MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON JUDICIARY

Call to Order: By **BRUCE D. CRIPPEN, CHAIR**, on February 10, 1995, at 10:00 a.m.

ROLL CALL

Members Present:

Sen. Bruce D. Crippen, Chairman (R)
Sen. Al Bishop, Vice Chairman (R)
Sen. Larry L. Baer (R)
Sen. Sharon Estrada (R)
Sen. Lorents Grosfield (R)
Sen. Ric Holden (R)
Sen. Reiny Jabs (R)
Sen. Sue Bartlett (D)
Sen. Steve Doherty (D)
Sen. Mike Halligan (D)
Sen. Linda J. Nelson (D)

Members Excused: None.

Members Absent: None.

Staff Present: Valencia Lane, Legislative Council
Judy Feland, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: SB 292, SB 241, SB 249, SB 233
Executive Action: None.

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HEARING ON SB 292

Opening Statement by Sponsor:

SENATOR BOB BROWN, Senate District 40, including Whitefish and Western Flathead County, appeared to open the hearing as the primary sponsor of SB 292. He read the title, " the womens' right to know act, providing for publication and dissemination of information concerning abortion, clarifying informed consent, providing civil remedies for failure to obtain informed consent, and amending certain sections of the law."

SENATOR BROWN said that because the decision to have an abortion is a major one, having ramifications not only for the physical and psychological health of the mother, but also for the life of the unborn child, it is only right and proper that the state guarantee the mother access to all information relevant to her decision. It only follows, therefore, that anyone who consistently upholds the womans' right to choose, must show equal vigor in ensuring that every woman considering abortion is provided all the information necessary to enable her to make a truly informed decision. This rationale was upheld by the U.S. Supreme Court in 1992 in the case of Planned Parenthood of Southern Pennsylvania vs. Casey. He quoted the decision of the court, "it cannot be doubted that most women considering an abortion would deem the impact on the fetus relevant if not dispositive to the decision. In attempting to assure that a woman apprehend the full consequences of her decision, the state furthers the legitimate purpose of reducing the risk relating to fetal development and the assistance available to her should she decide to carry the pregnancy to full term, is a reasonable measure to assure informed choice, one that might cause the woman to choose childbirth over abortion."

The sponsor stated that research shows the American public is overwhelmingly in support of the informed consent concept. Since the Casey decision, eight states have enacted legislation based on the model presented in SB 292. The real key to the bill is found in Sections 4-7. They provide for publication of materials made available by the Department of Health and contain information relating to the development of fetal stages and objectives and alternatives to abortion. He presented a booklet entitled, "Fetal Development and Family Planning." **(EXHIBIT 1)** He said that Section 6 outlined the physicians' reporting procedures, and Section 7 outlined civil remedies available. **SENATOR BROWN** pointed out the fiscal note of the bill, which would be the charges for publication for the informational materials.

<u>Proponents' Testimony</u>:

Cheryl A. Wilke, Florence, represented herself. She presented and read from written testimony. **(EXHIBIT 2)**

Darci Heck, Power, spoke representing herself. She presented written testimony. **(EXHIBIT 3)**

Nancy Vigel represented herself. She gave written testimony and read from it. **(EXHIBIT 4)**

Kathy Keller, Mrs. Montana for 1994. Ms. Keller read and presented written testimony. **(EXHIBIT 5)**

Dr. Robert M. St. John, M.D., Butte, Obstetrician/Gynecologist, represented himself. He said it was his professional responsibility to keep his patients informed of anything dealing

with their physical and mental health, guided by Codes of Ethics. In addition, there was considerable case law to direct him. He presented a booklet on ethics, **(EXHIBIT 6)**, and a collection of case law studies and legal opinions pertaining to informed consent. **(EXHIBIT 7)**

Dr. Mark H. Mozer, Ph.D., Helena, Clinical Psychologist, and father of nine children, spoke in favor of SB 292. He presented and read written testimony. **(EXHIBIT 8)**

Sharon Hoff, representing the Montana Catholic Conference, and acting as a liaison for Montana's two Roman Catholic bishops on matters of public policy, said her organization supported SB 292. She presented written testimony and read from the same. **(EXHIBIT 9)**

Peggy Ann Blumhagen, B.S.N., R.N., spoke in favor of the bill. She read and presented written testimony. **(EXHIBIT 10)**

Georgia Branscome, Kalispell, asked for support of SB 292. She read written testimony. **(EXHIBIT 11)**

Walt Dupeu, Bigfork, represented himself. Mr. Dupeu asked how anyone would want to deny information that would stop the sort of trauma they had heard in the hearing thus far. He stated that the only reason for opposition would be money.

REPRESENTATIVE TIM WHALEN, represented the Montana Right-to-Life Association, an affiliate of the National Right-to-Life Association, which, he stated was the largest and oldest pro-life organization in the country. They formally stood in support of SB 292. He said his group was instrumental in drafting the proposed bill, and every care was taken to see that it was both enforceable and effective. He cited a study from a book entitled, Aborted Women, Silent No More, that women who have had abortions are nine times more likely to attempt suicide that women in the general population. He believed the reason was the traumatizing experiences after the procedure, including regrets on uninformed decisions.

Arlette Randash, Helena, representing Eagle Forum, spoke in favor of SB 292. She read and submitted written testimony. **(EXHIBIT 12)**

Lauri Koutenik, Executive Director, Christian Coalition of Montana, said she represented the state's largest advocacy organization. She stated there was only one choice, to pass SB 292.

Also submitted by non-speaking participants or unknown donors:
Cindy L. KeLay, letter **(EXHIBIT 13)**
Signatures in support of SB 292 **(EXHIBIT 14)**
Copy of pamphlet, "The Physical Risks of Abortion." **(EXHIBIT 15)**

Opponents' Testimony:

Eliza Frazer, Executive Director, Montana Affiliate, National Abortion and Reproductive Rights Action League, spoke for her organization in opposition to SB 292. She read and presented written testimony. **(EXHIBIT 16)** She also presented a copy of a booklet entitled, "The Myth of the Abortion Trauma Syndrome." **(EXHIBIT 17)**

Janet Crepps, Staff Attorney and Director, State Legislative Program with the Center for Reproductive Law and Policy, read and presented written testimony. **(EXHIBIT 18)**

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Deborah Frandsen, Executive Director of Planned Parenthood of Missoula, spoke in opposition to the bill and read from written testimony. **(EXHIBIT 19)** She provided signed letters from physicians who considered appearances at the hearing dangerous. **(EXHIBIT 20)** and she also presented a "fact sheet" from Planned Parenthood on informed consent requirements. **(EXHIBIT 21)**

REPRESENTATIVE JOAN HURDLE, House District 13, Billings, spoke against SB 292 and urged the committee to kill SB 292. She said much of the bill was untrue, unfounded and inflammatory. She said that only licensed counselors, nurse practitioners or physicians do decision-making counseling. She wished the committee could hear the stories women her age had to tell of the illegal abortions in the 1940's, 50's and 60's. She stated that 4 million illegal abortions are performed annually in Mexico. Many of those women, she said, are not here to testify at all, unlike the women speaking today. She said some of the women testifying at the hearing were attributing many of their other problems in life to the fact that they had a safe and legal abortion. She said the bill was blatant governmental interference into individual lives. She said it would require a large fiscal note. Page 6, Lines 21-23 where it makes a legislator, "the enforcement cop" was her biggest concern.

Ann Brodsky, representing herself, opposed the bill. She spoke about her abortions, saying she should not have to testify, to lose her right of privacy to protect her right of privacy. She reported that she received more information in advance of the abortions than she did from doctors when she delivered a baby. She said the bill was not put forth to rectify a problem because detailed, objective informed consent is already the practice of abortion providers in Montana. She said the bill was put forth to pass judgement on the abortion decision. She related that one abortion she received was because of severe chromosomal abnormalities detected in extensive medical testing. She stated that under this new bill, she would have been subjected to the litany of information in those circumstances, in addition to the 24-hour waiting period. She said that SB 292 runs contrary to the tenet of less government interference in peoples' most

private arenas.

Christine A. Phillips, opposed SB 292. She read and presented written testimony. **(EXHIBIT 22)**

Kate Cholowa, representing the Montana Womens' Lobby, contended that much of the testimony heard thus far in the hearing did not have to do with the bill. She stated that the ultimate intent and purpose of the drafters of the bill was to deny women their reproductive rights, she said. She asked the committee to look beyond the hypocrisy that the bill is an attempt to look out for the well-being of women. Placing obstacles between women and their medical decisions, lobbying them when they are trying to make medical decisions, and saying women lacked sense of what to do without legislative direction, is all extremely insulting. The bill violates two of the preeminent missions of this legislature: 1) less government (it is more government in the doctor's office and in private and personal decisions) and 2) cut state spending (the fiscal note does not cover the project outlined in the bill). She asked for opposition to the bill.

Brandee Strayer, a 19-year-old college student, spoke in opposition to SB 292. She said she was not, as some proponents had said, pro-abortion. She said she was pro-choice. She said she supported the right of abortion for all women in the state. She cautioned the committee to look beyond emotional testimony for an answer in law. She pointed to the language of the bill as it relates to coercion, and said the door swings both ways, they should not be coerced into NOT having an abortion either. She said the bill bullies women and should not be passed.

Diane Sands, representing herself, said she had been asked by **The Blue Mountain Womens' Clinic in Missoula** to read testimony to the committee from **Sally Mullen, Executive Director. (EXHIBIT 23).**

Ms. Sands also entered into testimony a letter **(EXHIBIT 24)** from a woman named, **Danni,** who wished to testify about an abortion she received at the **Blue Mountain Womens' Clinic,** telling about the informed consent information and support she had received.

Brad Martin, Director, Montana Democratic Party, opposed SB 292. He said his organization believed that the bill created an unnecessary intervention by the state into a decision that should be solely between a woman and her doctor. The measure had two faulty assumptions: 1) that counseling is NOT currently available to women who choose to have an abortion, and 2) that the women who choose to have an abortion are somehow not adequately reviewing the decision. Both are fundamentally false, he said, and if the bill is passed, it would be built on these false assumptions that should not be the basis of law. He strongly encouraged opposition to SB 292.

Kay Fox, representing herself, said she first wanted to address the underlying motivation of the forced-pregnancy forces that

have put the language in the bill. She said many legislators were talking about getting government "off our backs." She said she wanted them "off their fronts," too. She said the fiscal note should also include litigation money. She told the story of a rape committed against her when she was 19. She said she had no information about carrying the unwanted child of a rapist. She urged an amendment pertaining to this situation and also to the issue of neglected children. She said that no one has died (from abortion procedures) since abortion was legalized in this state.

Sandi Olsen represented the Business and Professional Women (BPW), whose organization included several hundred diverse Montana working women belonging to both parties. Their position was to support choice, she said. Medical decisions are personal decisions. This bill would not respect privacy and contains many provisions that are inconsistent with its purpose. BPW urged opposition to SB 292, she said.

Maureen Clary Schwinden, represented herself as a farmer/rancher, nurse and private citizen. She said she had done volunteer work with young girls carrying children and who are responsible for caring for them on their own. The focus of the legislative body should be on educating these young women as to responsible choices so they don't have to be in the position to make the choice of receiving an abortion. She said the choice then, should remain between a woman and her physician.

Sara Holmes, representing herself, spoke in opposition of SB 292. She read and presented written testimony. **(EXHIBIT 25)**

Scott Crichton, representing the American Civil Liberties Union, (ACLU), as their Executive Director, said he also spoke as a **father and husband,** presented prepared testimony. **(EXHIBIT 26)**

The following letters were presented in opposition to SB 292:

Joan McCracken, Executive Director of InterMountain Planned Parenthood. (EXHIBIT 27)

Internal Medicine Associates, Helena. (EXHIBIT 28)

SENATOR STEVE DOHERTY, Senate District 24, Great Falls. (EXHIBIT 29)

Patricia Goudie, R.N., Sun River (EXHIBIT 30)

Questions From Committee Members and Responses:

SENATOR MIKE HALLIGAN asked **REP. TIM WHALEN** why they had the section in the bill that allows a legislator to intervene in a civil lawsuit.

REP. WHALEN said it would be used only if the Constitutionality

of the statute is challenged. He said if the legislature is going to adopt a bill, they should have the right to appear in court and present evidence and file briefs as to why they did what they did.

SENATOR HALLIGAN said he had been called to testify as a legislator/attorney and the judge had ruled that the testimony can only come from the minutes, and not the testimony of the legislator.

REP. WHALEN said that he had been able to testify at the request of the judge on a railroad case as to the intent of the legislature. The reason for the right of intervention is intended for Supreme Court rules and is not mandatory, he said.

SENATOR STEVE DOHERTY asked **SENATOR BROWN** about Section 2, regarding legislative findings. He said the fiscal note stated that in Fiscal Year 1992, there were 3,400 abortions in Montana. He asked how many of those 3,400 were performed in a facility offering limited or impersonal counseling services?

SENATOR BROWN was unsure, but said the statistical information will be available if the bill passes.

SENATOR DOHERTY further questioned that of the 3,400 abortions, how many occurred in facilities in which there were untrained and unprofessional counselors?

SENATOR BROWN said they may disagree on what an "untrained counselor" is before he specifically answered the question.

SENATOR DOHERTY said that it would be someone licensed by the state as a counselor.

SENATOR BROWN said that the problem with the laws that exist now, is that regardless of the qualifications of the counselors, there isn't much counseling taking place. SB 292 would better assure that it would happen, he contended.

SENATOR DOHERTY asked how many of the 3,400 abortions occurred in abortion facilities whose primary goal was, "to sell" abortions?

SENATOR BROWN said he did not specifically know the answer to the question. He said he did not think that many abortions took place in offices of private practioner/physicians. There are only a few locations in Montana that offer abortions on any regular basis, he said.

SENATOR DOHERTY asked if those were non-profit organizations?

SENATOR BROWN said, "no".

SENATOR DOHERTY asked about legislative purpose and findings on Page 2. He quoted that "we find from the moment of conception

that that is an unborn child." He wanted to know the foundation for making that legislative finding.

SENATOR BROWN acknowledged that they may disagree about that issue. He said if the developing human being is allowed to come to term, then obviously it is a human being. If it is killed any time before that takes place, its right to live in this world has been terminated.

SENATOR DOHERTY said he respected that deeply-held religious belief, but he said the sponsor was asking the legislature to make a basic finding based upon a deeply-held religious belief.

SENATOR BROWN said it was not a religious belief, it was a fact. He said if the developing human being came to term, it would be a human being. He asked how it could not be developing life if that was the case? How does that have to do with religion, he asked? It seemed to him to be an indisputable fact.

SENATOR DOHERTY said that in making legislative findings, they were often called upon to submit evidence. He said he had heard nothing in this presentation from any scholars or theologians. When he heard this argument on the federal level, people came from all over the map, he said, listing medical ethicists, doctors, theologians, etc. How can they make that finding given the respect for the diversity of opinion.

SENATOR BROWN said that **SENATOR DOHERTY** had tried to characterize the statement of the process of life inside the mother as a religious feeling, now he was asking him to present testimony from theologians. He was not sure if he wanted religion in or out of the debate. He said that two people on the proponent side of the question held doctor degrees and they should be quizzed instead on the medical aspects or the psychological aspects of post-abortion syndrome or physical problems.

SENATOR SUE BARTLETT asked **SENATOR BROWN** for more information on his reason for introducing the bill and if the bill would achieve everything he wanted it to achieve, what would be the result of the legislation ?

SENATOR BROWN said if he could accomplish what he wanted, there would be fewer women who would suffer from the post-abortion syndrome and there would be fewer women who might lose their lives or their ability to have babies in the future through the physical problems sometimes associated from abortion.

SENATOR BARTLETT asked why those things would be the results.

SENATOR BROWN replied that this legislation, unlike the status quo in Montana today, provides objective information to all women considering abortion if they choose to take advantage of it and a 24-hour waiting period to consider it before they enter into the decision of whether or not to have an abortion. He said he knew

it was not a decision women entered into lightly, but agonizing without sufficient, objective information on which to base the decision did not make it possible to have an informed choice. If they were seriously interested in protecting the consumer, in this case, women, from being victimized, they wanted to make every opportunity available to make her decision an informed one.

SENATOR BARTLETT said that if the bill passed and five or ten years down the road they collect information showing no decrease whatsoever in the abortion rate in the state, would the bill have achieved his purpose?

SENATOR BROWN said it was a speculative, hypothetical question to which no one knew the answer. He thought it was worth a try. He was amazed that people testified that there was adequate information now, yet opposed the bill. It seemed to him they should be proponents, as should she, he said.

SENATOR BARTLETT said that the bill notes that information provided would include facts about the medical risks associated, perhaps psychological as well, of carrying a pregnancy to term and delivering. The information received minor attention in the bill. She asked if it would be his desire to have that information as fully covered as the information in relation to abortion.

SENATOR BROWN said he was interested in comprehensive, objective information on the pros and cons of abortion before the decision is made. He said they had some examples from other states, but they would do their own in Montana, based on the models from other states.

SENATOR LINDA NELSON wanted to know about the fiscal note because of the fiscal responsibility relating to the session. She asked about Assumption #3 that said there are 3,400 abortions done annually in Montana, then Assumption #5 on the telephone number offered 200 minutes per month. It seemed woefully inadequate to her.

SENATOR BROWN said he was not sure of the assumption, but did not think costs would be too great because it would mostly appeal to people in rural areas to request information and make an appointment.

SENATOR NELSON said they would just have to disagree on it.

SENATOR HALLIGAN said that **Ms. Krepps** had testified that eight other states were enforcing the 24-hour mandatory delays and that this bill was the most stringent in the country. The Pennsylvania law allowed a physician, in cases where the information may cause severe psychological trauma, to defer or not provide it. This bill does not do that. He asked if it was his intention to make this bill the most stringent in the

country?

SENATOR BROWN said that every single provision in SB 292 is found in the provisions in the laws of the other eight states with the possible exception of the reporting requirements. They may be somewhat more comprehensive than in other states, he said. She had also made reference to the privacy provision in the state Constitution, which, he said, had never been tested in regard to this legislation. He said it would be pure speculation on her part. He said it could be tested. He said there was a severability clause in the bill if it would be found to be unconstitutional.

SENATOR BARTLETT asked someone from the Department of Health to attend the hearing and asked them to come forward to explain the question of telephone charges. She wanted to know why there was no fiscal impact associated with the reports that the Department of Health would have to prepare from all the forms the doctors submit. None was noted for the preparation and distribution of those reports in the bill, she said.

Judith Gedrose, Preventive Health Services Bureau of the Department of Health and Environmental Sciences, which, she explained, includes the Health Education Department of the Department of Health. She said she worked on the fiscal note relating to health education for other projects. The copy that she saw and helped prepare did not make mention of minutes that the phone hotline would be used. They had based it upon their experience of having a hotline related to communicable disease control.

<u>Closing by Sponsor</u>:

SENATOR BROWN wanted to respond to some of the comments by opponents. He said that **Eliza Frazer from Montana NARAL** contended that post-abortion syndrome is unsupported by scientific evidence. He said they had heard first-hand evidence of people in the hearing disputing that. The Surgeon-General quoted by others in the hearing was himself a physician at one time. He quoted from **C. Edward Koop,** "I have counseled women with this problem over the last 15 years." He gave an example of a woman who had an abortion at age 28 or 29 who many years later had a psychiatric mental breakdown as a result. **SENATOR BROWN** said there was no such thing as "post-appendectomy syndrome" or "post-adoption syndrome." This is an altogether different thing, he said, and it was reasonable then, to have women be informed before they make a decision.

He said that **Ms. Krepps** had testified that unique to the bill was the provision that would require two trips for the woman to obtain an abortion. He said it was absolutely not the case. If someone lived in a rural area, they could call and have the information mailed. They would not have to read it. They could ignore it if they chose. All the information would be available,

however. The reporting provisions were similar to other states, he said.

Deborah Frandsen of the Blue Mountain Clinic had stated that informed consent already occurs at that clinic. He said if that was the case, she should not object to this bill because this bill is a guarantee that everyone would receive it, have time to consider it, and be signed by the physician.

REP. JOAN HURDLE said it was blatant governmental interference. That just stupefied him, he said. This has almost nothing to do with the government. All the government would do is make information available. Individuals would then be able to make up their mind, based on the same information. He said this bill would empower individuals to make a choice. He contended that the bill was consumer legislation more than anything else.

He said that a comment was made that abortion was available in the 1880's. He said some of the greatest opponents to abortion were the suffragists. Susan B. Anthony was an outstanding opponent of abortion and argued against it saying it was exploitive of women and ought not occur.

The lobbyist from the **Montana Womens' Lobby** spoke of coercion, he said. He agreed as did the Casey decision agree. All it says is that women ought to be given an opportunity to make an informed decision before they make it.

He said the fiscal note is relatively small, $36,000. If there was a problem with underestimating the telephone bill, he could not imagine it would be greatly significant.

The bill he presented was Constitutional if experience from other states meant anything, he said, and it was reasonable. The measure would provide uniformity in terms of information available to all women in Montana who might be making a decision having a profound psychological or physical impact on them. It was needed legislation, he said. He hoped for a Do Pass recommendation.

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HEARING ON SB 249

Opening Statement by Sponsor:

SENATOR AL BISHOP, Senate District 9, Billings, presented SB 249. The bill is simple, he said. It would eliminate the Office of the Clerk of the Supreme Court and replace it with a clerk appointed by the Chief Justice. He asked for amendments, which will place all of the functions of that office under the Court Administrator. **SENATOR BISHOP** read from and presented written testimony. **(EXHIBIT 31)**

Opponents' Testimony:

Ed Smith, Clerk of the Supreme Court, read from written testimony. **(EXHIBIT 32)**

Rex Ranck, former assistant clerk of court from 1990 to 1991 and former deputy clerk from 1991 to 1995, testified about the workload of the court. He said the reference to staff workload as it related to district court was not appropriate because there were no times when staff members were idle, rather they worked from 8 to 5 and many times after standard work hours trying to fulfill the requirements. In addition to the caseloads, the number of attorneys they are required to license has grown substantially in the past three years to almost 300 new attorneys. Also, he said, preparations for the bar examination needed to be made for at least 150 bar applicants. He said these duties are not included in the standard workload but have to be absorbed. He said the office is directly related to the public, and their work included spending time of the telephone, helping citizens and attorneys with questions about procedure within the Supreme Court. They maintain an important public link between the court and the public. He restated that the employees work hard at that office.

Brad Martin, Executive Director, Montana Democratic Party, opposed to SB 249. He said that the party strongly believes in all attempts to make government leaner and more effective, but they thought one of the important thresholds not to cross are those that reduce the means and the methods in which the public had a say in who represents them in government. This office serves an important purpose and is run efficiently. They did not think it serves the interest of the people of Montana to reduce their say by getting rid of an elective office. He said he would defend the office regardless of the party designation of the electee. The public of Montana wants more say, not less, he said. The bill would hurt the citizens of Montana, and for that reason, they opposed the bill.

Nancy Sweeney, Lewis and Clark County, Clerk of District Court, appeared on her own behalf as well as that of the Montana Association of Clerks of District Court. The Clerk of Court's Office provides public access to the courts, she said. There are increasing numbers of parties representing themselves on both the district and Supreme Court level. The clerk's office is a valuable buffer for the judges and an unbiased source of information for the litigants who are many times frustrated, confused and angry. She saw a need for the office to remain independent of the courts and answerable to the public though the voter's approval. SB 249 would further undermine the public tenuous confidence in government and the courts in general. She said that after a two-year study of all facets of the court, the Judicial Unification Committee rejected a proposal to make the Clerk of Court an appointed office. She asked rejection of the bill. She also presented a letter from **Kathleen D. Breuer, Clerk**

of District Court, Missoula County and President of the Montana Association of the Clerks of District Courts in opposition to the bill. **(EXHIBIT 33)**

Russell Hill, representing the Montana Trial Lawyers Association (MTLA), said they would rise to oppose SB 249. He said that the sponsor in his opening had said that it was not his intent that the bill be political. **Mr. Hill** said he wanted to make it clear that he did not think it was a partisan bill, but **MTLA's** members think that SB 249 is political in the same sense that a marriage is political. That is, there are certain things that he deals with well with his wife, and certain things he did not. He said that attorneys not only dealt with substantive matters coming down from the court and in which the Chief Justice plays a central role in, but also have to deal with the administrative functions. If the attorneys run into problems in terms in getting records in and out, moving things along, treatment of records, accuracy of the records, etc., they feel much more comfortable in expressing their complaints and frustrations to an independent Supreme Court clerk than they would to a clerk appointed by the Chief Justice. The appointed clerk may also be involved in the substantive legal issues of the cases. MTLA members are comfortable dealing with an independent clerk.

Ralph Yeager, Helena, small business owner, represented himself. In 1989-1991 he served as Deputy Clerk of the Montana Supreme Court. He stated his opposition to the bill as a Montana citizen and a former clerk. The measure offers promises, minimal cost savings and really no guarantees of increased efficiency, all at the cost of taking choices away from Montana voters. Streamlining could only mean reductions in the size of the clerk's staff which he believed to be extremely ill-advised. The Supreme Court had never experienced a reduction in size and neither had the administrative office that serves the court. Downsizing the staff would achieve exactly the opposite of this bill's intent by making overall operations of the office far less efficient and less responsive to the needs of Montanans. The clerk should be answerable to the voters and if anything, the size of the office should be increased by one FTE. He said the employees there are flat out overworked.

Helen Christiansen, representing the Montana State AFL-CIO, read a letter from **Don Judge, Executive Secretary,** as presented. **(EXHIBIT 34)**

Questions From Committee Members and Responses:

SENATOR REINY JABS asked **Ed Smith** about the hours worked per day at his office, and asked what the law requirement was on that position.

Ed Smith stated that statewide elected officials collected their salaries and it would be up to each one individually. He assured the senator that he worked 8 hours a day, 5 days a week.

SENATOR JABS further questioned if there was a statute that specifically stated how many hours an elected official has to work?

Ed Smith said there was no statewide statute that says any statewide office holder has to work from 8 to 5.

SENATOR RIC HOLDEN stated that in Eastern Montana might regret the loss of voting rights to this position. He asked **SENATOR BISHOP** how he might defend an "aye" vote to his constituents.

SENATOR BISHOP said it would be easy. He said the constituents would certainly not object to the cost savings. This office is one over which the voter has no conception of who or what they are voting for. Most of the people he knew thought they were voting for "Big" Ed Smith. The office is so obscure that the media doesn't even pick up on the office or give any notoriety to it.

SENATOR HALLIGAN said that the legislators naturally would know more about this office than the general public. He asked how the sponsor felt about the Reorganization Committee's rejection of this very proposal. Also, he wondered how he felt about the compelling argument that lawyers would feel intimidated about going to a Supreme Court Justice appointee to question some administrative procedures or accessibility issues as opposed to going to an elected official. **SENATOR HALLIGAN** asked if this would not have a chilling effect on a lawyer's ability to represent a client.

SENATOR BISHOP said everything might depend on the personality of the appointee. He had been a lawyer for 40 years or more, and said he was not intimidated by any judge or justice. Many are his contemporaries now, he said. The judges are not going to concern themselves with the every day operation of the office of the court administrator.

SENATOR HALLIGAN asked that if there was a procedure that a lawyer would question that affected his case or the ability to appeal that case that might come to the Supreme Court, would there be a potential conflict? He was concerned that the Chief Justice would have appointed the person who is being questioned as to their procedural decision.

SENATOR BISHOP said he would never ask the Clerk of the District Court about procedure. If he did not know what to do himself, he would not want to rely on a clerk to advise him on what to do as an attorney. He would rather have the court tell him. He thought it would actually improve the situation.

SENATOR BARTLETT asked if the fiscal note was accurate after the change in the amendments.

SENATOR BISHOP answered that it was accurate. He said that he

would pass out a letter from **Terri Perrigo, Office of the Legislative Fiscal Analyst,** given to him by **REPRESENTATIVE ED GRADY,** who had requested information about this in early January. **(EXHIBIT 35).** She had estimated a General Fund savings of approximately $117,702 over the biennium. **SENATOR BISHOP** said it did not seem like much money, but if every one of the 150 legislators here came up with an idea to save about $60,000 a year, that would amount to $9 million a year and $18 million over the biennium. He said he had another bill incorporating the offices of the lieutenant governor and the secretary of state which would save about $130,000 a year.

SENATOR DOHERTY asked that rather than getting rid of the clerk, why not just get rid of the administrator or the staff of the administrator?

SENATOR BISHOP said he would never consider that. It would be moving backward. He said all across the country there was a groundswell moving toward streamlining government. That suggestion would be the opposite of what they were trying to do.

SENATOR DOHERTY asked if it would not be streamlining government if they X'd out the administrator and the staff that were currently supported by taxpayer's funds?

SENATOR BISHOP said he was trying to eliminate the Office of the Clerk of the Supreme Court which is also supported by General Fund monies. The fiscal note and the Legislative Fiscal Analyst had both concluded that there will be a cost savings. He said if the senator wanted to go ahead and spend money needlessly, it was his affair. He did not. He said people sent them here to effect cost savings and to run government as effectively as they could with the least amount of money necessary.

Closing by Sponsor:

SENATOR BISHOP told the committee that he never seeks proponents to bills he sponsors. He said the concept either sell themselves or they should fail. He maintained it was not a political appointment, any more than was already there. He asked the panel to closely examine two letters handed out. One is from **Ethel Harrison, a former Clerk of the Supreme Court, (EXHIBIT 36).** The other letter is from **Justice John Conway Harrison, former Justice of the Supreme Court (EXHIBIT 37).** He asked consideration of the letters because they both support the concept that it was time to move on and time to put the functions of the Clerk of the Supreme Court into the Court Administrator's Office. He said it did not create, but rather, solved, problems. This office is not being singled out as the best place to cut, he said, it was ONE place to cut. He urged support for the bill.

HEARING ON SB 241

Opening Statement by Sponsor:

SENATOR STEVE BENEDICT, Senate District 30, Hamilton, said SB 241 is legislation which would help correct a situation in which the "good guys" are being treated as "bad guys", unfairly, in order to try to catch the bad guys. Present law requiring a waiting period to purchase firearms is backwards, he said, as it sends the message that a person is proven guilty until proven innocent. The bill would propose, in using an instant background check, to develop a state-of-the-art way of keeping known felons from purchasing handguns from a retailer while allowing law abiding citizens to make their purchases in an efficient and unencumbered manner. He introduced **Gary Marbut,** explaining that he had worked on the mechanics of the bill for six months and could explain the mechanics of the system. **SENATOR BENEDICT** said the fiscal note prepared by Greg Petesch would reduce the fiscal note by about 90 per cent. **(EXHIBIT 38)**

Proponents' Testimony:

Gary Marbut, Missoula, President, Montana Shooting Sports Association, spoke in favor of SB 241. He said his organization is a statewide group of gun owners involved in politics. He said he also **represented Gun Owners of America and the Citizens Committee for the Right to Keep and Bear Arms, and the Western Montana Fish and Game Association and the Big Sky Practical Shooting Club.** He had never seen anything anger the people as much as federal gun control forced on the people of Montana. He said they neither wanted nor needed gun control in Montana. The particular law of concern was the Brady Law, which imposes a 5-day waiting period for purchase of a handgun on everybody in America. It has been litigated in the courts. The courts ruled that the federal Brady Law cannot command the sheriff to do the background check because that is a Constitutional usurpation of the regulatory and administrative processes of the state. Consequently, there is no requirement that a background check be done. Basically, what's left is a cooling off period which may be important in an urban area, he argued, but in Montana that rule did not make much sense. He estimated that 90 per cent of the homes in Montana already contain firearms. The guns are there. In the law, however, there is an exception. It said that in a state that has a system of licensing people to purchase firearms with a records check, those people are exempt from the Brady bill. They proposed to use that clause to exempt all the law-abiding, non-criminal people in the state from the law, and the five-day wait. He said they would require that one more magnetic strip be placed on the back of the driver's license. He told that the legislature had provided for those strips containing the same information as on the front of the license. **Mr. Marbut** said they would ask that a simple, "Yes" or "No" be placed on the strip in addition to what is there already. The question answered is, "Is the person eligible to purchase firearms?" When people renew their licenses, the Department of Justice will have the information on the computer. When the people try to buy a firearm, the dealer would put the card through a standard credit card machine to electronically "read"

the strip to determine if the transaction would be allowed to proceed. The transaction would not feed any information to a central computer, important to his organization because most background checks are fed to a databank information pool and lists can be compiled of gun buyers. They preferred the system with the licenses.

In extensive interaction with the Department of Motor Vehicle people, they learned that state records are in terrible shape, almost scraps of paper in electronic form. It would be very difficult for them to do any standardized background checks, so they allowed amendments to the bill saying the program would not take effect until November, 1998, when federal law requires the state's record-keeping to be up to speed. In the meantime, anyone who wanted to get a license with the "Yes" mag strip on the back could ask for and be granted a duplicate license. And also there are federal funds available under the Brady Law and under the Burn amendment to aid the states in effecting a program with an electronic bounce of one computer to the next. It would be inexpensive for the state to administer. He reminded the committee that nationwide, waiting periods have not been effective in reducing crime whatsoever. Even the proponents of the Brady Law after it passed admitted that this bill would not have any consequence in terms of preventing criminal acts. He said people could buy guns out of the classified ads and circumvent the waiting period. He also asserted that it was a tenth Amendment issue.

Alfred "Bud" Elwell, represented the Montana Weapons Collectors and the Northwest Arms Collectors. He said they were the people who do the gun shows. He rose in reluctant support of the bill, he said. He said he resented the federal interference in background check systems and cooling-off periods for guns. He maintained if the people of Montana needed a law, they would have legislated one of their own. He thought Montana fell into the middle of the scale for violent crime per capita. There are more murders in Los Angeles in a 24-hour-period than there are in Montana for a year. He said his organization felt that perhaps this would be the least expensive way to comply.

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Informational Testimony:

Jim Oppedahl, Administrator, Computer Services and Planning Division of the Department of Justice, said he was asked to be available in case there were questions. The Department of Justice takes no position on SB 241.

Opponents' Testimony:

None.

Questions From Committee Members and Responses:

SENATOR HOLDEN asked **Mr. Marbut** if this is something that would have to be done in 1998 anyway?

Mr. Marbut said that the federal law says that all the states have to be up to speed on some kind of system to do background checks by 1998. The questions is: will it be the instantaneous system which allows recording of the names of gun buyers in a centralized computer, or will it be a more broad-based system where everyone is pre-qualified.

SENATOR HOLDEN asked if he meant they would not spend any money on the project until 1998?

Mr. Marbut said there would have to be some money spent to upgrade the Criminal Justice Computer Data Bank in the Department of Justice that will have to be spent anyway. There is federal money available to the Department of Justice to upgrade that system.

SENATOR HOLDEN further questioned if the systems update wouldn't be premature, particularly if the Brady bill was repealed?

Mr. Marbut said that the federal law requires it. There is a contingent provision in the bill, he said, that says if the Brady law is thrown out by the courts or expires or is repealed by Congress, this measure would evaporate as well. The standard across the country has been the instant background check, but there have been abuses.

