

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10199 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

HB

1 1 2

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

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

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: Services available to pregnant women/ BRU: State Health Services
informed consent for abortion Component: Maternal, Child, & Family Hlth
 Sponsor: Rep Coghill
 Requester: House (HES) Component Number: 290

Expenditures/Revenues (Thousands of Dollars)

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

| OPERATING EXPENDITURES | FY 2002 | FY 2003 | FY 2004 | FY 2005 | FY 2006 | FY 2007 |
|------------------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Personal Services | 22.1 | 23.9 | 25.7 | 27.5 | 29.3 | 31.1 |
| Travel | 10.0 | 4.0 | 4.2 | 4.4 | 4.3 | 4.5 |
| Contractual | 16.0 | 5.5 | 3.2 | 3.3 | 3.3 | 3.4 |
| Supplies | 2.0 | 1.0 | 0.8 | 0.9 | 0.9 | 1.0 |
| Equipment | | | | | | |
| Land & Structures | | | | | | |
| Grants & Claims | | | | | | |
| Miscellaneous | | | | | | |
| TOTAL OPERATING | 50.1 | 32.4 | 33.9 | 36.1 | 37.8 | 40.0 |

| | | | | | | |
|-----------------------------|--|--|--|--|--|--|
| CAPITAL EXPENDITURES | | | | | | |
|-----------------------------|--|--|--|--|--|--|

| | | | | | | |
|-------------------------------|--|--|--|--|--|--|
| CHANGE IN REVENUES () | | | | | | |
|-------------------------------|--|--|--|--|--|--|

FUND SOURCE (Thousands of Dollars)

| | | | | | | |
|--------------------------|-------------|-------------|-------------|-------------|-------------|-------------|
| 1002 Federal Receipts | | | | | | |
| 1003 GF Match | | | | | | |
| 1004 GF | 50.1 | 32.4 | 33.9 | 36.1 | 37.8 | 40.0 |
| 1005 GF/Program Receipts | | | | | | |
| 1037 GF/Mental Health | | | | | | |
| Other (Specify Type) | | | | | | |
| TOTAL | 50.1 | 32.4 | 33.9 | 36.1 | 37.8 | 40.0 |

Estimate of any current year (FY2001) cost: 0.0

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

POSITIONS

| | | | | | | |
|-----------|---|--|---|---|---|---|
| Full-time | | | | | | |
| Part-time | 2 | | 2 | 2 | 2 | 2 |
| Temporary | | | | | | |

ANALYSIS: (Attach a separate page if necessary)

Personnel: \$22.1

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

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

Travel: \$10.0

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

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

Prepared by: Karen E. Pearson Phone (907) 269-3408
 Division: Public Health Date/Time 2/12/01 12:00 AM
 Approved by: Elmer A. Lindstrom, Special Assistant Date _____
 Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

Revision Date:

Bill Version:

ANALYSIS: HB 112 (continued)

Contractual: \$16.0

Material printing costs:

Initial \$10.0

Ongoing \$ 2.0

Postage:

Initial \$6.0

Ongoing \$1.5

Supplies: \$2.0

Initial \$2.0

Subscriptions/books for ANP \$0.5

Envelopes \$0.7

Letterhead \$0.8

Ongoing \$1.0

Alaska Civil Liberties Union

An Affiliate of the American Civil Liberties Union

P. O. Box 201844, Anchorage, AK 99520-1844

Phone: (907) 258-0044 Fax: (907) 258-0288 Email: akclu@alaska.net

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

Re: **HB 112 – MANDATORY EXTRA “COUNSELING” FOR ABORTION**

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much for your careful consideration.

