of immaturity from teenagers who commit minor offenses. It is unfair to treat pregnant teens differently with proposals to strip personal responsibility in decisions about reproductive matters.

Parental consent laws are an unconstitutional attack on a women's right to abortion, and in Alaska, on an individual's right to privacy. *Roe v. Wade* entitled all women to legal, safe abortion. Parental consent as well as other provisions of SB 24 such as the creation of civil liability for performing abortion, are barriers manufactured to interfere with this constitutional guarantee. Should this bill become law in Alaska, there will most certainly be court challenges, as the Constitution of the State of Alaska specifically guarantees each citizen the right to privacy.

While NASW supports strong families and believes that parents have profound interests in their children's well-being, in the case of pregnancy, a teenager's privacy rights must be paramount. Courts have found that teenagers who want to keep their pregnancies a secret almost always have sound reasons. When there is a reason to expect an extremely abusive parental reaction to a young woman's unplanned pregnancy, her right to privacy must come first since she is in the best position to know whether or not she is in danger. A legislature that is unfamiliar with a young woman's particular situation is not is a position to force her to involve her parents. Where abortion is concerned, privacy can be a life or death matter for teenagers.

In acknowledging and affirming the social work profession's commitment to respecting diverse value systems in a pluralistic society, we recognize that the issue of abortion is controversial because it reflects the different value systems of different groups. Consequently, NASW does not take a position concerning the morality or immorality of abortion.

NASW's position concerning abortion services is based on the principle of self-determination. Every individual must be free to participate or not participate in abortion services. In the event that a woman choose abortion the following services should be available to her:

- *counseling and referral provided by professionally trained staff who are knowledgeable of the social and psychological dynamics of unwanted pregnancy and abortion*
- *safe surgical care, including pre- and post-operative services*
- *counseling regarding the use of contraception and the prevention of unwanted pregnancies*
- *provision of appropriate contraceptive devices. These devices should be available to all women.*

NATIONAL ASSOCIATION OF SOCIAL WORKERS
ALASKA CHAPTER

525 Main Street, Juneau AK 99801
586-4438 1-800-478-6279 Fax: 586-4439
naswak@alaska.net

FACTS ON ABORTION

Safety of Abortion

- 97% of women who obtain abortions before 13 weeks of pregnancy report no complications. (American Medical Association Council Report, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 1992).

- Abortion is 11 times safer than carrying a pregnancy to term. (Gold, R. B, *Abortion and Women's Health: A Turning Point for America?*, 1990).

- **Teenage girls are more than 24 times more likely to die from childbirth that from a first trimester, legal abortion.** (Ory, H W, "Mortality Associated with Fertility and Fertility Control," *Family Planning Perspectives,* vol. 15, no. 2).

- Of the 3.4 million woman who become pregnant unintentionally in the U.S. each year, approximately 1.6 million terminate their pregnancies by medically safe, legal abortion. (Gold, R. B, *Abortion and Women's Health: A Turning Point for America?*, 1990).

Health Risks to Women

- Legislation mandating parental involvement in decisions about abortion does **increase the risk of harm to the adolescent** by delaying access to appropriate medical care. (American Academy of Pediatrics, Committee on Adolescence, "The Adolescent's Right to Confidential Care When Considering Abortion," *Pediatrics*, vol. 97, no 3).

- Complication rates increase for abortions performed between 13 and 24 weeks. (American Medical Association Council Report, *Induced Termination of Pregnancy Before and After Roe v. Wade*, 1992).

- The American Medical Association noted that "because the need for privacy may be compelling, minors may be driven to desperate measures to maintain the confidentiality of their pregnancies. They may run away from home, obtain a "back alley" abortion, or resort to self-induced abortion. The desire to maintain secrecy has been **one of the leading reasons for illegal abortion deaths since...1973**. (AMA, "Mandatory Parental Consent," 83.).

Possible Links Between Abortion and Breast Cancer

- Only about 20 studies have examined the risk of developing breast cancer for women who have has abortions. (National Women's Health Network Fact Sheet: "*Abortion and Breast Cancer: The Unproven Link.*" January, 1994).