SENATOR HALLIGAN asked **Mr. Marbut** about the use of Social Security numbers on the drivers' license and if the strip on the back of the card would still tie the gun owner to the information.

Mr. Marbut answered yes and no. He said that the license already blocks a certain amount of information, which goes onto the strip. When people are agreeable, the Social Security number is also included. The only thing they wanted to add was Yes or No. Have they been convicted of a felony crime? And, have they been adjudicated mentally incompetent? There would be other ways to mark the license, such as a check-off, or a square that would turn orange when a light was applied, but this would be the least intrusive, he said, and the least available for anyone to look at.

SENATOR HALLIGAN asked about the timeliness of the program. For instance, if he renewed his license tomorrow, then committed a felony next week, how would that new information be conveyed to the Department of Justice? Or if a trial was pending?

Mr. Marbut said the federal law only required that the gun seller accept a gun permit from the state. He said they could not improve on whatever system was in place, such as the illegality of the state to capture the information about someone with mental

health problems. There is provision, however, that says if a person commits a crime, the court can confiscate their drivers' license and they could apply for a new one, which of course would indicate in the strip that they now had a criminal history. There is also a stipulation that the Department of Justice should circulate a list to the gun sellers of the state quarterly about those people who have been convicted of crimes so that the seller could check the list at the point of sale.

SENATOR NELSON said that in this session, they were contemplating having an 8-year drivers' license.

Mr. Marbut said that the bill provides that anyone committing a crime would be ineligible, and the court must confiscate the drivers' license so the person must get a new one with updated information on the mag strip. If they don't have a license, the Department circulates a list with the names to all the federally licensed firearm dealers in the state.

SENATOR LORENTS GROSFIELD asked him about the fiscal note. He said they were only looking at 10 per cent of the fiscal note, which would still amount to $180,000. He wondered if the biggest impact would be to the Department of Justice? And he wanted to know if it would trigger an investigation?

Mr. Marbut said it would not trigger an investigation. The Brady law would only require a records check, being done currently. He agreed that most if not all of the expense would be borne by the Department of Justice. The measure might decrease that, he said. The people who are likely to ask for their drivers' license be marked are repeat gun buyers. They would have to only be checked once, whereas they are currently checked every time they purchase a gun.

SENATOR GROSFIELD asked about the Fiscal Note in 1998. Would it be then $180,000 or close to the $2 million?

Mr. Marbut said it would be closer to $180,000 or even less. The expenses will be for some programming of the computer, so the Division of Motor Vehicles computer can talk with the Criminal Justice Data Bank Computer. There would also probably have to be a hardwire link between the two computers, and there would have to be a little bit of time when the drivers' license operator operated the transfer.

SENATOR GROSFIELD asked how many handguns per year they were talking about purchasing and how much each would cost based on a calculation of that number into the $180,000. He asked if he would object to some kind of an excise tax on handguns in order to cover that cost?

Mr. Marbut replied that the Department would be able to give better information. He said that the Department recently had a workshop about guns and they would have the numbers, he did not.

He said he would have to think about the excise tax. Frankly, he said, the gun owners of Montana did not create this problem. He thoughts perhaps that the gun owners of Montana would not want to solve it. There were federal monies available. The federal government imposed the law upon us, off the cuff, he said. The federal government could jolly well pay for it.

SENATOR DOHERTY asked if anyone between now and 1998 who wanted the mag strip could request it? In order to reduce the fiscal impact, maybe those who wanted it could pay to add it to their license.

Mr. Marbut said an argument could certainly be made, but those people who are requesting the marking on their license are actually going to save the state money. This is because they are probably multiple gun buyers and the state could research the records once instead of multiple times.

Closing by Sponsor:

SENATOR BENEDICT told the committee there are always questions on a brand new idea. The adoption of the bill would be a good step in trying to halt the erosion of people's Constitutional rights to keep and bear arms. The cities and towns in Montana are not the same as Los Angeles or California. We need to develop a policy in Montana that really reflects our differences. This bill will not hinder efforts to keep handguns out of the control of criminals. It will put into place a user-friendly, efficient way of dealing with background checks and allow the "good guys," (law abiding Montanans) to be treated with some dignity and respect when they exercise their right to purchase a handgun.

HEARING ON SB 233

Opening Statement by Sponsor:

SENATOR JOHN HARP, Senate District 42, Kalispell, opened the hearing on SB 233, a bill that has been before the committee the past two sessions. It is also very similar to an attorney bill passed two years ago. That bill related to the defense side, too, he said, but this one is strictly dealing with the claimant side. He said there would be people opposing the bill because in dealing with attorney fees, it would infringe upon their livelihood. He said the theme behind the bill would deal with two parts, one dealing with attorney fees and the other question would be in response to a court decision of Chapman vs. Montana. In that case, it was determined that even after an individual has been found guilty of fraudulent claim, that the attorney still has the ability to retain those dollars from the insurance company or the state fund. The Supreme Court upheld that in their findings on existing statutes. He said he did not believe that the people of Montana ever intended for them to keep the fees in a fraud case. The attorney in that case was able to

retain some $17,000. Rather than give the Workers' Comp judge the jurisdiction to follow the decision when fraud is detected within 60 days of that decision, this bill adds an additional period of two years before the time the insurer can discover the fraud or deception. Obviously, 60 days is not long enough.

SENATOR HARP said many changes have been made to Workers' Compensation in the last two years. He said a better system for the program and third parties, be it insurers or providers, is needed to get back to the original intent of Workers' Compensation which is a contact between employers and employees. He thought the guidance of attorneys dealing with these cases would still be there. They wanted to ensure that an attorney should be involved if a claimant recognizes that he is not receiving his compensable injury dollars, and to make sure his benefits are not being treated unfairly. He said that if an attorney provided the additional effort that he should be compensated, up to $7,500 or a fee of $75.00 per hour. The fee amount may be a little low and he said he was open to suggestions on that, although he said it was consistent with the Department of Labor, Workers' Compensation attorney fee regulation. He said he would be more comfortable putting it into the statutes and stated that it was good public policy. The bill would reduce attorney fees from 20 per cent to 15 per cent and his intention was to see that the injured worker gets the maximum amount of dollars in those cases. The attorneys will say that by reducing those fees, they won't be able to get the quality representation that they need. In 39-71-614 of the codes, the Workers' Comp judge can assess costs, and the bill would not preclude that. The bill would not supersede that ruling and thus recognize flexibility. He said they would hear the argument that if an attorney was involved, the injured worker would receive more benefits. He said that the study that provided that scenario was done before the managed care provisions passed two years ago, and he predicted that there will not be a great distinction between having attorney involvement or not.

Proponents' Testimony:

Carl Swanson, President of the State Fund, appeared to give testimony on the Chapman case which is a portion of the bill. It truly is a rare occurrence, but when it happens, is truly profound. The State Fund had a claimant that was awarded permanent, total disability benefits in the Workers' Comp Court and his attorney was also awarded attorney fees. After an investigation revealed that fraud was present, the State Fund immediately proceeded to district court for a criminal conviction. They also requested the Workers' Comp judge to vacate the earlier decision granting benefits to Donald Chapman and fees to his attorney. The judge ordered Chapman and his attorney to reimburse the State Fund, but the decision was later overturned by the Supreme Court. Consequently, the decision allowed the attorney to keep approximately $17,000. It also stated that the Workers' Comp Court did not have the authority to

set aside its prior judgement unless it was done within 60 days of the judgement. The case essentially reduced the strength of the Workers' Comp Court to exercise decision-making powers and narrowed the window for fraud to 60 days. This defeats the ability to pursue fraud investigation beyond a short time. They support the Chapman provision in SB 233 because the issues need to be addressed administratively.

Oliver Goe, representing the Montana Municipal Insurance Authority and also the Montana School Groups Authority, self-insurers composed of cities and towns, supported SB 233 on one issue: fraud. Section 2 of the bill allows the Workers' Comp Court the jurisdiction to address fraud-related issues. They strongly supported adoption of the section.

Opponents' Testimony:

Russell Hill, representing the Montana Trial Lawyers Association, (MTLA), submitted written testimony. **(EXHIBIT 39)** He said that the proponents addressed the Chapman section and not the fees provision. He was doing just the opposite, MTLA opposes the fees provision in SB 233 and has no position on the Chapman provision. He also included in his hand-out a proposed amendment and a clipping.

Helen Christensen, representing the Montana AFL-CIO, read prepared testimony from **Donald R. Judge.** She urged opposition to SB 233. **(EXHIBIT 40)**

Gary Todd, representing himself, said he was an injured worker. He was hurt in 1989 and finally retained counsel in March of 1991. The claim was handled by private insurance and he was offered a settlement of $8,000. Four days after he retained counsel, the offer was $28,000. In over five years, he said, they had never disputed the injury, and they had not settled. He listed several of the hearings related to the case, but the insurance company refuses to settle or acknowledge his claim.

Don Sullivan, representing himself, told the committee he opposed SB 233. He suffered a disabling injury in 1986 and went by the Workers' Comp rules and drew Social Security, reducing the Workers' Comp payments. He finally consulted an attorney, who adjusted the Social Security, and doubled the settlement.

Joseph Nyland, representing himself, opposed SB 233. He said the bill would affect his ability to acquire competent counsel when a problem arises. He was injured in 1994 and called Workers' Comp the next day. He was told by three different people that his was a compensable claim and was given a file number. He was contacted a week later and told it was not a compensable claim. He immediately contacted an attorney and they filed a grievance. They were given a November mediation conference, to which Workers' Comp had promised to abide by. It was proclaimed a compensable claim, but then Workers' Comp would not honor it. He

had been without medical coverage, medical coverage, financial coverage since September of 1994.

Mary Kay Stearn, Plaintiffs' attorney, Butte, representing herself and two of the injured workers appearing in the hearing, said there had been a dramatic decrease in benefits for injured workers in the last 10 years. There had also been a significant decrease in attorney's fees available for their representatives. Ten years ago the fees were 33 per cent, it moved to 25 per cent, and now it was at 20 per cent. This bill would provide for 15 per cent. There comes a point at which a person running a business can no longer take cases. This bill would eliminate a lot of competent counsel for injured workers. She said it was a bad bill.

Norm Grosfield, attorney, Helena, represented himself and corrected the sponsor, saying it was the FOURTH time he's been here. He said he represents injured workers. He said the average cost to an insurance carrier of taking a case all the way to the Supreme Court could be up to $20,000 to $30,000. The average good defense counsel charges in excess of $100 an hour. He said the overhead in an attorney's office is probably about $65-75 an hour. He encouraged the committee to find the first section of the bill to not be fair and proper. Attorney fees are currently regulated by the State Department of Labor through statutory law created in 1975.

Ben Everett, attorney, representing himself, presented a copy of the attorney retainer agreement provided by the Employment Relations Division that attorneys are bound to follow. He said that by reading the agreement, the committee could see that many of the things they do for their clients, they cannot charge for. If the sponsor wants to make sure the injured worker is adequately compensated, make the insurance be fair. He said he would be out of a job, but until they do that, the injured worker needs an attorney. He said they have to be there, they have to be competent, they have to spend the time. **(EXHIBIT 41)**

Jim Hunt, attorney, Helena, representing himself, said he could have brought 50 claimants to testify at the hearing. He said they could have adequately explained why attorneys are needed in these cases. He said more and more people are coming because they are not receiving benefits they are entitled to receive. Many times the benefits are not calculated properly. In over half the cases, the rate is incorrectly calculated. It is very seldom when he can't increase benefits. The $7,500 cap is very unfair, he said, because a claimants' attorney, unlike a defense attorney, uses a lot of time dealing with an adjustor. The adjustors are sophisticated, the claimants are not. It is unfair to match them under those circumstances and limit fees on one side and not the other.

Jan Van Riper, attorney, representing herself, said she represents injured workers and posed a couple a questions. Who's

stating the problem? What is the problem? She had not heard any news coverage or any claimants complaining about the current fee situation. The second question is: Why would this body want to limit this access to the judicial system in this situation? It's the arm of government that tells entities that "you gotta do what the legislature told you to do."

Questions From Committee Members and Responses:

SENATOR DOHERTY asked **Mr. Swanson** if he only expressed support for the fraud provisions of the bill. Did he support the section of the bill that limited claimants' attorneys as well?

Mr. Swanson said he was only here to give testimony on the Chapman portion of the bill. The Department of Labor regulates the fees and he is not giving testimony on that portion.

SENATOR DOHERTY asked his feeling if they were to insert a clause into the bill limiting defense attorneys to the same restrictions as would be for plaintiffs' attorneys.

Mr. Swanson said he did not think it would be appropriate based upon insurance company attorneys, because they are typically on hourly rates. On the other side there are usually retainers involved. It was apples and oranges.

SENATOR HALLIGAN asked **SENATOR HARP** if he did construction work, if he worked at all for utilities. He asked if they were limited in their charges to work for regulated utilities.

SENATOR HARP replied that when the utilities put a project up for bid, they usually have 3-5 contractors bid on the project. They don't always take the low bidder because they have an internal mechanism that kicks in, called an engineer's estimate. If the estimate is above 5 or 6 per cent of the bid, the proposal is thrown out. So there is some internal pressures besides the outside forces of competition to limit his ability to make a profit.

SENATOR HALLIGAN asked if his overall concern was not the quality of the work and the fact that they would take the bid giving the most quality work. Wouldn't that affect the bill here, either inaccessibility to a system or the lack of confidence in a system to represent injured workers.

SENATOR HARP said he makes a point, and it was not his intent to close access. He said 90 per cent of the people in the business were admirable, but the 10 per cent who continue to capitalize on injured workers and certain individuals running "factories" going through a lot of claimants, spend very little time, and don't do a good job in receiving benefits, are the ones he is trying to target. He hoped to reduce the percentage of the group taking advantage of injured workers.

SENATOR HALLIGAN asked **Mr. Grosfield** how the bill would affect Old Fund cases prior to 1987? Would it restrict attorney's fee is those cases as well?

Mr. Grosfield said that based on Supreme Court precedent, the laws and rules in existence at the time of the injury would govern. This particular legislation would probably not affect anything prior to January, 1995.

Closing by Sponsor:

SENATOR HARP closed on SB 233 without further comment.

ADJOURNMENT

Adjournment: **CHAIRMAN CRIPPEN** adjourned the hearing at 12:05 p.m.

BRUCE D. CRIPPEN, Chairman

JUDY FELAND, Secretary

BDC/jf

MONTANA SENATE
1995 LEGISLATURE
JUDICIARY COMMITTEE

ROLL CALL DATE 2-10-95

NAME	PRESENT	ABSENT	EXCUSED
BRUCE CRIPPEN, CHAIRMAN	✓		
LARRY BAER	✓		
SUE BARTLETT	✓		
AL BISHOP, VICE CHAIRMAN	✓		
STEVE DOHERTY	✓		
SHARON ESTRADA	✓		
LORENTS GROSFIELD	✓		
MIKE HALLIGAN	✓		
RIC HOLDEN	✓		
REINY JABS	✓		
LINDA NELSON	✓		

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SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 1
DATE 2-10-95
SB. NO. 50292

FETAL DEVELOPMENT & Family Planning

George V. Voinovich
Governor
Peter Somani, M.D., Ph.D.
Director of Health

(brochure)

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 2
DATE 2-10-95
BILL NO. SB292

February 10, 1995

Cheryl A. Wilke
15655 Queen Annes Ln.
Florence, MT 59833

TESTIMONY

My name is Cheryl Wilke. My views stem from an abortion I received on January 28, 1986 at the Western Montana Clinic in Missoula, Montana.

At the age of 17, I found myself pregnant, scared, and at a loss for what to do. I went to Planned Parenthood where I talked to a "counselor". My conversation was extremely brief and looking back, quite unbelievable. I had no opinion on abortion. I was not "FOR" or "AGAINST" it. I was pregnant and faced with the most important decision of my life. I specifically asked her if what I had was a baby yet, and I remember taking comfort in her response, which now I know was a lie. She told me that "It" was just an accumulation of tissue, at 11 weeks. I now know a baby at this gestational age is very definitely alive and responsive. I then asked her if it would be painful and was told that it would only be uncomfortable for a short period of time. Considering the emotional pain of Post Abortion Syndrome for years to follow, that was the understatement of the year. I was given abortion as the only option suited to my situation. I saw no pictures on fetal development. Adoption was never even mentioned. I received no pamphlets or other material to read. No medical or psychological risks of abortion were discussed.

I went to an OB/GYN/Abortionist and again, information that I deserved was not given to me. How was I, a 17 year old girl supposed to make a truly informed choice with only information that supported the abortion choice? A choice that has changed my life, forever. Just as in the office of Planned Parenthood, I received no information on any alternatives. It would take longer to tell you what she didn't tell me than what she did. She concentrated on the dyer medical situation I was in. The abortion itself was very quick and impersonal, which led me considering what it's done to my life.

I have come to realize, as in my own situation, that the decision to have an abortion is for almost all women, one made under coercion, which makes it even more important to have complete, accurate information and that after information has been disclosed. Most women like myself have not been warned about P.A.S. and are COMPLETELY unprepared for the psychological consequences of abortion.

6 1/2 years after I aborted my baby, I went back to my abortionist

to ask her questions regarding my abortion. This was a time of intense emotional pain for me. I asked her why she had inadequately informed me as required specifically in the Montana Abortion Control Act. She stated that the act was not enforceable. I asked her why she did not warn me about P.A.S. She stated that she did not see enough evidence of it to tell her patients about it. It seems she was only willing to do the abortion, but not to accept the fact that it carries some severe penalties for women.

Over the last 2 years I have been a volunteer for a crisis pregnancy center where I have opportunity to hear of many cases like mine, but some much worse. 2 years ago during the legislative session you read the testimony of a woman who got an abortion at the tender age of 16. She was never told the risk of sterility. She lives with that painful fact every day of her life now, wanting a child she can never have.

Informed consent was not working then, and it is not working now. A year and a half ago I received a phone call from a woman who had questions about the abortion she was to receive. As I spoke with her, she told me the abortionist was the same as mine. I received the call on a Friday morning. During the course of our conversation, she informed me that the dilation procedure had already been started the day before. An instrument used to dilate her was already in place. I asked her what information the abortionist had given her about her baby, or anything else for that matter, and was shocked at her answer. She said she hadn't yet met the physician!! Everything to that point had been handled by a nurse! NO INFORMATION HAD BEEN GIVEN HER. I told her about her baby's development, risks being taken, and my own experience with abortion. Her appointment to finish the abortion was 1:00 that afternoon. I encouraged her to go to an obstetrician whom I knew would give her all of the information she deserved. He took her that day without appointment and answered all of her questions. He allowed her to hear her baby's heartbeat. Her decision to keep her baby was immediate upon receiving accurate information. In addition to that, the clinic told her that it was too late to change her mind. They also required a cash payment from her, which took the clinic 2 weeks to return.

I have demonstrated that this bill IS necessary and I sincerely hope that you can see the NEED of it.

If these abortionists are truly "Pro-choice", then they should have NO problem with presenting the CHOICE choices to their patients. ANYONE WHO WOULD DISCOURAGE THE PASSING OF THIS BILL IS NOT TRULY PRO-CHOICE, BUT THEY ARE IN FACT PRO-ABORTION. THERE IS A DIFFERENCE. And their interest and care do not truly lie with the patient.

Thank-you.

It's hard to imagine the heaviness and emptiness I and my 2 girls felt as we left Casper, Wyoming in 1937. Little did we know that circumstances and people would soon enter our lives which would unlock the secret that triggered in me the alcoholism that has haunted my family for generations and killed my father at the age of 42.

Having moved in with my mother yet having a void in my life that she nor my girls could fill, I spent most of my time hiding my pain in the bottomless pit of a bar glass surrounded by friends who thought I was just wonderful! Classy they called me- with my newly dyed jet black hair, tight wranglers, and high-heeled cowboy boots. What a sight I was on the outside... how I was dying on the inside. In 2 short months I'd gone from a respectable, responsible, loving mother of 3 to a full blown, hard-core alcoholic who hid bottles of booze around my mom's house. There were some mornings that I'd wake to find I'd only drempt I was in the bathroom and had soiled myself. Eventually my mom became sick of my behavior so we moved into our own house. She refused to watch my girls, age 3 and 5, so I'd leave them home alone as I continued to drown my sorrows. When I was home, I'd drink till I passed out, leaving them to fend for themselves. Living the sleazy lifestyle I did, I found myself pregnant. The father was younger than I and a baby was not a part of his plans for his future. We were both alcoholics, he into drugs as well, so I figured it was best to abort. I had 2 kids, lost my job, no money, couldn't pay the rent, on welfare...The Classic case for abortion. News got out that I was pregnant and my mom was mad! I was a disgrace! She insisted I abort. The Sunday before my scheduled appointment, my ex-husbands sister called me to see if I would talk with her and her husband. To most people we should have been enemies but never the less I agreed. They took me to the Lutheran church in Power, Montana and there they asked me what my plans were. I told them of my scheduled appointment in the morning for the abortion. They informed me of places I could go for financial help, clothing, etc. things that seem so trivial when you're considering the life of a child but are so monumental when the options seem so slim. They showed me pictures of a 10 week fetus and I saw a baby. They then showed me pictures of what happens to these babies during an abortion and my secret exploded through heaves of horror and torrents of tears. You see, 6 months earlier I, a 28 year old wife and mother of 3 had had an abortion. I was not your typical unwed, alcoholic, welfare candidate. I was a housewife of 8 years with a husband who found someone else, handed me $350.00 and told me to take care of the situation. I didn't know where to go or who to turn to so alone I went to the office,

alone I had the abortion, alone I returned home, took a nap and never thought of it again...until that day in the church. I was so horrified as I remembered the smell, the sight of the remains in the jar, the cold metal on my feet and back and the sick empty feeling I felt as I lay on the table. But most vivid of all was the sound as the very life of that baby was sucked out of me. I knew I could never do such a horrible thing again. I might add that the only counseling I received was to go to the hospital if there were any complications.

On November 24, 1983, I gave birth to a beautiful baby girl named Katy Kay Heck. Appropriately she came on Thanksgiving Day. Remember my mother who insisted on abortion? When Katy was born she became the apple of Grandma's eye. I June of 1991, my mom became very sick with cancer. As she fought the battle, she would often want me to take her in her wheelchair from her chemotherapy treatment to see the newborn babies. Katy would crawl on her lap and together they would admire those precious babies. As her life was nearing an end, it seemed important for her to se new life beginning. In June of 1992, 2 hours before her 63 birthday, she took her last breath, with 4 year old Katy holding her hand.

What about my life? Ten months following Katy's birth, I married her dad. We have overcome the alcoholism, drugs, and we are no longer welfare recipients. We have children who can be proud of their parents not ashamed of them.

Abortion nearly killed me and Katy. But because 2 people took the time to let me know where to find financial help, clothes, and food and showed me exactly what abortion entails, I and my family are healthy, strong, self-supporting and full of life.

There you have it, my testimony... It may not mean an awful lot to you but let me introduce you to someone it means very much to. I'd like you to meet Katy Kay Heck. I don't think there is one of you who could do to this little girl here and now what is done inside the womb of a mother choosing abortion. This little girl is the same person she was at 9 weeks in my womb. Please support SB292 and let these women know all the facts before they make a decision that will cost a life.

Dana Heck
Box 135
Power, MT.
59468

February 10, 1995

Nancy Vigel
SB 292

In April 1976, I had just turned 15 and found out I was pregnant. Scared and confused I confided in my brother's girlfriend Kathy. Kathy went with me to tell my mother. Mom made the arrangements, they then drove me to Dr. Armstrong's office.

The nurse, Susan Cahill, escorted me to the room where the abortion would happen. It was a cold and dead feeling. I took my clothes off as she watched and told me very gruffly to "get up on the table and put your feet into these stirrups." I remember being afraid of her because she was so gruff and mean, her face showed much anger and her obvious disgust. I felt dirty and ashamed already, but this woman really treated me like I was a bad dog needing to be punished. I crawled up on the table, and did as she commanded. She examined me and summoned Dr. Armstrong.

I heard them say I was over 12 weeks (it was illegal at that time to abort over 12 weeks). He told her to go ahead anyway. Dr. Armstrong left, and I never saw him again. I wanted to run, to hide, "This is my baby" I thought..... "Or is it just a blob." "Why is it that they are concerned over 12 weeks?" I am so confused, this must be wrong.

Remember, I was barely 15! Would you want your 15 year old child going through this?

With no pain killer, or information, I lay on that table scared and very confused.....**and NO ONE ever** talked to me about any of it. **Before or after**.

As Susan began to manually dilate my cervix it felt like I was tearing in two or being shredded and the pain was overwhelming me. I cried out-screaming in agony. Susan looked up from between my legs angrily and said, "Oh shut up! And take your medicine! You were woman enough to get into this mess-now act like a woman!" So, with tears streaming down my face into my ears, I bit my lip and clenched the table until my hands went numb. I heard and felt the scraping and suctioning as I clenched the table even tighter, I thought I might pass out from the pain. I hemorrhaged from the procedure which no-one ever acknowledged.

When I came out of that room in shock my mother and Kathy were very concerned because I was so white and weak.They helped me to the car and asked several times if I was okay and if I needed to go to the emergency room. I lay in the back seat trying to prove that I was okay. **I felt like I might die, I believe, in a sense that day, I did.**

For over 10 years I buried the painful memory of the abortion I had when I was just a child.

The memories began to flood back when I finally ended up in alcohol treatment in 1987 and I had to write a life story. Prior to that my life was a blur of running away. I drank, was promiscuous, ate compulsively. Anything to not feel. Even now the symptoms of post abortion syndrome still haunt me. While I tried to escape, the torment still leaked through. Pain and flashbacks ran through my

mind. Nightmares and more shame. Even though I had completely justified my abortion, and believed that it was okay. I was tormented and didn't know why.

The anger and resentment I'd buried toward Dr. Armstrong, his nurse, myself, and my mother and sister-in-law festered. I got married and had 3 more children, trying desperately to compensate for my loss. But, also, the rage inside fell on my husband and 3 boys. Until, in 1986 I was divorced and my children ended up in foster homes. At this time I still didn't connect all this with the abortion.

I ended up by God's grace, in a Bible study for women who've had abortions. There it all started to make sense. I believe, and so does Mom, that if we'd have been informed and counseled that my baby would be here today alive.

SENATE JUDICIARY COMMITTEE
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February 10, 1995

SB 292
Kathy Keller

Mr. Chairman, Members of the Committee, my name is Kathy Keller. Mrs Montana for 1994. I am the mother of a 2 year old boy and currently 12 weeks pregnant. 3 ½ years ago I was in an abusive relationship and pregnant.

A few weeks after I found out I was actually pregnant I called Blue Mountain Clinic in Missoula to make an appointment to get an abortion. After giving them the pertinent information over the phone they said that by the next week I would be 12 weeks along and that I had to hurry up and decide or it would cost me more money. They told me this without even confirming for themselves that I was pregnant or how far along I was. They also told me that I needed to come in for counseling in the morning and come back in the afternoon for the "procedure". Panicked, I made the appointment. What was I going to do? I only had enough money to get it done NOW.

I remember talking to my baby several times between the time we spoke on the phone and the time I actually arrived at the clinic. I told him how sorry I was for having to do this. I told my baby that I knew this was for the best, considering he wouldn't even have a dad. I even remember rubbing my stomach.

On October 2, 1991 I went to have the abortion at 8:30 A.M. You may be wondering why I remember the date and the time so well? That was the day my life changed, the day I chose to destroy my own baby. That was the day I put out a contract on the life of my own child. I paid the doctor $350 to destroy my first child. I remember sitting there with all the other girls, no one looking or saying a word. Some were older, some younger, all counting on the fact that by dusk our 'problems' would be taken care of. Little did I know, they were just beginning.

I was numb, very numb, at one point I looked up during the so-called counseling and asked her if "it" was a baby. She smiled politely and said, "No, I is just a blob of tissue that isn't even alive." I asked her if "it" had a heart beat. She said, "NO." (I had to call him "it" or I wouldn't be able to go through with the abortion.) I was afraid to interrupt her again, but I had to be sure, I asked her if "it" could feel pain, and again she said "No", only this time I could see she was getting a bit uncomfortable. She then told me she had had an abortion and it had been the best thing for her. She asked me if I wanted some Valium. She told me that there was no extra charge and that it would take the edge off. I guess that tiny pill was supposed to take my mind off the tiny person inside me. It didn't.

As I entered the room I was shaking. The doctor told me not to touch the machine or the air above it because it was all sterile, he was very gruff about it. He was more concerned about his machinery than he was about me. Couldn't he see that I was scared and shaking? He at least could have treated me like a person instead of some sheep about to be sheared. Sheared of my dignity and my child.

There I was with a paper gown that barely coved my front, laying on a cold table in a cold lonely room screaming in my mind: "How can you be doing this? How did you get yourself into this? Just before the Valium kicked in the doctor started doing his job....without saying a word. He took the rods to dilate me and started sticking them in and pulling them out. Each one more painful than the preceding one. There was nothing gentle about it. Then he stuck the suction tip in and turned on the machine. My body jerked with pain as he moved it around and around inside of my body. I remember digging my fingernails into my hands so hard I thought I was bleeding. The machine jolted my body up and down as he sucked my baby down a long white tube and into a big glass jar. God how I wish I would have never turned my head to see that jar. I saw it filling up with blood and pieces of human parts. My mind raced.....that was my baby. That blood was my baby's blood. That blood wasn't just mine, it was my baby's. That bloody jar. I will remember it for the rest of my life. When he was done he disconnected the jar, picked it up and left the room. Not a word. He just left. Left me laying there stripped of everything important to me.

The counselor told me she would be waiting outside the door and to come out after I got dressed. I wasn't even sure I could sit up, let alone get dressed. The only way for me to sit up was to clench my teeth, my hands, my eyes and my soul hoping that the memory of that jar would be gone when I opened them. Some how it worked. The counselor told me that I needed to take my temperature twice a day to make sure I didn't have a fever. She told me I would bleed for about a month, a lot like a heavy period. My ride took me home.....but I was never happy again unless I was getting drunk. I didn't care about myself or anything else. All I wanted to do was forget the pain.

Soon after I moved to Bozeman. But it didn't help, it was just a new place to party. Knowing that something was wrong I began searching for some relief over that alcohol. All the drinks and sex couldn't fill that empty place left where my child used to be. 4 ½ months after my abortion I became pregnant again. Later I learned that this is called an atonement baby. That is when you try to make up for the child that you have lost by having another child. It is common.

But becoming pregnant again didn't fill that hole in my heart. I did get married, and delivered, my son Dalton, but after holding him in my arms I realized even more what I had done just a little over a year before. My husband would come home and find me crying and rocking our son uncontrollably. I was weeping for the child Dalton would never get to play with, the grandchild my parents would never take to a baseball game.

You see abortion doesn't just happen to a baby. It happens to the women who have chosen to no longer have children in their wombs. It happens to the fathers of those children, to the grandparents, to the siblings, to his classmates.....All because women are not receiving the help they so desperately need. The help that women long for. The encouraging arm of acceptance during a difficult time. Abortion offers women only one solution: a dead child. Help mom's celebrate their children's birthdays, not mourn over what their lives could have been or should have been.

SENATE JUDICIARY COMMITTEE
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BILL NO. SB 292

American Medical Association
515 North State Street
Chicago, Illinois 60610

Consent to Operation, Anesthetics, and Other Medical Services at Teaching Institution

Form 23

A.M.
Date_____ Time_____P.M.

1. I authorize the performance upon _____
(myself or name of patient)

of the following operation _____
(state name operation)

2. I understand that the operation is to be performed at_____, a teaching institute.

3. I understand that the operation, the medical services rendered in conjunction with the operation, and the post-operative care are to be performed and rendered by those individuals selected and deemed qualified by the teaching staff of the _____
(name of the institution)

Witness_____ Signed _____
(Patient or person authorized to consent for patient)

8.1 Informed Consent—The Doctrine

To be legally valid, the consent given for a treatment or procedure must be an informed consent given with an understanding of what is to be done and the risks involved. No universal, informed consent form exists since informed consent is a process, while the form serves merely to document the process.

Lawsuits that allege a lack of informed consent are based on the concept of negligence.[1] This concept stems from two principles of law. The first is the fiduciary relationship between the physician and the patient. The second principle is the concept that people have a right to make major decisions about their bodies. The often-cited statement of principle is derived from Judge Cordozo's opinion in *Schloendorff v. Society of New York Hospitals*: 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . ."[2]

Informed consent may be defined as the physician's responsibility to give the patient the right kind and amount of information so

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that the patient can decide whether to undergo the proposed treatment or procedure. The kind and amount of information that must be given was originally defined by the courts, but most states have subsequently enacted legislation that attempts to define the facts that must be disclosed.[3] Because of the almost limitless number of diseases, procedures, treatments and patients, no definitive listing of elements of disclosure is possible. Several common elements can, however, be found in the laws and opinions.

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1 Hodge v. Lafayette General Hospital, *399 So.2d 744 (La. 1981);* LaCaze v. Collier, *434 So.2d 1039 (La. 1983).* See generally, *Miller, L.S., Informed Consent, 244:18 Journal of the American Medical Association, 2100 et seq. (Nov. 7, 1980);* Leonard v. New Orleans Orthopedic Clinic, *485 So.2d 1018 (1986);* Hondrouus v. Schumacher, *531 So.2d 450 (1988);* Seals v. Pittman, *499 So.2d 114 (1986);* Stafford v. LSU, *448 So.2d 852 (1984);* Jones v. Levy, *520 So.2d 457 (1988).*

2 105 N.E.2d 92, 93 (N.Y. 1914); Keogan v. Holy Family Hospital, *622 P.2d 1246 (1980);* Harbeson v. Parke-Davis, Inc., *656 P.2d 483 (1983);* Alexander v. Gonser, *711 P.2d 347 (Wash. App. 1985);* Pratt v. U. of Minn. Affiliated Hospitals, *(Minn. 1987).*

3 See *Alaska Stat. §09.55.556; Del. Code Ann. tit. 18, §6852 (Supp.); Idaho Code §39-4304; Iowa Code Ann. §147.137 (1983 Supp.); Ky. Rev. Stat. §304.20-320 (Supp.); Ohio Rev. Code §2317.54 (Page); Me. Rev. Stat. tit. 24 §2905 (Supp.); N.Y.Pub. Health Law §2805-d (McKinney); Pa. Stat. Ann. tit. 40, §1301.103 (Purdon) (Insurance Code); Utah Stat. Ann. §78-14-5; Vt. Stat. Ann., tit. 12, §1909 (Supp.); Wash. Rev. Code Ann. §7.70.050 (Supp.);* See also *Nev. Rev. Stat. §41A.110 (consent).*

8.2 Disclosure of Information for Informed Consent

There are several kinds of information that need to be disclosed.[1]

(a) *The Diagnosis.* Because informed consent involves the patient's right to decide, the disclosure of diagnosis should be as candid as possible.