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AMERICAN CIVIL LIBERTIES UNION

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

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

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

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

- The National Cancer Institute has charged that the study has been interpreted inaccurately and "[t]here is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion."²
- The American Cancer Society has concluded, "the inconsistencies of existing research do not permit definitive scientific conclusions."³
- On the day the study was published, JNCI printed an editorial stating that "the overall results [of the study] as well as the particulars are far from conclusive, and it is difficult to see how they will be informative to the public." The study was particularly criticized because of the methodological problem of possible inaccurate reporting of a history of abortion by participants.⁴
- Four recent reviews published in scientific journals have assessed more than 30 studies and concluded that the available data on the relationship between induced or spontaneous abortions and breast cancer are inconclusive.⁵
- A 1995 article in Cancer Causes and Controls reported on "Abortion and Breast Cancer Causes in Seven Countries." The study concluded, "In summary, these data suggest that any overall relation between abortion and risk of breast cancer is likely to be weak at most."⁶



Alaska State Legislature

Please enter into the record my testimony to the House Health, Education & Social
 committee name Services
 committee on HB 112, dated 4/21/01
 bill/subject

PLEASE SEE TESTIMONY ATTACHED

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

Signed: Dr. Bob Johnson
 Testifier

Representing (Optional)
PO Box 945 Kodiak, Ak 99615
 Address

Phone No.

ABORTION
(12-09-93)

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

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

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

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

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

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

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

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

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

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

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

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE COGHILL

TO: HB 112

1 Page 3, line 9:

2 Delete "make"

3 Insert "advertise the availability of"

4

5 Page 3, line 10:

6 Delete "available"

7 Insert "and distribute the information"

8 Following "requester.":

9 Insert "The department shall also place the information in public hospitals,
10 clinics, or other health facilities throughout the state and, upon request of an
11 administrator, in a private hospital, clinic, or health facility so that members of the
12 public may obtain the information voluntarily, without request."

Alaska State Legislature



Interim:

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Fairbanks, AK 99701
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(907) 456-8245 - Fax

Session:

State Capitol, Room 102
Juneau, AK 99801
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(907) 465-3258 - Fax

Representative John Coghill

Sponsor Statement

HB 112

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

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

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

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

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Representative John Coghill

Sectional analysis - HB 112

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

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

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

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

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

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

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

CURRENT STANDARD:

ALASKA ADMINISTRATIVE CODE - ABORTION/INFORMED CONSENT

2 AAC 40.070

INFORMED CONSENT.

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

History -

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

Authority -

AS 08.64.105

Sec. 08.64.105. Regulation of abortion procedures.

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

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

EXAMPLE:

AS 18.16. REGULATION OF ABORTIONS

AS.18.16.010. Abortions.

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

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

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

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

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

HB 112 WOULD INSERT:

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

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

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

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

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

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

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

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

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

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Representative John Coghill

"INFORMED CONSENT FOR ABORTION" LAWS IN THE UNITED STATES

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

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

- ❖ 21 states have introduced legislation concerning this issue in 2001 to both initiate laws and to update current laws.
- ❖ Alaska is one of 12 states that have legislation in 2001 that would update the current state laws on abortion informed consent.
- ❖ Separate medical informed consent laws for abortion procedures have been upheld at the Federal level (U.S. Supreme Court *Casey*). 7 states currently have their laws enjoined due to state court rulings. The central issue behind these injunctions being that the laws also required a waiting period, which was ruled unconstitutional under the individual state constitutions.
- ❖ The determining factor for federal constitutionality of informed consent laws is the judgment of whether or not the laws pose an undue burden to a woman seeking an abortion.

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

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

(H) Health, Education, & Social Services

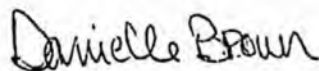
House Bill 112

Representatives,

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

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

Thank you for your time,



Danielle B. Brown

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Juneau, AK 99802
(907)586-6665

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Representative John Coghill

MEMORANDUM

To: Representative Fred Dyson, Chairman
House Health, Education & Social Services Committee