- Cancer researchers at the **National Cancer Institute,** the **American Cancer Society,** and major universities say that the most reliable studies show no increased risk, and they call the entire body of research inconclusive.

- **Harvard School of Public Health** researchers concluded in the January issue of *Cancer Causes and Control,* that abortion does not appreciably increase or decrease a woman's risk for breast cancer.

Long-Term Effects of Abortion

- Anti-choice groups are circulating unfounded claims that a majority of American women who choose to terminate their pregnancies suffer severe and long-lasting emotional trauma as a result. They call this largely nonexistent phenomenon "post-abortion trauma," or "post-abortion syndrome." They hope that terms like these will gain wide currency and credibility despite the fact that **neither the American Psychological Association nor the American Psychiatric Association recognizes their existence.**

- For most women who have had abortions, the procedure represents a maturing experience, a successful coping with a personal crisis situation. In fact, **the most prominent emotional response of most women to first-trimester abortion is relief.** (Zabin, L.S. et al. "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy." *Family Planning Perspectives*, 21(6), Nov/Dec 1989; Adler, N. et al. "Psychological Responses After Abortion." *Science*, April 6, 1990; Lazarus, A. "Psychiatric Sequelae of Legalized Elective First Trimester Abortion." *Journal of Psychosomatic Obstetrics & Gynecology,* 43(3), September 1985; Russo, N.F. and Zierk, K.L. "Abortion, Childbearing, and Women's Well-Being." *Professional Psychology: Research and Practice,* 23(4), 1992; Armsworth, M.W. "Psychological Response to Abortion." *Journal of Counseling and Development*, 69, March/April 1991.).

- A study of a group of teenage black women who obtained pregnancy tests at one of two Baltimore clinics found that the young women who choose to have abortions were **are more likely to graduate from high school** than those of similar socioeconomic status who carried their pregnancies to term or who were not pregnant. They showed no greater levels of stress at the time of the pregnancy and abortion and no greater rate of psychological problems two years after the abortion that did the other women. (Zabin, L.S. et al. "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy." *Family Planning Perspectives*, 21(6)).

- Up to 98% of the women who have abortions **have no regrets and would make the same choice again** in similar circumstances. (Dagg, P.K.B., MD "The Psychological Sequelae of Therapeutic Abortion - Denied and Completed." *American Journal of Psychiatry*, 148(5), May 1991).

- In July 1987, President Ronald Regan directed Surgeon General C. Everett Koop to provide the administration with a report on the health effects of induced abortion. In a letter to the president dated January 8, 1989, Dr. Koop stated that he could not form a conclusion with the available data. (Koop, C. Everett, letter to President Regan, January 9, 1989. Reproduced in "A Measured Response: Koop on Abortion," *Family Planning Perspectives,* 21(1), Jan/Feb, 1989.

- In a 1988 closed meeting, Surgeon General Koop told representatives from several anti-abortion organizations that the risk of **significant emotional problems following abortion was "minuscule"** from a public health perspective. (House Committee on Government Operations. "*The Federal Role*

in Determining the Medical and Psychological Impact of Abortions on Women, H.R. Rep. No. 329, 101st Congress, 2d Sess. 14 (1989)).

- In 1989, a panel of experts assembled by the **American Psychological Association** concluded unanimously that legal abortion **"does not create psychological hazards for most women undergoing the procedure."** The panel noted that, since approximately 21% of all U.S. women have had an abortion, if severe emotional reactions were common there would be an epidemic of women seeking psychological treatment. There is no evidence of such an epidemic. (Adler, N., University of California at San Francisco, statement on behalf of the American Psychological Association before the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, U.S. House of Representatives, March 16, 1989.)

Regarding Senate Bill No. 24 January 31, 1997
Regarding House Bill No. 37 February 6, 1997

My name is Sharylee Zachary,

My husband, Dan, and I have 3 wonderful daughters ages 11, 9, and 7. We are working hard and faithfully at instilling in them high moral values and standards to live by. For every action, there is a consequence and you should own up to those actions and consequences and not blame them on anyone else. No one else should pay the price for your consequences. But also, we stand together as a family to work through the happenings and consequences of our actions. We learn from them, deal with them, encourage each other to make wiser decisions the next time. We are teaching our children to be responsible and to look out for the welfare of those around them.