(b) *The Procedure or Treatment.* The procedure or treatment should describe what will happen and whether the procedure is diagnostic or therapeutic.[2]

(c) *Risks and Consequences.* The risks and consequences involved in the procedure or treatment should be listed. A risk, it should be noted, is something that *might* occur, while a consequence is something that is *expected* to occur. Although this area has spawned many actions related to informed consent, it would be impractical to require a physician to disclose all possible risks.[3]

In one case, for example,[4] a patient brought a malpractice action against a physician and a nurse who were treating her because of

an injury that had resulted from anesthesia. The court ruled that the doctor could not be expected to explain all the possible risks to the patient, but only those that were serious. The court held that a test must be applied to determine if a person in the patient's position could reasonably have expected to be informed of the risks associated with general anesthesia and also of the possibility of alternative treatment.[5]

In a similar case,[6] the court held that a physician's failure to inform a patient before performing a biopsy to determine whether a growth on her vertebra was malignant and perhaps incurable, was not a misrepresentation that would vitiate the plaintiff's consent to the biopsy. The purpose of the biopsy, the court pointed out, was to rule out an incurable malignancy and clear the way for treatment of the woman's back pain. The court further stated that a reasonable patient would have consented to such a diagnostic biopsy despite the slight chance of irreparable neurological injury.[7]

Risks that are very improbable or not serious can usually be omitted from disclosure since they would not be material to a patient's decision whether to undergo the proposed treatment.[8]

In one such case,[9] a plaintiff entered a hospital for a diagnostic outpatient angiogram as prescribed by his physician. The patient signed a consent form and was taken for the angiogram but was not informed of any serious risks. The patient died from an anaphylactic reaction to the angiographic dye contrast material. The plaintiff contended that failure to administer epinephrine intraveneously constituted negligence.[10] The court held that the test for determining whether a particular peril must be divulged is its relevance to the patient's decision. All risks potentially affecting the decision must be disclosed.

No uniform statistics indicate what degree of risk is too remote.[11] One court has stated that whenever a procedure involves a known risk of death or serious bodily harm, the physician must disclose that information;[12] risks that are commonly known to the reasonable patient do not require disclosure.[13]

(d) *Outcome Probability.* The possibility of successful treatment or of failure, should be discussed with a patient. In agreeing to provide treatment or perform an operation, the doctor does not, in the absence of a special contract, guarantee particular results or a cure.[14] The physician warrants only that he or she possesses the de-

gree of knowledge and skill ordinarily common to a member of the medical profession in good standing in the community and has the ability to use that knowledge and skill in treating the patient![15] When a physician agrees to perform a procedure, the agreement includes an implied warranty that the doctor has the skill required to perform the procedure![16]

A physician may expressly agree to achieve a particular result or effect a cure. If the doctor enters into such a contract, however, and fails to achieve the promised result or effect a cure, liability for breach of contract may occur even though the highest professional skill was employed![17]

(e) *Feasible Treatment Alternative.* Feasible alternative treatments should always be discussed with the patient. In one instance![18] a patient was advised to undergo a kidney biopsy, but the physician failed to discuss the alternative of an open biopsy. The court stated that it required that "... all viable alternatives be disclosed, even though some involve more hazards than others."[19]

(f) *No Treatment Outcome.* Finally, the physician should discuss what could happen if nothing is done. In one such case, the patient declined to have a pap test and subsequently developed cervical cancer.[20] The doctor was found liable for negligently failing to warn her of the risks of failing to have to the diagnostic procedure.

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1 *Razovsky, F.A. Consent to Treatment: A Practical Guide. Little, Brown & Co. Boston. Toronto p. 41-50 Generally.*

2 Gates v. Jensen, *595 P.2d 919 (Wash. 1979).*

3 Smith v. Shannon, *666 P.2d 351 (Wash. 1983);* In Re Schouler, *723 P.2d 1103 (Wash. 1986);* Brown v. Dahl, *705 P.2d 781 (1985).*

4 Brown v. Dahl, *705 P.2d 781 (Wash. App. 1985).*

5 Id. *at 788.*

6 Leonard v. New Orleans East Orthopedic Clinic, *485 So.2d 1008 (1986).*

7 Id. *at 1013.*

8 See *Utah Code Ann. §78-14-5 (2)(a).*

9 Jones v. Griffith, *688 F. Supp. 446 (N.D. Ind. 1988).*

10 Jones v. Griffith, *688 F. Supp. 446 (N.D. Ind. 1988).*

11 See, e.g., Stottlemire v. Cawood, *213 F.Supp. 897 (D.D.C. 1963) (1/800,000 chance of aplastic anemia);* Yeates v. Harms, *393 P.2d 982 (1964) (1.5% chance loss of eye);* Starnes v. Taylor, *158 S.E.2d 339 (1968) (1/250 to 1/500 chance of perforation of the esophagus). Disclosure required:* Bowers v. Talmage, *159 So.2d 888 (Fla. App. 1963) (3% chance of death, paralysis, or other injury);* Scott v. Wilson, *396 S.W.2d 532 (Tex. Civ. App. 1965)* aff'd *412 S.W.2d 299 (Tex. 1966) (1% chance of hearing loss).*

12 Cobbs v. Grant, *104 Cal. Rptr. 505, 515 (1972).*

13 See generally, Jones v. Griffith, *688 F. Supp. 446, (1988);* Petty v. U.S., *740 F.2d 1428 (1984).*

14 Dazet v. Bass, *254 So.2d 183 (Miss. 1971);* Custodio v. Bauer, *59 Cal. Rptr. 463,(1967);* Bishop v. Byrne, *265 F. Supp. 450 (W. Va. 1967);* Lane v. Cohen, *201 So.2d 804 (Fla. 1967);* Bria v. St. Joseph's Hospital, *220 A.2d 29 (Conn. 1966);* Hawkins v. McCain, *79 S.E.2d 493 (S.C. 1954);* Waynick v. Reardon, *72 S.E.2d 4 (N.C. 1952);* Vann v. Harden, *47 S.E.2d 314 (Va. 1948);* Piper v. Halford, *25 So.2d 264 (Ala. 1946);* Fritz v. Horsfall, *163 P.2d 148 (Wash. 1945);* Wall v. Brim, *138 F.2d 478 (C.C.A. 5 1943);* Lake v. Baccus, *2. S.E.2d 121 (Ga. 1939);* Keating v. Perkins, *293 N.Y.S. 197 (1937).* See *N.Y. Pub. Health Law §2805-d(4)(a) (McKinney); Utah Code Ann. §78-15-4(2)(b); Vt. Stat. Ann. tit. 12, §1909(c)(1).*

15 Creighton v. Karlin, *225 So.2d 288 (La. 1969);* Benson v. Mays, *227 A.2d 220 (Md. 1967).*

16 Wolfe v. Virusky, *306 F. Supp. 519 (Ga. 1969).*

17 Guilmet v. Campbell, *188 N.W.2d 601 (Mich. 1971);* Brooks v. Robinson, *163 So.2d 186 (La. 1964);* Camposano v. Claiborn, *196 A.2d 129 (Conn. 1963);* Noel v. Proud, *367 P.2d 61 (Kan. 1961);* Robins v. Finestone, *127 N.E.2d 330 (N.Y. 1955);* Colvin v. Smith, *92 N.Y.S.2d 794 (1949);* Hawkins v. McGee, *146 A. 641 (N.H. 1929);* Brooks v. Herd, *257 238 (Wash. 1927).*

18 Logan v. Greenwhich Hospital Association, *465 A.2d 294 (Conn. 1983);* see also, Jones v. Griffith, *705 P.2d 701 (Wash. App. 1985).*

19 Id. *at 302.*

20 Truman v. Thomas, *611 P.2d 902 (Cal. 1980).*

Refusal to Submit to Treatment

Form 24

A.M.
Date_____ Time_____P.M.

I have been advised by Dr._____ that it is necessary for me to undergo the following treatment:_____

_____

_____

(Describe operation or treatment)

The effect and nature of this treatment have been explained to me.

Although my failure to follow the advice I have received may seriously imperil my life or health, I nevertheless refuse to submit to the recommended treatment. I assume the risks and consequences involved and release the above-named physician, the hospital and its staff from any liability.

Witness_____ Signed_____

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8.3 **Standards for Disclosure**

In addition to certain kinds of information, the physician has a responsibility to give the patient the appropriate amount of information. Two jurisdictional approaches exist.

(a) The first is the traditional or the professional standard approach. Most courts have held that in a lawsuit based on lack of informed consent, the patient must establish by expert medical testimony that the physician failed to disclose a risk which the reasonable medical practitioner would have disclosed in similar circumstances.[1] Expert medical testimony is required because the necessary extent of disclosure is not common knowledge or within the experience of laymen.[2] Without such testimony a jury would be unable to decide whether or not a physician breached a duty owed to a patient.[3] A few courts have held that, while a patient must produce expert medical testimony if the adequacy of the disclosure is at issue, the patient need not produce any expert medical testimony if the patient claims that no disclosure of any kind was made.[4]

(b) *Minority Approach.* Some courts have departed from the general rule and adopted the reasonable patient "patient need" or "material risk" approach. Expert medical testimony is not necessary to establish the adequacy of the scope of disclosure made by the physician in these jurisdictions. These courts have stated that the medical profession is not permitted to determine its own responsibilities to the public.[5] The question is whether or not the physician disclosed sufficient information to enable the patient to intelligently decide whether to consent to the treatment or procedure.[6] The necessary scope of disclosure is to be determined by applying the standards of the reasonable layman, not the reasonable medical practitioner.[7]

In *Cooper v. Roberts*,[8] a woman was admitted to a hospital for a gastroscopic examination. Although she was not informed of any of the risks of the procedure, she signed a "blanket consent form." Shortly after the examination was performed, it was discovered that her stomach had been punctured. The woman claimed that the examination had been performed without her informed consent. The medical evidence indicated that the incidence of such a puncture was only 1 in 2500 or .0004%.

The trial judge instructed the jury that the physician's duty to disclose risks to the patient is not determined by what the members of

the jury would disclose to the patient in similar circumstances. The required scope of disclosure is determined by what the reasonable medical practitioner would do.

Reversing the judgment in favor of the physicians, the Pennsylvania appellate court said that any medical expert would only testify as to what the expert would do in similar circumstances or what the expert thinks another physician should do. The court ruled that the necessary scope of disclosure consists of those facts, risks, and alternatives which a reasonable layman in a similar situation would deem significant in deciding whether or not to consent to a treatment or procedure.

If a proposed treatment or procedure is novel or unorthodox, the physician has an additional duty of disclosure. The physician must inform the patient that the treatment or procedure is novel or unorthodox and then must inform the patient of the possible risks.

In *Fiorentino v. Wenger*, a physician recommended a specific procedure to correct a minor's scoliotic condition. He did not inform the boy's parents that the procedure was not the generally accepted medical treatment in the community for scoliosis. He also failed to inform them that he was the only physician in this country utilizing the procedure and that untoward results had occurred in five of the thirty-five instances in which the procedure was performed. The procedure was performed and resulted in an exsanguinating hemorrhage during which the boy died.[9] Affirming judgment for the parents, a New York appellate court ruled that the physician had a duty to disclose the fact that the procedure was novel and unorthodox and that there were risks incident to, or possible in its use.[10]

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1 *That the physician's duty of disclosure is determined by a professional standard is still the majority rule. Arizona, Arkansas, Colorado, Delaware, Florida, Illinois, Iowa, Kentucky, Michigan, Mississippi, Missouri, Montana, New Jersey, North Carolina, Tennessee, Texas, Virginia, and Wyoming and by federal courts in Idaho and North Dakota, and some appellate courts in Louisiana.*

2 Aiken v. Clary, *396 S.W.2d 668 (Mo. 1965).*

3 Visingardi v. Tirone, *178 So.2d 135 (Fla. 1965).*

4 Collins v. Meeker, *424 P.2d 488 (Kan. 1967);* Williams v. Menehan, *379 P.2d 292 (Kan. 1963);* Natanson v. Kline, *354 P.2d 670 (Kan. 1960). See also* Woods v. Burmlop, *377 P.2d 520 (N.M. 1962).*

5 Getchell v. Mansfield, *489 P.2d 963 (Ore. 1971);* Berkey v. Anderson, *82 Cal. Rptr. 67 (1969);* Brown v. Dahl, *705 P.2d 781 (1985);* In Re Schouler, *723 P.2d 1103 (Wash. 1986).*

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6 *At present the material risk approach has been adopted by courts in California, the District of Columbia, Louisiana, Maryland, Massachusetts, Minnesota, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin, although in two such states, New York and Vermont, the professional standard approach has been reimposed by statute. By statute in Utah. Utah Code Ann. §78-14-5.*

7 Hunter v. Brown, *484 P.2d 1162 (Wash. 1971). See also* Mason v. Ellsworth, *474 P.2d 909 (Wash. 1970);* Jones v. Griffith, *688 F. Supp. 446 (N.D. Ind. 1988).*

8 *286 A.2d 647 (Pa. 1971).*

9 Fiorentino v. Wenger, *19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).*

10 *See also* Natanson v. Kline, *350 P.2d 1093 (Kan. 1960);* Hunter v. Burroughs, *96 S.E. 360 (Va. 1918);* See also, Karp v. Cooley, *493 F.2d 408 (1974);* Lambert v. Park, M.D., *597 F.2d 236 (1979).*

8.4 Exceptions to Informed Consent

(a) *Therapeutic Privilege.* There are exceptions to the requirement of informed consent. The doctrine of therapeutic privilege allows the physician to withhold information from the patient in some situations. A court discussed this concept in *Cantebury v. Spence*:[1]

> . . . when the risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient, and we think it is clear that portents of that type may justify the physician in action he deems medically warranted.
>
> The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being. The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs.

Some states have codified the therapeutic privilege exception.[2] Since this privilege is contrary to the assumptions underlying the informed consent doctrine, its use should be circumscribed. A physician should explain, in the medical record, why the information was withheld.

An Iowa court held that a doctor could not withhold any information from a patient contemplating a vasectomy for socioeconomic reasons.[3] The court noted that the patient was a well and normal person not requiring surgical intervention or therapy. The surgery was not corrective, but designed to interfere with a normal bodily function.[4] Similar reasons may apply to some cosmetic procedures.

(b) *Patient Waiver.* A second exception to an informed consent requirement occurs when a patient knowingly waives the right to receive any information. While a waiver may be valid, its use is not recommended. If a waiver is used, the physician should require the patient to sign a form acknowledging the latter's decision to refuse information.

(c) *Emergency Exception.* The third exception to informed consent occurs in the case of an emergency. Such a situation obviates the need for any consent at all.[6]

The law recognizes that in some circumstances a physician may perform a procedure different from the one to which the patient consented. These circumstances arise in emergencies and unanticipated situations.[7] A physician can usually act without consent if an unanticipated condition is found that requires immediate action. This is also true in an emergency situation where the life of the patient is endangered, and the doctor is unable to obtain the person's consent.[8]

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1 464 F.2d at 789.

2 Alaska Stat. §09.55.556(b)(4); Del. Code Ann. Stat. tit. 18, §6852(b)(3) (Supp.); N.Y. Pub. Health Law §2805-d(4)(d) (McKinney); Pa. Stat. Ann. tit. 40, §1301.103 (Purdon) (Insurance Code); Utah Code Ann. §78-15-4(2)(d); Vt. Stat. Ann. tit. 12, §1909(d) (Supp.) (provide information to immediate family).

3 Cowman v. Hornaday, *329 N.W.2d 422 (Iowa 1983).*

4 Id. at 427.

5 N.Y. PUb. Health Law §2805-d(4)(b) (McKinney); Utah Code Ann. §78-14-5(2)(c); Vt. Stat. Ann. tit. 12, §1909(c)(2)(Supp.).

6 See Chapter 4, fns. Ky. Rev. Stat. §304.40-320 (Supp.); Nev. Rev. Stat. §41A.120; N.Y. Pub. Health Law 2805-d(2)(a) (McKinney); Pa. Stat. Ann. tit. 40, §1301.103 (Purdon) (Insurance Code); Vt. Stat. Ann. tit. 12, §1909(b); Wash. Rev. Stat. Ann. §7.70.050(4) (Supp.).

7 Rozovsky, Consent to Treatment, A Practical Guide §1.6.4.

acog committee opinion

Committee on Ethics

Number 108—May 1992

Ethical Dimensions of Informed Consent

Informed consent is an ethical concept that has become integral to contemporary medical ethics and medical practice. In recognition of the ethical importance of informed consent, the Committee on Ethics affirms that:

1. Informed consent for medical treatment and for participation in medical research is an ethical requirement (which legal doctrines and requirements can in part reflect).
2. Informed consent is an expression of respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within caring relationships.
3. Informed consent not only ensures the protection of the patient against unwanted medical treatment, but it also makes possible the active involvement of the patient in her or his medical planning and care.
4. Freedom is maximized in relationships marked by mutuality and equality; this offers both an ethical ideal and an ethical guideline for physician–patient relationships.
5. Communication is necessary if informed consent is to be realized, and physicians can help to find ways to facilitate communication not only in individual relations with patients but also in the structured context of medical care institutions.
6. Informed consent should be looked upon as a process, a process that includes ongoing shared information and developing choices as long as one is seeking medical assistance.
7. The ethical requirement of informed consent need not conflict with physicians' overall ethical obligation to a principle of beneficence; that is, every effort should be made to incorporate a commitment to informed consent within a commitment to provide medical benefit to patients and thus to respect them as whole and embodied persons.
8. There are limits to the ethical obligation of informed consent, but a clear justification should be given for any abridgement or suspension of the general obligation.
9. Because ethical requirements and legal requirements cannot be equated, physicians should also acquaint themselves with the legal requirements of informed consent.

The application of informed consent to contexts of obstetric and gynecologic practice invites ongoing clarification of the meaning of these nine statements. What follows is an effort to provide this.

HISTORICAL BACKGROUND

In 1980, the Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) developed a statement on informed consent.* This statement reflected what is now generally recognized as a paradigm shift in the ethical understanding of the physician–patient relationship. The 1970s had seen in the United States a marked change from a traditional almost singular focus on the benefit of the patient as the governing ethical principle of medical care to a new and dramatic emphasis on a requirement of informed consent. That is, a central and often sole concern for the medical well-being of the patient gave way to, or was at least modified to include, concern for the patient's autonomy in making medical decisions.

*This statement, "Ethical Considerations Associated with Informed Consent," was subsequently approved and issued in 1980 as a Statement of Policy by the Executive Board of ACOG. In 1989, it was withdrawn for revision by the Committee on Ethics.

In the 1980s this national shift was both reinforced and challenged in medical ethics. Clinical experience as well as developments in ethical theory generated further questions about the practice of informed consent and the legal doctrine that promoted it. If in the 1970s informed consent was embraced as a corrective to paternalism, the 1980s exhibited a growing sense of need for shared decision-making as a corrective to the exaggerated individualism that patient autonomy had sometimes produced. At the same time, factors such as the proliferation of medical technologies, the bureaucratic and financial complexities of health care delivery systems, and the growing sophistication of the general public regarding medical limitations and possibilities continued to undergird an appreciation of the importance of patient autonomy and a demand for its safeguard in and through informed consent.

In the 1990s there are good reasons for considering once again the ethical significance and practical application of the requirement of informed consent. This is particularly true in the context of obstetric and gynecologic practice. Here medical options, public health problems, legal interventions, and political agendas have not only expanded but interconnected with one another in unprecedented ways. ACOG's concern for these matters is reflected in its more recent documents on informed consent and on particular ethical problems such as maternal–fetal conflict, sterilization, and surrogate motherhood (1–9). While a general ethical doctrine of informed consent cannot by itself resolve problems like these, it is nonetheless necessary for understanding them.

Informed consent for medical treatment and for participation in medical research is both a legal and an ethical matter. In the short 20th-century history of informed consent, statutes and regulations as well as court decisions have played an important role in the identification and sanctioning of basic duties. Judicial decisions have sometimes provided insights regarding rights of self-determination and of privacy in the medical context. Government regulations have rendered operational some of the most general norms formulated in historic ethical codes.* Yet there is little recent development in the legal doctrine of informed consent, and the most serious current questions are ethical ones before they are ones of the law. As the President's Commission reported in 1982, "Although the informed consent doctrine has substantial foundations in law, it is essentially an ethical imperative" (10). What above all bears reviewing, then, is the ethical dimension of the meaning, basis, and application of informed consent.

THE ETHICAL MEANING OF INFORMED CONSENT

The ethical concept of "informed consent" contains two major elements: *free consent* and *comprehension* (or understanding). Both of these elements together constitute an important part of a patient's "self-determination" (the taking hold of one's own life and action, determining the meaning and the possibility of what one undergoes as well as what one does).

Free consent is an intentional and voluntary act which authorizes someone else to act in certain ways. In the context of medicine, it is an act by which a person freely authorizes a medical intervention in her or his life, whether in the form of treatment or participation in research. As "consent," it implies the opposite of being coerced or unwillingly invaded by forces beyond oneself. As "free," consent implies a choice between alternatives. It includes the possibility of choosing otherwise—as the result of deliberation and/or of identification with different values and preferences. Free consent, in other words, implies the possibility of choosing this or that option or the refusal of any proposed option.

Comprehension (as an ethical element in informed consent) includes awareness and some understanding of information about one's situation and possibilities. Comprehension in this sense is necessary in order for there to be freedom in consenting. Free consent, of course, admits of degrees, and its presence is not always verifiable in concrete instances; but if it is to be operative at all in the course of medical treatment, it presupposes some level of understanding of available options.

Many people who are thoughtful about these matters have different beliefs about the actual achievement of informed consent and about human freedom. Whether and what freedom itself is has often been disputed. Despite continuing differences in underlying philosophical perspectives, however, important agreement has grown in this society about the need for informed consent and about its basic ethical significance in the context of medical practice and research. It is still important to try to clarify, however, who

*The Nuremberg Code in 1948 and the World Medical Association's Declaration of Helsinki in 1964 identified ethical restrictions for medical research on human subjects. For a history of the development of such codes and a general history of the ethical and legal concept of informed consent, see Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986). A culminating summary of federal regulations in the United States can be found in the *Federal Register* (June 26, 1991).

and what informed consent serves, and how it may be protected and fostered. This clarification cannot be achieved without some continuing consideration of its basis and goals and the concrete contexts in which it must be realized.

THE ETHICAL BASIS AND PURPOSE OF INFORMED CONSENT

One of the important arguments for the ethical requirement of informed consent is an argument from *utility*, or from the *benefit* that can come to patients when they actively participate in decisions about their own medical care. That is, the involvement of patients in such decisions is good for their health—not only because it is a protection against treatment which patients might consider harmful, but because it contributes positively to their well-being. There are at least two presuppositions here: One is that patients know something experientially about their own medical condition that can be helpful and even necessary to the sound management of their medical care. The other is that, wherever it is possible, the active role of primary guardian of one's own health is more conducive to well-being than is a passive and submissive "sick role." The positive benefits of patient decision-making are obvious, for example, in the treatment of alcohol abuse. But the benefits of active participation in medical decisions are multifold for patients, whether they are trying to maintain their general health, or recover from illness, or conceive and deliver healthy babies, or live responsible sexual lives, or accept the limits of medical technology, or enhance whatever processes they are in that bring them to seek medical care.

Utility, however, is not the only reason for protecting and promoting patient decision-making. Indeed, the most commonly accepted foundation for informed consent is probably the principle of *respect for persons*. This principle expresses an ethical requirement to treat human persons as "ends in themselves" (that is, not to use them solely as means or instruments for someone else's purposes and goals). The logic of this requirement is based on the perception that all persons as persons have certain features or characteristics that constitute the source of an inherent dignity, a worthiness and claim to be affirmed in their own right. One of these features has come to be identified as *autonomy*—a person's capacity or at least potential for self-determination (for self-governance and freedom of choice). To be autonomous in any degree is to have the capacity to set one's own agenda—in some important way to choose one's actions and even one's attitudes, to determine the meaning of the outcome of one's life. Given this capacity in persons, it is ordinarily an ethically unacceptable violation of who and what persons are to coerce their actions or to refuse their participation in important decisions that affect their lives.

One of the important developments in ethical theory in recent years is the widespread recognition that autonomy is not the only characteristic of human persons that is a basis for the requirement of respect. Human persons, it is noted, are essentially social beings, *relational* in the structure of their personalities, their needs, and their possibilities. Given this "relationality," then, the goal of human life and the content of human well-being cannot be adequately understood only in terms of self-determination—especially if self-determination is understood individualistically and if it results in human relationships that are primarily adversarial. A sole or even central emphasis on patient autonomy in the informed consent process in the medical context risks replacing paternalism with a distanced and impersonal relationship of strangers negotiating rights and duties. If persons are to be respected and their well-being promoted, informed consent must be seen as serving a fuller notion of relationship.

Patients come to medical decisions with a history of relationships, personal and social, familial and institutional. Decisions are made in the context of these relationships, shared or not shared, as the situation allows. Above all, these decisions are made in a relationship between patient and physician (or often between patient and multiple professional caregivers).

The focus, then, for understanding both the basis and the content of informed consent must shift to include the many facets of the physician–patient relationship. Informed consent, from this point of view, is not an end, but a means. It is a means not only to the responsible participation by patients in their own medical care; it is also a means to a new form of relationship between physician (or any medical caregiver) and patient. From this perspective it is possible to see the contradictions inherent in an approach to informed consent that would, for example:

1. Lead a physician (or anyone else) to say of a patient, "I *gave* her informed consent"
2. Assume that informed consent was achieved simply by the signing of a document
3. Consider informed consent primarily as a safeguard for physicians against medical liability

It is also possible to see, from this perspective, that informed consent is not meant to undergird a patient's unlimited demand for treatment, arbitrary noncompliance with agreed upon treat-

ment, or whimsical withdrawal from an agreed upon research protocol.

Freedom is maximized in relationships of trust; understanding is enhanced in the nuanced frameworks of conversation. Self-determination need not be either combative or submissive, but situated in relationships of mutuality of respect and, insofar as possible, equality of personal power. These kinds of professional relationships represent the preferred context for informed consent.

OBSTETRICS AND GYNECOLOGY: SPECIAL ETHICAL CONCERNS FOR INFORMED CONSENT

The practice of obstetrics and gynecology has always faced special ethical questions in the implementation of informed consent. How, for example, can the autonomy of patients best be respected when serious decisions must be made in the challenging situations of labor and delivery? What kinds of guidelines can physicians find for respecting the autonomy of adolescents, when society acknowledges this autonomy by and large only in the limited spheres of sexuality and reproduction? Do "recommendations" compromise patient autonomy in the context of genetic counseling? How much information should be given to patients about controversies surrounding specific treatments? How are beneficence requirements (regarding the well-being of the patient) to be balanced with rights of patient choice, especially in a field of medical practice where so many key decisions are irreversible? These and many other questions continue to be important for fulfilling the ethical requirement of informed consent.

Developments in the ethical doctrine of informed consent (regarding, for example, the significance that relationships have for decision-making) have helped to focus some of the concerns that are particular to the practice of obstetrics and gynecology. Where *women's* health care needs are addressed, and especially where these needs are related to women's sexuality and reproductive capacities, the issues of patient autonomy and relationality take on special significance. In other words, the gender of patients makes a difference where ethical questions of informed consent are concerned, because gender in our society has been a relevant factor in interpreting the meaning of autonomy and relationality. This is not to say that in some essential sense autonomy or relationality (or informed consent and relationships) ought to be different for women and men; indeed, quite the opposite. Rather, this alerts us to the possible inconsistencies in the application of the ethical requirement of informed consent.

While issues of gender are to be found in every area of medical practice and research,* they are particularly important in the area of obstetrics and gynecology. Of special relevance here, for example, are the insights now being articulated by women out of their experience—that is, their experience specifically in the medical setting, but also more generally in relation to their own bodies, in various patterns of relation with other persons, and in the larger societal and institutional contexts in which they live. These insights offer both a help and an ongoing challenge to the professional self-understanding and practice of obstetricians and gynecologists (whether they themselves are women or men).

Obstetrics and gynecology has in a special way seen new dimensions of informed consent emerge, and here new models for the active participation of health care recipients have been created. Some of these developments are the result of effective arguments that pregnancy and childbirth are not diseases, though they bring women importantly into relation with medical professionals. Even when women's medical needs are more precisely needs for diagnosis and treatment, their concerns to hold together the values of both autonomy and relationality have been influential in shaping not only ethical theory but also medical practice. Women themselves have questioned, for example, whether autonomy can really be protected if it is addressed in a vacuum, apart from an individual's concrete roles and relationships. But women as well as men have also recognized the ongoing importance of respect for autonomy as a requirement of moral justice in every relationship. Many women therefore continue to articulate fundamental concerns for bodily integrity and self-determination. At the same time they call for attention to the complexity of the relationships that are involved when sexuality and parenting are at issue in medical care.

The difficulties that beset the full achievement of informed consent in the practice of obstetrics and gynecology are not limited to individual and interpersonal factors. Both providers and recipients of medical care within this specialty

*See, for example, a recent study of court decisions on refusal of treatment regarding dying patients (Miles SH, August A. Courts, gender, and the "right to die." Law Med Health Care 1990;18(1–2 [Spring–Summer]): 85–95). The conclusion of this study is that court decisions for women patients differ from court decisions for men; that is, in general, men's previously stated wishes about "extraordinary" or "heroic" measures of treatment are taken more seriously than are women's.

have recognized the influence of such broad social problems as the historical imbalance of power in gender relations; the constraints on individual choice posed by complex medical technology; and the intersection of gender bias with race and class bias in the attitudes and actions of individuals and institutions. None of these problems makes the achievement of informed consent impossible. But, they alert us to the need to identify the conditions and limits, as well as the central requirements, of the ethical application of this doctrine.

ETHICAL APPLICATIONS OF INFORMED CONSENT

Insofar as comprehension and free consent are the basic ethical elements in informed consent, its efficacy and adequacy will depend on the fullness of their realization in patients' decisions. There are ways of assessing this and strategies for achieving it, even though—like every event of human freedom—informed consent involves a process that is not subject to precise measurement.

It is difficult to specify what consent consists in and requires, for it is difficult to describe a free decision in the abstract. Two things can be said about it in the context of informed consent to a medical intervention, however, elaborating on the conceptual elements we have already identified. The first is to describe what consent is *not*, what it is freedom *from*. Informed consent includes freedom from external coercion, manipulation, or infringement of bodily integrity. It is freedom from being acted upon by others when they have not taken account of and respected one's own preference and choice. This kind of freedom for a patient is not incompatible with a physician's giving *reasons* that favor one option over another. Medical recommendations, when they are not coercive or deceptive, do not violate the requirements of informed consent. For example, to try to convince a patient to take medication that will improve her health is not to take away her freedom (assuming that the methods of convincing are ones that respect and address, not overwhelm, her freedom). Or in another example, an attempt to persuade a woman who has tested positive for the human immunodeficiency virus that she should communicate the results of her testing to medical personnel who will be treating her infant is not in itself coercive; it need not violate her freedom.

The second thing that can be said about informed consent to a medical intervention is that while it may be an authorization of someone else's action toward one's self, it is—more profoundly—an active participation in decisions about the management of one's medical care. It is therefore (or can be) not only a "permitting" but a "doing." It can include decisions to make every effort toward a cure of a disease; or when cure is no longer a reasonable goal, to maintain functional equilibrium; or, finally, to receive medical care primarily in the form only of comfort. The variety of choices that are possible to a patient ranges, for example, from surgery to medical therapy, from diagnostic tests to hormone replacement, and from one form of contraception to another. For women in the context of obstetrics and gynecology, the choices are often ones of positive determination of this kind of assisted reproduction or that, this kind of preventive medicine or that—choices that are best described as determinations of their own actions rather than the "receiving" of care as a "patient."

Consent in this sense requires not only external freedom but the internal freedom which is a capacity for self-determination. Internal freedom includes not only freedom from inner compulsion and fear, but (as we have already observed) freedom from ignorance. Hence, consent is specified as "informed," and it depends on the further specification of what "comprehension" means.

Because comprehension requires information, it implies the disclosure of information and a sharing of interpretations of its meaning by a medical professional. The *accuracy* of disclosure, insofar as it is possible, is governed by the ethical requirement of truth-telling (11). The *adequacy* of disclosure has been judged by various criteria, including:

1. The common practice of the profession
2. The reasonable needs and expectations of the ordinary person who might be making a particular decision
3. The unique needs of an individual patient faced with a given choice*

Although these criteria have been generated in the rulings of courts, the courts themselves have not provided a unified voice as to which of these criteria should be determinative. Trends in judicial decisions in most states were for a time primarily in the direction of the "professional practice" criterion, requiring only the consistency of one physician's disclosure with the practice of disclosure by other physicians. Now the trend in

*For an overview of legal standards for disclosure, and of ethical questions that go beyond legal standards, see Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986:30–34, 306–316).

many states is more clearly toward the "reasonable person" criterion, holding the medical profession to the standard of what is judged to be material to an ordinary person's decision in the given medical situation. The criterion of the subjective needs of the patient in question has been generally too difficult to implement in the legal arena, though the force of its ethical appeal is significant.

Health care providers should engage in some ethical discernment of their own as to which criteria are most faithful to the needs and rightful claims of patients for disclosure. All three criteria offer reminders of ethical accountability and guidelines for practice. All three can help to illuminate what needs to be shared in the usually significant categories for disclosure: diagnosis and description of the patient's medical condition; description of the proposed treatment, its nature and purpose; risks and possible complications associated with the treatment; alternative treatments or the relative merits of no treatment at all; and the probability of success of the treatment.

Listing categories of disclosure does not by itself fill out all the elements that are important to adequacy of disclosure. For example, the obligation to provide adequate information to a patient implies an obligation for physicians to be current in their own knowledge, for example, about treatments, and disease processes. And when physicians make informed consent possible for patients by giving them the knowledge they need for choice, it should be clear to patients that their continued medical care by a given physician is not contingent on their making the choice that the physician prefers (assuming the limited justifiable exceptions to this that we will note below).

Those who are most concerned with problems of informed consent insist that central to its achievement is communication—communication between physician and patient, but also communication among the many medical professionals who are involved in the care of the patient, and communication (where this is possible and appropriate) with the family of the patient. The role of documentation in a formal process of informed consent can be a help to necessary communication (depending on the methods and manner of its implementation). Yet the completion of consent forms, however legally significant, cannot substitute for the communication of disclosure, the conversation that leads to free refusal or consent (2).

To note the importance of communication for the implementation of an ethical doctrine of informed consent is, then, to underline the fact that informed consent involves a process. There is a process of communication that leads to initial consent (or refusal to consent) and that can make possible appropriate ongoing decision-making.

There are, of course, practical difficulties with ensuring the kind of communication necessary to informed consent. Limitations of time in a clinical context, patterns of authority uncritically maintained, underdeveloped professional communication skills, "language barriers" between technical discourse and ordinarily comprehensible expression, situations of stress on all sides—all of these frequently yield less than ideal circumstances for communication. Yet the ethical requirement of informed consent, no less than a requirement for good medical care, extends to a requirement for reasonable communication. The conditions for communication may be enhanced by creating institutional policies and structures that make it more possible and effective.