From: Representative John Coghill

Re: Request for hearing - HB 112

Date: February 22, 2001

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

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

Subject: TESTIMONY--HB112

Date: Sun, 22 Apr 2001 10:31:30 -0800

From: "R. Holmes Johnson" <drbob@keconnect.net>

To: Representative_Fred_Dyson@legis.state.ak.us

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

Dear Mr. Dyson,

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

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

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

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

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

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

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

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

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

Sincerely,

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

HB 112: Testimony

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

Debbie Joslin



Alaska State Legislature

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

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

I would urge PASSAGE of this information ENSURING INFORMED CONSENT before AN ABORTION may be performed. The consequences of AN ABORTION ARE SO MANY & SO SERIOUS. They include POTENTIAL DAMAGE to the CERVIX, UTERUS, TUBES AND BREASTS. MAJOR IMMEDIATE complications include INFECTION, EXCESSIVE BLEEDING, RIPPING or PERFORATION of the UTERUS, ANESTHESIA complications, CONVULSIONS AND HEMORRHAGING. WOMEN who HAVE HAD A SURGICAL ABORTION ARE AT HIGHER RISK for BREAST CANCER, PREGNANCY complications, MIS-CARRIAGE, PREMATURE delivery AND depression. A study reported in the MARCH issue of the AMERICAN JOURNAL of DRUG & ALCOHOL ABUSE found that WOMEN with ONE ABORTION were 5 TIMES more likely to ABUSE DRUGS OR ALCOHOL. A RECENT study of GOVERNMENT MEDICAL RECORDS in FINLAND found that the RISK of SUICIDAL death to be 6 TIMES higher in women who HAVE HAD ABORTIONS. JOEL BRIND, founder of the BREAST CANCER PREVENTION INSTITUTE in FIGHTKEEPSIE N.Y. estimated that AS MANY AS 10,000 BREAST CANCER CASES EACH YEAR ARE due to induced ABORTIONS. WOMEN ARE AT RISK AND ITS UNREALISTIC to expect the ABORTION INDUSTRY to TALK WOMEN out of AN ABORTION. They MAKE their income by PROVIDING ABORTIONS. The STATE or A NEUTRAL

Signed: ROSANNE CURRIAN

Testifier

Representing (Optional)

Address

Phone No.

party needs to inform these women of the RISKS of EMOTIONAL HEARTACHE inherent in AN induced ABORTION.

MARY M. DYE

April 21, 2001

Attn: Randy Lorenz

Representative Dyson
Alaska State Legislature
Alaska State Capitol

Re: House Bill NO. 112

Dear Chairman Dyson and Members of the Committee,

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

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

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

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

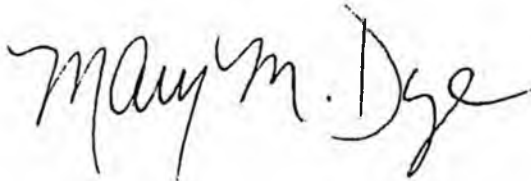
"The American Civil Liberties Union (ACLU) is our nation's guardian of liberty, working daily in courts, legislatures and communities to defend and preserve the individual rights and liberties guaranteed to all people in this country by the Constitution and laws of the United States." Apparently, guardianship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

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

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

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

Sincerely,

A handwritten signature in cursive script that reads "Mary M. Dye". The signature is written in dark ink and is positioned below the typed name "Mary Dye" in the header.

MIEC Loss Prevention Claims Alert

Number 17
September 1998

Informed Consent Revisited: What is Expected of Physicians

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

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

Why we have consent laws

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

Implied consent for minor procedures and for emergencies

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

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

Benefits of Informed consent

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

When consent is withheld for religious reasons

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

MIEC's Claims Department will attempt to assist an insured in situations in which a court order may be

needed. See the state law insert for additional discussion of this topic.

Answers to common questions about informed consent

Does getting the patient's signature on a consent form suffice?

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

Who is responsible for obtaining a patient's informed consent?

In most jurisdictions, obtaining consent is the obligation of the physician who will perform a procedure. (State law may allow consent to be obtained by another physician who is able to perform the procedure and is familiar with the benefits and risks, but who may not perform the procedure on the subject patient. This is a common practice among anesthesiologists and radiologists.) Courts have recog-

nized that, with respect to a specific patient, only a qualified physician can determine if a procedure is indicated and explain the risks for that patient. Nonphysicians, including nurses and medical assistants, can help educate patients in a general way about a procedure and answer basic questions. But the physician must "fine tune" this information, based on a specific patient's medical condition and history.

How much information does a patient need to give an informed consent?