High on our list is to teach them the great value and sanctity of human life, a precious life that God has given to every conceived baby, whether that baby is two cells or full term. Ideally, we live our life so that a baby is conceived within the bonds of a love relationship between a husband and wife and we do not have sex until marriage. We believe in the preservation of the family unit.

I realize that one of the main reasons this bill has come about is because a lot of people don't feel this way and are not living their lives in this manner and are not teaching these truths to their children. Instead of living according to absolute moral values, they live by their 'feelings' and their 'right' as an American citizen to do what they please. The consequences have been disastrous to our nation. There is now a huge number of broken families, single parent families where there was never a marriage or commitment (just 'feelings'), and a huge abortion rate where the 'consequences' of peoples 'feelings', the resulting babies, are being slaughtered. We have a multitude of fatherless families living in poverty; crime is running rampant, -children are joining 'gangs' in order to find security and a 'family' feeling. The effects of the misuse of drugs and alcohol are running rampant. You are quite aware of all this, I know.

I also realize that another main reason this bill has come about is because of the pregnancy consequences women end up with because of the abuse they have suffered at the hand of some man (men) (which can take many forms). My heart aches for these women. And I am very sorry that our society has given them the message that the only way out is by handing down a death sentence to their unborn child.

I am grateful that this bill is designed to deciso strongly recognize the rights of the family and the parents to support their children through such crisis and to guide them in making wise sions.

Unfortunately, few people are taking appropriate responsibility for the consequences of their actions. For years, now, around the country children are being educated that, 'You

are going to have sex anyway so use condoms, they will protect you from disease and pregnancy'. Well, that does not work. Instead, we need to plant seeds in the children that they have the ability to live an abstinent lifestyle (which is the only true means of birth control and disease prevention) and still be happy and content. Then we need to raise up support groups to encourage that type of responsible behavior. Our children are told that if they get pregnant, the only way out is abortion. "And, by the way, lets keep it a secret from your parents, we will provide all you need to get the abortion." (Who usually pays for the medical costs as the result of the abortion? - the parents, not the clinic that botched things up!)

Talk about driving a major wedge in the parent/child relationship!!! Parents are not even given a chance to help their child through the crisis. If one of our daughters were to become pregnant, we would support her through the pregnancy, and help her make the wisest decision for her and her baby as far as keeping her baby or adoption into a healthy, loving family. It is unfortunate that everywhere you go there are people and resources outside the family who are filling our children with those types of lies.

Please continue to encourage the ability and right of the parents and families to support our children in times of crisis.

I realize that there are those parents who are currently abusing their children and would continue to treat their children badly (or worse) upon hearing the news of an unwanted pregnancy. And there are cases of incest and rape where people feel this is the time for an abortion. My husband and I, and hundreds of thousands of folks like us, are not ignorant nor cold-hearted toward the plight of these unfortunate children. But we do believe that if a baby is on the way, that viable life has a right to be born. Communities do need to support the mother through the pregnancy and onto a healthier life style. There also needs to be community help for the fathers to take on their responsibility for their actions, - they need support groups to help them, also. They should not be ignored. Many of them have had no positive role models to show them the way toward responsible behavior toward those around them, - as well as toward themselves. It is also really 'key' that Churches, once again, are allowed back into the arena of helping folks get their life in shape.

Please continue to work for legislation that does not allow for the breakdown of our families and our nation.

Two questions:

1) If this legislation does not pass, what provisions can be done for the family whose daughter, unknown to them, has had an abortion and is living through the emotional scars of that procedure, the emotional scars of the unwanted pregnancy and often the accompanied abandonment by the father, etc., - - there is something wrong with their daughter, and they don't have a chance to help her through it because they don't even know about it?

2) I have met several adult women who, while in their teens, were forced by their parents to have an abortion, - against their will, and they are still carrying the emotional (and some physical) scares this produced in their lives. Is there legislation to safeguard children against this type of abuse?

Alaska has made many wise pro-family, pro-nation choices in it's laws and I am very proud of that.