It is obvious that while disclosure and consent are basic ethical requirements and not only ideals, they admit of degrees. There will always be varying levels of understanding, varying degrees of internal freedom. The very matters of disclosure are of a kind that are often characterized by disagreement among professionals, uncertainty and fallibility in everyone's judgments, the results not only of scientific analysis but of medical insight and art. And the capacities of patients for comprehension and consent are more or less acute, of greater or lesser power, focused in weak or strong personal integration, compromised or not by pain, medication, or disease. Some limitations mitigate the obligation of informed consent, and some render it impossible. But any compromise or relaxation of the full ethical obligation of informed consent requires specific ethical justification.

THE LIMITS OF INFORMED CONSENT

Because informed consent admits of degrees of implementation, there are, then, limits to its achievement. These are not only the limits of fallible knowledge or imperfect communication. They are limitations in the capacity of patients for comprehension and for choice. Assessment of patient capacity is itself a complex matter, subject to mistakes and to bias. Hence, a great deal of attention has been given to criteria for determining individual capacity (and the legally defined characteristic of "competence") and for just procedures for its evaluation (12). When persons are entirely incapacitated for informed consent, the principle of respect for persons requires that they be protected. Much attention has also been given to the ways and the means of this protection. In general, decisions must be

made in these situations for the patient—either by attempts to give a "substituted judgment" (a decision based on what the patient would have wanted, assuming some knowledge of what the patient's wishes would be) or by a decision made according to the "best interests" of the patient. The relative merits of these two options depend on the concrete situation of the patient and those who know and care for her.

The judgment that informed consent is impossible in some circumstances indicates a kind of limit that is different from a minimized, or partial, actualization of consent. One way to acknowledge this is to say that there are limits to the obligation to obtain informed consent at all. Another way is to identify alternative means (for example, "substituted judgment") by which the values and goals of informed consent can be preserved. Both of these ways are perhaps served by saying simply that there are exceptions to the strict rule of informed consent. These exceptions are of several kinds.

First, *impossibility* of any achievement of informed consent suspends the ethical obligation. This is exemplified in emergency situations where consent is unattainable and in other situations where a patient is not at all competent or capable of giving consent. In the practice of obstetrics and gynecology, as in any other special practice, there are situations where decisions can be based only on what is judged to be in the "best interest" of the patient—a judgment made, if possible, by family members (or a legal guardian) and medical professionals together. Yet often when a patient is not able to decide for herself (perhaps, for example, because of the amount of medication needed to control pain) a "substitute judgment" or a judgment on the basis of *prior* informed consent can be made with confidence *if* care has been taken beforehand to learn the patient's wishes. This signals the importance of early communication so that what a patient would choose in a developing situation is known—so that, indeed, it remains possible to respect the self-determination that informed consent represents.

A second way in which the rule of informed consent may be suspended is by being *overridden* by another obligation. There are a number of other ethical obligations that can in certain circumstances override or set limits to the extent of the requirement of informed consent. For example, strong claims for the *public good* (specifically, public health) may set limits to what a patient can choose or refuse. That is, the rights of others not to be harmed may sometimes take priority over an individual's right to refuse a medical procedure (as is the case in exceptional forms of mandatory medical testing and reporting). On the other hand, scarcity of personnel and equipment may in some circumstances mean that individual patients cannot have certain medical procedures "just for the choosing." Also, what is known as *therapeutic privilege* can override an obligation to disclose information and hence to obtain informed consent. "Therapeutic privilege" is the limited privilege of a physician to withhold information from a patient in the belief that this information about the patient's medical condition and options will seriously harm the patient. Concern for the patient's well-being (the obligation of beneficence) thus comes into conflict with respect for the patient's autonomy. This is a difficult notion to apply, however, and great caution must be taken in any appeal made to it. It should not, for example, be used as a justification for ignoring the needs and rights of adolescents to participate in decisions about their sexuality and their reproductive capacities. It is reasonable to argue that therapeutic privilege is almost never a basis for completely overriding the obligation of informed consent, and that when it is, it may characterize a temporary situation, one that will later allow the kind of communication conducive to the freedom of the patient.

Third, and finally,* there are limits intrinsic to the *patient–physician relationship* that keep the requirement of informed consent from ever being absolute. Physicians are moral agents or decision-makers, too, and as such retain areas of free choice—as in the freedom not to provide medical care that they deem medically or ethically irresponsible (a freedom that is sometimes called a right to "conscientious objection"). Interpretations of medical need and usefulness may lead a physician, for example, to refuse to perform surgery or prescribe medication

*Sometimes another exception to the rule of informed consent is thought to occur in the rare situation when a patient effectively *waives* her right to give it. This can take the form of refusing information necessary for an informed decision, or simply refusing altogether to make any decision. However, there are two reasons for not considering this an exception with the same status as the others listed here:

1. A waiver in such instances seems to be itself an exercise of choice, and its acceptance can be part of respect for the patient's autonomy.
2. Implicit in the ethical concept of informed consent is the goal of maximizing a patient's freedoms, which means that "waivers" should not be accepted complacently without some concern for the causes of the patient's desire not to participate in the management of her care.

In any case, it should be noted that in states where informed consent forms are required, it may be necessary to meet this requirement in some legally acceptable way.

(though the physician should provide the patient with information about her medical options). In the mutuality of the patient–physician relationship, each one is to be respected as a person and supported in her or his autonomous decisions insofar as those decisions are not, in particular circumstances, overridden by other ethical obligations. The existing imbalance of power in this relationship, however, is a reminder to physicians of their greater obligation to ensure and facilitate the informed consent of each patient. That is, differences in professional knowledge can and should be bridged precisely through efforts at communication of information. Only in this way can decisions that are truly mutual be achieved.

Acknowledging the limits of the ethical requirement of informed consent, then, clarifies but does not weaken the requirement as such. In recognition of this, the ACOG Committee on Ethics affirms the nine statements with which this document began.

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The American College of Obstetricians and Gynecologists
409 12th Street, SW • Washington, DC 20024-2188

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 8
DATE 2-10-95
BILL NO. SB 292

MARK H. MOZER, Ph.D.
Clinical Psychologist
Suite 4G, Arcade Building
Helena, MT 59601
(406) 442-0333

February 9, 1995

Mr. Chairman, members of the committee:

I am Dr. Mark Mozer, clinical psychologist and father of nine children, five of them adopted.

In the course of twenty-three years of clinical practice, I have talked to many women who have long carried a heavy burden of guilt from abortion. Indeed, the bitter, bitter controversy over abortion is a measure of its paramount emotional impact.

We provide warnings related to health risks of cigarettes, as well as the impact of alcohol on pregnancy. Since ~~abortion~~ abortion is a matter carrying such serious emotional consequences, the decision to abort a baby should not be made without objective information available related to all the options.

Life's important choices should be informed ones. It seems clear that anyone opposing SB 292 must be pro-abortion, rather than pro-choice. I urge your support of SB 292.

Sincerely,

MARK H. MOZER, Ph.D.
Clinical Psychologist

Montana Catholic Conference

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 9
DATE 2-10-95
BILL NO. SB 292

February 10, 1995
SENATE BILL 292

CHAIRMAN CRIPPEN, MEMBERS OF THE COMMITTEE, I AM SHARON HOFF, REPRESENTING THE MONTANA CATHOLIC CONFERENCE. IN THIS CAPACITY, I ACT AS LIAISON FOR MONTANA'S TWO ROMAN CATHOLIC BISHOPS ON MATTERS OF PUBLIC POLICY. THE MONTANA CATHOLIC CONFERENCE SUPPORTS SENATE BILL 292.

ENACTING A WOMAN'S RIGHT-TO-KNOW LAW ACCOMPLISHES THREE MAJOR GOALS: FIRST, WOMEN ARE INFORMED OF THE POTENTIAL RISKS OF ABORTION SURGERY TO THEIR LIVES AND THEIR REPRODUCTIVE HEALTH. GIVE WOMEN THE KNOWLEDGE WHICH WILL OPTIMIZE THEIR POWER TO MAKE A DECISION THAT WILL MINIMIZE THE RISK OF INJURY TO THEIR PHYSICAL AND MENTAL HEALTH. SECOND, WOMEN ARE GIVEN *INFORMATION ABOUT AVAILABLE MEDICAL AND FINANCIAL RESOURCES* SHOULD THEY DECIDE TO CONTINUE THE PREGNANCY. THIRD, THE LAWS *PROTECT UNBORN CHILDREN'S LIVES AND HEALTH* BY PROVIDING THEIR MOTHERS WITH INFORMATION ABOUT WHERE THEY CAN SECURE PRENATAL AND POSTNATAL SERVICES, THUS INCREASING THE LIKELIHOOD OF A HEALTHY PRENATAL AND POSTNATAL ENVIRONMENT FOR THE BABY.

Tel. (406) 442-5761 P.O. BOX 1708 530 N. EWING HELENA, MONTANA 59624

THE REQUIREMENT THAT A WOMAN WAIT TWENTY-FOUR HOURS AFTER RECEIVING COUNSELING AND OTHER INFORMATION BEFORE AN ABORTION IS IN DIRECT RESPONSE TO EVIDENCE THAT MANY ABORTION CLINICS USE HIGH-PRESSURE TACTICS TO "SELL" A WOMAN AN ABORTION. OFTEN WE HEAR THAT THOSE WHO ARE "PRO-CHOICE" ARE EITHER "NEUTRAL" ABOUT ABORTION OR EVEN PERSONALLY "ANTI-ABORTION." BUT, IT IS TOTALLY NAIVE TO THINK THAT PERSONS WHO ARE ***EMPLOYED*** IN CLINICS WHERE ABORTIONS ARE PERFORMED ARE ANYTHING BUT "PRO-ABORTION." IT IS CLEARLY IN THE CLINIC'S BEST INTERESTS TO ENCOURAGE WOMEN TO CHOOSE ABORTION. ANYONE WHO IS GENUINELY "PRO-CHOICE" WOULD SEE THAT GIVING A WOMAN TIME TO CONSIDER HER OPTIONS FOR WHAT IT TRULY IS: GOOD MEDICAL PRACTICE.

MONTANA LAW COVERING CONSUMER PURCHASING PROTECTS A BUYER'S RIGHT TO CANCEL A PERSONAL SOLICITATION WITHIN THREE BUSINESS DAYS (SECTION 30-14-504 MCA). A DECISION TO HAVE AN ABORTION IS HARDLY COMPARABLE TO BUYING A VACUUM CLEANER, BUT IF A CONSUMER IS GIVEN THREE DAYS TO REVERSE THAT KIND OF DECISION, SHOULD WE NOT PROVIDE ONE FULL DAY TO MAKE A DECISION WHICH IS IRREVERSIBLE?

THE ABORTION INDUSTRY IN THIS COUNTRY IS URGING WOMEN TO EXERCISE THEIR "RIGHT TO CHOOSE" WITHOUT FIRST ENSURING THEIR *RIGHT TO KNOW*. COURTS, STATE BUREAUCRACY, ABORTION

EXHIBIT 9
DATE 2-10-95
SB 292

DOCTORS AND CLINICS, AND HUMAN NATURE SOMETIMES ACT TO PREVENT WOMEN FROM RECEIVING CRITICAL HEALTH INFORMATION, INFORMATION THAT COULD HELP AVOID YEARS OF PHYSICAL PAIN AND PSYCHOLOGICAL AGONY. THE POWER THAT A WOMAN RECEIVES WHEN SHE GAINS ACCESS TO VITAL INFORMATION AND RATIONAL SOLUTIONS WILL ENABLE HER TO MAKE AN INFORMED DECISION, AWAY FROM THOSE WHO FINANCIALLY PROFIT FROM ABORTIONS AND AWAY FROM A SOCIETY THAT MISLEADS HER WHEN IT IMPLIES THAT ABORTION IS HER ONLY CHOICE.

WE URGE YOUR SUPPORT OF SB292. THANK YOU.

Dear Ladies and Gentlemen of the Montana Senate Judiciary Committee:

Thank-you for the priviledge to present to you written and oral testimony concerning my experience with abortion. It is my sincere hope that many lives will be saved through the enactment of the legislation entitled the Mother's Right to Know act. Perhaps my baby's death will have some meaning in giving life to others.

In June of 1977, I was nineteen years old, unmarried, and pregnant for the first time. I was terrified and ashamed. I had a good, steady job with full benefits as a veterinary specialist (E-4) in the U.S. Army. It was the first time I had been away from my parents and remote country home. It was my first experience living in the big city. I lived fifteen hundred miles away from family and friends and had not developed a network of emotional support.

I was faced with a decision concerning my pregnancy and chose abortion. My reasons were based in fear and shame. I justified my position with the self-talk that said, "It's not really a baby", "You can't miss what you don't know", "It's best for the baby and for me", "I don't have a home to raise a child in (which ment I didn't have a marriage)", and "It's only tissue and cells right now". I didn't feel capable of delivering a child and raising him or her on my own.

My knowledge of human reproduction was limited to a sixth grade film presenting menstruation. I was extremely embarrassed when it came to the subject of sexuality and it was not discussed with me at home. I had no knowledge of human sexuality until I experienced it firsthand. Losing my virginity at age nineteen resulted in an unexpected pregnancy. I was in a panic and couldn't identify anyone to help me. I decided that abortion was my only answer. But deep inside I did not want to do it.

I can remember being in my apartment and answering the telephone. A young woman on the other end asked me my name and told me that I was pregnant. I can't remember how I had contacted them, who they were, nor how I got the urine sample to their office. I don't remember how I received the referral to the abortion clinic. I know that I called to make the appointment myself. I arranged for time off from work and drove myself to the clinic. I had never faced anything serious concerning my body before without the comfort of my mother.

I was warmly welcomed by the receptionist in the neat, well decorated outer office. I filled out the information required and sat waiting to talk with the counselor. I was so upset inside. I didn't want to do this. I just saw no other way out. In a few minutes my "mistake" would be behind me forever and it would be like it never even happened. No one would know...it would be "OK". I was very proud and fought back tears because I never cried in public.

The counselor was a middle-aged woman who was very compassionate. I can't remember her face. My anxiety was so high that my only memory is of her voice. She closed the door and empathetically asked me a few questions. She asked me if I wanted an abortion. I said, "Yes." At sometime during the interview she asked, "Why? or Are you sure?" My only answer was, "Yes, because you can't have a baby without a family." My anguish was so great when she asked that question that I started to cry. The counselor looked concerned but got up and left the room until I could regain composure. When I was quiet she returned. Her options were that I could leave and come back again after I had thought more about my decision. That thought terrified me even more because I thought that if I waited to long, the cell and tissue within me would turn into a real baby. I couldn't hurt a real baby.

Although I was filled with doubt and confusion, deep remorse and pain...I chose to continue

with the abortion process. I had grown up in outbursts of violence. I had the ability to appear calm in life threatening and stressful circumstances...even at a young age. Through the tears, I signed the papers and prepared to undergo the procedure.

Had I been given informed consent? You be the judge. I had virtually no knowledge of fetal development or the birth process. I had not experienced a problem-solving process with the help of an adult. No adoption options were presented to me. The potential complications were explain ed to me but I didn't know what a cervix was nor how it fit anatomically with my body. I couldn't focus on what was being said to me. I didn't comprehend it. Growing up at home when things be came violent and unbearable, I was known for "tuning out" all that went on around me.

I remember being asked to return to the waiting area. Other women were now present. I was still wiping tears. The counselor came out and looked concerned for me. She bent down and was at eye level and asked me if I was ok. I shook my head, "yes".

To this day I can't remember anything about how I got to the gurney in the stark white operating room. I don't remember anything.

The next memory is of being in a hospital gown on the examining table with my heels in stirups, draped with a clean towel for temporary privacy. There was a woman on my left side at my feet (the nurse), a white ceiling, sunlight coming into the room from the left, and soft sounds out of my reach. I was crying quietly. There was equipment brought in to my right side where people were coming and going.

The woman near my feet spoke to me in a steady, quiet tone and explained that I would experience a sharp pain in my cervix when medication was injected. The medication would dialate the cervix wide enough so the doctor could remove the contents from my uterus. It sounded simple enough. From my right a woman came and held my hand. I don't remember anything about her except the warmth and strength of her hand holding mine. She gave me courage.

The doctor whom I had not yet met entered the room. I could see him from the chest up over my draped and elevated knees. I don't know if he told me his name. He smiled and seemed cheerful. He examined ne and I distinctly remember that he seemed happy to touch new life. He said, "You have a big baby about 12 weeks old". His statement terrified me. Hadn't it only been eight weeks since my last period? Did he mean that now the "tissue" was a real baby?

The doctor must have seen my fear because he became very professional and focused on the procedure. He told me it would be uncomfortable. He performed the abortion. It was the greatest pain in body and soul that I had ever known. I cried with the injection of medication in to my cervix. I felt a sharp pain, then a burning sensation from my cervix up into my m abdomen. There was a little wait and I said,"I'm sorry, I'm not good at handling pain....I won't ever let this happen again..." ,the tears flowed and everyone looked concerned. The woman on my right squeezed my hand tighter as I clung to her with my hand. I heard the sounds of a suction machine and experienced a pulling sensation in my groin...it ached so bad. When all was done,the doctor left and I was told to rest. I felt so weak and shaky. I turned to my right at the woman who was holding my hand let go. I saw a glass container now for the first time. I focused because I wondered what it was and I saw blood and the leg of a human body from the thigh to the toes perfectly formed. Horror gripped my heart...I could not accept the reality of what I had just seen. That scene was shut out of my mind as the woman who was holding my hand walked away pushing the glass container quickly out of the room. I was numb. I didn't allow myself to remember this event again for 17 year.

I can't remember getting dressed or leaving the room. I know they gave me pain pills because

they cautioned me about driving...but I was alone and had to drive myself back home.

The only post abortion instructions I remember were...."bleeding....if there is to much bleeding, then call us."

My clearest memory was being in my new apartment alone on the couch, holding my stuffed animals...sobbing. The pain in my lower abdomen was dulled by the pain medication but I was acutely aware of a deep sensation of loss. I felt a presence...gone. I was never aware that there was a sense of life within me until it was gone. My baby HAD been a REAL baby. A mother experiences physically and emotionally the loss of her baby no matter how old the baby is when he or she dies. Denial was my friend.

I cried out to God for forgiveness and experienced a softness inside. I believed God was carrying me in His forgiveness...this sustained my life...for I was plagued with suicidal thoughts for a long time.

The physical consequence post abortion was a friable cervix. This means that I bleed very easily. Also, I would experience an unusually painful burning sensation from my pelvis to mid abdomen whenever I had pap smears.

The psychological consequences occurred primarily when I married. Upon the consummation of our marriage, I became fearful, withdrawn, and at times, unresponsive. I began to experience dissociation when my husband touched me. This ment that I would be present in body but would "check out" on the inside. My husband was very patient with me. I cried every night for our first year of marriage. At times I would shake uncontrollably and cry out as if in pain. He just held me firmly as he ministered to me in song or by reciting Scripture. I felt like I was in a hole so deep inside that I could not climb out. Each Scripture felt like a ladder thrown to me with each truth being a rung of hope which I clung to for life...one by one...until it passed and I was "OK" again. Truth set me free. In time I was able to face the truth of what happened.

1. My first baby was real and alive.
2. My first baby was healthy.
3. It really was my baby's leg that I saw in that glass container.
4. I "chose" to participate in the destruction and death of my own baby.
5. All those present at the abortion of my baby were also partakers in my baby's death.

Once I faced the truth...then God was able to lead me into grieving, repentance, forgiveness and healing.

The effect of my choice to abort my baby has affected me,my husband, and children. It also affects other family members and the community as a whole. How? Because it is a violation of public trust. The public expects a mother to love, care for, protect, and nurture her baby. The public does not expect a mother to do violence to her baby which will result in his or her death. Yet, this is what I did. I participated willfully in a procedure that vacuum sucked my baby into pieces which resulted in his or her death. The public (wether a family member or stranger) suffers from the violation of public trust...a tragedy. It is felt for generations of time.

I would like to take this opportunity to publicly ask for forgiveness.

Each of you understand the weight of public trust as you fulfill your duties as our elected representatives. You have an opportunity to enact a law that will save thousands of lives. You can be the "Adult" influence that could provide a young woman who doesn't want to have an abortion the opportunity for problem-solving. And at the least you can rest knowing that true informed consent his being provided for the daughters of the people of the state of Montana

It has been my experience that God is real and that His authority is real. Leaders who rule

must live by God's authority or fight against it and pervert justice. The Scriptures say it is a terrible thing to fall into the hands of the living God without knowing and trusting in His Salvation, Yeshua, Jesus.

I am certain that if I would have been given the information and waiting period provided by the Mother's Right to Know act, I would not have chosen to end my baby's life through abortion. May God lead you in your decision.

Sincerely,

Peggy Ann Blumhagen, B.S.N.,R.N.

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 11
DATE 2-10-95
BILL NO. SB 292

Senator
to Bruce Grieppen
Committee members:

Ref SB 292 "Womens right to know"
I am writing asking for your support of SB 292.

My daughter had an abortion a few years ago, a direct result of that abortion was a Complete mental Breakdown and the loss of the life of my grandchild..
my daughter was a teen at the time, had graduated from school and was living on her own. She told me when she went for family planning they assured her of a safe (?) paid for end of her pregnacy. She was so upset they drugged her gave her an abortion sent her home. a few days later she called home with her father on the phone I drove 150 miles and brought my broken daughter home.
Safe abortions? for every person going in 1 dies, the baby, my grandchild. may he rest in peace, Please

stop the killing of our
children.

Please support. SB 292

Georgia Branscome
101 Wagner Lane
Kalispell, Mt.

P.S. there is no safe abortion
Some one always dies.

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 12
DATE 2-10-95
BILL NO. SB292

February 9, 1995

SB292
Arlette Randash / Eagle Forum

Mr. Chairman, members of the Committee, abortion is the most commonly performed surgery in America and it is performed on only half of the population. In Montana even though family physicians practice across the state, all reported abortions take place in just 6 locations. Abortions are not performed by a caring family physician familiar with a woman's family or medical history, but by those whose main speciality is abortion.

Testimony you have heard today is but a sampling of the roughly 64,000 woman aborted since 1973 in the state of Montana.....all most all of whom are silenced by shame and denial as to the lack of accurate and true counseling they received prior to an abortion. The circumstances surrounding abortion complicate the situation because many women find themselves in lonely, and frightening situations at the time they seek an abortion. Often the fear of abandonment by boyfriends, husbands, or families, coerce women to choose abortion over bringing a child to term. The state of Montana has a compelling interest to protect women from making a uniformed decision to abort for their own health and for the life of their unborn child.

Public health compels Montana's interest, not only for the well being of both the man, woman, and unborn child, but for the costs born by the community at large when significant numbers suffer from the realities of abortion: infertility, miscarriages, premature births, guilt, depression, drug and alcohol abuse, suicidal feelings, promiscuity, or frigidity, and bearing atonement children.

You will hear abortionists say they are providing informed consent today. If that is true why are they resisting the passage of SB 292? If that is true why are a growing number of women willing to face public scrutiny to testify that in their abortion they were totally uninformed?

You will hear abortionists say that SB 292 puts an undue burden on women because of the distances traveled in Montana? When all of the information may be supplied by certified mail and over the telephone does that argument have any merit?

You will hear that the materials depicting the incremental gestational age of the child will be a biased representation influencing the woman in her abortion decision. SB 292 calls for the DHES to develop the material. No one has argued the point that DHES has been biased in representing the facts concerning the AIDS crisis in Montana so why should they be unable to develop the booklet called for in SB 292?

You will hear, no matter the value of the fiscal note attached to SB 292, that in tight budgets the amount needed to develop and disseminate these booklets is just too much. Are the women of Montana suddenly so insignificant to the feminists, the champions of choice, that their right to an *informed choice* concerning an abortion is not worth even this amount of expenditure? If we were arguing for the funding of contraceptives this amount would suddenly be far to little in their opinion.

You have heard President Clinton and the Democrats say they want abortions to be safe, legal and rare. Why would the abortion advocates of Montana oppose a bill that might provide woman options to abortion and the information to choose adoption or bringing their child to live birth.....*making abortion rarer*? Could it be there is another motive at work? *I submit there are no dollars in the abortion business when women choose to not abort. Furthermore, the admission that not all women would choose an abortion when given real options and information would be a crack in the veneer of the political correctness of abortion.*

Why, when the rights of woman are being heralded across the world, are the studies (at least 24 published) that induced abortions cause at least a 50% increase in cancer, are the champions of women's rights resisting SB 292 that would compel doctors to give accurate medical information to women weighing the decision to abort, particularly when breast cancer is specifically being linked to abortions?

You will undoubtedly be told that the state of Montana will face court battles if SB 292 is passed on constitutional issues. The United States Supreme Court has ruled definitively in the Casey Case that an undue burden is not placed on woman by being informed and having 24 hours to consider an abortion decision. What motive, when other states have successfully litigated this issue, to relitigate the issue? What motives drive those would have you believe they champion woman's rights, denying a woman the right to be informed prior to an abortion as she is in all other medical procedures?

You will hear that woman are already burdened at the time of an abortion.....that more facts will only complicate and further burden her emotionally. Can you imagine a man contemplating a tough business decision that will affect not only his family but the lives of his employees giving credence to that argument by resisting more information on which to base his decision? Why should we accept such a paternalistic argument for a woman who is facing such a profound decision, one she intrinsically knows will affect her and her unborn child?

I submit their arguments are fallacious, eschewed by the profit motive, and their sacred idol, abortion. Even reasonable attempts to make sure that women and their unborn child be protected from the uninformed decision to abort are resisted. The police and supposedly bullet proof vests in evidence today are an attempt to smear the real violence done to the dignity and intelligence of women and their vulnerable unborn children by denying them the same information all discerning people need when faced with a surgery and a medical decision that has life time consequences for them, and life and death consequences for their unborn child. SB 292 is good public health, good law, and good public policy. Please give a 'do pass' to SB 292.

TO WHOM IT MAY CONCERN:

My name is Cindy DeLay. I'm a 34 yr. old mother of two. 50292 I'm lucky & blessed to have them both, because between the ages of 16 & 25, I subjected my body to SIX abortions. I wasn't informed that numerous abortions could make it hard for me to carry a child, or that it would cause me to spontaniously abort two children before I finally carried one to full-term.

Thou performed in different states, there were common factors. Never once, whether in Detroit, MI., Portland, OR., or Alpena, MI., did the developmental stage of the child I was aborting get disclosed to me. I was told "It's a blood clot" or "It's only a fetus". Risks, according to "trained counselors" were minimal. "Abortion is safer than childbirth" was a common statement. 'The best thing to do' 'Best choice' 'Safe' 'Quick & easy' and 'Painless' were all associated with the procedure. After an abortion at 14-16 wks. gestation, I awoke screaming "I KILLED MY BABY! OH GOD! I KILLED MY BABY!". The recovery-room attendant came & took my hand, "Now you calm down, sweetie, it wasn't a baby yet. It was only a fetus."

I've since learned that "fetus" is a stage of development, NOT A STATE OF " UN-BEING". Taken from Latin, "fetus" means "young one". I've learned the heart beats around 21 days, and by eight weeks, a fully-formed, tiny human baby exists. Complete with fingers&toes; a waking/sleeping cycle; ability to swim, suck it's thumb, hear, respond to light, and FEEL PAIN.

I've learned what abortion is and DOES, and why the containers in the procedure rooms are always covered. Un-informed women across the country are being told out-right lies, causing them to make a choice most are to regret later. They find out between 6 & 8 weeks they're pregnant, and because the truth is kept from them, or explanations are too vague, they're having their fully-developed, living & growing babies ripped from their wombs one tiny limb at a time. Or, if into their second tri-mester, the babies are burned within the womb first with a saline solution, causing the woman to deliver a dead or dying infant within 48 hours. Many times the woman finds out later that it WAS a BABY, and must live with the pain & guilt of what she's done.

I believe if women were informed of the developmental stage the "fetus" was at; what EXACTLY the procedure would involve; and given time to think about it, less women would choose to abort. Had I been made aware of the facts, I'd have been more responsible, and avoided pregnancy, abortion, and the resulting years of therapy. I still wonder, "What would those children have become?".

I find it insulting that the laws in these "UNITED" States can, in one court, say that a woman who does "crack-cocaine" during her pregnancy is "abusing" her "child", while upholding the Supreme Court's decision that an "unborn fetus" IS NOT A CHILD. This is a DOUBLE-STANDARD; A hipocritical line of politically correct jargon that tries to walk BOTH sides of the fence & stroke everyone in order to further other agendas. Our Constitution guarantees, FIRST & FOREMOST, "EQUALITY" & "LIFE...". If we remove the right-to-"LIFE" portion, what good will "Liberty & the pursuit of Happiness" be?

I SUPPORT AN "INFORMED CONSENT" BILL. I SPEAK FROM MY OWN EXPERIENCE WHEN I SAY THATAWOMAN SHOULD BE TOLD THE WHOLE TRUTH REGARDING ANY & ALL SURGERIES PERFORMED ON HER BODY

Thank-You,

Cindy L. DeLay

862-4380
Box 2032 COLFAX MT. 59112

23. _____

24. _____

25. _____

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 14
DATE 2-10-95
BILL NO. SB 292

Exhibit No. 14 includes 4 pages of signatures. The original is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694

WE THE UNDERSIGNED SUPPORT SENATE BILL 292

1. [illegible] Box 783 Whitefish MT 59937
2. [illegible] 152 Trailridge Rd, Kalispell, MT, 59901
3. [illegible] 27 Willow Dr. Kalispell MT 59901
4. Anne Pannell 387 Ponderosa Ln. Kalispell Mt. 59901
5. Christine Melby 3849 MT Hwy 40 W. #38 Col. Falls MT 59912
6. Edna Baldrett 637 E Evergreen Dr Kalispell Mt 59901
7. ~~[illegible]~~
8. Patti L. Cassidy 1430 6th Ave W Kalispell, MT 59901
9. Sandra L Potter 204 Arbor Dr. E. Kal. Mt. 59901
10. [illegible] 204 Arbor Dr. E Kal MT 59901
11. Darrel & Rose Gould 210 Liberty St. Kal. 59901

T H R E E

The Physical Risks of Abortion

Abortion is a surgical procedure in which a woman's body is forcibly entered and her pregnancy is forcibly "terminated." Because it is intrusive, and because it disrupts a natural process (pregnancy), abortion poses both short-term and long-term risks to the health and well-being of the aborted woman. Abortion is never without risks.

A few abortion advocates continue to insist that abortion is so safe as to be virtually "risk free," but such claims are exaggerations resulting from some blind belief in the slogans and clichés fostered by the early abortion reformers.[1] In contrast to these few abortion zealots, most defenders of abortion, particularly those in the health fields, admit that there are inherent risks to abortion. Within the medical profession the intense debate is not over whether there are risks or not but over how often complications will occur. Some claim the risks are "acceptable," while others insist they are not.

Answering the question "How safe is abortion?" is crucial to any public policy on abortion; but it is even more crucial to the women facing the abortion decision. Unfortunately for hundreds of thousands of women, their "safe and easy" abortions proved to be neither safe nor easy. Even more outrageous is the fact that almost none of these women were given a realistic assessment of the risks of abortion.

A Systematic Cover-up

Maintaining abortion's image of "safety" is important to groups supporting abortion for a variety of reasons. Obviously, for abortion referral agencies, abortion counselors, and the abortionists themselves, financial success depends upon their ability to assure clients that abortion is "safe." For population control groups that encourage abortion, achieving their long-range goals for population control depends on their ability to promote abortion as a "safe" and even "preferable" alternative to childbirth. And finally, the ideological success of the pro-choice philosophy in feminism depends on the "desirability" of abortion. After all, if abortion is found to be dangerous to women, its legalization can hardly be claimed as a triumph for "women's rights." For these reasons and others, abortion providers, population controllers, and pro-choice feminists are all anxious to believe that abortion is safe, and they are even more anxious to spread this belief to the general public. They support the contention that abortion is "relatively" safe by citing national statistics which report a "low" incidence of abortion-related deaths. But are these statistics accurate? Probably not.

In the first place, accurate statistics are scarce because the reporting of complications is almost entirely at the option of abortion providers. In other words, abortionists are in the privileged position of being able to hide any information which might damage their reputations or trade.

How can this be so?

Federal court rulings have sheltered the practice of abortion in a "zone of privacy." This prohibits any meaningful form of state or federal regulation other than broad "general requirements as to the maintaining of sanitary facilities and . . . minimal building code standards . . ."[2] As a result, any laws which attempt to require that deaths and complications resulting from abortion be recorded, much less reported, are unconstitutional.[3] Thus the only information available on abortion complications is the result of data which is *voluntarily* reported. Since abortionists want to hide their failures, underreporting of complications is the rule rather than the exception.[4]

The deliberate underreporting of abortion complications occurs primarily for three reasons: 1) Abortionists are seeking to protect their personal and professional reputations; 2) By minimizing the existence of unfavorable records, abortionists can minimize the availability of damaging evidence in the event of malpractice suits; and 3) Abortionists want to maintain the general myth that abortion is safe.

But even assuming that abortionists were totally willing to report complications, underreporting would still occur for other reasons:

1) Most outpatient abortion clinics do not provide follow-up examinations. Without these, the clinics simply assume there are no complications unless they receive a complaint. Other clinics do provide post-abortion exams, but these are usually brief and superficial.

2) Even if a post-abortion exam is insisted upon, conditions which may develop into long-range complications, such as sterility or an incompetent uterus, are not easily detectable without prolonged surveillance.

3) Many women hide their identities when seeking an abortion and may fail to return for a post-abortion exam even when one is available.

4) Over 60 percent of the women who need emergency treatment following an outpatient abortion go to a nearby hospital instead of going back to the abortionist. In these cases, an abortionist may never know that a complication occurred.[5]

5) When women are treated for long-term complications such as infertility, they may hide their past abortion experience or simply not realize that it is relevant.[6]

What all these factors add up to is simply this: complication records from outpatient clinics are virtually inaccessible, or nonexistent, even though these clinics provide the vast majority of all abortions. Even in Britain where reporting requirements are much better than in the United States, medical experts believe that less than 10 percent of abortion complications are actually reported to government health agencies.[7]

When treatment for a complication takes place in a hospital, however, the records are much more likely to be contributed to the health agencies which compile national health statistics; but this still does not mean that the records will be completely accurate. Instead, complications due to abortion are often listed under other categories. Sometimes this is done to disguise the cause of death. In one case, for example, a 21-year-old woman died only a few hours after a saline abortion, and her death was creatively listed as due to "spontaneous gangrene of the ovary."[8] The reason for the cover-up is relatively

obvious—abortionists don't want to be held legally and financially responsible for the complications and deaths which are a natural result of "routine" abortions.

In many cases, even physicians who are not involved with performing abortions contribute to the cover-up. There are primarily two reasons for this: loyalty to one's patient, and loyalty to one's profession. Examples of the first category occur when young women who have been aborted want to hide the cause of their hospitalization from their families and friends, even when they are in danger of dying.[9] Thus, what begins as an attempt to avoid embarrassing a woman and her family ends up as an omission of facts in the hospital's official records and, subsequently, as a distortion of national abortion statistics.

Secondly, there exists in the medical profession, as in most professions, an unstated code of "brotherhood" which discourages pointing fingers at the mistakes of other physicians. Therefore, in keeping with the general rule of the fraternity, "see no evil; speak no evil," the physician attending an abortion complication at a local hospital is quite likely to simply treat the condition and avoid recording that it was the result of an incomplete abortion performed by his colleague down the street.