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

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

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

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

Do risks have to be disclosed if the patient does not want to know?
Patients can decline an informed consent discussion, a decision the physician should document. If the

surgery is elective or if nonsurgical alternatives are possible, the physician should encourage the patient to listen to the choices and their risks. Prudent physicians often decline to do elective surgery if a patient is unwilling to be informed about potential risks, adverse outcomes or failure of the surgery. Such patients usually have unrealistic expectations.

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

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

Document consent, refusal

For reasons noted earlier, a signed consent form is less likely to be questioned in litigation if it is backed up by a physician's handwritten or dictated note that verifies an informed consent was obtained. Defense attorneys recommend that

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

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

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

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

Use audiovisual, written aids

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

reduce the amount of time the physician must spend explaining and reiterating.

Summary of Recommendations

1. Understand your state's informed consent laws. Get advice from MIEC's Loss Prevention or Claims Departments if in doubt about what is required in specific situations.
2. Ask colleagues in your specialty what they disclose to patients about specific procedures; physicians in group practices should know how their colleagues obtain and document informed consent.
3. Use plain language to explain medical procedures to patients. The law does not require physicians to give patients a mini-course in medicine or to disclose every problem that could occur.
4. Encourage patients to ask questions. Consider asking the patient to invite a spouse or other relative to join in the informed consent discussion. Don't be offended if a patient seeks a second opinion about the surgery or tests you recommend. Third-party payers often require second opinions; support for your recommendation is a plus.
5. Train your staff to assist you to educate patients and families generally about treatment or surgery. Use written materials, models and audiovisual aids to supplement discussions. Document educational efforts.
6. At the conclusion of an informed consent discussion, ask the patient to sign a consent form, even if the

hospital has its own. Sign the form yourself and give the patient a copy.

7. Document a summary of your informed consent discussions in your office chart and in the hospital admitting history and physical report (not in the operative report); include the name and relationship of others who were present, and the name of foreign or sign language interpreters who participated in your discussions with the patient.
8. Don't wait until the last minute to discuss a surgery or procedure in order to obtain a patient's informed consent.
9. Don't delegate the task of obtaining a patient's informed consent to your staff or to hospital staff. Although these individuals can help educate patients in a general way about a planned surgery or procedure, a physician should explain to individual patients why they need surgery, what the risks are, and feasible alternatives for that patient.
10. Don't confuse "informed consent" with "consent form." In most jurisdictions, a signed consent form carries little weight if the physician has not discharged his or her obligation to inform a patient of the material risks of a surgery or procedure, as discussed in this newsletter.
11. Don't give guarantees, make exaggerated claims or minimize risks. Patients should understand that problems can occur under the best of circumstances and in the most skilled hands. Refer to the literature, and consider your own experience when responding to questions about the historical success of a surgical procedure.

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

Alaska Supplement to MIEC Claims Alert #17

Informed Consent Revisited: What is Expected of Physicians

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

Informed Consent

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

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

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

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

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

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

The Alaska Supreme Court has held that a physician is obligated to provide, in layman's terms, the information that a reasonable person in the patient's position would need to know in order to make an informed and intelligent decision about the proposed treatment. A

physician must disclose all "material" risks. A risk is material if the probability of that type of harm is a risk a reasonable patient would consider in deciding on treatment. A physician must not only disclose the identity of all known material risks, but also the likelihood of their occurrence in meaningful terms. [Korman v. Mallin, 858 P.2d 1145 (Alaska 1993)]

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

The decision to withhold such information is based on a practitioner's medical judgment and must be substantiated in order to stand up in a court of law. Three basic criteria should be taken into account in reaching the conclusion that

information should be withheld or phrased in such a way as to not upset the patient:

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

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

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

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MIEC Claims Alert #17

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

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

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

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

When a patient is mentally incapable of giving informed consent, a physician or mental health professional is required to

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

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

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

Who is responsible for obtaining consent?

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

Consent for treating minors

The age of majority in Alaska is

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

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

Payment for treatment of a minor

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

Treating minors in emergencies

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

Parental consent for minor seeking an abortion

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

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

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

The State of Alaska is appealing Judge Tan's decision to the Alaska

Supreme Court. MIEC will notify Alaska policyholders of the Supreme Court's ruling.