Alaska has to stand strong, not to go the route of many of the lower-48 states that are falling apart because of their unwise, anti-family choices in their living styles and laws.

Alaska needs to be the North Star state pointing the way to strong families, strong communities, strong states, and a strong nation founded and built on absolute values and taking responsibility for personal actions and the consequences thereof so that the innocent no longer suffer.

Very Sincerely and Respectfully,

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

THE LEAGUE
OF WOMEN VOTERS

House State Affairs Committee
Alaska State Legislature
Twentieth Legislature-First Session

February 8, 1997

Dear Committee Chair James:

On behalf of all Alaskan citizens who are members of the League of Women Voters, I urge you to oppose CSHB 37, relating to the requirement of parental consent before a minor can receive an abortion, and establishing a judicial bypass procedure. The League of Women Voters is dedicated to the protection of citizens' constitutional rights of privacy and freedom, in this case pertaining to reproductive choices, and we believe that CSHB 37 increases government intrusion into the private lives of citizens.

As you know, CSHB 37 adds the judicial bypass procedure required by the State Supreme Court to make a parental consent statute enforceable. However, we are concerned that teenage girls faced with the trauma of unwanted pregnancy will not be able to negotiate the many difficulties which a judicial bypass process presents. The idea that teenage girls will be able, knowledgeable and mentally prepared to pursue a judicial bypass to parental consent for an abortion is unrealistic and dangerous.

In the nineteen states with laws mandating parental consent, the result is delays which increase the physical and emotional health risk to the teenager. Requiring parental consent or judicial bypass adds time to the process, putting teenages into second trimester abortions and endangering their health. Oftentimes teens leave the state for an abortion, further adding an unnecessary health risk as they travel soon after the procedure and are distanced from professional and sterile facilities.

We believe that CSHB 37 is unnecessary, as most pregnant teens already consult one of their parents when faced with this difficult situation. Those teenagers who do not involve their parents are oftentimes victims of child abuse and fear that telling their parents would be dangerous. According to the federal district court which examined the effects of Minnesota's parental notification statute, "Notification of the minor's pregnancy and abortion decision can provoke violence, even where parents are divorced or separated." Again, it's a dangerous policy

Parental consent laws in other states have had a detrimental impact: Teens who cannot safely consult their parents face second trimester abortions due to delays, go out of state for abortions, and fear violent retribution should their parents find out. Please protect the health and safety of pregnant teens by opposing CSHB 37. Thank you.

Sincerely,

Marianne Mills

Marianne Mills, President
League of Women Voters of Alaska

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the HOUSE STATE AFFAIRS committee on HB 37 dated 2-11-97 teleconference.

My name is Ruth Ewig and I reside at 2325-30th Avenue. I am in complete support of HB37 and do commend Representative Pete Kelly and all the other pro-family legislators down in Juneau, on their continuing courage in support of the stable, traditional family.

In talking with my sixteen year old son, he shook his head, and expressed how ridiculous it is that abortions are possible without the parents involved or consenting.

HB37 is a bill of compassion, love, and protection for our youth, minors who by law are under parental guardianship, guidance, protection, and training. Abortion procedures vary but have included being hooked up to an IV at times. This can be quite traumatic if a teen is getting the abortion alone without support or input from loved ones. The post-abortion syndrome including depression, suicidal tendencies, and dysfunction for most of the rest of those teens' lives is very real and supported by statistics.

The argument that HB37 violates privacy is not applicable where greater harm results because of it, such as destroying a baby in the womb, the devastating isolation a teenage girl may subject herself to out of shame, which leads to disorders and death. Privacy does not mean undermining legal guardians, the parents, by performing abortions behind their backs, out of their control, and influence. Constitutionally, laws are put into place relative to others so that we may live together in a civilized society. Intimidation by special interests such as the Colorado attorney who testified threatening to sue the state if HB37 passes the legislature, should not be allowed to destroy and interfere with a greater good served by this bill, protection of the family unit. I would be interested in her money source enables her to file suit. Is this the notorious ACLU that is government-funded?

What an embarrassment it is that an ambulance service seeks parental consent before treating a minor, a parent must give permission for minors to have their ears pierced or get prescription medicines, but parental permission is not required to be informed by a doctor about serious surgery like abortion with its traumatic pre-syndrome and post-syndrome complications.