All of the above factors have been mentioned to explain the lack of complete records on abortion complications in America. Political and financial motives, as well as respect for personal privacy, all hinder the reporting of these statistics. With these factors in mind, it should be remembered that the figures which will be cited in the following sections are *minimum* complication rates based on partial studies. They reflect only what is voluntarily reported, not what is actually happening.

Abortion Morbidity

The rate of complications following a medical procedure is known as the morbidity rate. For the reasons cited above, the morbidity rate due to abortion in America is unknown, though a few hospital studies have been done. But while the rate of complications is uncertain, the variety of complications which occur is well documented.

Over one hundred potential complications have been associated with abortion. Some of these complications can be immediately spotted, such as a puncture of the uterus or other organs, convulsions, or cardiac arrest. Other complications reveal themselves within a few days, such as a slow hemorrhage, pulmonary embolisms, infection and

fever. Still other complications are long-term in nature, usually the result of damage to the reproductive system, and may result in chronic infection, an inability to carry a subsequent pregnancy to term, or sterility. These latent complications may not be apparent until a later pregnancy is attempted or until the uterus is so infected as to require removal. Thus, an abortion recorded as complication-free in a short-term study might in fact have caused long-term damage. Thus, as many investigators have discovered, short-term studies of abortion complications reveal only the tip of the iceberg. Indeed, the longer women are kept under surveillance after an abortion, the higher are the reported rates of latent morbidity.[10] Women who may appear physically unaffected by an abortion after a one year follow-up may be found to be severely effected by the abortion as many as ten to fifteen years later.

Because of the large number of possible complications, it is difficult for any medical study to check for them all, especially the more elusive ones. Furthermore, because of the great time variation between short-term complications and long-term complications, no major scientific studies have been done to tabulate both.

After noting all of these qualifications, a few general observations can be made. First, every type of abortion procedure carries significant risks. Second, the earlier the abortion is done, the lower is the rate of immediate and short-term "major" complications. Third, every type of abortion procedure poses a significant long-term threat to a woman's reproductive health. Fourth, the younger the patient, the greater the long-term risks to her reproductive system.

Overall, the rate of immediate and short-term complications is no less than 10 percent. This figure is based on a *reported* 100,000 abortion complications in 1977, when the total number of legal abortions in that year was approximately one million.[11] This 10 percent morbidity rate, it should be remembered, is an undisputed *minimum* rate for immediate and short-term complications. It does not include unreported complications or long-range complications such as infertility. As we will see, the evidence indicates that the actual morbidity rate is probably much higher.

Immediate and Short-term Risks

Suction Curettage

Almost 90 percent of all abortions are performed by suction curettage, commonly known as vacuum abortions. In this procedure, the vagina

and cervix are forcibly dilated with progressively larger tapered cylinders called dilators. Dilation provides the abortionist with the necessary "working room" through which he inserts the abortion instruments, in this case a cutting instrument attached to a high powered vacuum (29 times more powerful than a home vacuum). With this device, the abortionist dismembers the "products of conception" (i.e., the unborn child and its placenta) and simultaneously vacuums out the pieces. Abortionists insist that in skilled hands suction curettage is the safest form of abortion. Many physicians disagree.[12]

According to two independent studies, the immediate or short-term complication rate for vacuum abortions is approximately 12 percent.[13] The reported "major" complication rate (strictly defined to include only life-threatening complications) is 4000 per million. Obviously, defining "major" complications in restrictive terms would make abortion appear safer than it really is.[14] Considering both immediate and long-term complications, a major German study found that the total morbidity rate for vacuum aspiration abortions exceeded 31 percent.[15]

Because the abortionist operates blindly, by sense of feel only, the cutting/suction device is potentially deadly. Perforation of the uterus is one of the most common complications (this can occur during dilation or evacuation) which leads to severe hemorrhage and can occasionally result in damage to other internal organs. In a few recorded cases, abortionists have inadvertently sucked out several feet of intestines in a matter of only a few seconds.[16]

Another common complication results from failure to extract all the "products of conception." If a limb or skull is left in the uterus, or if a portion of the placenta remains intact, severe infection may result, causing severe cramping and bleeding. Treatment may require another dialation followed by mechanical curettage and antibiotics. If the infection becomes too advanced or is persistent, a hysterectomy will be necessary to remove the diseased uterus.[17]

Third, as with all forms of abortion, suction curettage results in a high incidence of embolisms. An embolism is an obstruction of a blood vessel by a foreign substance such as air, fat, tissue, or a blood clot. Usually, such a blockage is minor and goes unnoticed and is eventually dissolved. But if the block occurs in the brain or heart, it may result in a stroke or heart attack. If it occurs in the lungs, it may result in a pulmonary thromboembolism. This condition may occur anywhere from two to fifty days after an abortion and is a relatively frequent major

complication. In one group of abortion-related deaths, pulmonary embolisms were the second most common cause of death. Because of the nature of embolisms, these abortion fatalities are unpredictable and often unavoidable. This risk, like most others, is seldom revealed to women during counseling at abortion clinics, even though it is widely known in medical circles. Pulmonary emboli are reported to afflict about 200 aborted women each year.[18]

Fourth, due to the rich blood supply around the uterus during pregnancy, local and general anesthesia during abortions are particularly risky. Anesthesia complications during first trimester abortions are fairly common and unpredictable. When an adverse reaction to anesthetics occurs in an outpatient abortion clinic, there is generally little equipment and expertise available on the site to deal with the emergency. Convulsions, heart arrest, and death are not an uncommon result of these circumstances. In one study of 74 women killed by legal abortions, anesthesia complications ranked as the third leading cause of death. The officially reported rate of anesthesia complications is 20 per 100,000 first trimester abortions.[19]

The nine most common "major" complications resulting from vacuum abortions are: infection, excessive bleeding, embolism, ripping or perforation of the uterus, anesthesia complications, convulsions, hemorrhage, cervical injury, and endotoxic shock.[20] "Minor" complications include: minor infections, bleeding, fevers and chills, second degree burns, chronic abdominal pain, vomiting, gastro-intestinal disturbances, weight loss, painful or disrupted menstrual cycles, and Rh sensitization.[21]

A word about the last item: only 42 percent of aborted women receive Rh screening prior to their abortions; and even for the minority that are tested, the analysis of the blood samples are often rushed and inaccurate.[22] Unless a woman with Rh negative blood receives a RhoGam injection immediately after the abortion, sensitization may result. In a later "wanted pregnancy" this sensitization may endanger both the life of the mother and her child, a complication which could no longer be considered "minor."

Dilation and Curettage (D&C)

Dilation and curettage is very similar to suction curettage but is used primarily in late first trimester and early second trimester abortions. It differs from suction abortions in that instead of vacuuming out the "products of conception," the abortionist manually dismembers the

fetus and scrapes the organs out of the uterus and into a basin. Because it uses sharper instruments and involves more scraping, D&C abortions typically result in much greater blood loss and a higher rate of overall complications.

The types of complications associated with D&C abortions are virtually the same as with vacuum abortions, but are approximately 20 percent more frequent.[23]

Saline Abortions

Each year there are between 100,000 and 150,000 second and third trimester abortions. Most of these are saline abortions. The rate of "major" complications associated with saline abortion is reported to be about five times greater than for first trimester suction abortions.[24]

In a saline abortion, also known as a "salting out," a concentrated salt solution is injected into the amniotic sack surrounding the baby. This solution burns the skin of the fetus and slowly poisons his system, resulting in vasodilation, edema, congestion, hemorrhage, shock and death.[25] This process takes from one to three hours, during which the distressed unborn kicks, thrusts, and writhes in its attempts to escape. Twelve to forty-eight hours after the child dies, the mother's hormonal system shifts in recognition of this fact and she goes into natural labor. Normally, within 72 hours after the injection, she will deliver a dead fetus.

The technique of saline abortion was originally developed in the concentration camps of Nazi Germany.[26] In Japan, where abortion has been legalized since the 1940s, the saline abortion technique has been outlawed because it is "extraordinarily dangerous."[27] Indeed, in the United States saline abortion is second only to heart transplants as the elective surgery with the highest fatality rate.[28] Despite this fact, state laws attempting to prohibit saline abortions because of their great risk to aborting women have been declared unconstitutional by the courts.[29]

Severe infections and hemorrhages are extremely common following saline abortions. In addition, seepage of the salt solution into the woman's blood system may result in life-threatening coagulation problems. Incomplete abortions and retained placentas occur in from 40 to 55 percent of all cases, the correction of which requires additional surgery. Furthermore, infections or uterine damage incurred during saline abortions frequently require removal of the uterus.[30]

Prostaglandin Abortions

In a technique similar to saline abortions, the chemical prostaglandin is injected into the amniotic fluid. But instead of killing the unborn outright, this method induces intense contractions of the uterus and causes forced labor. Usually the child dies during the trauma of premature labor, but frequently it does not. This results in one of the most disturbing "complications" of prostaglandin abortions, a live birth.

When prostaglandins were first introduced, there was great hope among abortionists that this new technique would be safer than saline injections. But when six women died and a large number of "aborted" babies were delivered *alive*, the enthusiasm for prostaglandins dwindled rapidly.[31]

Frequent complications associated with prostaglandin abortions include spontaneous ruptures in the uterine wall, convulsions, hemorrhage, coagulation defects, and cervical injury. Incomplete abortions are also very common. In these cases the decay of retained tissue may result in severe infections, prolonged hospitalization, additional surgery, and in many cases the need for an emergency hysterectomy.[32]

In sum, rather than replacing saline abortions, prostaglandins have simply caused a debate within the aborting community as to which method is the most dangerous. Oddly enough, however, although the evidence seems to indicate that prostaglandins are slightly less dangerous, most abortionists continue to prefer saline abortions. The reason for this is simple. Live births following prostaglandin abortions are extremely disturbing to both the medical staff and the mothers. In other words, a higher priority is being placed on killing the fetus than on providing the safest way for a woman to be rid of her pregnancy.[33]

The Living Complication

Except when dilation and curettage is used, second and third trimester abortions always run the risk of producing a live born aborted baby. These premature infants generally die within a few minutes or hours. Some, however, live for days, and a few live to adulthood.[34]

Besides the extraordinary trauma which a live birth abortion poses for a woman, live births constitute the most difficult ethical and legal dilemma faced by abortionists. Is a physician who is being paid to kill an unwanted fetus one moment, required to attempt to save an unexpected baby the next? According to Dr. Robert Crist, a Kansas City abortionist, "the abortion patient has a right not only to be rid of the

growth, called a fetus in her body, but also has a right to a dead fetus."[35] But when witnesses reported that they saw Dr. William B. Waddill choke and kill a live born baby which resulted from a nonlethal saline abortion, the physician was subjected to trial for murder.[36]

Though most doctors do not actively attempt to kill live born babies following an abortion, most do attempt to ensure death through neglect. Following most second and third trimester abortions, abortion staffs make a conscious effort *not* to discover whether the child is alive or dead. Any signs of movement or breathing which might be noticed are dismissed as "reflex," unless movement and crying reach a level which cannot be ignored. One abortionist describes his policy this way:

> At the time of delivery, it has been our policy to wrap the fetus in a towel. The fetus is then moved to another room while our attention is turned to the care of [the woman]. She is examined to determine whether complete placental expulsion has occurred and the extent of vaginal bleeding. Once we are sure her condition is stable, the fetus is evaluated. Almost invariably all signs of life have ceased.[37]

Wrapping the fetus in a towel accomplishes two things. First, it conceals all "signs of life" which may be disturbing to the patient and staff. Second, if the premature baby is not already dead, the towel will prevent the baby from getting the oxygen it needs to survive.

Most abortionists will do anything to avoid treating a live born aborted baby.[38] One of the most shocking examples occurred in Pine Bluff, Arkansas, where an abortion resulted in a kicking and screaming baby:

> In the examining room after the abortion, the doctor wrapped the baby in a towel and laid it aside while he finished caring for Marie. The infant continued to squirm and cry.
>
> Soon afterward, Marie left the doctor's office for a friend's house nearby. The physician then placed the child in a sack and gave it to one of the two friends who had accompanied Marie. . . .
>
> In a few minutes, the woman with the sack arrived at the house where Marie was waiting. She said the doctor had told her to "take it along with you, and pretty soon it will stop moving."
>
> After Marie fell asleep, the friends kept their death watch over the aborted infant until they decided to seek help.[39]

In this case, even after prolonged neglect, the baby survived. Marie, filled with guilt, is glad that her child lives.

Live birth abortions occur in the United States at a rate of 400 to 500 times per year, literally an every day experience.[40] The number may be higher, since (1) there is no effort to determine if a child is live born, and (2) most abortionists avoid reporting live birth abortions. Dr. Williard Cates, chief of abortion surveillance at the Center for Disease Control in Atlanta, describes the cover-up this way: "It's like turning yourself in to the IRS for an audit. What is there to gain? The tendency is not to report because there are only negative incentives."[41]

In order to avoid the "complication" of live births, abortionists are experimenting with more deadly techniques for second and third trimester abortions. One new technique involves the injection of a poisonous dose of digitoxin directly into the unborn child's heart. As with most experimental abortion procedures, women are generally not informed that the procedure is untested.[42] These new techniques may solve the "abortionists' dilemma," but they may also pose unforeseen dangers to the health of women.

Long-range Risks

A high risk of infection is common to all forms of abortion. Infection may result from bacteria and viruses introduced into the womb during the abortion or from the decay of damaged uterine tissue or unremoved "products of conception." In one series of 1,182 abortions which occurred under closely regulated hospital conditions, researchers found that 27 percent of the patients acquired post-abortion infections resulting in fevers lasting three days or longer.[43] The infection rate from outpatient "abortion mills" is probably much higher.

Many infections are dangerous and life-threatening, and severe pain will typically prompt the patient to seek emergency treatment. But the majority of infections are of a milder order. These lesser infections will cause only minor discomfort, if any. Eventually a woman's body will overcome these milder infections, but long-term damage may still result.

Mild or severe infections may extend from the uterine lining to the fallopian tubes or to organs adjacent to the uterus. Scar tissue left by the infection may block the fallopian tubes, resulting in total or partial infertility and an increased probability of ectopic pregnancies. If a chronic infection results, a total hysterectomy may be required several months or even years after the abortion.[44]

Studies have shown that a woman's risk of an ectopic pregnancy dramatically increases following an abortion. One study suggests that the risk increases 100 to 150 percent, another study suggests a 400 percent increased risk, and a third indicates an 800 percent increased risk.[45] Since the legalization of abortion in 1973, there has been a 300 percent increase in the occurrence of ectopic pregnancies in the United States.[46] Other countries with legalized abortion have witnessed the same effect.

Treatment of an ectopic pregnancy requires major surgery to remove the impregnated fallopian tube before it bursts. For every 100,000 cases of ectopic pregnancy, 300 women die due to rupture and hemorrhage.[47] These deaths are always listed under the "maternal mortality" category rather than as "abortion deaths," even though abortion may be the root cause of most ectopic pregnancies today.

If the scar tissue caused by post-abortion infection is severe enough to completely block the fallopian tubes, total sterility will result. Women who undergo just one induced abortion are three to four times more likely to suffer from secondary infertility than non-aborted women.[48] Numerous studies have found that 3 to 5 percent of all aborted women are inadvertently left sterile by the operation.[49] If a woman is also infected by a venereal disease at the time of her abortion, the risk of being rendered sterile is even greater.[50]

After infection, cervical damage is the next leading cause of post-abortion reproductive problems. Damage to the cervix may occur during the "scraping out" in a vacuum or D&C abortion, or during the "expulsion" in a saline or prostaglandin abortion. But undoubtedly, it is during the forced dilation of the uterus in vacuum and D&C abortions that most cervical damage is incurred.

Normally the cervix is rigid and tightly closed throughout the pregnancy. Only at the time of birth does it begin to naturally soften and open. But in an artifically induced abortion, no such natural change occurs; the cervix is hard and "green," designed by nature to resist intrusion and to protect its charge. In this context, it is clear that abortion is an attack not only on the unborn, but also on the woman's reproductive organs, which are designed to protect the child. Thus, during the forcible dilation which occurs in all early abortions, a tremendous stress is placed upon the woman's "green" cervical muscles. This stress virtually always causes microscopic tearing of the muscles, and occasionally results in severe ripping of the uterine wall (a "major" complication). According to one hospital study, 1 in 8 suction curretage

abortions required stitches for cervical laceration.[51] Another study indicated that laceration of the cervix occurred in 22 percent of aborted women. Again it should be remembered that in outpatient abortion clinics, such lacerations are frequently not noticed, much less treated.

In any case, whether the dilation damage to the uterine muscles is microscopic or macroscopic, this damage frequently results in a permanent weakening of the uterus. This weakening may result in an "incompetent cervix" which, unable to carry the weight of a later "wanted" pregnancy, opens prematurely, resulting in miscarriage or premature birth.[52] For this reason, the chance that a later "wanted" child will die during pregnancy or labor is at least twice as high for previously aborted women.[53]

Cervical damage is extremely frequent in young women pregnant for the first time, because the cervix is much more rigid in women who have not previously given birth.[54] This fact is particularly unnerving since nearly 60 percent of all abortions are for first pregnancies. Most of these women will later seek a "wanted" pregnancy, but because of cervical damage they may instead face the traumas of repeated miscarriages and premature births.

According to one study, the risk of a second trimester miscarriage increases tenfold following a vaginal abortion. Similarly, the risk of premature delivery also increases eight to ten times. Though normally only 5 percent of all babies are born prematurely, this rate jumps to 40 percent among women who have had abortions.[55] In another study of first pregnancy abortions, a researcher found that 48 percent of the women studied suffered from abortion-related complications in later "wanted" pregnancies. Women in this group experienced 2.3 miscarriages for every one live birth.[56]

These figures reflect the increased risks for the average woman undergoing an abortion. But when the woman is only a teenager, the frequency and severity of the damage is even worse since a teenager's "green" cervix is still growing and changing. This fact is best illustrated in a comparative study done by Dr. J. K. Russell. In this study, Dr. Russell tracked the reproductive lives of 62 pregnant teenagers. When first pregnant, 50 of the girls had abortions, 11 gave birth and 1 miscarried. Of the 11 teenagers who gave birth, 9 later became pregnant with "wanted" children and delivered with no complications and a 100 percent success rate. Among the 50 girls who had undergone abortions, there were 47 subsequent "wanted" pregnancies. Of these 47 "wanted" pregnancies, 66 percent ended in defective births (includ-

ing 19 miscarriages and seven premature births). Only 34 percent of the pregnancies among the previously aborted group ended with a full-term delivery of a healthy child.[57]

Induced abortion may cause not only cervical incompetence, but also cervical rigidity. Permanent damage to the uterine wall may result in the faulty placement and development of the placenta during later pregnancies. A 1981 study at Vanderbilt University found that after a single abortion the risk of placenta previa in later pregnancies increases seven to fifteen times.[58] Abnormal development of the placenta due to uterine damage increases the risk of fetal malformation, perinatal death, and excessive bleeding.[59]

Due to uterine damage, previously aborted women also face much more difficult and dangerous deliveries in later pregnancies. Aborted women face at least three times more labor complications than non-aborted women.[60] Previously aborted women require longer periods of labor during all three stages of labor; they are more likely to require manual or instrumental assistance to complete their labor; they are more likely to suffer from retained and adherent placenta following delivery; they are more likely to experience rupture of their uterus during labor; and they are more likely to suffer from severe hemorrhage at parturition and experience substantially greater blood losses than their non-aborted sisters.[61] In short, abortion places women and their future children at much greater risk during both their pregnancies and their deliveries.

Finally, there is a large class of long-term complications which is only now being investigated. For example, a recent study performed by California researchers found that the risk of breast cancer doubled among women who abort their first pregnancy.[62] Two known studies are now underway to determine if there is a link between abortion and the high incidence of cervical cancer among aborted women.[63]

The explanation for increased breast cancers and cervical cancers among aborted women lies in the unnatural disruption of their changing bodies. Early in pregnancy, the breasts and uterus undergo a rapid growth and change. Suddenly disrupting these changes before their completion may render these cells susceptible to "neoplastic stimuli" (tumor initiation) or might hasten the growth of cells which are already malignant.

Only the future will reveal how many other side effects result from abortion. But already it is clear that because of its many immediate and long-term complications, legal abortion is perhaps the leading cause of

gynecological and obstetric emergencies in the United States.[64] This is reflected in the trend in medical malpractice insurance toward creating a new "ultra-risk" category for surgeons who perform abortions.[65]

Evidence from Other Countries

As we mentioned at the beginning of this chapter, the American "experiment" with abortion has yet to provide any comprehensive data. The abortion industry has everything to gain by withholding data, and nothing to lose. Most of the data that is available comes from hospital supervised abortions, which are not representative of the "average" clinic abortion; and even these studies are usually narrow in range and scope.

But though information about abortion complications is generally obstructed in the United States, this is not always the case in other countries which have had longer experience with legal abortion. In particular, many European nations have socialized medicine, including Britain and Sweden, and in these cases government control provides a more systematic method for the gathering of abortion statistics than is available in the United States—though this does not necessarily mean that these governments provide an impartial tabulation and release of these statistics.

Overall, however, the foreign experience with abortion complications seems to confirm the worst fears about its health risks in America. Abortion proponents in this country typically ignore foreign data or insist that such figures are not representative of the "better health care" in America. But in fact, medical care in many European countries is regarded by medical authorities as superior to that in America. In addition, because many of these countries have socialized medicine, most of their abortions are performed in hospitals, with little regard for cost, and the patient is hospitalized for two to three days in order to watch for complications and treat them promptly. Since Americans rely primarily on outpatient abortion clinics, the abortion complication rate in America is probably much higher than that experienced in these other countries.[66] Here are a few examples.

Japan

Japan has had the most experience with legal abortion. It was first legalized there as part of the population control measures established during the American occupation following World War II.

According to one Japanese study, women undergoing abortions experienced the following complications: 9 percent were subsequently sterile; 14 percent suffered from recurring miscarriages; 17 percent experienced menstrual irregularities; 20–30 percent reported abdominal pain, dizziness, headaches, etc.; and there was a 400 percent increase in ectopic pregnancies.[67]

England

In Great Britain the high complication rate associated with abortion has been a major subject of concern among physicians. Records at one university hospital revealed a 27 percent infection rate among aborted patients; 9.5 percent hemorrhaged enough to require blood transfusions; 5 percent of early vacuum and D&C abortions tore the cervical muscle; and 1.5 percent perforated the uterus. Anticipating the counterargument that more skilled abortionists would have fewer complications, the author of this study made special note that: "It is significant that some of the more serious complications occurred with the most senior and experienced operators. This emphasizes that termination of pregnancy is neither as simple nor as safe as some advocates of abortion-on-demand would have the public believe."[68] In other words, abortion is an inherently risky and intrusive operation, and even the most skillful surgery will result in complications.

Another detailed British study found that many complications are easily missed without repeated follow-ups. The authors stated that "the prevalence of morbidity following induced abortion . . . depends on how long the women concerned are kept under surveillance after the operation. *The longer the surveillance, the higher the morbidity reported.*" [emphasis their own] Two meticulous studies cited by these investigators revealed 35.6 percent and 36 percent of aborted women suffer from abortion-related complications.[69]

Sweden and Norway

Swedish and Norwegian studies indicate an incidence of total sterility following 4 to 5 percent of all abortions, a figure which is less than half the reported rate in Japan.[70] Assuming this conservative 4 percent figure is applicable in America where 1.5 million women are aborted each year, one would conclude that 60,000 women per year are inadvertently rendered sterile by abortion. Most of these women are aborting a first pregnancy and will later be seeking a "wanted" pregnancy in vain.

Hungary

First trimester abortions have been allowed in Hungary under increasingly permissive laws for about thirty years. During the course of this time, the rates of miscarriages, premature births, low birth weights, and damaged infants have increased in proportion to abortions provided, despite continually improving health care. Perinatal mortality alone has doubled since abortion was made easily available.

These figures have led Hungarian health authorities to declare that "the cause-effect correlation between first trimester induced abortion and subsequent difficulties in pregnancy has been established beyond a doubt." And for this reason the Hungarian government has passed a law with "numerous restrictions for women seeking abortions early in their reproductive life, but without restriction for those who, having borne two or three children, had presumably completed their families. The officially stated purpose of the new law was to avoid the negative effects of induced abortion upon subsequent gestations."[71]

Czechoslovakia

Under socialized medicine in Czechoslovakia, abortion is legal up to twelve weeks after conception. Vacuum curettage is used and the patient is kept under observation in the hospital for three to five days, ordered to take bed rest for one week at home, and paid by insurance for her lost wages. More ideal conditions could hardly be expected, but the complication rate is still high. According to a thirteen-year study done at a university hospital in Prague:

> Acute inflammatory conditions occur in 5 percent of the cases, whereas permanent complications such as chronic inflammatory conditions of the female organs, sterility and ectopic pregnancies are registered in 20–30 percent of all women. . . . A high incidence of cervical incompetence resultant from abortion has raised the incidence of spontaneous abortions [miscarriage] to 30–40 percent.[72]

In sum, the Czechoslovakia Deputy Minister of Health states that, "Roughly 25 percent of the women who interrupt their first pregnancy have remained permanently childless."[73]

Why The Truth Remains Buried

The morbidity rate from induced abortion is undoubtedly high. Some abortion advocates may continue to argue about the particulars, just as tobacco companies continue to insist that the dangers of smoking are exaggerated, but the trend of the evidence is certainly clear. Compared to childbirth, the morbidity rate of abortion is astronomical. For childbirth, the overall maternal morbidity rate is approximately 2 percent.[74] But as we have seen, the reported immediate complication rate, alone, of abortion is no less than 10 percent. In addition, studies of long-range complications show rates no less than 17 percent and frequently report complication rates in the range of 25 to 40 percent. One public hospital has even reported an overall complication rate following abortion of 70 percent![75]

The extraordinary degree to which this evidence has been suppressed and ignored is shocking but instructive. When contrasted to the regulation and publicity surrounding other potentially dangerous activities, the silence surrounding abortion morbidity is deafening. For example, the FDA frequently bans drugs for fear of complications which are much less documented or severe than in the case of abortion. Similarly, the Surgeon General requires each pack of cigarettes to carry a warning of the potential dangers of smoking, and the newspapers and magazines are full of health and safety warnings about automobiles, toys, acid rain, saccharin, etc. But except for some minor activity within anti-abortion groups, virtually nothing is being done by the abortion industry, the government, or the general press to warn women considering abortions about its high rate of short-term and long-term risks.

Indeed, the Supreme Court has given abortionists "super rights" which allow them to use any abortion technique they desire, no matter how dangerous it may be, and the Court has made abortion clinics immune from any requirements for minimal standards of counseling.[76] According to this latter "constitutional right," abortion clinics are allowed, and even encouraged, not to tell their clients any of the risks associated with abortion. Instead, patients are to be kept in ignorance and thereby "protected" from "unnecessary fears" which may lead them to reevaluate the desirability of the abortion option. The Court guarantees "freedom of choice" but denies the right to "informed choice." *Abortionists can legally withhold information*, or even avoid their

clients' direct questions, in order to ensure that the patient will agree to an abortion which will be, they assume, "in her best interests."

All this silence has led one British surgeon to complain that:

> There has been almost a conspiracy of silence in declaring its [abortion's] risks. Unfortunately, because of emotional reactions to legal abortion, well-documented evidence from countries with a vast experience of it receives little attention in either the medical or lay press. This is medically indefensible when patients suffer as a result. . . . [The] termination of pregnancy is neither as simple nor safe as some advocates of abortion-on-demand would have the public believe.[77]

Why is there such widespread silence about the dangers of legal abortion? Wasn't abortion legalized in order to *improve* health care for women rather than to encourage them to take unnecessary risks?

The answers to these questions are complex. We will deal with them at length later on. For now it is sufficient to say that there are very definite pro-abortion forces in this country who seek to encourage increasing numbers of abortions without regard to the risks which women will face. These include government and private agencies who seek to promote abortion as a means of population control, groups which promote abortion particularly among the poor for eugenic reasons, and clinics and doctors who perform abortions for financial gain. Obviously, none of these truly pro-abortion groups wants to admit to the dangers of abortion; they would rather be inclined to contribute to a cover-up.

But perhaps more important to the present discussion is the large number of people who do not want to know about the dangers of abortion. These people do not advocate abortion for its own sake, they are simply "pro-choice." But they create and maintain the social attitude that abortion is the "easy way out"—for mother, child, relatives and friends, and even for society as a whole. These people never encourage abortion for reasons of social engineering or personal gain. Instead, they support the option of abortion with paternalistic advice like, "It would probably be the best thing for everyone, honey."

The "pro-choice" option allows the paternal friend and society at large to avoid the costly, time-consuming, emotional involvement which would otherwise be necessary to deal with these mothers and

their "unwanted" children in positive, creative ways. Abortion is a convenient "band-aid" solution to real problems, a half-hearted solution promoted by those with a half-hearted concern. Thus, many pro-choice advisors simply *want* to believe abortion is safe because they want to have a "solution" to offer women with problem pregnancies which does not involve a demanding personal relationship with the woman and her child.

Finally, abortion, like most evils, is tempting. Because it promises to solve so neatly a potentially major problem, many women themselves want to believe in it, too. Abortion is a promise too valued to allow it to be tarnished by facts.

But if there are really so many complications from abortion, why aren't they more apparent? Why haven't more aborted women complained before now? There are many reasons for this.

1) Many women have tried to tell others about the physical damage they incurred from abortions. But they usually find themselves ignored and turned away: "You're just the exception. Everyone knows that abortion is safe. Unfortunately, you were the victim of an accident, but don't be bitter and say it happens all the time." If people don't want to hear, they won't hear. Furthermore, educated Americans tend to place far greater credibility on statistics than on personal testimony. Unfortunately, however, it is the abortionists who control the statistics.

2) Most abortionists require clients to sign forms relieving them from responsibility for complications—after they assure women that complications are rare, of course. What most women do not know, however, is that these release forms are not legally binding.[78] Abortionists require these forms to be signed only to intimidate and bluff women into submission, if and when complications develop. These release forms are only an extra tool in the abortionists' arsenal of deceit.

3) In most cases abortion is a personal or family secret. Only in the most radical feminist circles is abortion something that women talk about with aplomb. This air of secrecy and shame compels a majority of abortion's victims to be silent about the complications they experienced. Few are willing to air their grievances in public, especially if the complications are "minor" and can be "fixed" or endured. Like the abortion itself, the complications are something many women simply try to put out of their minds.

4) Especially with regard to the long-term complications, most women simply cannot be sure that their problems relate to the original abortion. Even if a gynecologist knows that a woman's problems may be abortion-related, he may not tell her so—if only to avoid rubbing salt into her wounds.

5) Many women view the complications as punishment which they "deserve" for having undergone an abortion in the first place. For this reason, they remain silent about both their "sin" and their "punishment."

6) Finally, although it is the women who experience the pain and complications of abortion, it is the abortionists who keep and control the statistics. In other words, the party which suffers least, and indeed has the most to gain, also has complete control of the information.

The Underreporting of Abortion Deaths

On June 14, 1977, Barbaralee Davis underwent a routine suction abortion at the Hope Clinic for Women in Granite City, Illinois. After the customary period of observation in the clinic's recovery room, she complained of weakness and was sent home with instructions to rest. Alone in her bedroom, she slept and quietly bled to death. Her body was found less than twelve hours after the abortion. After the incident was reported in the local press, Michael Grobsmith, chief of the Illinois Department of Public Health's Division of Hospitals and Clinics, commented on the death by saying: "It's unfortunate, but it's happening every day in Chicago, and you're just not hearing about it."[79]

One year later, during an investigation of only four Chicago-based clinics (in a state with over twenty abortion clinics), the *Chicago-Sun Times* uncovered twelve abortion deaths that had never been reported.[80] Even when abortion-related deaths such as these are uncovered, they are generally not included in the "official" total since they were not reported as such on the original death certificates.[81] If there are this many unreported abortion deaths in one city from only a few clinics, in a state with regulations as strict as any allowed by the courts, how many more are there across the country?

As with other abortion complications, there is no accurate mechanism for gathering statistics about abortion-related deaths. The Supreme Court's abortion cases have struck down all requirements for reporting abortion-related complications and deaths on the grounds

that such reporting might discourage women from seeking abortions.[82] This new freedom allows abortionists and others to disguise abortion deaths under other categories when filling out death certificates.[83] Even the Center for Disease Control, a data bank for U.S. health statistics which is strongly pro-abortion in its editorial opinions, admits that the reported rate of deaths due to legal abortion is being deliberately kept low through selective underreporting.[84]

But though there are no precise figures for the number of deaths from legal abortions, there is no doubt that the figure is much higher than the officially reported totals. On one occasion, for example, Dr. Lester Hibbard, chairman of the Los Angeles County Medical Society Committee, which is charged with keeping track of maternal deaths, told a newspaper reporter that there had been only four abortion-related deaths officially reported as such. But, Dr. Hibbard added, he *personally* knew of at least four other deaths which had followed legal abortions but had not been reported as such on the death certificates. Furthermore, he said he was certain that these unreported abortion deaths were only the tip of the iceberg.[85] According to one estimate, less than 10 percent of deaths from legal abortion are reported as such.[86]

The degree to which abortion deaths are underreported is hinted at in the results of a 1974 survey which asked 486 obstetricians about their experience with complications resulting from legal abortions. Of the doctors surveyed, 91 percent had treated patients for complications, 87 percent had hospitalized one or more patients, and 6 percent (29 doctors) reported one or more patients having died from a legal abortion.[87] It can be assumed that these doctors witnessed these deaths between the years 1968 and 1974, since 1968 was the first year in which abortion became legal in some states. Therefore, extrapolation of this 6 percent sample rate to all 21,700 obstetricians in the U.S. in 1974 would indicate a probability of 1,300 patient deaths due to abortion-related complications during the six-year period between 1968 and 1974. But the actual number of deaths from legal abortions reported for that period was 52, only *5 percent* of the projected figure.[88] In order for the reported figure of only 52 deaths during this period to be accurate, the 486 doctors surveyed in this study must have coincidentally seen *over half* of all the nation's deaths from legal abortion—a very unlikely coincidence. Finally, this projection of 1,300 deaths between 1968 and 1974 is based on a survey of obstetricians only. Aborted women who died under the care of general practitioners or other health

professionals would not be included in this survey, so the actual mortality rate, and cover-up, could be even worse.

What should be clear is that there is a major flaw in the mortality statistics for legal abortion. It is quite possible that only 5 to 10 percent of all deaths resulting from legal abortion are being reported as abortion-related. Even if 50 percent were being accurately reported, that extra margin of risk is far greater than women are being led to believe. Indeed, based on the *reported* abortion deaths alone, abortion is already the fifth leading cause of maternal death in the United States.[89]

The most common causes of death from legal abortion include: hemorrhage, infection, blood clots in the lungs, heart failure, and anesthetic complications.[90] These can occur after any type of abortion procedure and are generally unpredictable. Some of these deaths result because outpatient clinics are seldom equipped to handle an emergency. But more frequently the death occurs *after* the patient leaves the clinic. According to one study: "43% of abortion deaths occurred on the day of the abortion, 4% on the second postabortion day, 22% on the third day, and 30% thereafter."[91] Obviously, fifteen minutes or an hour in a clinic recovery room (usually under the supervision of a staff person without medical training) is not sufficient to ensure that an abortion is "complication free." Without daily follow-ups, infections, blood clots, and slow hemorrhages will continue to take their toll.