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

'Informed Refusal'

Patients have the right to refuse medical treatment, surgery, or diagnostic tests. When a test or procedure is recommended but initially declined, physicians are encouraged to inform patients of the consequences of their refusal to undergo recommended treatment, surgery, or diagnostic tests.

Because it is not always possible to know the eventual effect of the

patient's failure to accept a physician's advice, the consequences of the patient's decision sometimes must be discussed in general terms. When the consequences are likely to be significant, such as the worsening of an existing condition, serious bodily harm or death, or the possibility that a serious disease will go undetected, the physician should review these possibilities with the patient. Whenever a patient refuses to undergo recommended treatment, surgery, or diagnostic tests, the physician should note the patient's decision in the medical chart, and also indicate that the risks of the decision have been discussed with the patient. As with all entries, such notes should be initialed and dated.

Revised October 1998

From the Loss Prevention Department, Medical Insurance Exchange of California
6250 Claremont Avenue, Oakland, CA 94618
Phone: 800/ 227-4527 • Fax: 510/ 420-7066 • E-mail: lossprevention@miec.com

Physician's Surgery and Procedure Consent Form (For completion at conclusion of informed consent discussion)

Date: _____ Time: _____ am/pm

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

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

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

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

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

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

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

7. I do not have allergies or intolerance to anything except _____
Initials

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

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

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

Physician's signature Signature of patient, parent or person authorized to sign for patient

COPY GIVEN TO PATIENT

Subject: TESTIMONY--HB112

Date: Sun, 22 Apr 2001 10:31:30 -0800

From: "R. Holmes Johnson" <drbob@keacconnect.net>

To: Representative_Fred_Dyson@legis.state.ak.us

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

Dear Mr. Dyson,

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

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

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

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

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

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

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

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

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

Sincerely,

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



ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the House HESS
Committee Name
 Committee on HB 112 Informed Consent Dated Mar 8, 2001
Bill / Subject

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

SIGNED:

Ruth Ewig
 Testifier

Alaska Interior Right to Life
 Representing

2325 - 35th Avenue, Fairbanks, Alaska 99701
 Address / Phone Number

HB112

~~HB112~~ Testimony

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

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

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

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

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

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

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

I am telling you this story so you can understand why I stand before you today and ask that you pass ~~HR 29~~ H 112

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

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

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

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

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

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

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

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

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

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

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

Thank you.

Debbie Joslin

Box 377
Delta Junction, AK 99737

(907) 875-4565

Alaska Civil Liberties Union

An Affiliate of the American Civil Liberties Union

P. O. Box 201844, Anchorage, AK 99520-1844

Phone: (907) 258-0044 Fax: (907) 258-0288 Email: akclu@alaska.net

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much for your careful consideration.

MAR-07-01 03:04 PM AK WOMENS HEALTH

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P. 02

March 7, 2001

Rep. Fred Dyson

Rep. Peggy Wilson

Rep. John Coghill, Jr.

Rep. Vic Kotiring

Rep. Gary Stevens

Rep. Sharon Cissna

Rep. Reggle Joule

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

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

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

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

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

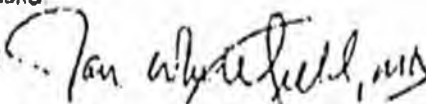
of carrying a pregnancy to term? Of what value are these pictures? When I counsel patients regarding an ongoing pregnancy or an abortion, should a patient ask me for drawings or photographs of a fetus at various stages of development, I have an encyclopedia containing the information, and I go over it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

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

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

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

Jan Whitefield



Medical Director, Alaska Women's Health Services

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

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

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

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

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

Testimony of Renee Gayhart

Re: HB 112

March 8, 2001

House Health, Education, and Social Services Committee

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

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

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

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

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

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

ALASKA STATE LEGISLATURE



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

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-6600
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SENATOR LYDA GREEN
SENATE DISTRICT N

Memo

To: Representative Fred Dyson, Chairman of the House HESS Committee
From: Senator Lyda Green *Lyda*
Date: 03/22/01
Re: Hearing Request for CS Senate Bill 112 (FIN), An Act placing certain employees of the Alaska Mental Health Trust Authority in the exempt Service; and establishing a minimum salary for the long term care ombudsman.