Vote YES for HB37, it is the only reasonable solution. I would like to be personally informed about the vote and results of this at every level. I have personal experience with the devastation and emotional impairment I have suffered in the wake of an abortion 24 years ago. I am in full agreement with the penalties which will result if a doctor recklessly performs an abortion without parental consent.

Sincerely Yours,

Ruth Ewig
2325-30th Avenue
Fairbanks, Alaska 99701
(Fairbanks, AK.)
Phone/Fax: 452-5538

STATE OF ALASKA
LEGISLATIVE AFFAIRS AGENCY
DIVISION OF PUBLIC SERVICES

DATE: 2/11/97

Please accept the enclosed original(s) of written testimony for the HB 37 teleconference hearing that was scheduled on 2/11/97.

A copy of this testimony was transmitted to your committee via fax on 2/10/97.

Thank you,

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

Alaska State Legislature

Please enter into the record my testimony to the House State Affairs committee name

committee on HB 37 bill/subject, dated Feb. 11, 1997.

2/10/97

Parental consent laws endanger teens' lives. We would all like to live in a world where all children could freely consult with their parents about what is happening in their lives. However, it is a fact that some teens live in dangerous situations, they justifiably fear abuse, neglect, death and other horrific scenarios if they had to admit to their parents that they were pregnant and choosing a legal procedure to terminate their pregnancy.

Fortunately, parents have thousands of opportunities to open communication with their teenagers, and to show them that they can be trusted, empathetic and supportive as parents. This is the kind of family communication that, for many, prevents the need for abortion in the first place. This is where the communication ought to happen; communication should not be legislated into the lives of families by laws like parental consent.

Sincerely,

Signed: Diane Kvalnes
Testifier

Representing (Optional)

1830 Edgecumbe Dr. Sitka 99835
Address

907-747-7851
Phone No.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Alaska State Legislature

Please enter into the record my testimony to the House State Affairs committee name committee on HB 37 bill/subject, dated Feb. 11, 1997.

2/10/97

Parental consent laws endanger teens' lives. We would all like to live in a world where all children could freely consult with their parents about what is happening in their lives. However, it is a fact that some teens live in dangerous situations, they justifiably fear abuse, neglect, death and other horrific scenarios if they had to admit to their parents that they were pregnant and choosing a legal procedure to terminate their pregnancy.

Fortunately, parents have thousands of opportunities to open communication with their teenagers, and to show them that they can be trusted, empathetic and supportive as parents. This is the kind of family communication that, for many, prevents the need for abortion in the first place. This is where the communication ought to happen; communication should not be legislated into the lives of families by laws like parental consent.

Sincerely,

Diana Kushner

Diana J. Kushner, Sitka Alaska

Signed: Diana Kushner
Testifier

Representing (Optional)

1830 Edgecumbe Dr. Sitka 99835
Address

907-747-7851
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House State of Affairs Committee on HB 37, "Parental Consent before a minor receives an abortion with a judicial by pass option. dated February 11, 1997.

In every case that I worked with, I have seen family bonds strengthened when a minor told her parents she was pregnant. Most parents love and care for their children and any thing that weakens the bond between parents and child destroys the family bonds of trust. It is inconceivable to me why any one who is not receiving money or personal satisfaction from weaking the bonds between parent and child, would want to help a minor sneak behind her parents back and have such an intrusive surgical procedure as an abortion. Remember it is the parents who are the ones who are left with their child's emotional and physical problems after an abortion. One such problem is increased risk of breast cancer in women who terminated their first pregnancy with an abortion. Studies at the Fred Hutchinsons' Cancer Center have verified this sad fact.

Please pass HB 37. Thank You.

Signed Virginia C. Phillips T
Testifier

Self
Representing(Optional)

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

907-747-8024
Phone Number

Alaska State Legislature

Please enter into the record my testimony to the House State Affairs committee name committee on 2-11-97, ~~dated~~ on HB 37.

I am strongly against HB 37, regarding parental consent for minor abortions.