Furthermore, it should be noted that abortion actually increases the chance of maternal death in later pregnancies. Medical researchers Margaret and Arthur Wynn, who favor abortion on request, state in their comprehensive study of the effects of abortion on later pregnancies that: "Any patient who has had a previous history of an abortion should be regarded as a high risk patient."[92] This is because abortion dramatically increases the risks of ectopic pregnancies, cervical incompetence, miscarriage, and other complications of pregnancy. These conditions increase the risk of death for both mother and child in later pregnancies. But despite the fact that abortion is indirectly responsible for these deaths, deaths resulting from these conditions will be included only under the maternal mortality column; they will *not* be proportionately attributed to abortion.[93]

Finally, the present claims for a low abortion mortality rate in the United States should be compared to experience prior to *Roe v. Wade* when states with permissive abortion laws were allowed to require reporting of abortion-related deaths. Of course, this did not guarantee that all deaths would be reported, but failure to report might result in

legal problems and even the revoking of a physician's license. Under these conditions, Oregon reported 13.9 abortion deaths per 100,000 legal abortions compared to only 8.4 maternal deaths per 100,000 live births. Maryland reported 40.5 deaths per 100,000 legal abortions as compared to 23.1 maternal deaths per 100,000 live births.[94] According to these pre-*Roe* state statistics, the mortality rate for legal abortion is nearly twice as high as the overall maternal mortality rate.

The only state which claimed an abortion mortality rate lower than the maternal mortality rate was New York. There, a public health official, citing the official records, claimed only 5.3 deaths per 100,000 abortions. But these New York figures are widely recognized as invalid because only 32 percent of all the abortions performed were included in the follow-up. Any deaths among the other 68 percent would not have been recorded. Indeed, even among the abortion-related deaths that were reported, at least seven known deaths were arbitrarily excluded from the "official" total for strained, technical reasons. In addition, a large number of other known deaths which had occurred after the patients had flown back to their homes out of state were also excluded from the "official records."[95]

In contrast to New York's "official" safety record for abortion, a 1971 study done by Dr. Joseph J. Rovinsky concluded that the actual abortion mortality rate in New York was no less than 38 per 100,000.[96] Indeed, by 1972, the year prior to *Roe* v. *Wade*, the *reported* number of women who had died from legal abortions exceeded the number dying from illegal abortions by almost two to one.[97] Only after all requirements for reporting were struck down did the number of reported deaths from legal abortion even begin to level off.[98]

The experience in other countries also confirms that abortion mortality rates, even during the first trimester, are invariably larger than their respective maternal mortality rates. For example, in Sweden the death rate for legal abortion is 39 per 100,000, and in Denmark the reported death rate is approximately 30 per 100,000. These rates are more than double the maternal mortality rates of these countries.[99] Canadian figures list 36 deaths per 100,000 abortions.[100] And in one British study at Glasgow University, fifteen deaths were found in a series of 20,000 legal abortions yielding an unexpected fatality rate of 75 per 100,000.[101]

In sum, what can we say about abortion mortality rates? First, not all abortion-related deaths are reported as such. Indeed, circumstantial evidence indicates that only a minority of abortion deaths are reported

as abortion-related. Second, for the average, healthy woman, *abortion is far more risky than childbirth.*[102]

But it should be remembered that in terms of practical decision-making for the individual, mortality rates for both abortion and childbirth are virtually meaningless. As Dr. Thomas Hilgers points out:

> If a woman achieves pregnancy and carries it through to term with the delivery of the infant, her chances of surviving that pregnancy are 99.99 percent. In fact, her chances of surviving that pregnancy are higher, at all age levels, than her chances of simply surviving the next one year of life.[103]

Likewise, the chances of surviving an abortion are only slightly worse or slightly better, depending on whom you believe. The vast majority of pregnant women will survive either childbirth or abortion.

In terms of a pregnant woman's decision-making, comparing the *complication* rates of abortion and childbirth is far more important than the mortality rates. When judging the comparative health risks of abortion versus childbirth on the basis of morbidity rates, it is an indisputable fact that the risk of long-term complications following an abortion is ten to twenty times greater than the risk of *any* complications following childbirth.[104]

The question which women considering abortion must face is not so much a question of their survival as it is a question of how *well* they will survive. Since abortion is frequently damaging to a woman's reproductive system, women who may wish to have children at a later date are especially at risk.[105]

Summary

This chapter has dealt with the subject of physical complications related to abortion. The subject is complex because so little is known. The reporting of abortion complications is not required by law and there are numerous motives for not reporting them. All evidence seems to confirm that *underreporting is the rule rather than the exception.*

But even assuming that all complications and deaths from legal abortion are reported, the safety record of abortion is dismal. The *reported* rate of immediate complications following induced abortion is fully 10 percent. The frequency of late complications is not documented in American statistics, but based on foreign experience, long-

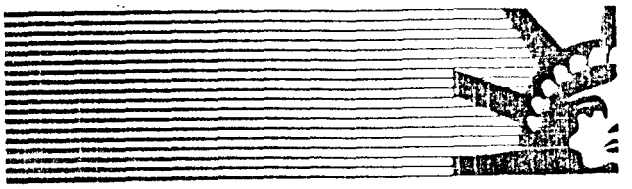
term complications can be expected in from 17 to 50 percent of all aborted women. Most of these long-term complications result in partial or total infertility, and an increased risk of ectopic pregnancies, miscarriages, and premature births. These risks are especially high among young women who have not yet had their families.

The evidence overwhelmingly proves that the morbidity and mortality rates of legal abortion are several times higher than that for carrying a pregnancy to term. But this fact has been largely suppressed in America for political and population control reasons.

All of these points, of course, are open to dispute to the degree that it is impossible to prove the cause of any health problem. Just as tobacco growers and cigarette companies continue to claim that the "causal link" between smoking and lung cancer has not yet been "proven," so do abortion providers insist that the dangers of abortion are still "uncertain."

But one thing is certain. Despite the legalization of abortion, complications and deaths continue to occur, and little or nothing is being done to warn women about the possibility of such negative results. No one doubts that legal abortion is marginally safer than illegal abortion, but neither is there any doubt that decriminalization has encouraged more women to undergo abortions than ever before. Risk goes down, but numbers go up. As we will see in later chapters, this combination means that though the odds of any particular woman suffering ill effects from an abortion have dropped, the *total* number of women who suffer and die from abortion is far greater than ever before.

Before looking at that comparison, however, there is another area of post-abortion complications which needs to be examined. These complications are not physical, but they are certainly no less painful.



SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 16
DATE 2-10-95
BILL NO. SB 292

Chairman Crippen, members of the committee, my name is Eliza Frazer and I am the Executive Director of the Montana affiliate of the National Abortion and Reproductive Rights Action League. Thank you for this opportunity to testify against SB 292.

I would like to start by acknowledging the courage of the women who testify on both sides for sharing their most private stories in a public forum.

I ask the committee to keep in mind that this legislation will affect the whole population and how these stories fit into a larger picture.

MT NARAL is absolutely opposed to this unnecessary and misleading bill. SB 292 purports to address a problem: that women are at risk from abortion trauma syndrome - vulnerable because there is a lack of information.

But what this bill does is put the government squarely in the middle of a most private decision. You were elected with the clear message to "take government off our back, not then to put it into our bedrooms."

There is no medical or psychiatric evidence that there is "post abortion syndrome". There is evidence that waiting periods in fact increase medical risk as well as the financial and personal problems women face.

Post abortion trauma is a myth - based on anecdotes. For documentation I refer you first to the article in the Journal of American Medical Association. "The allegation that legal abortion performed under safe medical conditions cause severe and lasting psychological damage is not borne out by the facts." It states, abortion whether spontaneous or induced, entails loss. A symptom or a feeling is not equivalent to a disease... The majority [of women] experience relief after the procedure."

Second, at the request of President Reagan, former Surgeon General C. Everett Koop undertook an exhaustive study of the emotional aftermath of abortion. Despite personal opposition to abortion, Koop had the personal and professional integrity to assess the issue based on facts. After examining more than 250 studies and many interviews, Koop wrote that the evidence did not support the premise that abortion does or does not produce post abortion syndrome. Koop noted, however, that emotional problems are "minuscule from a public health perspective."

I urge you to read the full report.

The evidence is overwhelming from the best sources that abortion

trauma is a myth, not a problem.

Yet SB 292 proponents feel that it is necessary to better inform women, - who already are well informed - and create 24 hour waiting periods.

So what's wrong with 24 hours to think through an important decision? NOTHING

What is wrong, is that this bill creates process that is 24 hours or much more of paperwork, not reflection. Counseling, which the proponents contend is missing, is not even mentioned.

The AMA found legislated waiting periods often caused delays of 4-6 days. The same AMA report concluded that mandatory waiting periods undermine medical safety. Basically the later the stage, the greater the risk associated with the procedure. Keep in mind that according to Montana vital statistics the complication rate in Montana is hovers at 1/2 of 1%. and that since statistics have been kept on legal abortion in Montana not one woman has died from an abortion. Although first or second trimester abortion is far safer than childbirth, after eight weeks the risks of death or major complications significantly increase for each week of delay.

SB 292 takes a non-problem - abortion trauma - and instead creates barriers that cause real medical and personal problems for women. I urge you to table SB 292.

Journal of American Medical Association

The Myth of the Abortion Trauma Syndrome

THIS is an article about a medical syndrome that does not exist. A so-called abortion trauma syndrome has been described in written material and on television and radio programs. For example, leaflets warning of deleterious physical and emotional consequences of abortion have been distributed on the streets of cities in the United States.[1] Women who have undergone induced abortion are said to suffer an "abortion trauma syndrome or "postabortion trauma" that will cause long-term damage to their health. One such leaflet states,

> Most often a woman will feel the consequences of her decision within days of her abortion. If they don't appear immediately, they will appear as she gets older. Emotional scars include unexplained depression, a loss of the ability to get close to others, repressed emotions, a hardening of the spirit, thwarted maternal instincts (which may lead to child abuse or neglect later in life), intense feelings of guilt and thoughts of suicide. Don't be fooled—every abortion leaves emotional scars.[1]

Press reports indicate that women who seek care and counseling at so-called pregnancy crisis clinics are verbally presented with similar statements.[2]

"Syndrome" indicates a constellation of signs and symptoms recognized by the medical community as characterizing a disease or abnormal condition. "Trauma" is borrowed from "posttraumatic stress disorder," a psychiatric syndrome defined in the *Diagnostic and Statistical Manual of Mental Disorders* as a disabling condition characterized by nightmares and flashbacks, precipitated by a traumatic event outside the range of usual human experience.[3] News reporters from all sections of the United States have requested information about abortion trauma syndrome from the American Psychiatric Association (oral communications, John Blamphin, Director of Public Affairs, American Psychiatric Association, Office of Public Affairs, 1988, 1989, 1990, 1991). Unfortunately, it is impossible to document the sources of the allegations that concern these journalists because they are often not traceable through the media or found in the scientific literature. It is to bring the discussion into the scientific medical literature that this contribution has been written.

Abortion is a subject that is embroiled in fierce debate. The US Supreme Court's increasingly permissive stance toward individual states' restricting abortion[4] has precipitated divisive arguments among individuals, social groups, jurists, and legislators. The same is true of a recent federal regulation forbidding some health care providers to discuss abortion at federally funded clinics.[5] The heat of the conflict tends to melt boundaries between medicine and philosophy, between church and state, between demonstrated fact and personal belief. The legislative and judicial outcome of this debate may profoundly affect both the physical and psychological health of the population as well as the practice of medicine.

Our patients look to us, their physicians, to provide sound scientific information to help them make informed decisions about health issues. The allegation that legal abortions, performed under safe medical conditions, cause severe and lasting psychological damage is not borne out by the facts.[6-9] Prior to the 1973 *Roe v Wade* decision of the Supreme Court,[10] valid scientific investigation of the sequelae of abortion was precluded by the criminal and illicit nature of the procedure.[11] It was also impossible to distinguish the effects of the procedure from those of the frightening and often dangerous circumstances under which it was performed. While he was Surgeon General of the United States, C. Everett Koop, MD, interviewed representatives from a wide range of groups favoring, opposing, and expert about access to abortion, in the course of researching a report on abortion's effects on women that had been requested by then President Ronald Reagan. After hearing and reviewing the evidence, Dr Koop wrote President Reagan to state that the available scientific evidence did not demonstrate significant negative (or positive) mental health effects of abortion.[12]

A critical examination of the psychiatric impact of abortion requires the consideration of underlying realities and a summary of the relevant scientific literature.

Underlying Realities

An uninterrupted pregnancy eventuates in labor and delivery. Therefore, any physical and psychological sequelae of legal abortion can only be meaningfully understood in contrast with those of illegal abortion or unwanted childbirth. After undesired childbirth, a woman must face either the stresses of relinquishing a child for adoption or those of rearing a child.

Abortion is a consideration for women who become pregnant under problematic circumstances, in which they feel that the birth of a child might be untenable. Such circumstances commonly include the threat or reality of abandonment by the woman's male partner or the absence of an ongoing relationship with him, financial deprivation, lack of social support, the need to care for other young children, the possible loss of educational and career opportunities, the diagnosis of fetal defect, and/or an impregnation by rape or incest. A birth control method may have failed; the woman may be unwilling or unable to care for a child. She may be physically or mentally ill or disabled. She may have suffered physical or psychiatric complications after childbirth in the past. All of these circumstances may influence subsequent psychiatric reactions regardless of the woman's decision to abort or to continue the pregnancy.[13]

The outcome of any medical procedure is demonstrably

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shaped by the general and individual social and psychological climate in which it is performed.[14] Criminalization and/or membership in a religious or social group opposed to abortion can be expected to increase a woman's feeling of distress, as can insensitive, negative, or hostile behavior and remarks by health care professionals or others she encounters in the process of considering or obtaining an abortion. Meikle et al[15] studied 100 women applying for abortions before and after abortion was legalized and noted a comparative decrease in the incidence of emotional distress related to the increased social acceptance of the procedure.[16]

Abortion is a reality, practiced throughout history, in every area of the world, regardless of religious and cultural belief and whether legal or outlawed.[16] In 1972, the year before the *Roe v Wade* decision, approximately 1 million illegal abortions were performed in the United States alone.

Data in the Literature

An extensive search of MEDLINE, Psychological Information Data Base, Sociological Abstracts, Health Information Data Base, and review articles and their bibliographies reveals that there is no specific abortion trauma syndrome described—in survey populations or as individual cases—in the psychiatric and psychological literature.[6,7,9] A small number of papers and books based on anecdotal evidence and stressing negative effects have been presented and published under religious auspices and in the nonspecialty literature.[17]

Significant psychiatric sequelae after abortion are rare, as documented in numerous methodologically sound prospective studies in the United States and in European countries. Comprehensive reviews of this literature have recently been performed and confirm this conclusion.[6,7,9] The incidence of diagnosed psychiatric illness and hospitalization is considerably lower following abortion than following childbirth. In one large prospective British population study, psychosis occurred after delivery in an average of 1.7 cases per 1000 and after abortion in 0.3 of 1000.[18]

Significant psychiatric illness following abortion occurs most commonly in women who were psychiatrically ill before pregnancy, in those who decided to undergo abortion under external pressure,[18] and in those who underwent abortion in aversive circumstances, for example, abandonment. Lask attributed the adverse reactions in 11% of the subjects he studied to those factors.[19]

The term "unwanted pregnancy" indicates that the woman regrets the fact that conception occurred. Abortion, whether spontaneous or induced, entails loss. Both regret and loss result in sadness. The word "depression," which is both a common term for a feeling of sadness and the technical term for a psychiatric disorder, can be especially confusing. A symptom or a feeling is not equivalent to a disease. Some women who undergo abortion experience transient feelings of stress and sadness, as distinguished from psychiatric illness, before and for a short time afterward.[20] The majority experience relief after the procedure.[21] Greer et al[21] interviewed 360 women before they underwent abortions and at follow-up an average of 18 months later. The subjects demonstrated significant improvement in guilt feelings, personal relationships, and psychiatric symptoms. Of 207 women followed by Partridge et al,[22] 94% reported that their mental health improved or remained the same after abortion. Many women report that the difficult decision to terminate a pregnancy was a maturational point in their lives, one at which they experienced taking charge of their futures for the first time.[20] A recently published study of a national sample of over 5000 US women followed for 8 years concluded that the experience of abortion did not have an independent relationship to women's well-being, and that there was no evidence of widespread postabortion trauma.[23]

Abortion is a weighty issue and a medical procedure about which both physicians and the lay public have a wide variety of profound feelings and views. In their professional role physicians counsel, advocate for, and treat individual patients on the basis of medical knowledge and in the patient's best interest. It would be preferable to use the resources of society and medicine to prevent unwanted pregnancies and to decrease the ensuing demand for abortions, but it is unlikely that the demand will ever be eliminated. Therefore, physicians must provide patients with accurate information about abortion's medical and psychological implications. Scientific studies indicate that legal abortion results in fewer deleterious sequelae for women compared with other possible outcomes of unwanted pregnancy. There is no evidence of a postabortion trauma syndrome.

Nada L. Stotland, MD

Thanks are due to James Thompson, MD, who suggested that an article be written on this subject.

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MONTANA VITAL STATISTICS 1992.

INDUCED ABORTIONS

Induced terminations of pregnancy (abortions) have been reported to the department since July 1, 1974, when the Montana Abortion Control Act was implemented. Fewer than twenty states report abortion statistics to the National Center for Health Statistics and only a few states exchange resident abortion statistics. For these reasons, national abortion rates are estimates based on incomplete reporting and Montana's complete resident abortion statistics are unknown. The statistics provided in this report are for those abortions occurring in Montana and any references to Montana residents must be viewed as incomplete.

From 1983 to 1992, the Montana ratio of occurrences of abortions per 1,000 occurrences of live births has ranged from a low of 249.0 in 1985 to a high of 295.6 in 1983. These ratios exhibit a statistically unstable trend line and little can be said about direction of trend. The abortion ratio in 1990 was 295.2, close to the decade high in 1983, and the 1992 ratio was 255.3, the third lowest ratio for the decade.

Table 19A (page 92-40) shows the frequency of abortion by place of residence and of occurrence. In 1992, 15.8% of the induced abortions occurring in Montana were provided to non-residents. In 1990, 24% of patients were non-residents; in 1991, 26% were non-residents. The reduction in the proportion of non-residents receiving abortions appears to have resulted from a change in the availability of abortions in Canada. Abortions were performed on 88 Canadian citizens in 1992, as compared to 452 in 1991, 412 in 1990, 332 in 1989, and 411 in 1988. The change in the number of Canadians receiving abortions also accounts for much of the reduction in abortion ratio observed from 1991 to 1992. The abortion ratio would be 247.4 in 1992 if Canadian residents were eliminated from the calculation. The same elimination from calculation would yield abortion ratios of 245.6 in 1991 and 259.0 in 1990.

Table 19 on page 92-40 shows induced abortion by type of procedure and completed week of gestation. Suction curettage was the predominant procedure used to terminate pregnancies in 1992, 91.7% of patients having had this procedure. Suction curettage has been the most frequently used primary procedure since 1974.

There have been no deaths to women receiving abortions in Montana that were attributable to the procedures since reporting began in 1974.

There have been relatively few complications resulting from these procedures. In 1992, 99.4% of patients experienced no complications; the 1991 figure was 99.3% and in 1990 it was 99.6%. Reported complications include infection, uterine perforation and other specified and uncategorized complications.

The average (mean) age of women receiving abortions in Montana was 24.9 years. A woman who had an abortion in 1992 was most likely to be 18 to 22 years old. Fifty percent of the women were 19 to 30 years old. The mean years of education for abortion patients was 12.8 years. About 82.5% had 12 years of education or more. About 20% were married.

The frequency of induced abortion by number of previous pregnancies and number of previous abortions is shown in **Table 17** (page 92-39). Overall, 67.4% of the women receiving abortions in Montana in 1992 had received no prior abortions. About half of those who had not previously had an abortion - 38.5% of all patients - had not had a prior pregnancy, and 28.9% had been pregnant but had not had prior abortions.

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TABLE 19

FREQUENCY OF INDUCED ABORTION BY COMPLETED WEEK OF GESTATION AND BY PRIMARY PROCEDURE
MONTANA OCCURRENCES, 1992

PRIMARY PROCEDURE *	TOTAL	LENGTH OF GESTATION IN WEEKS							
		9 OR FEWER	10–11	12–13	14–15	16–17	18–19	20 OR MORE	NOT STATED
TOTAL	2,869	2,026	439	175	81	69	38	34	7
SUCTION CURRETTAGE	2,632	2,021	433	104	36	21	7	3	7
SHARP CURRETTAGE	8	4	1	–	–	1	2	–	–
DILATION AND EVACUATION (D&E)	228	1	5	71	45	47	29	30	–
OTHER	1	–	–	–	–	–	–	1	–

* THE PROCEDURE THAT TERMINATED PREGNANCY, AS OPPOSED TO "ADDITIONAL PROCEDURES USED."

TABLE 19A

FREQUENCY OF INDUCED ABORTION BY COUNTY OF RESIDENCE AND COUNTY OF OCCURRENCE
MONTANA, 1992

COUNTY	RESIDENCE	OCCURRENCE	COUNTY	RESIDENCE	OCCURRENCE
BEAVERHEAD	14	–	PONDERA	14	–
BIG HORN	24	–	POWDER RIVER	3	–
BLAINE	7	–	POWELL	19	–
BROADWATER	16	–	PRAIRIE	2	–
CARBON	25	–	RAVALLI	56	–
CARTER	1	–	RICHLAND	20	–
CASCADE	193	144	ROOSEVELT	36	–
CHOUTEAU	7	–	ROSEBUD	32	–
CUSTER	35	–	SANDERS	17	–
DANIELS	2	–	SHERIDAN	5	–
DAWSON	12	–	SILVER BOW	94	–
DEER LODGE	30	–	STILLWATER	13	–
FALLON	3	–	SWEET GRASS	5	–
FERGUS	17	–	TETON	9	–
FLATHEAD	219	375	TOOLE	7	–
GALLATIN	187	271	TREASURE	1	–
GARFIELD	1	–	VALLEY	11	–
GLACIER	38	–	WHEATLAND	1	–
GOLDEN VALLEY	1	–	WIBAUX	3	–
GRANITE	6	–	YELLOWSTONE	420	1,040
HILL	38	–	NOT STATED	15	
JEFFERSON	12	–	TOTAL MONTANA		
JUDITH BASIN	3	–	RESIDENTS	2,417	
LAKE	45	–			
LEWIS & CLARK	143	253	OUT OF STATE		
LIBERTY	3	–	RESIDENTS		
LINCOLN	35	–	IDAHO	39	NA
MCCONE	2	–	NORTH DAKOTA	37	NA
MADISON	11	–	SOUTH DAKOTA	44	NA
MEAGHER	2	–	WYOMING	227	NA
MINERAL	12	–	OTHER STATES	14	NA
MISSOULA	436	786			
MUSSELSHELL	11	–	CANADA	88	NA
PARK	29	–	REST OF WORLD		NA
PETROLEUM	1	–	NOT STATED	3	NA
PHILLIPS	13	–			
			TOTAL	2,869	2,869

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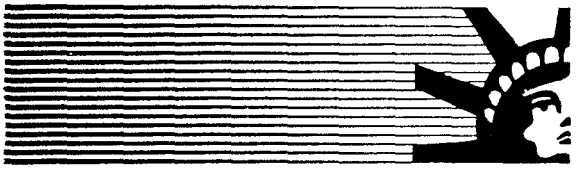

MANDATORY WAITING PERIODS AND THE FREEDOM TO CHOOSE

Mandatory waiting periods that impose delays on women who have already made the decision to have an abortion serve no useful purpose and create a substantial, often harmful obstacle for many women. Due to the severe and escalating shortage throughout this country of doctors who perform abortions, a mandatory waiting period often requires women to make at least two trips to a city hundreds of miles from home or to stay away overnight. Women are forced to take multiple days off from work, risk loss of employment, lose wages, leave families unattended or arrange for costly child care, or travel out of state. The laws further endanger women by increasing their exposure to anti-choice violence and harassment at clinics. Anti-choice activists are now trained to trace the license plate numbers of women in order to harass them at their homes during the state-mandated delay.

- Mandatory waiting period laws are currently enforced in seven states: Kansas, Mississippi, Nebraska, North Dakota, Ohio, Pennsylvania and Utah.

- In 1993 and 1994 legislative sessions, at least thirty-five states introduced bills requiring waiting periods.

Mandatory delay laws are not promoted by -- and, indeed, are opposed by -- medical professionals and others concerned with providing quality health care. These laws are a tool used by anti-choice legislators seeking to severely limit access to safe and legal abortion and to take away a woman's fundamental right to choose. There is no evidence that state-mandated waiting periods foster informed decision-making; rather, these laws reflect the demeaning and erroneous assumption that women do not think carefully about abortion and are unable to make responsible decisions without governmental interference.

State-Imposed Waiting Periods Create Substantial Obstacles

The delay and added expense imposed by mandatory waiting periods are substantial and are particularly burdensome for low-income women, single mothers, young women, women who work, and women who do not have access to cars or public transportation. The added costs and burdens may force some women to seek unsafe, illegal alternatives.

- The shortage of physicians trained, qualified and willing to provide abortion services, especially in rural areas, is acute. Nationwide, 84 percent of counties have no abortion provider.[1] Women in many parts of the country must travel long distances to obtain abortion services.

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- During the first five months after Mississippi's waiting period law went into effect, the number of abortions obtained in the state declined by 23 percent.[2] Women who can afford to are traveling out of state to avoid unhealthy delays and increased harassment.[3] The number of residents who left Mississippi to obtain an abortion rose by 16 percent in the five months following the law taking effect.[4]

- A 28-year-old woman hitchhiked 130 miles to a clinic in Jackson, Mississippi with $265 in cash for the procedure and $14 spending money. After an offer to stay at a friend's house fell through, the woman would have slept on an outdoor bench had the clinic not paid for her to stay at a nearby motel.[5]

- One woman who complied with Mississippi's newly enforced waiting period was forced to leave her six children overnight to travel four hours away from her farm to one of the state's three abortion clinics.[6]

- Women from Dickenson, North Dakota have to travel at least 289 miles -- each way -- to reach the state's only abortion clinic.[7] Women in the rural state of Nebraska are forced to travel as far as 700 miles to obtain abortion services.[8]

State-Imposed Waiting Periods Cause Dangerous Medical Delays

A 24-hour waiting period can mean a forced delay of days or even weeks. Many clinics offer abortion services only two or three days a week and have waiting lists for appointments.[9] Even if a woman can get an appointment, she may be unable to return the following day or even within the same week because of work, family demands or lack of resources. Delays of one or two weeks can force a woman to undergo a later abortion that poses increased health risks and is significantly more expensive.

- The American Medical Association concluded in a recent study that mandatory waiting periods "increase the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure."[10] Although a first- or second-trimester abortion is far safer than childbirth, after eight weeks the risks of death or major complications significantly increase for each week of delay.[11] Abortion after the first trimester is available at fewer than half the locations that offer first-trimester abortion services.[12]

- Some providers offer abortion services only two to three days per week. If a woman makes her initial visit to a clinic and is unable to take two consecutive days off of work, get transportation to the clinic again, arrange for child care, or get an appointment the following day, she will be forced to wait a week or longer before she can undergo the procedure.

- Mandatory waiting periods can force a woman to delay an abortion until the second trimester of pregnancy. During the first five months after Mississippi's waiting period law went into effect, the proportion of women who had abortions after the first trimester rose by 18 percent.[13]

- During seven weeks of compliance by one clinic with Tennessee's 48-hour waiting period, the law caused four women to experience delays that forced them to undergo riskier, more expensive second-trimester abortions. Because no clinics in Tennessee perform second-trimester abortions and no hospital in the state provides abortions, the women had to travel to Georgia or Kentucky.[14]

Waiting Periods Increase Exposure To Anti-Choice Harassment

Government-imposed waiting periods subject women to increased harassment by anti-choice extremists.

- The 24-hour waiting period is used by anti-choice extremists to track women down and make harassing visits or phone calls to their homes. Members of anti-choice groups stake out parking lots at abortion clinics, write down license plate numbers, trace the owner's home address and phone number, and then use this information to find the woman, her husband, boyfriend, parent, clergy, or anyone else they think may be able to interfere.[15]

- In the first seven months the Mississippi law was enforced, one member of an anti-choice group made harassing phone calls to more than 120 people.[16]

Waiting Periods Do Not Foster Informed Decision-Making

Advocates of mandatory waiting periods claim that these laws help women make informed decisions about abortion. The reality is that they do not. Rather than promoting true informed consent, they create serious, and at times insurmountable, obstacles for women seeking safe and legal abortions. Government-imposed delays are not promoted by medical professionals or others concerned with improving the quality of health care services; they were devised by anti-choice legislators and activists seeking to make abortion illegal or unavailable for all women.

- Mandatory waiting periods reflect the demeaning and erroneous assumption that women do not think carefully about abortion and are unable to make responsible and informed decisions.

- According to the American Public Health Association, Pennsylvania's waiting period and biased counseling provisions -- upheld by the U.S. Supreme Court in *Casey* -- "will interfere with constructive consultation between physicians and their patients and will undermine patients' health" and "are in fact antithetical to informed consent."[17]

- Even people undergoing procedures as dangerous as heart or brain surgery are not subjected to government-imposed waiting periods. Standard medical practices and existing informed consent requirements already ensure that by the time a patient reaches the physician's office, clinic or hospital for a medical procedure, they have weighed the consequences and made an informed decision.

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Notes

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Fact Sheet

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Abortion & Waiting Period/Mandatory Information Laws

A number of states have enacted or are considering so-called "informed consent" legislation mandating that women be given a specific list of state-dictated information designed to discourage them from having an abortion, and then imposing a waiting period, typically of 24 hours, before the abortion may be performed. In Planned Parenthood of Southeastern Pennsylvania v. Casey, the U.S. Supreme Court in June 1992 upheld the right of states to enact legislation designed to persuade a woman to choose childbirth over abortion.(1) Although the court upheld as constitutional a Pennsylvania law that requires a woman to be given certain information 24 hours before her abortion, the court left open the possibility that if a law could be shown to have a sufficiently serious impact on women's access to abortion, it could be struck down as unduly burdensome.

These laws typically require: that the woman be offered and sometimes handed booklets that describing fetal development, with pictures; that the woman be given a listing of adoption agencies; and that the physician remind the woman that her partner is liable to support the resulting child, and that Medicaid assistance may be available to help her carry the pregnancy to term. For women firm in their decision, women who are victims of rape or incest, and women seeking abortions for health reasons or because the fetus has genetic defects, these recitations are nothing less than harassment that exacerbate a difficult decision. In addition, waiting periods can increase the health risk of the procedure and cause other hardship, especially to poor and rural woman, for whom two trips to an abortion clinic can pose severe financial and personal problems.

In its 1983 decision in City of Akron v. Akron Center for Reproductive Health, the Supreme Court itself recognized that "informed consent" laws are designed "not to inform the woman's consent, but rather to persuade her to withhold it altogether." In that decision, the court found that requiring physicians to provide patients with a specific list of information prior to performing an abortion is unrelated to obtaining truly informed consent and that a waiting period places an unjustified burden on abortion.(2) And in its 1986 decision in Thornburgh v. American College of Obstetricians and Gynecologists, the Supreme Court held that a state "may not require the delivery of information designed 'to influence a woman's informed choice between abortion and childbirth.'"(3) With the Casey decision, a majority on the court abandoned this position.(1)

Legislation Now in Effect

Waiting period/mandatory information laws currently are in effect in Pennsylvania, Mississippi, Kansas, Nebraska, North Dakota, Ohio, and Utah. The Mississippi law, the first of its type in the nation to take effect, went into effect after the federal court of appeals refused to allow a pre-enforcement "undue burden" challenge and the Supreme Court refused to hear the appeal.(4) A challenge has been mounted in state court.(5) A similar law was upheld in Ohio.(6) The Nebraska law allows persons other than the physician to deliver the required information over the telephone. Both the North Dakota(7) and Utah(8) laws were sustained after courts interpreted them to allow provision of information over the telephone. The Kansas law requires an eight-hour waiting period.

Legislation That Has Been Enjoined by the Courts

Since the Casey decision, waiting period/mandatory information laws have been enjoined by federal courts in South Dakota(9) and Michigan(10). A state court in Tennessee held a waiting period unconstitutional and enjoined it.(11)

Mandatory Waiting Periods

Mandatory waiting periods do little, if anything, to foster informed decision making by women seeking abortions. Even without them, women carefully consider their decisions and almost always consult with others before undergoing the procedure. Such requirements, however, do cause serious problems for women by increasing the cost of the abortion and creating delays that raise the health risk to the woman.

- In 1983, the Supreme Court recognized that mandating a waiting period serves little purpose: "There is no evidence suggesting that the abortion procedure will be performed more safely. Nor are we convinced that the state's legitimate concern that the woman's decision be informed is reasonably served by requiring a 24-hour delay as a matter of course."(2)

- Women having abortions carefully consider their decisions in light of their individual circumstances and whether they are ready to have children. Most women have more than one reason for wanting to terminate a pregnancy; the average abortion patient cites four different reasons for her decision.(12)

- Women having abortions rarely make their decisions alone. One study found that nearly nine in 10 had consulted with at least one other person — most often a partner, close friend, parent, minister, or guidance counselor — before undergoing the procedure.(13)

- More than eight in 10 women in the study said they already had "thought carefully about the morality of having an abortion" and "didn't need the required waiting period to think more about that question."(13)

- 93 percent of patients in the study were unable to name any benefit from having been required to wait 24 hours before the abortion.(13)

Logistical Problems: Increased Risk to Women's Health

While patients have found little value in a mandatory waiting period, they have said that such a mandate — which requires them to return for a second appointment to have the abortion — has caused significant problems.(13) Any additional delay in obtaining an abortion resulting from logistical and scheduling problems increases the risk to the woman's health.