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

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

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

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

Thank you for your consideration of this request.

LG/hn

ALASKA STATE LEGISLATURE



Interim:

600 East Railroad Avenue
Wasilla, Alaska 99654
(907) 376-3370
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Session:

State Capitol
Juneau, Alaska 99801-1182
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SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE
SENATOR LYDA GREEN, CHAIR

SPONSOR STATEMENT
SB 112

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

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

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

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

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

LG/hm

SENATOR LOREN LEMAN, VICE-CHAIR
SENATOR JERRY WARD, SENATOR GARY WILKEN, SENATOR BETTYE DAVIS

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

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

Revision Date/Time (Note if correction): _____ Dept. Affected: Revenue
Title: Long-Term Care Ombudsman; BRU: Mental Health Trust Authority
Mental Health Trust Authority Component: Mental Health Trust Authority
Sponsor: Senate Health, Education & Social Services
Requester: Senate Health, Education & Social Services Component Number: 1423

Expenditures/Revenues (Thousands of Dollars)

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

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

FUND SOURCE (Thousands of Dollars)

| | | | | | | |
|---------------------------|------------|------------|------------|------------|------------|------------|
| 1002 Federal Receipts | | | | | | |
| 1003 GF Match | | | | | | |
| 1004 GF | | | | | | |
| 1005 GF/Program Receipts | | | | | | |
| 1037 GF/Mental Health | | | | | | |
| Other (Specify Type) 1094 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| TOTAL | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

Estimate of any current year (FY2001) cost: 0.0

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

POSITIONS

| | | | | | |
|-----------|--|--|--|--|--|
| Full-time | | | | | |
| Part-time | | | | | |
| Temporary | | | | | |

ANALYSIS: (Attach a separate page if necessary)

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

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

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

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

For distribution information, call the Governor's Legislative Office

SB 112 LONG-TERM CARE OMBUDSMAN; MENTAL HEALTH AUTHORITY

SECTIONAL ANALYSIS

Prepared by Aurora Hauke, Senate HESS Committee Aide

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

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

The T
TRUST

The Alaska Mental Health Trust Authority

February 27, 2001

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

Re: SB 112

Dear Senator Green,

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

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

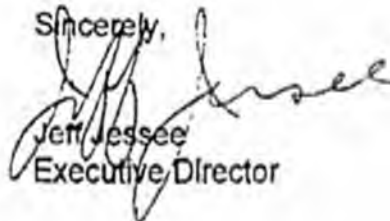
At the time the initial Board of Trustees was appointed in 1995, it was forced to petition the State Personnel Board to have the Executive Director position established as partially exempt. Without this action, the Trustees would have been seriously restricted in their ability to hire an appropriate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

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

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

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

Sincerely,



Jeff Jesse
Executive Director

Cc: Board of Trustees

Alaska Civil Liberties Union

An Affiliate of the American Civil Liberties Union

P. O. Box 201844, Anchorage, AK 99520-1844

Phone: (907) 258-0044 Fax: (907) 258-0288 Email: akclu@alaska.net

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much for your careful consideration.



AMERICAN CIVIL LIBERTIES UNION

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

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

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

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

- The National Cancer Institute has charged that the study has been interpreted inaccurately and "[t]here is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion."²
- The American Cancer Society has concluded, "the inconsistencies of existing research do not permit definitive scientific conclusions."³
- On the day the study was published, JNCI printed an editorial stating that "the overall results [of the study] as well as the particulars are far from conclusive, and it is difficult to see how they will be informative to the public." The study was particularly criticized because of the methodological problem of possible inaccurate reporting of a history of abortion by participants.⁴
- Four recent reviews published in scientific journals have assessed more than 30 studies and concluded that the available data on the relationship between induced or spontaneous abortions and breast cancer are inconclusive.⁵
- A 1995 article in Cancer Causes and Controls reported on "Abortion and Breast Cancer Causes in Seven Countries." The study concluded, "In summary, these data suggest that any overall relation between abortion and risk of breast cancer is likely to be weak at most."⁶