I believe you are putting the health of young women in jeopardy. I know a girl who, upon finding she was pregnant, smoke, drank and starved herself to the point of aborting because her parents are fundamentalists & she believed, would have kicked her out of the house.

Signe

Sincerely,

Julie Marquardt

JULIE MARQUARDT

Box 6071, Sitka 99835

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

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

"Parental Consent of Minors Seeking Abortion"

My name is Sharylee Zachary,

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

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

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

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

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

Very Sincerely and respectfully,

Sharylee M Zachary

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

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

THE LEAGUE
OF WOMEN VOTERS

2806 John Street #2
Juneau, Alaska 99801
February 14, 1997

Representative Jeannette James
Alaska State Legislature
Juneau, Alaska 99801-1182

Dear Representative James:

Last week I sent a letter via FAX to members of the House State Affairs Committee relating to House Bill 37. I made the mistake of using the FAX machine at my place of employment, Catholic Community Service (CCS), which has created some confusion. Since the FAX received indicates "Catholic Community Service" at the top, some folks wondered if my message reflected the opinion of CCS. I wish to emphasize that **the contents of the faxed material in no way was related to or reflected the views of CCS**. Should this issue come up among your colleagues, please let them know that.

I apologize for any confusion my FAX may have caused.

Sincerely,

Marianne Mills

Marianne Mills

Parental Consent

February 3, 1997

Represenative Jeanette James
716 West 4th Avenue
Anchorage, Alaska 99501

Dear Representative James:

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

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

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

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

Sincerely,

Jan Whitefield

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

4115 Lake Otis Parkway • Anchorage, Alaska 99508 • (907) 563-7228

Alaska State Legislature

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

committee on HB 37 bill/subject, dated 2-13-97.

As a parent and fellow Alaskan, I ask your support of HB 37. This is a very important bill for families - for family freedom, for family cohesiveness, for parental responsibility. The privacy propaganda and unconstitutionality is bunk, pure and simple. Indeed, it is liberal judges with this same mind set that have, in fact, invaded family privacy to allow a child's abortion surgery without a parent's knowledge or consent. Parental consent & knowledge was constitutional for the first 200 years in this nation and still is. If the state intervenes in the parent/child relationship and takes the parents' responsibility away from them in a life and death situation, as well as a major surgery decision, such as abortion on their child, the state is close to taking all responsibility from parents for raising their children. Please support HB 37 for the sake of Alaskan Families.

Signed: Nina N Medendorp

Testifier

Representing (Optional)

PO Box 595 STERLING, AK 99672

Address

262-9319

Phone No.

STATE of ALASKA

Delta Junction Legislative Information Office

P.O. Box 1189
Room 210, Jarvis Office Center
Delta Junction, AK 99737
(907) 895-4236 Fax: (907) 895-5017

February 11, 1997

TO: House State Affairs
Please accept the enclosed originals of written testimony for the House State Affairs hearing that was scheduled on 2/11/97.

Copies of this testimony were transmitted by fax on 2/11/97.

Thank you,

Tammy Renee' Hall
Information Assistant

Enclosures: 1

Alaska State Legislature

Please enter into the record my testimony to the HOUSE STATE AFFAIRS committee name committee on HB 307 bill/ subject, dated 11 FEB. 1997.

I am testifying + sending this POM as a parent. My husband + I have 2 adult sons, both married, + 1 granddaughter.

As a parent, I am concerned about parental rights + responsibilities. Parents are given the responsibility, including the teenage but still minor years, to guide their children in safety toward adulthood, including guiding their children to make good choices along the way. I believe parents also have a right to know of crucial choices happening along the way. If parental consent is needed for school field trips, + taking of any medication at school, surely consent should be needed for a surgical procedure, such as abortion. The risk in an abortion to the baby is obvious + immediate – the risk to that girl is present also, both physically + emotionally. For a parent to not be included in that decision makes absolutely no sense to any thinking person. I urge a YES vote on this bill.

Signed: BARBARA KAMALT

Testifier

REPUBLICAN PARTY OF AK - DIST 35 FINANCE CHAIR

Representing (Optional)

PO BOX [redacted] DELTA JCT, AK 99737

Address

(907) 895-1946

Phone No.