- In one study, nearly two-thirds of the women who had complied with a state-mandated waiting period could name one or more problems caused by the requirement. Problems most frequently cited were additional mental anguish, transportation and logistical problems, and extra physical discomfort.(13)

- In 1985, 6 percent of all abortion patients — 89,000 women — traveled outside their home state to obtain an abortion, most likely because there were no abortion facilities in their area.(14)

- In 1988, 83 percent of all U.S. counties — in which almost one-third of all women of reproductive age lived — had no abortion provider.(14) Abortion services are less available in rural than in urban areas; in 1988, 93 percent of nonmetropolitan counties had no facility that performed

abortions.(15) Moreover, this lack of availability is becoming more pronounced. Between 1985 and 1988, the number of abortion providers in rural areas of the U.S. decreased by 19 percent.(15)

- For all women, a waiting period delays an abortion by 24 or 48 hours. For some, arranging a second appointment is particularly problematic and could result in a far longer delay. For example, many of the 6 percent of patients who have to cross state lines to obtain abortion services might be unable to return for a second appointment for days, even weeks.(16)

- The logistics of arranging a second appointment may be cumbersome or even prohibitive for many of the 68 percent of patients who are working (and would have to arrange additional time off from work), the 42 percent who already have children (and would have to make child care arrangements), and the 31 percent who are in school.(17)

- Additionally, breaches of confidentiality can result from the need to be absent from home overnight, which happens when women must travel long distances and return the next day for their appointment to have an abortion.

- Many clinics perform abortions only a few days a week, so delays could often extend beyond 24 or 48 hours.

- An analysis of the effects of Mississippi's 24-hour waiting period abortion law that became operational in August 1992 showed that Mississippi residents had 13 percent fewer abortions than expected in the five months following the law taking effect. Additionally, abortions occurred later in pregnancy as a result of the law; the percentage of abortions in the second trimester was 18 percent higher than before the law took effect. The law also had a greater effect on women with less than a high school education; the number of abortions among these women dropped 29 percent after the law took effect.(18)

Increased Cost to the Abortion Patient

A mandatory waiting period significantly increases the cost of the abortion procedure to the woman, thereby posing a particular problem for low-income patients.

- In one study, 62 percent of patients who had complied with a state-mandated waiting period said the requirement had resulted in additional costs in terms of lost wages, transportation, lodging, or additional child care.(13)

- Where the cost of the abortion varied according to the woman's income, compliance with the waiting period requirement increased the cost for low-income women by at least 48 percent and for more affluent women by at least 14 percent.(13)

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Council Report

Induced Termination of Pregnancy Before and After *Roe v Wade*

Trends in the Mortality and Morbidity of Women

Council on Scientific Affairs, American Medical Association

The mortality and morbidity of women who terminated their pregnancy before the 1973 Supreme Court decision in *Roe v Wade* are compared with post–*Roe v Wade* mortality and morbidity. Mortality data before 1973 are from the National Center for Health Statistics; data from 1973 through 1985 are from the Centers for Disease Control and The Alan Guttmacher Institute. Trends in serious abortion-related complications between 1970 and 1990 are based on data from the Joint Program for the Study of Abortion and from the National Abortion Federation. Deaths from illegally induced abortion declined between 1940 and 1972 in part because of the introduction of antibiotics to manage sepsis and the widespread use of effective contraceptives. Deaths from legal abortion declined fivefold between 1973 and 1985 (from 3.3 deaths to 0.4 death per 100 000 procedures), reflecting increased physician education and skills, improvements in medical technology, and, notably, the earlier termination of pregnancy. The risk of death from legal abortion is higher among minority women and women over the age of 35 years, and increases with gestational age. Legal-abortion mortality between 1979 and 1985 was 0.6 death per 100 000 procedures, more than 10 times lower than the 9.1 maternal deaths per 100 000 live births between 1979 and 1986. Serious complications from legal abortion are rare. Most women who have a single abortion with vacuum aspiration experience few if any subsequent problems getting pregnant or having healthy children. Less is known about the effects of multiple abortions on future fecundity. Adverse emotional reactions to abortion are rare; most women experience relief and reduced depression and distress.

(*JAMA*. 1992;268:3231-3239)

UNTIL the mid 19th century, the induced termination of pregnancy through the first trimester (ie, the first 12 weeks of pregnancy) was legal in the United States under common law.[1] At that time, several state legislatures enacted laws proscribing such procedures, a result of efforts to discourage illicit sexual conduct, growing concerns about the hazards of medical and quasi-medical abortion procedures on women's health, and effective lobbying by physicians.[1] By 1900, abortion was prohibited by law throughout the United States unless two or more physicians agreed that the procedure was necessary to preserve the life of the pregnant woman.[2] By the late 1960s, state legislatures began to reconsider the legalization of abortion in response to changes in public opinion and opinions from national medical, legal, religious, and social welfare organizations.[3] Between 1967 and 1969, 13 states (Arkansas, California, Colorado, Delaware, Florida, Georgia, Kansas, Maryland, New Mexico, North Carolina, Oregon, South Carolina, and Virginia) modified their abortion laws, though they differed widely in the restrictions placed on the procedure.[3,4] In 1970, Alaska, New York, Hawaii, and Washington removed nearly all restrictions on their abortion laws.[4] By January 1973, when the Supreme Court made abortion legal on a national basis in *Roe v Wade* (410 US 113, 1973) and *Doe v Bolton* (410 US 179, 1973), 17 states had liberalized their abortion laws.[4]

In *Roe v Wade* and *Doe v Bolton* the Supreme Court ruled that states could not interfere with the physician-patient decision about abortion during the first trimester of pregnancy (12 weeks and earlier), and that during the second trimester (13 to 28 weeks), a state could intervene only to ensure safe medical practices reasonably related to maternal health. For the third trimester (29 to 40 weeks), a state could regulate and even proscribe abortion unless medical judgment deemed the procedure necessary to preserve the life or health of the pregnant woman. Although obliged to comply with these guidelines, states continue to differ in how easily a woman can obtain an abortion. For example, 30 states and the District of Columbia prohibit the use of state funds to pay for an abortion unless the woman's life is in danger; eight other states permit public funding in limited circumstances such as a pregnancy resulting from rape or incest.[5] Mandatory waiting periods and/or parental consent or notification laws have also been used to deter

From the Council on Scientific Affairs, American Medical Association, Chicago, Ill.

This report was presented to the House of Delegates of the American Medical Association at the June 1992 Annual Meeting as Report H of the Council on Scientific Affairs. The recommendation was adopted as amended and the remainder of the report was filed.

This report is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. This report reflects the scientific literature as of June 1992.

Reprint requests to Council on Scientific Affairs, American Medical Association, 515 N State St, Chicago, IL 60610 (Janet E. Gans, PhD).

Table 1.—Number of Abortions and Abortion-Related Deaths, United States, From 1973 Through 1985*

Year	No. of Legal Abortions	No. of Deaths From Legal Abortion	No. of Spontaneous, Other, and Unknown Abortion Deaths	No. of Deaths From Legal Abortion per 100 000 Procedures
1973	744 610	25	13	3.3
1974	898 570	26	22	2.9
1975	1 034 170	29	15	2.8
1976	1 179 300	11	14	0.9
1977	1 316 700	17	16	1.3
1978	1 409 600	9	10	0.6
1979	1 497 670	18	9	1.2
1980	1 553 890	9	7	0.6
1981	1 577 340	7	3	0.4
1982	1 573 920	11	6	0.7
1983	1 575 000	10	7	0.6
1984	1 577 180	11	7	0.7
1985	1 588 550	6	7	0.4

*Data on the number of legal abortions are from Henshaw and Van Vort.[14] Data on the number of deaths from abortion are from Lawson et al.[15]

women from seeking an abortion.[6-9] In 1977, the Hyde Amendment restricted the use of federal funds for abortion.[10]

At the 1991 Annual Meeting, the American Medical Association House of Delegates referred Resolution 17 for a report at the 1992 Annual Meeting. Resolution 17 asks "[t]hat the American Medical Association, in order to educate and improve the understanding of the American public, perform an objective study of available data on the mortality and morbidity associated with illegally induced abortions prior to the US Supreme Court's *Roe v Wade* decision and compare it with the mortality and morbidity incurred by abortions performed today" and "that the results of this study be published in a manner accessible to legislators and the public by the 1992 Annual Meeting."[11]

This resolution comes at a time of continued heated national debate on abortion. There are those who oppose the medical procedure under any circumstance, or who would permit it only to save the pregnant woman's life.[4] Others would support the procedure to preserve the woman's physical or mental health, prevent the birth of a child with severe genetic or congenital defects, or in cases of rape or incest.[4] Still others view the decision to terminate the pregnancy as a private matter between a woman and her physician.[12]

This report provides an assessment of the mortality and morbidity of women who terminate their pregnancy through induced abortion and examines how the safety of abortion has changed through time. It also assesses the likely impact of restrictive abortion laws on the mortality and morbidity of pregnant women who choose to terminate their pregnancy. In keeping with the intent of Resolution 17, the purpose of this report is to enable the voting public and government officials to make informed decisions concerning this medical procedure based on scientific facts.

The report is divided into seven sections. The first two sections examine the decline in the number of deaths from induced abortion after the 1973 Supreme Court decision in *Roe v Wade*, along with reasons for this decline. The next section compares trends in death from legal and illegal induced abortion prior to 1973. Controversies over the relative safety of abortion, particularly when compared with that of pregnancy and childbirth, are examined in the fourth section, to assess the likely impact that more restrictive abortion policies might have on maternal death rates. The fifth section describes complications associated with induced abortion, including mental health and future fecundity. Factors that may jeopardize the safety of induced abortion are discussed in the sixth section. The report concludes with a summary and discussion of the possible health effects of abortion restrictions. Morbidity and mortality associated with the use of mifepristone (RU 486) by pregnant women are not considered in this report because there are no data on its use by women in the United States. Mifepristone is an antiprogestin drug that can be used as an abortifacient.

MORTALITY FROM LEGAL ABORTION SINCE 1973

The Centers for Disease Control (CDC) (Atlanta, Ga) defines an induced abortion as "a procedure intended to terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age."[13(p8)] A molar pregnancy, ectopic pregnancy, or fetal death diagnosed before any intervention is not regarded as an induced abortion. Induced abortions are further classified as either legal or illegal. According to the CDC, an abortion is legal if it is performed by a licensed physician or someone acting under the immediate supervision of a physician.[13]

The CDC defines a woman's death as abortion-related if it "resulted from a direct complication of an abortion, an indirect complication caused by the chain of events initiated by the abortion, or aggravation of a preexisting condition by the physiologic or psychologic effects of the abortion, regardless of how long it occurred after the abortion."[13(p9)] As shown in Table 1,[14,15] there were 25 deaths from the 744 610 legal abortions performed in 1973 (the first year that abortion became legal nationwide), a rate of 3.3 deaths per 100 000 legal abortions. In 1985, six deaths resulted from 1 588 550 legal abortions, a rate of 0.4 death per 100 000 procedures. Thus, between 1973 and 1985 there was more than a fivefold decline in the number of deaths per 100 000 legal-abortion procedures, most of which took place during the 1970s.

Several factors contributed to the reduction in abortion-related deaths. Physician skills in performing abortions and handling complications increased substantially.[16,17] In the years following *Roe v Wade* the number of residency programs offering training in abortion procedures and training opportunities for practicing physicians increased, as did the number of women seeking an abortion.[18,19]

Legal abortion also became safer as the methods used shifted from sharp curettage to suction curettage, particularly during the first trimester. Between 1972 and 1988, the percentage of abortions done by suction curettage rose from 65% to 95%, while those performed by sharp curettage dropped from 23% to 3%, by intrauterine instillation from 10% to 1%, and by hysterotomy, hysterectomy, or other methods from 1% to fewer than 0.4%.[20] The shift from instillation to dilation and evacuation for second-trimester abortions also helped reduce abortion mortality.[18,21,22]

Improved access to legal-abortion services reduced abortion-related mortality by enabling women to undergo the procedure earlier in pregnancy, when it is safest. Between 1973 and 1988 the number of hospitals, clinics, and private physicians' offices providing legal abortions increased by 59%, from 1627[23] to 2582.[24] Between 1973 and 1987 the percentage of legal abortions performed at less than 9 weeks' gestation rose dramatically from 38% to 51%,[14] and the percentage of second-trimester abortions (13 weeks' gestation or later) de-

Table 2.—Causes of Death From Legal Abortion, United States, From 1972 Through 1985*

Cause of Death	Period: 1972-1978, No. of Deaths (%)†	1979-1985, No. of Deaths (%)†	1972-1985, No. of Deaths (%)†
Hemorrhage	27 (19)	16 (22)	43 (20)
Infection	34 (24)	10 (14)	44 (21)
Embolism	34 (24)	11 (15)	45 (21)
Anesthesia	22 (16)	21 (29)	43 (20)
Other	24 (17)	14 (19)	38 (18)
Total	**141 (100)**	**72 (100)**	**213 (100)**

*Reproduced with permission, from Atrash et al.[22]
†Excludes illegal and spontaneous abortion. Numbers in parentheses refer to the actual number of deaths. Percentages may not sum due to rounding.

Table 3.—Mortality Rate and Relative Risk From Legal Abortion, United States, From 1972 Through 1985*

Factor	Mortality Rate†	Relative Risk
Age, y		
15-19	1.0	Referent
20-24	1.4	1.4
25-29	1.4	1.4
30-34	1.7	1.7
≥35	2.4	2.4
Race		
White	0.9	Referent
Black and other	2.6	2.9
Type of procedure		
Curettage	0.9	Referent
Instillation	9.6	10.7
Other	9.7	10.8

*Reproduced with permission, from Atrash et al.[22]
†Deaths per 100 000 procedures. The number of procedures is based on Centers for Disease Control estimates, 1972 through 1985.[22]

clined from 14% to 10%.

Although legal abortion became much safer during the past two decades, it still has risks associated with it. As shown in Table 2, between 1972 and 1985 the leading causes of death from legal abortion were embolism, infection, hemorrhage, and complications from anesthesia, each of which was responsible for approximately the same number of deaths.[22] During these years the number of deaths due to infection, embolism, and hemorrhage dropped sharply. The number of deaths related to general anesthesia, used more often in second-trimester abortions, remained stable. Because of declines in other areas, however, anesthesia-related deaths increased proportionately.

Gestational age is probably the most important determinant of the risk of death from legal abortion. Between 1979 and 1985, the death rate from a legal abortion was 0.5 per 100 000 abortions within the first 12 weeks since the last menstrual period, 1.2 per 100 000 abortions for weeks 13 through 15, and 5.8 per 100 000 at 16 weeks or more.[22]

Age, race, and method used each also affect the risk of death among women from legal abortion. As shown in Table 3, the mortality rate and risk of death from legal abortion is lower among women who are under the age of 35 years, white, and who terminate their pregnancy through curettage rather than instillation, hysterectomy, hysterotomy, vaginal suppositories, or other methods.[22]

In sum, the risk of death from legal abortion fell dramatically between the 1973 Supreme Court decision in *Roe v Wade* and the mid 1980s. Increased physician education and skills in the procedure, improvements in medical technology, and the trend toward earlier termination of pregnancy each helped reduce abortion-related mortality. Death from legal abortion is more common among minority women than white women, women over the age of 35 years, and those who undergo the procedure during the second rather than the first trimester.

MORTALITY FROM ILLEGAL ABORTION SINCE 1973

The CDC defines an abortion as illegal if it was self-induced or induced by someone other than a licensed physician who is not acting under the immediate supervision of a licensed physician. Illegal abortions continued after 1973, with an estimated 5000 to 23 000 procedures occurring annually between 1975 and 1979.[25] Estimates of the number of illegal abortions have always been speculative, but there is consensus that the number declined dramatically after legalization[4,17,26] and is minimal today.

Between 1973 and 1985, 47 illegal abortion-related deaths were reported to the CDC, 13% of all abortion-related deaths during that period.[15] Over half (53%) of deaths from illegal abortion occurred during 1973 and 1974, shortly after abortion was legalized nationwide. Sixty-three percent of deaths from illegal abortion in the United States between 1972 and 1985 resulted from infection, 22% from embolism, 7% from hemorrhage, 2% from anesthesia, and 6% from other causes including respiratory arrest from anesthesia, pennyroyal toxic effects, and potassium poisoning.[22]

The most recently published detailed information about deaths from illegal abortion comes from a review of the 17 fatal cases in the United States reported to the CDC between 1975 and 1979.[25] The median age of these women was 29 years, half were married, 11 had at least two previous pregnancies, and seven had two or more living children. Seven had at least one previous abortion, and four of the seven had obtained one or more illegal abortions. Nine of the women lived in urban areas where legal-abortion facilities were available. Eleven of the 17 women were black, three were Hispanic, and three were non-Hispanic white. Nine induced the abortion themselves. Their methods included instillation of cleaning solutions into the uterus, ingestion of pennyroyal oil or herbal abortifacients, and intrauterine insertion of Foley catheters, cotton swabs, glass thermometers, metal objects, coat hangers, and plastic tubes.

For nine of the women, the desire to keep the abortion a secret was an important reason for seeking an illegal abortion. Six women had financial reasons for selecting an illegal abortion. For other women, geographic location, ignorance about obtaining legal-abortion services, or choosing a provider in their own ethnic community were important reasons.

It is difficult to determine whether illegal abortion became safer or more dangerous after 1973. Some suggest that it may have become more dangerous because physicians who had been performing illegal abortions could now provide them legally, in a safe setting.[25] Illegal abortions would, therefore, be done primarily by untrained individuals or by the women themselves. On the other hand, if illegal practitioners used the equipment and safer techniques used by providers of legal abortion, and women who self-induced abortions used safer methods, then illegal abortion may have also become safer since 1973.[27] Regardless of legal status, the critical safety issues are the conditions under which the procedure is done, the safety of the procedure used, the competence of the abortion provider, and gestational age.

MORTALITY FROM INDUCED ABORTION BEFORE 1973

It is impossible to know for certain how many induced abortions took place before 1969, the year the CDC began its surveillance of the number of abortions and abortion deaths in the United States. Tietze[28] estimated that prior to the adoption of more moderate abortion laws in 1967, there were 1 million abortions an-

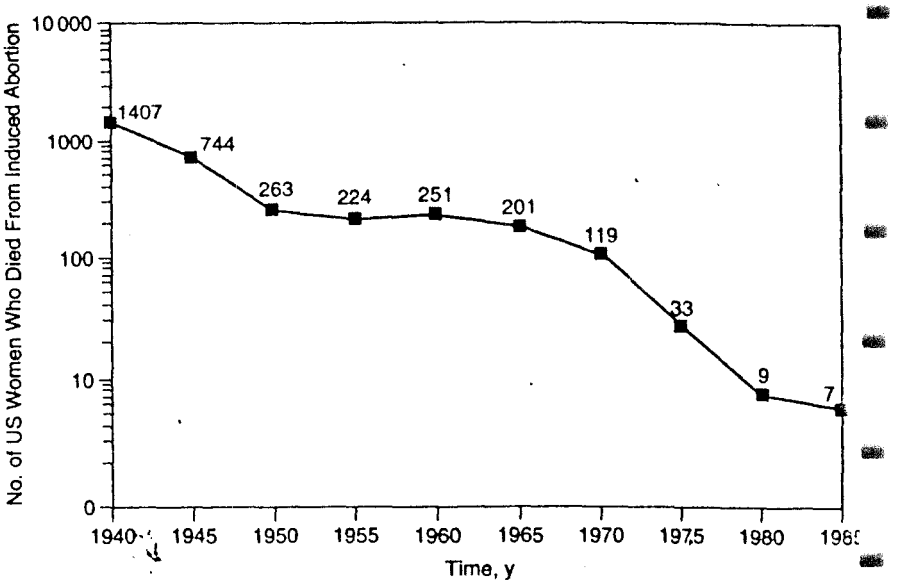
nually nationwide, of which 8000 were legal, resulting in an abortion rate of five per 1000 people and an abortion ratio of 30 per 100 live births.

The only available national data on abortion-related deaths prior to 1969 come from death certificate information reported to the vital statistics system of the National Center for Health Statistics (NCHS) (Hyattsville, Md). The NCHS estimates of abortion-related deaths are considered conservative because many deaths that were abortion-related were not listed as such on the death certificate. The physician may not have known that the death was abortion- related or may have omitted that information on the death certificate, given the stigma and illegality associated with the procedure.[29] However, NCHS data offer the only information on abortion-related deaths before 1969 that allow comparisons to be made over time.

As shown in the Figure, abortion-related mortality in the United States has declined dramatically over time.[15,30-37] The decline, however, began long before abortion laws became less restrictive. In 1940 there were 1407 abortion-related deaths (excluding spontaneous abortions). By 1966 there were 160 abortion-related deaths, an 89% decline that took place before any state had passed less restrictive abortion laws. Between 1966 and 1972, the period when many states were liberalizing their abortion laws, the number of abortion-related deaths declined an additional 64% to 58.

The decline in abortion mortality during the 1940s and 1950s has been attributed to the introduction of antibiotics to manage sepsis following induced abortion.[26] The further decline during the 1960s was probably because of the widespread use of effective contraceptives (especially the birth control pill and intrauterine devices), particularly by married women. This reduced the number of unintended pregnancies, thereby reducing the number of women who could have died from an induced abortion. The number of physicians who provided illegal induced abortions may also have increased during the 1960s, thereby making induced abortion safer and contributing to a reduction in overall abortion mortality.[38]

The death rate per million women of reproductive age in the United States from legal abortion was very low between 1958 and 1969, primarily because so few legal procedures were performed during this time (Table 4).[16] It increased in 1970 and 1971, reflecting physician inexperience in performing abortions and an increased demand for the procedure after four states made abortion legal in 1970. By 1972, the death rate from legal abortion was half that of the previous year, despite a 19% increase in the number of procedures performed (calculated from CDC data[39]).



Number of US women who died from induced abortions from 1940 through 1985. Data prior to 1973 are from the National Center for Health Statistics.[30-37] Data from 1973 through 1985 are from Lawson et al.[15] For the years 1971 through 1974, mortality figures were as follows: 1971, 90; 1972, 58; 1973, 44; and 1974, 32.

Table 4.—Legal and Illegal Abortion-Related Deaths per Million Women Aged 15 to 44 Years, United State 1958 Through 1972*

Year or Period†	Rate of Abortion-Related Deaths: Legal Abortion	Rate of Abortion-Related Deaths: Illegal Abortion‡	Tot
1958-1962	0.14	9.93	10.07
1963-1967	0.10	6.96	7.06
1968-1969	0.10	3.85	3.
1970	0.84	3.09	3.
1971	1.24	2.04	3.28
1972	0.54	0.92	2.02

*Reproduced with permission, from Tietze.[16]

†Rates for 1958 through 1971 are estimates by Tietze[16] and are based on National Center for Health Statist data. Data for 1972 are based on Centers for Disease Control reports.

‡Includes spontaneous abortion mortality rate except for 1972, when the mortality rate for spontaneous abortion was 0.56.

In sum, the number of deaths from induced abortion declined between the 1940s and 1972, both in absolute terms and in the rate per million women of reproductive age. The increased use of antibiotics and more effective contraceptive use help account for these declines, particularly between the 1940s and the mid 1960s. By the 1960s and mid 1970s there was a gradual substitution of legal for illegal abortions, as it became increasingly possible for women to obtain a legal-abortion. During the early 1970s the legal-abortion mortality rate increased, reflecting physician inexperience coupled with an increased demand for legal abortion procedures. The legal-abortion mortality rate began to decline slowly again during the mid 1970s and 1980s.

CONTROVERSY OVER THE RELATIVE SAFETY OF INDUCED ABORTION

The health risks associated with induced abortion have traditionally been

compared with maternal health risks associated with pregnancy and childbirth. If laws concerning the termination of pregnancy become more restrictive, it is likely that fewer women will have an abortion and more will give birth. Thus, the relative safety of these pregnancy outcomes is an important reproductive health issue.

Maternal deaths declined sharply over the past 50 years, falling from 376 deaths per 100 000 live births in 1940 to 37 deaths per 100 000 live births in 1960, and 9 deaths per 100 000 live births in 1980.[41] According to the CDC, the maternal mortality ratio was 9.1 maternal deaths per 100 000 live births between 1979 and 1986 in the United States and Puerto Rico.[42]

This is in sharp contrast to legal-abortion mortality between 1979 and 1985, which was 0.6 death per 100 000 abortions (calculated from Lawson et al[15] and Henshaw and Van Vort[14]). This figure is more than 10 times lower than the maternal mortality ratio. The discrepancy is even larger when adjustments are made for age, race,[43] and preexisting conditions.[44]

The risk of death from induced abortion also appears to be lower than that from pregnancy and childbirth when gestational age (up to 16 weeks or more) is taken into account. Between 1979 and 1985 there were 5.8 deaths per 100 000 procedures.[22] Published data between 1979 and 1985 are not available at later gestational ages, but published data on abortion mortality between 1981 and 1985 show that at 21 weeks' gestational age or later there were 12.7 deaths per 100 000 procedures.[45]

It has been suggested that these data underestimate the risks associated with abortion and exaggerate the risks associated with pregnancy and childbirth.[46] Some have alleged that the omission of abortion-related information from death certificates results in an undercount of these deaths. Because other pregnancy-related deaths and childbearing rarely carry such stigma, such events generally would not be underreported.

To assess the degree to which abortion-related deaths are underestimated, the CDC compared the number of abortion-related deaths reported by NCHS in the vital statistics system with CDC estimates.[47] Since its first year of abortion surveillance in 1972, it is estimated that the CDC surveillance system alone identified approximately 90% of all abortion deaths; the vital statistics system, 52%; and the two systems combined, 94%. The CDC estimates of abortion-related deaths are higher and considered more accurate than NCHS data because the CDC, as part of its surveillance system, has committees in each state that report abortion-related deaths. These reports come from those who favor and those who oppose elective abortion. The CDC conducts a thorough investigation of each reported abortion-related death to verify the cause and circumstances surrounding the death.

The maternal mortality ratio—the number of deaths per 100 000 live births—has been criticized as being biased because it restricts the denominator to live births, but includes in the numerator deaths from ectopic pregnancy, molar pregnancy, and fetal deaths, each of which do not result in a live birth and, therefore, would not appear in the denominator.[46,48] For this reason, some have suggested that the measure exaggerates the danger of pregnancy and childbirth.

If, however, all causes of maternal death other than those associated with live births were removed from the numerator of the maternal mortality ratio—stillbirths, ectopic pregnancy, abortion, molar pregnancy, undelivered and unknown causes—52% of deaths would still be left (calculated from Koonin et al[41]). The maternal mortality ratio for 1985 would be approximately 4.7 deaths per 100 000 live births, still nearly 12 times greater than the legal-abortion mortality ratio of 0.4.

In fact, there is substantial evidence that state and national vital statistics systems underestimate the true incidence of maternal deaths. As a result, the maternal mortality ratio is a conservative estimate of the dangers of pregnancy and childbirth. Maternal deaths were underestimated by 27% in Georgia,[49] 40% in Washington State,[50] 60% in North Carolina,[51] 71% in Puerto Rico,[52] 73% in Massachusetts,[53] and 81% in New Jersey.[54] A national study assessing pregnancy-related deaths between 1974 and 1978 found that the actual incidence of maternal mortality during this time was 20% to 30% greater than that published in national vital statistics.[55] A seven-state review of maternal deaths in 1983, conducted as part of a CDC pilot surveillance system of maternal mortality, identified 39% more deaths than were reported by the vital statistics system alone.[56] Thus, the actual risk of death from pregnancy and childbirth has been underestimated over time and when compared with the risks from abortion.

In sum, the risk of dying from pregnancy and childbirth has declined substantially over the past 50 years, but remains substantially greater than the risk of dying from a legal abortion. The difference, however, decreases with gestational age.

ABORTION-RELATED COMPLICATIONS AND SEQUELAE

Hospital Admissions

Abortion-related morbidity is difficult to gauge because definitions of what constitutes a complication vary widely, and because in the United States there are no national surveillance data on abortion-related morbidity. The most commonly used indicator is admission to a hospital. While this excludes minor physical sequelae, it portrays fairly accurately the more serious aftereffects of induced abortion. Major complications from induced abortion are defined by the CDC as those that result in major unintended surgery, a hemorrhage requiring a blood transfusion, a hospitalization of 11 days or more, or a temperature of at least 38.0°C (100.4°F) that lasts for 3 or more days.[57]

The risk of major complications from abortion-related procedures declined dramatically between 1970 and 1990. The best available national data on complications during the 1970s come from the Joint Program for the Study of Abortion, which consisted of three prospective studies of abortion in a sample of hospitals and clinics throughout the United States between 1971 and 1978, sponsored by the Population Council (New York, NY) and the CDC.[21] Between 73 000 and 84 000 women were involved in each phase of the Joint Program for the Study of Abortion. From 1970 through 1971 there were eight major complications per 1000 abortion patients who did not have a preexisting medical condition or undergo sterilization in those years.[58] By 1975 through 1978, the rate dropped to five major complications per 1000 abortions.[57] The National Abortion Federation (Washington, DC) estimates that in 1990 there was one complication per 1000 abortions (written communication, Patricia K. Anderson, MPH, December 1991).

According to the National Abortion Federation, the most common major complication in 1990 was the need to repeat the procedure. A repeated procedure was conducted on 2.3 women per 1000 abortions because the initial procedure missed the embryo or fetus, usually because it was so small (written communication, Patricia K. Anderson, MPH, December 1991). Other leading complications were infection requiring intravenous treatment (1.3 per 1000), perforation of the uterus (0.9 per 1000), and problems requiring laparoscopy (0.4 per 1000), laparotomy (0.4 per 1000), or transfusion (0.3 per 1000).

Estimates of minor complications following first-trimester induced abortions were reported in a study of three New York City clinics that performed 170 000

abortion procedures between 1971 and 1987.[59] None of the complications required hospitalization, and the overall minor complication rate was eight per 1000 abortions.

As with abortion-related mortality, the risk of complications increases with gestational age.[45,58] In 1975 through 1978, the last years of the Joint Program for the Study of Abortion, approximately two patients per 1000 experienced major complications among those who had the abortion performed at 8 weeks' gestational age or earlier, and who had no preexisting medical condition. At 13 to 14 weeks, it was closer to six per 1000, and at 20 weeks or later the major complication rate was approximately 15 per 1000.[58]

The risk of complications is also related to the abortion method used. Vacuum aspiration has a complication rate of two per 1000 procedures, while dilation and evacuation, which is typically used only for second-trimester abortions, has a complication rate of seven per 1000. Procedures that induce labor, usually used later in gestation, have the highest rate of complications.[58] Women who are presumed healthy have lower complication rates than those with preexisting conditions (5.3 and 6.7 per 1000 abortion patients receiving follow-up care, respectively).[58] A review of all physician-provided abortions in South Australia also showed that lower complication rates were associated with early gestational age and use of vacuum aspiration.[60]

Data on complication rates following illegally induced abortion in the United States are very limited, and are either anecdotal or based on a small number of cases in individual hospitals.[61-63] For example, one study identified six women who experienced complications from induced chemical abortions—septic shock, uterine necroses, and renal failure—among 218 women treated for abortion complications between 1962 and 1968 in a Boston, Mass, hospital.[61] A 1977 investigation of complications resulting from illegal abortions among nine women in McAllen, Tex, revealed that two women required a hysterectomy due to septic complications, and four others had a temperature of 37.6°C (99.7°F) or more. *Clostridium perfringens* organisms were isolated from endometrial or blood specimens from three of the hospitalized women.[63] Complication rates associated with illegal abortion are assumed to be higher than those associated with legal abortion.[40]

Emotional Aftermath

Until the 1960s, many assumed that serious emotional problems following induced abortion were common.[64,65] In 1969, after reviewing more than 250 studies of the emotional aftermath of abortion, Surgeon General C. Everett Koop concluded that the data were "insufficient ... to support the premise that abortion does or does not produce a post-abortion syndrome."[66(p196)] He noted, however, that emotional problems resulting from abortion are "miniscule from a public health perspective."[67] Koop and others have criticized research on the emotional consequences of induced abortion for (1) the failure to use a representative sample as the basis for making generalizations to the entire population, (2) study designs that do not differentiate between the symptoms or disorders attributable to the abortion and those experienced either before or after the abortion, (3) an insufficient follow-up period after the procedure (usually a year or less, which is too short to detect long-term complications), (4) research designs that do not include control groups of women who carry wanted or unwanted pregnancies to term and then either keep the infant or give it up for adoption, and (5) a lack of consensus about the symptoms, severity, and duration of adverse mental reactions.[5,66,68]

An evaluation of the most rigorous research on the emotional impact of abortion concluded that "legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for most women."[68(p41)] Rather, the incidence of severe negative reactions is low and the predominant feelings following abortion are of relief and happiness. Sadness, regret, anxiety, and guilt are generally mild when they occur.[68,69] A 1990 review of 225 studies on the psychiatric consequences of induced abortion also found that most women reported feeling relief and reduced distress, depression, and anxiety after terminating an unwanted pregnancy.[70] In testimony before Congress, Adler (1989) noted that "if severe reactions were common, there would be an epidemic of women seeking [mental health] treatment. There is no evidence of such an epidemic."[71(p140)]

In a recent study, 360 African-American women 17 years of age and below who sought pregnancy tests from two Baltimore, Md, family planning providers were interviewed 2 years after the test to assess whether those who obtained abortion experienced more stress and anxiety than those who gave birth or had not been pregnant.[72] Adolescents who obtained an abortion were no more likely than those who gave birth or who were not pregnant to experience emotional problems. A less recent study with a 1-year follow-up compared women who had a therapeutic abortion with women receiving normal antenatal care from obstetricians' offices.[73] This study found that women with abnormal psychiatric assessment scores before the abortion had normalized within 6 months to a year after the abortion. The control subjects showed no change in their scores after delivery.

Women who experience negative emotional reactions to abortion generally have had the abortion for medical or genetic indications, have had prior psychiatric contact before the abortion, have had a second-trimester abortion, expressed serious ambivalence about the procedure or did not make the decision freely, or had wanted to become pregnant.[64,69,70] Women who have had more than one abortion have reported more distress in interpersonal relationships after the procedure than women having their first abortion.[74] Women with symptoms of distress and dysphoria after an induced abortion typically also had those symptoms prior to the abortion.[70]

Few studies have examined emotional outcomes following induced abortion prior to 1973, particularly for illegal abortion. In a 1958 study of 442 American women who had an induced abortion—most performed illegally—most subjects were well-educated, white, upper-middle-class women.[75] The vast majority experienced no significant emotional problems after the procedure. Studies of women in the United States who had a legal (therapeutic) abortion prior to 1970 show only rare adverse emotional consequences.[76-79]

The emotional effects of denied abortion are difficult to assess because the research took place more than two decades ago (before abortion was legal in the United States) or involved women living in other countries. However, on the whole, these studies show that 25% to 30% of women report continued negative feelings toward the child and ongoing adjustment problems several years after the procedure was denied.[68,79]

Although adverse emotional reactions after induced abortion and childbirth are low, a study in the United Kingdom found that adverse reactions to abortion were far fewer than those associated with normal deliveries. In a 15-month prospective study involving 1.3 million women, Brewer (1977) found a hospital admission rate because of postabortion psychosis of 0.3 per 1000 legal abortions and 1.7 per 1000 normal-term deliveries.[81] It is not clear whether this pattern also characterizes the experience of women in the United States. To determine scientifically whether abortion poses serious emotional consequences, studies are needed that com-

pare postabortion with puerperal emotional effects or adoption. Because adoption is a relatively rare event and the adoption process has been highly confidential, research on the emotional consequences of adoption is minimal. Some data suggest that many women who place their children for adoption experience grieving and other negative emotional consequences, but the studies are based on small, self-selected samples.[82,83]

Future Fecundity and Health of Subsequent Children

Most women (70%) in the United States who have an abortion want to have children in the future, according to a 1987 survey of 11 313 women attending 103 abortion facilities nationwide.[84] The CDC assessed the risks of abortion on women's future childbearing capabilities in three reviews of the scientific literature between 1982 and 1990.[85-87] The CDC concluded that vacuum aspiration, which accounts for 90% of pregnancy terminations in the United States today, does not pose a measurable risk to a woman's future childbearing capacity. They also concluded that a single induced termination of pregnancy by vacuum aspiration does not increase the risk of subsequent infertility or ectopic pregnancy. Women who experience a single induced abortion are also at no greater risk of future miscarriage, stillbirth, infant mortality, or congenital anomalies, low-birthweight infants, or major complications during pregnancy or delivery.[87]

The timing and method used to terminate a pregnancy can adversely affect subsequent fertility. Dilation and evacuation, commonly used for second-trimester abortions, increases significantly the risk of subsequent spontaneous abortion,[88] premature delivery, and low birth weight.[87] It is not possible to assess the independent effects of the timing of the procedure and gestational age on these outcomes.