- A 1996 article in the Journal of the American Medical Association evaluating the association between pregnancy terminations and risk of breast cancer concluded, "Our data suggest that the risk of breast cancer associated with any pregnancy termination is likely to be small, if it exists at all."⁷
- The California Medical Association convened a task force to review all of the literature on abortion and breast cancer. The task force found the evidence to be inconclusive. "Some studies reported an adverse effect, some no effect, and some a positive effect. . . . [E]vidence is insufficient to support claims that induced abortion has an effect on the later development of breast cancer." This position was adopted by the American College of Obstetricians and Gynecologists (ACOG).⁸
- A widely noted 1997 study of more than 1.5 million women in Denmark, where abortion histories are corroborated by a government sponsored medical registry, and no chance of reporting bias exists, concluded that "induced abortions have no overall effect on the risk of breast cancer." In a New England Journal of Medicine editorial accompanying the Danish research, Dr. Patricia Hartge of the National Cancer Institute said of the study. "[I]t provides important new evidence to resolve a controversy that previous investigations have been unable to settle. . . . In short, a woman need not worry about the risk of breast cancer when facing the difficult decision of whether to terminate a pregnancy."⁹

February 1997

1. Janet R. Daling, Kathleen E. Malone, Lynda F. Voigt, Emily White, and Noel S. Weiss, "Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion," Journal of the National Cancer Institute, Vol. 86, No. 21, November 2, 1994.
2. National Cancer Institute, Department of Health and Human Services, Risk of Breast Cancer Associated with Abortion. Washington, DC, February 13, 1996.
3. American Cancer Society, "Abortion and Breast Cancer" Fact Sheet, Document 002039, January 5, 1996.
4. Lynn Rosenberg, "Induced Abortion and Breast Cancer: More Scientific Data Are Needed," Journal of the National Cancer Institute, Vol. 86, No. 21, November 2, 1994.
5. Supra note 2; Karin B. Michels and Walter C. Willett, "Does Induced or Spontaneous Abortion Affect the Risk of Breast Cancer?," Epidemiology, Vol. 7, No. 5, September 1996. A contrasting opinion is offered by Joel Brind, Vernon M. Chinchilli, Walter B. Severs, Joan Summy-Long, "Induced Abortion as An Independent Risk Factor for Breast Cancer: A Comprehensive Review and Meta-Analysis," Journal of Epidemiology and Community Health, Vol. 50, No. 5, October 1996.
6. Karin B. Michels, Chung-cheng Hsieh, Dimitrios Trichopoulos, and Walter C. Willett, "Abortion and Breast Cancer Risk in Seven Countries," Cancer Causes and Controls, Vol. 6, 1995.
7. Polly A. Newcomb, Barry E. Storer, Matthew P. Longnecker, Robert Mittendorf, E. Robert Greenberg, and Walter C. Willett, "Pregnancy Termination in Relation to Risk of Breast Cancer," Journal of the American Medical Association, Vol. 275, No. 4, January 24, 1996.
8. "Statement on Links Between Induced Abortion and Subsequent Breast Cancer," ACOG Newsletter, September 1995.
9. Mads Melbye, Jan Wohlfahrt, Jorgen H. Olsen, Morten Frisch, Tine Westergaard, Karin Helweg-Larsen, and Per Kragh Andersen, "Induced Abortion and the Risk of Breast Cancer," New England Journal of Medicine, Vol. 336, No. 2, January 9, 1997.



Alaska State Legislature Written Testimony Form

Please enter into the record my testimony to the HHEISS Committee on
4/19/2001 dated HB 112
(bill/subj) (Committee Name)

*Page 1 of 2
Testimony on 2*

Testifier Signature

Representing: (Optional)

Address

Phone Number

From Cordova L10 Fax 424-5462

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

To Whom It May Concern:

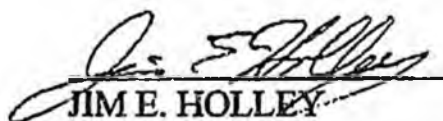
First we'd like to say that we are sorry that we are unable to provide this testimony via teleconference; however, as registered Alaskan voters, we urge you to pass:

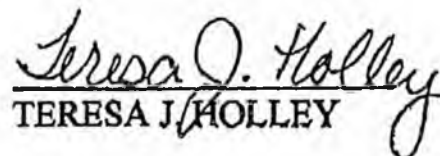
HOUSE BILL NO. 112; *"An Act relating to information and services available to pregnant women and other persons; and ensuring informed consent before an abortion may be performed, except in cases of medical emergency"*.

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

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

Sincerely,


JIM E. HOLLEY


TERESA J. HOLLEY

Alaska Civil Liberties Union

An Affiliate of the American Civil Liberties Union

P. O. Box 201844, Anchorage, AK 99520-1844

Phone: (907) 258-0044 Fax: (907) 258-0288 Email: akclu@alaska.net

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

Re: HB 112 – MANDATORY EXTRA “COUNSELING” FOR ABORTION

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much for your careful consideration.



AMERICAN CIVIL LIBERTIES UNION

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

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

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

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

- The National Cancer Institute has charged that the study has been interpreted inaccurately and "[t]here is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion."²
- The American Cancer Society has concluded, "the inconsistencies of existing research do not permit definitive scientific conclusions."³
- On the day the study was published, JNCI printed an editorial stating that "the overall results [of the study] as well as the particulars are far from conclusive, and it is difficult to see how they will be informative to the public." The study was particularly criticized because of the methodological problem of possible inaccurate reporting of a history of abortion by participants.⁴
- Four recent reviews published in scientific journals have assessed more than 30 studies and concluded that the available data on the relationship between induced or spontaneous abortions and breast cancer are inconclusive.⁵
- A 1995 article in Cancer Causes and Controls reported on "Abortion and Breast Cancer Causes in Seven Countries." The study concluded, "In summary, these data suggest that any overall relation between abortion and risk of breast cancer is likely to be weak at most."⁶

HB112-

~~HB112~~ Testimony

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

Debbie Joslin

Box 377
Delta Junction, AK 99737

(907) 895-4565

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

346-8226

Distribution

Affiliation

Reg Voter

60

V

Date POM Sent

Constituency

Bill Number

Response

Subject

03/05/2001

N

HB 112

Supports

I encourage you to vote for HB 112.

Email Address

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

Distribution

Affiliation

Reg Voter

60

V

Date POM Sent

Constituency

Bill Number

Response

Subject

03/05/2001

N

HB 112

Supports

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

Email Address

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

235-8906

Distribution

Affiliation

Reg Voter

60

Y

Date POM Sent

Constituency

Bill Number

Response

Subject

03/05/2001

N

HB 112

Supports

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

Email Address

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

235-8906

Distribution

Affiliation

Reg Voter

60

Y

Date POM Sent

Constituency

Bill Number

Response

Subject

03/05/2001

N

HB 112

Supports

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

Email Address

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

278-1736

Distribution

Affiliation

Reg Voter

60

V

Date POM Sent

Constituency

Bill Number

Response

Subject

03/05/2001

N

HB 112

Supports

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

Email Address

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

786-7755

Distribution

Affiliation

Reg Voter

60

Y

Date POM Sent

Constituency

Bill Number

Response

Subject

03/05/2001

N

HB 112

Supports

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

Email Address

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

488-5550

Distribution

Affiliation

Reg Voter

60

V

Date POM Sent

Constituency

Bill Number

Response

Subject

03/06/2001

N

OIL & GAS

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

Email Address

lmckeehan@gci.com

Stanley D Tucker,
1001 Dellwood Dr
Wasilla, AK 99654

373-7139

Distribution

Affiliation

Reg Voter

11

Y

Date POM Sent

Constituency

Bill Number

Response

Subject

03/06/2001

N

HB 112

Supports

Please support HB 112. Thanks

Email Address