It is less clear whether women who have had more than one abortion are at greater risk for adverse outcomes in subsequent pregnancies. Some studies have linked multiple abortions to future childbearing difficulties,[4] but the procedure used most often was dilation and curettage, which is rarely used in the United States today. Recent research has suggested that women who had more than one abortion after the mid 1970s were not at increased subsequent risk of miscarriage.[89] Additional research is needed to determine the impact of multiple abortions on a woman's ability to bear healthy children in subsequent pregnancies.

THREATS TO THE SAFETY OF INDUCED ABORTION

Abortion is safest for a woman when performed early in pregnancy and by a well-trained, experienced physician who is working in a setting that is equipped to handle complications that might arise. In recent years, the introduction of mandatory waiting periods and parental consent and notification statutes, a reduction in the number and geographic availability of abortion providers, and a reduction in the number of physicians who are trained and willing to perform first- and second-trimester abortions have the potential to threaten the safety of induced abortion. Each of these factors increases the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure.

Mandatory waiting periods usually range from 24 to 72 hours. A survey of 426 women attending clinics in Memphis and Knoxville, Tenn, which had a mandatory waiting period for women seeking an abortion, found that 59% of the women reported experiencing one or more problems by the delay.[6]

Twenty-nine percent experienced additional mental anguish, 24% incurred added transportation expenses, 19% had additional nausea, 14% missed work or school, 5% had to arrange for additional babysitters, and 1% may have entered the fourth month of pregnancy. On the other hand, 15% of women cited the opportunity to consider the wisdom of the decision to be an advantage of the waiting period.

As of November 1992, 18 states had mandatory parental consent or notification laws in effect for a minor to obtain an abortion, and 12 additional states had considered bills during the 1992 legislative session that were intended to limit access to abortion through these statutes.[90] A recent review by the American Medical Association of the impact of parental consent and notification laws concluded that while they may result in a short-term reduction in pregnancy rates, the statutes do not significantly increase the proportion of adolescents who consult their parents about a pregnancy. Rather, they appear to increase the health risks to the adolescent by delaying medical treatment or forcing the adolescent into an unwanted childbirth.[91]

After Massachusetts enacted a mandatory parental consent statute, court proceedings delayed the termination of pregnancy by an average of 4 to 5 days, with some adolescents delayed by nearly 6 weeks.[92] After Minnesota enacted mandatory parental consent laws in 1981, the proportion of second-trimester pregnancy terminations increased by 12% and abortion procedures were delayed an average of 1 to 3 weeks.[8] Adolescent abortion and birth rates declined in Minnesota during the 2-year period following the enactment of its mandatory parental notification law.[93] These declines may reflect the impact of mandatory parental notification laws, but they may also be due, in part, to a 20% increase in public funds for family planning services in Minnesota between 1980 and 1981, or heightened concern over sexually transmitted diseases during the 1980s.[94]

A drop in the number of physicians who receive adequate training in abortion procedures and who are willing to perform abortions once in practice may also increase the risks associated with terminating an unwanted pregnancy. A 1985 survey of US residency programs in obstetrics and gynecology found that the majority of programs include first-trimester and second-trimester abortion techniques in their training (72% and 65%, respectively), but 13% of residents in obstetrics and gynecology appear to have no access to training in these medical procedures.[19] Between 1976 and 1985, the number of residency programs in obstetrics and gynecology that did not offer training in first-trimester abortion increased from 7% to 28%, and from 16% to 36% for second-trimester abortion. In 1985, half of obstetrics/gynecology programs included abortion training as an option; only 23% made it a routine part of training.

The shift away from hospital-based abortion to clinic- or office-based procedures further reduced medical residents' experience with abortion procedures. Between 1973 and 1988 the percentage of abortions performed in hospitals decreased from 52%[95] to 10%,[24] as it became clear that the procedure could be performed safely and at a lower cost in clinics and private physicians' offices.[96] Some consider abortion case loads in most hospitals to be insufficient for residency training programs and urge training programs to arrange with local abortion clinics for residents to gain experience in abortion procedures.[19]

The ambivalence of obstetricians and gynecologists toward abortion is illustrated by a 1985 national survey by the American College of Obstetricians and Gynecologists.[97] The American College of Obstetricians and Gynecologists survey found that 84% of obstetricians and gynecologists agreed that elective abortions should be performed under some circumstances, but only 34% of these physicians actually performed the procedures. A 1983 national probability sample of physicians that included 1290 ob-

stetricians and gynecologists found that 42% of obstetricians and gynecologists provided abortions and 55% referred patients.[98] Seventy-one percent of obstetricians and gynecologists who did not perform abortions cited moral or religious reasons.

The number of abortion providers has been shrinking in recent years, and has become unevenly distributed geographically. Between 1985 and 1988 the total number of hospitals, clinics, and private physicians who perform abortions decreased by 4% from 2680 to 2582.[24] As of 1988, 83% of counties in the United States lacked an abortion provider, despite the fact that 31% of all women aged 15 to 44 years lived in these counties.

Fifty-one percent of metropolitan areas and 93% of nonmetropolitan areas did not have an abortion provider in 1988.[24] Fewer providers mean that women have to travel increased distances, which may increase the cost of the procedure and delay pregnancy termination, thereby increasing the health risks to the woman. About half of women who have an abortion after 15 weeks of pregnancy are delayed by difficulties of making financial arrangements to pay for the procedure.[99]

The gestational age at which an abortion takes place affects both the cost of an abortion and the willingness of abortion providers to perform the procedure. On the average, the cost of a first-trimester abortion at an abortion clinic is $245; at 16 weeks' gestational age, it is $509, and at 20 weeks' gestational age, it is $897.[100] Furthermore, virtually all abortion providers will provide an abortion during the first trimester, but only 62% of clinics, 13% of physicians, and 46% of hospitals that perform abortions will do so after the first 12 weeks of pregnancy. After 16 weeks, only 25% of abortion providers will perform an abortion.[3] Anything that delays the procedure increases the costs incurred, decreases providers' willingness to perform the abortion, and increases the health risks associated with the procedure.

IMPLICATIONS

Abortion is safest for a woman when performed early in pregnancy and by a well-trained, experienced physician who is working in a setting that is equipped to handle complications that might arise. Mandatory waiting periods, parental or spousal consent and notification statutes, a reduction in the number and geographic availability of abortion providers, and a reduction in the number of physicians who are trained and willing to perform first- and second-trimester abortions increase the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure.

Increasingly restrictive abortion laws in the United States would probably not result in mortality rates as high as those of 1940 through 1960. First, some who provide safe abortions will continue to do so, even under risk of prosecution. Second, if some states maintain nonrestrictive abortion laws and offer the procedures to nonresidents, many women will travel to states with more moderate abortion laws. Because poor and low-income women are most likely to have difficulty with financial arrangements for travel and the costs of the procedure, they are more likely to delay the procedure and are therefore at greater risk of abortion-related complications or death.

Adolescents and women who live in rural areas are especially vulnerable to difficulties in obtaining a desired legal abortion. They are likely to have difficulty making financial arrangements to terminate an unwanted pregnancy and making necessary travel arrangements. Adolescents who bear children are at a significantly higher risk of leaving or falling behind in school and experiencing economic hardship than their peers who terminate their pregnancy.[72]

Increasingly restrictive abortion laws are also likely to disproportionately affect young, poor, and minority women who may lose some of the access they currently have to the improved and sophisticated medical technology of current abortion procedures. Abortion-related morbidity and mortality will reflect, in part, the access that vulnerable populations have to safer technologies.

Deaths and medical complications are likely to increase among women who self-induce abortion or who use a nonmedically trained abortion provider to terminate their pregnancy. The risk of death or other adverse health outcomes for these women will depend on whether the provider uses safer medical technologies. If death from induced abortion increases, it is likely to happen gradually rather than in an immediate upsurge, and will be more common among adolescents, the poor, and minority women than among white women and those of greater economic means.

If national or state funding regulations or mandatory notification statutes deter or delay women from seeking an early termination of pregnancy, if opportunities for adequate medical training in abortion techniques decrease and provider willingness to perform abortions declines, or if the number and accessibility of qualified abortion providers decreases, then more women are likely to bear unwanted children, continue a potentially health-threatening pregnancy to term, or undergo abortion procedures that would endanger their health. As access to safer, earlier legal abortion becomes increasingly restricted, there is likely to be a small but measurable increase in mortality and morbidity among women in the United States.

The Council on Scientific Affairs recommends that this report be widely disseminated to appropriate individuals, agencies, and groups.

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TESTIMONY OF JANET CREPPS
THE CENTER FOR REPRODUCTIVE LAW & POLICY
IN OPPOSITION TO SB 292
SENATE JUDICIARY COMMITTEE
FEBRUARY 10, 1995

Mr. Chairman and members of the committee, my name is Janet Crepps. I am a staff attorney and director of the state legislative program at the Center for Reproductive Law and Policy, a non-profit organization. Center attorneys have been involved in nearly every major United States Supreme Court case involving abortion, and we have challenged and are currently challenging mandatory delay and biased counseling measures similar to SB 292 in several states. We have represented abortion providers in Montana in successful challenges to provisions of the Abortion Control Act requiring that all abortions be performed by a physician, that all abortions after the first trimester be performed in a hospital, and that a parent be notified prior to a young woman obtaining an abortion. We are currently representing providers and low-income Montana women in a challenge under the state constitution to the restrictions on public funding for abortion.

We have reviewed SB 292 and believe that if it is enacted it will be subject to challenge and found unconstitutional for violating the right to privacy guaranteed to Montana women by the state constitution.

Since the United States Supreme Court's decision in Planned

Parenthood v Casey[1] in 1992, eight states have begun enforcing so-called informed consent laws imposing mandatory delays on women seeking abortions from one hour to 24 hours. Of those 8, only Mississippi requires, like SB 292, that women travel to the clinic at least 24 hours before the abortion in order to complete the informed consent requirements. The experience in Mississippi has shown that more women are travelling out of state to obtain abortions, and more abortions are being performed later in pregnancy since the law went into effect. The burdens imposed by SB 292, however, are even more onerous than Mississippi's law because only the physician who is going to perform the abortion, not the woman's referring physician, can give the required information and receive the certification. And, unlike the Pennsylvania law upheld by the Supreme Court in Casey, SB 292 makes no exception to the provision of information if a physician concludes it would have a severe psychological impact. If enacted, Senate Bill 292 would be the most stringent mandatory delay law in the country.

It is true that most of the laws requiring 24 hour delays and counseling have survived facial challenges in federal court. The strict standards of SB 292 would provide a basis for a federal constitution challenge on the grounds that they impose an undue burden on women seeking abortions. For example, a federal district court in South Dakota has ruled the criminal penalties

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[1]112 S. Ct. 2791 (1992).

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in that state's informed consent law invalid and unenforceable[2] because, like SB 292, it contains no scienter requirement, thereby chilling the right of women to obtain abortion by potentially subjecting physicians to jail time even in the absence of a knowing violation of the statute.

But SB 292 must not only meet the requirements of the federal constitution, it must also be considered under the Montana Constitution. As you know, the Montana Constitution gives unusually explicit and strong protection to the right to privacy, Art II, § 10 provides:

> The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.

Mont. Const. art. II, § 10.[3]

Although the Montana Supreme Court has not been called on to apply the privacy provision in the context of abortion, it has made clear that "[t]he rights of privacy and dignity are . . . fundamental rights of every Montana citizen."[4]

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[2]Planned Parenthood v. Miller, Civ. No. 93-3033 (Cent. Dist. So. Dak.) (August 8, 1994).

[3] Earlier cases demonstrate that Montana's special protection of privacy predates the 1972 Constitution and was "expressed, though penumbrally," in the 1889 Const., Art. 3 § 7. State v. Hyem, 630 P.2d 202, 206 (Mont. 1981). See also State v. Brecht, 485 P.2d 47 (Mont. 1971); Welsh v. Pritchard, 241 P.2d 816, 819 (Mont. 1952) ("basis of the 'right of privacy' is the 'right to be let alone' and it is 'a part of the right to liberty and pursuit of happiness . . .'") (citations omitted); State ex rel. Samlin v. District Court, 198 P. 362 (Mont. 1921); State ex rel. King v. District Court, 224 P 862 (Mont. 1924).

[4]Gryczan v. State of Montana, No. BDV-93-1869, slip op. (Mont. Dist. Ct. June 28, 1994) (Sherlock, J.).

The Montana Supreme Court recently stated:

> Montana adheres to one of the most stringent protection of its citizens' right to privacy in the country. Montana's treatment of privacy rights is more strict than that offered by the Federal Constitution.[5]

There is no question that the core intent of Art. II, § 10 is "to protect citizens from . . . legislation and governmental practices that interfere[] with their autonomy to make decisions in matters that are generally considered private."[6] The Montana Supreme Court has explained that:

> Inasmuch as a citizens' personality and thoughts are protected as private, so are a citizen's physical solitude and right to be let alone.

Hyem, 630 P.2d at 205.[7]

Therefore, the right to choose whether to carry a pregnancy to term or to have an abortion is a fundamental right protected

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[5]State v. Burns, 830 P.2d 1318, 1320 & 21 (Mont. 1992) (quoting Judge Olson of the Fifth Judicial District's unreported opinion stating "'[w]e have the strongest privacy laws in this state of all of the states,'" and affirming his Order protecting personnel files from disclosure). See also State v. Sierra, 692 P.2d 1273, 1276 (Mont. 1985) (in finding that the Montana Constitution guarantees a "more expansive right to privacy than that guaranteed to [criminal defendants] by the Fourth Amendment," the court noted "we are not compelled to march lock-step with . . . the U.S. Supreme Court if our own constitutional provisions call for more individual rights protection than that guaranteed by the U.S. Constitution.").

[6]Larry M. Elison & Dennis NettikSimmons, Right of Privacy, 68 Mont. L. Rev. 1, 13 (1987) (reviewing debates on the constitutional amendment).

[7] Hyem has been overruled insofar as it held that Montana's state constitutional right to privacy provides protection against purely private conduct. See State v. Long, 700 P.2d 153, 155-56 (Mont. 1985). However, Hyem's recognition that Montana's constitutional right to privacy is one of the strongest in the country remains undisturbed. See Burns, 830 P.2d at 1320-21.

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under Montana's "stringent" guarantee of the right to privacy.[8] Without the right to choose, the right to privacy, physical solitude and liberty, would have little meaning.[9] Other states, including Florida, California, and Alaska, with express constitutional privacy provisions similar to Montana's have also found decisions about abortion to be protected as fundamental rights.[10] Many other courts across the country have found the right of reproductive choice to be a fundamental right under state constitutions even in the absence of explicit

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[8] See Hyem, 630 P.2d at 205 (right to privacy encompasses right to physical solitude and right to be let alone); Engrav v. Cragun, 769 P.2d 1224, 1227 (Mont. 1989) ("family and health problems, . . . interpersonal relationships . . . must all be protected under constitutional privacy interests."); In re C.H., 683 P.2d 931, 940 (Mont. 1984) ("physical liberty" is fundamental right).

[9] See In re C.H., 683 P.2d at 940 (fundamental right is one "without which other constitutionally guaranteed rights would have little meaning"); Butte v. Community Union v. Lewis, 712 P.2d 1309, 1311 (Mont. 1986) ("Lewis I") (same).

[10] In In Re T.W., 551 So. 2d 1186 (Fla. 1989), the Florida Supreme Court found that the state constitution's explicit privacy guarantee includes a fundamental right to choose abortion and that infringements on that right must be justified by a compelling state interest that is narrowly tailored to serve only that interest. The Court explained that it could "conceive of few more personal or private decisions concerning one's body that one can make during the course of a lifetime." Id. at 1192. Similarly, the California courts, in interpreting the California constitution's explicit right of privacy, apply the most demanding level of scrutiny of state laws or practices which impact upon the right to choose abortion. See Committee to Defend Reproductive Rights v. Myers, 625 P.2d 779, 784 (Cal. 1981) (explicit state constitutional right to privacy protects the right to choose abortion); American Academy of Pediatrics v. Lungren, tk: need P.2d cite. 1994 Cal. App. LEXIS 687 (June 30, 1994) (enjoining implementation of state law restricting abortion rights of minors based on state privacy guarantee). Mat-Su Coalition for Choice v. Valley Hospital, (order granting motion for preliminary injunction).

constitutional privacy provisions and have afforded broader protection under their state constitutions than is provided by the federal constitution.[11]

As required by the very words of the constitution, any infringement on the right of privacy must be justified by a compelling state interest. Unlike other waiting periods whic have been measured under the more lenient undue burden standard of the federal constitution, SB 292 would be judged under the most demanding constitutional standard. The restrictions imposed by SB 292, however, cannot meet this test. Restrictions nearly identical to those contained in this bill were held unconstitutional by the United States Supreme Court when it reviewed them under the strict scrutiny standard.

In a case challenging an Akron Ohio law requiring a 24 hour mandatory delay like SB 292's, the court held the requirement unconstitutional, finding that the city "has failed to demonstrate that any legitimate state interest is furthered by an arbitrary and inflexible waiting period."[12] The Court also invalidated a requirement that all of the information be provided by the "attending physician," on the grounds that the critical

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[11]See Mahaffsy v. Attorney General of Michigan, No. 94-406793, slip op. at 14-16, 18 (Mich. Cir. Ct., July 15, 1994); Women of the State of Minnesota, et al. v. Hass-Steffen, et al., Memorandum, MC 93-3995, slip op. at 2 (Dist. Ct. June 16, 1994); Right to Choose v. Byrne, 450 A.2d 925, 933-34 (N.J. 1982); Moe v Secretary of Admin & Fin., 417 N.E. 2d 387, 397-99 (Mass. 1981); Davis v. Davis, 842 S.W.2d 588 (Tenn. 1992); Doe v. Maher, 515 A.2d 134, 147-50 (Conn. Super. Ct. 1986).

[12]Akron v. Akron Ceter for Reproductive Health, 462 U.S. 416, 450.

factor in ensuring that a woman gives informed consent "is whether she obtains the . . . information . . . from a qualified person, not the identity of the person from whom she obtains it." Senate bill 292 suffers from the same shortcomings as the Akron law because it prohibits the woman from receiving the information required in section 5 of 50-20-104, from anyone but the physician who is to perform the abortion. Not even the woman's usual ob-gyn who refers her for the abortion, and is familiar with her medical history, can satisfy this requirement.

Even without the mandatory delay, SB 292 would still be subject to challenge because of the biased counseling requirements. In Thornburgh v. American College of Obst. & Gyn.,[13] the Supreme Court reviewed a Pennsylvania law that required the woman to receive almost the identical information listed in SB 292. Applying the strict scrutiny of the compelling state interest test, the Court held that the counseling requirements were unconstitutional for two reasons: first, it concluded that the information wasn't designed to inform the woman's consent so much as it was intended to persuade her to withhold it altogether. Second, the Court found that requiring the information in every instance interfered with the dialogue between the woman and her doctor -- the state was in effect trying to wedge its message into the privacy of the doctor-patient relationship. One example cited by the Court of how these requirements can have a negative impact is the situation in

[13]476 U.S. 747 (1986).

which a victim of rape by an unidentified assailant must be told that her attacker is liable for child support if she continues the pregnancy to term.

Under the strict scrutiny standard employed in earlier Supreme Court decisions, the state's interest in the potential life of the fetus does not justify the restrictions contained in SB 292.

In addition to violating the right of privacy, SB 292 would be subject to challenge under the state's guarantees of equal protection, which prohibit discrimination based on sex.[14] Like the right of privacy, the state's equal protection clause provides broader protection that the federal constitution.[15] Senate bill 292 discriminates against women by placing restrictions on a reproductive health care option sought only by women.[16] Only women get pregnant; only women seek abortions;

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[14] Mont. Const. Article II, § 4 provides:

> The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas.

[15] Pfost v. State, 713 P.2d 495, 500-01 (Mont. 1985). Accord In re C.H., 683 P.2d 931, 940 (Mont. 1984); Lewis I, 712 P.2d 1313-14.

[16] See Bankers Life & Casualty Co. v. Peterson, 866 P.2d 241 (Mont. 1993). Indeed, in Bankers Life, the Montana Supreme Court already held that "distinctions based on pregnancy are sex-linked classifications," and, therefore, a health insurance policy that did not cover pregnancy-related care violated a Montana anti-sex-discrimination insurance statute. Id. at 243.

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DATE 2-10-95
SB 292

only women are subject to coercive policies which pressure them to continue their pregnancies to term.

Senate Bill 292 would create unprecedented civil liability by allowing the father or grandparents to maintain an action against the person performing the abortion for a violation of the waiting period or biased counseling requirements. The bill does not limit "grandparents" to the parents of a minor who obtained an abortion. As a result, if a 35 year old married woman, acting with the consent and support of her husband, obtained an abortion 23 hours after completing the informed consent certificate, her parents or in-laws could sue the doctor.

The United States Supreme Court has refused to grant either the husband of a woman seeking abortion or the parents of a minor seeking an abortion absolute veto power over the woman's decision. *See, Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 69 (1976) (a state may not require a woman to obtain her husband's consent before an abortion); *Planned Parenthood Assn. of Kansas City v. Ashcroft*, 462 U.S. 476, 491 (1983) (a statute requiring parental consent must provide an alternate procedure for the minor to demonstrate she is mature or the abortion is in her best interest). In *Casey*, the Court struck down a mandatory husband notification provision in the Pennsylvania law, finding that the requirement would act "to prevent a significant number of women from obtaining an abortion," 112 S. Ct. at 2829, and thus created an "undue burden." Allowing fathers or parents a cause of action based on

a failure to comply with informed consent requirements is inconsistent with these holdings.

The bill allows the father of any fetus to maintain an action for civil damages. Thus, in cases where the pregnancy is the result of rape or incest, the father has standing to sue the physician. The father or parents may sue even if they supported the woman's decision to have an abortion or have had no contact with her and provided no financial or emotional support.

This provision is punitive and intended to intimidate doctors, thereby discouraging them from doing abortions. It shows that the real purpose of SB 292 is not to improve the process by which women decide whether to terminate a pregnancy, but to prevent the women of Montana from being able to exercise a constitutionally protected right by attempting to drive providers out of business.

Passage of Senate bill 292 will inevitably result in a state court challenge on the grounds that the strict mandatory delay and biased counseling requirements violate the right to privacy guaranteed in the Montana constitution. These lawsuits are expensive both from the standpoint of the resources it takes from the Attorney General's office, and from the fact that if the state loses, it may be required to pay attorney's fees. The Center received $30,000. in our successful challenge to the second trimester hospitalization and doctor only requirements, and that case settled. A challenge to SB 292 would undoubtedly be much more involved and expensive. Most importantly, however,

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SB 292 would impose unnecessary roadblocks and delays on women seeking abortions. These delays jeopardize the health of Montana women, and for that reason above all others, I urge you to vote against SB 292.

Planned Parenthood
of Missoula

Thank you very much, Mr. Chairman and members of the committee.

My name is Deborah Frandsen and I am the Executive Director of Planned Parenthood of Missoula. We are a family planning clinic that provides women and men's reproductive health care. We provide services such as pap smears, contraceptives, breast and testicular exams, counseling and education, sexually transmitted disease screening and care and much more. We provide these services on a sliding fee basis and no one is turned away due to an inability to pay. We also provide abortions and have been doing so for over a year.

I am here today because I feel obliged to take exception with the language of this bill, especially the language at the bottom of page one which states: "that abortion facilities or providers offer only limited or impersonal counseling opportunities; and many abortion facilities or providers hire untrained and unprofessional counselors whose primary goal is to sell abortion services."

Not only is this language patently insulting, it is utterly false. We hire only outstanding individuals to be our counselors and then we train them extensively. Patient feedback about the counseling services we offer, which include all pregnancy options and all abortion related risks, is uniformly positive. And I feel absolutely confidant that any woman would have the same quality experience at any other abortion provider in the state. To add that the counselor's primary goal is to sell abortions is a lie, pure and simple. To the contrary, a woman has to thoroughly convince us that an abortion is in her best interest before we will perform the procedure. Informed consent already happens, it's already the law and we already do it.

What is worse about this type of malicious language is that it further flames the beliefs of individuals who might act out their hatred upon our clinics, our staff and our patients. Violence against abortion providers is escalating and it is your responsibility as legislators not to add fuel to the fire but rather to look for opportunities to reduce the inflammatory rhetoric. Instead of degrading us you should be looking for opportunities to protect us. I ask you, what single thing have you done, as legislators, to protect the staff or patients at clinics in Montana?

For those of you who sponsored this bill, we are very disappointed in this insulting language and we are very disappointed in you for turning a blind eye to the terror that haunts women's health care providers. If anything happens to any of us, you will share in the responsibility because not only did you do nothing, you participated in the demonization of abortion providers by supporting this bill with its shameful language.

219 E. Main • Missoula, Montana 59802 • 406-728-5490

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 20
DATE 2-10-95
BILL NO. SB 292

February 10, 1995

The Honorable Members of the
Senate Judiciary Committee
The 54th Montana Legislature
The Capitol
Helena, Montana 59620

Dear Ladies and Gentlemen of the Committee:

I am a licensed, Board Certified physician who has practiced medicine in Montana for nearly 28 years. I perform abortions as part of my practice in women's health care. I am in total agreement that all of my patients need complete information before they decide to take any medication, have any tests, or undergo any procedure. It is a practice that I have adhered to for 38 years. It is a practice I have adhered to because I believe it is good medicine and because I believe that it is part of the doctor-patient relationship.

I find it ludicrous that a legislative body or any bureaucracy would feel it necessary to put words in my mouth or to decide how much time a patient needs to digest the material in order to make a decision. Some patients may need several days, some only a few hours. Where did the number "24" come from? Why not 12; why not 30? How did you decide what risk factors need to be included? Why breast cancer? Why not disseminated intravascular coagulopathy? Why not emboli? I believe that legislatures may know about enacting laws; I do not believe they know about what is good medicine.

Today, most groups in medicine and in legislatures are looking at ways to cut the cost of care. We endeavor to reduce the number of patient visits, not increase them. We use mid-level, trained and professional, practitioners to extend physician services in order to reduce costs.

I believe Senate Bill 292 is an unnecessary bill. It is not a bill to remedy a problem; it is a bill to make it more difficult for women to choose an abortion--more difficult and more expensive.

Sincerely,

C H McCracken

Clayton H. McCracken, M.D., M.P.H.

February 10, 1995

The Hon. Members of the
Senate Judiciary Committee
The 54th Montana Legislature
The Capital
Helena, MT 59620

Dear Ladies and Gentlemen of the Committee:

We the undersigned, who are family practice physicians, internists, obstetricians, gynecologists and more are writing you to object to **Senate Bill 292.** Some but not all of us also provide abortions through our practice or at clinics. We would be at the hearing today but due to the violence surrounding this issue, it is simply too dangerous for us to testify in public.

We take issue with this bill because it is inaccurate, disrespectful and inappropriately burdensome. First, the language regarding the lack of quality counseling that supposedly takes place before an abortion is absolutely erroneous. We would never refer a patient to a physician or work for a clinic in which we were not convinced that complete and accurate counseling would occur. Informed consent already happens, this is simply not a problem in Montana.

The notion that a woman needs an additional 24-hours to consider her decision is insulting. We have never encountered a woman who, considering an abortion, had not already carefully considered the issue and weighed the personal, emotional and ethical costs to herself and the fetus. For the legislature to interfere in the doctor-patient relationship in absolutely inappropriate. Both physicians and patients deserve more credit for devoting themselves to the thoughtful consideration of the issues and serious explanation of alternatives. This already happens without legislative action and we do not feel that this bill is within the legislator's "scope of practice." Also, a 24-hour waiting period is cruel and truly an undue burden on the women who have to travel hundreds of miles in Montana in order to have an abortion.

Ostensibly this legislature was elected to reduce the size of government. However, the DHES staff needed to staff the 24-hour hotline, produce the handouts and reporting forms and then process the reports is just more unnecessary bureaucracy.

In closing, we ask you to vote against this bill, **it is bad law and bad medicine.**

Sincerely yours,

EXHIBIT 20
DATE 2-10-95
SB 292

February 10, 1995

The Hon. Members of the
Senate Judiciary Committee
The 54th Montana Legislature
The Capital
Helena, MT 59620

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Sincerely yours,

MD

February 10, 1995

The Hon. Members of the
Senate Judiciary Committee
The 54th Montana Legislature
The Capital
Helena, MT 59620

Dear Ladies and Gentlemen of the Committee:

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We take issue with this bill because it is inaccurate, disrespectful and inappropriately burdensome. First, the language regarding the lack of quality counseling that supposedly takes place before an abortion is absolutely erroneous. We would never refer a patient to a physician or work for a clinic in which we were not convinced that complete and accurate counseling would occur. Informed consent already happens, this is simply not a problem in Montana.

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Ostensibly this legislature was elected to reduce the size of government. However, the DHES staff needed to staff the 24-hour hotline, produce the handouts and reporting forms and then process the reports is just more unnecessary bureaucracy. "get government off our backs"

In closing, we ask you to vote against this bill, **it is bad law and bad medicine.**

Sincerely yours,

Richard M.D.

EXHIBIT 20
DATE 2-10-95
SB 292

February 10, 1995

The Hon. Members of the
Senate Judiciary Committee
The 54th Montana Legislature
The Capital
Helena, MT 59620

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In closing, we ask you to vote against this bill, **it is bad law and bad medicine**.

Sincerely yours,

Thomas O. Baumgartner, M.D.

Fact Sheet

Planned Parenthood® Federation of America, Inc.

810 Seventh Avenue New York, New York 10019 (212) 541-7800

2010 Massachusetts Ave. NW Washington, DC 20036 (202) 785-3351

Abortion and "Informed Consent" Requirements

Some states have enacted, and others are considering, "informed consent" legislation mandating that women be given a specific list of state-approved information before an abortion may be performed. Typically, this information includes a detailed discussion of fetal development -- often at two-week intervals for the entire course of a pregnancy -- and information on the risks of abortion at all stages of pregnancy as well.

Most such laws would require physicians to recite a predetermined litany of often irrelevant and unduly frightening information about the risks of abortion without requiring a discussion of the significantly greater risks of pregnancy and childbirth. These laws are inherently biased and do nothing to foster the goal of truly informed consent. As the Supreme Court itself has recognized, these laws are designed "not to inform the woman's consent, but rather to persuade her to withhold it altogether."[1]

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that informed consent is a long-standing and fundamental principle of medical practice. In its 1982 report, the commission enunciated four major principles of informed consent.

- Patients "are entitled to accept or reject a health care intervention on the basis of their own personal values and in furtherance of their own personal goals."

- Truly informed consent "is a process of shared decision-making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form."

- Physicians must discuss all alternative treatments, including those he or she does not provide or favor, so long as they are supported by respectable medical opinion."

- Patients should be provided with complete and unbiased information. "Manipulation has more and less extreme forms.... Of particular concern in health care contexts is the withholding or distortion of information in order to affect the patient's beliefs and decisions."[2]

The principles of informed consent already are embodied in the basic standards of the medical profession, and the organizations to which abortion providers belong. These codes bind physicians to tell women about their alternatives to abortion and to obtain informed consent before performing an abortion.

- The American Medical Association recognizes that "the patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice."[3]

- The American College of Obstetricians and Gynecologists requires physicians treating a patient with an unwanted pregnancy to counsel her "about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy."[4]

- The standards of the two major organizations to which abortion providers belong also specifically embody these principles. Those of the Planned Parenthood Federation of America state, "Informed consent for abortion must be obtained in writing from all women ... prior to the procedure."[5] Those of the National Abortion Federation, whose members perform about half of all abortions in the United States, state, "It is the responsibility of each abortion provider to ascertain prior to the performance of an abortion that the patient understands and has freely chosen to terminate her pregnancy."[6]

- Health care providers who fail to adhere to these ethical imperatives can be charged with malpractice if the patient suffers complications that he or she was not told could occur or learns too late about an alternative approach that he or she would have preferred.

Requiring physicians to give all patients a specific litany of information does nothing to foster the goal of informed consent. It may harm patients by mandating a discussion of excessive risks and by requiring a discussion of the risks of only one alternative, abortion.

- According to the President's Commission, "patients' interests are not well served by detailed technical expositions of facts that are germane neither to patients' understanding of their situations nor to any decisions that must be made."

- More than nine in ten abortions are performed in the first trimester of pregnancy. There is no reason to subject a woman seeking an early abortion to a lengthy discussion of the risks entailed in an abortion later in pregnancy. These risks are irrelevant to her situation.

- Similarly, fetal development obviously changes as pregnancy progresses; a discussion of fetal development in the later stages of pregnancy is irrelevant to the medical treatment of a woman seeking an abortion at eight or nine weeks.

- A state-mandated litany of information is inherently biased if it requires a discussion of only the risks of abortion and not the risks to the woman from pregnancy and childbirth. Abortion is an extremely safe procedure, safer than a shot of penicillin. The risk of dying from childbirth is 11 times the risk of dying from an abortion.

- In 1983, the Supreme Court found that requiring physicians to provide patients with a specific list of information prior to performing an abortion is unrelated to obtaining truly informed consent. The Court struck down such a mandated "litany of information," which it said was tantamount to forcing physicians to present "a parade of horribles."[7]

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DATE 2-10-95
SB 292

References

1. City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983).

2. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship, Vol. 1, Washington, D.C., 1982.

3. American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association-1986, Chicago, 1986, pp. 31-32.

4. American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services, Washington, D.C., 1985.

5. Planned Parenthood Federation of America, The Manual of Medical Standards and Guidelines, New York.

6. National Abortion Standards, Standards for Abortion Care, 1986, Washington, D.C., 1985.

7. City of Akron v. Akron Center for Reproductive Health, 1983, op. cit. (See reference 1).

FOR FURTHER INFORMATION, CONTACT:

Planned Parenthood Federation of America

In New York:
PPFA Media Relations Department
212-603-4660

In Washington, D.C.:
Bahnsen Communications
202-387-6556

Prepared by The Alan Guttmacher Institute for Planned Parenthood Federation of America (FS-A8, 6/90)

February 10, 1995

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 22
DATE 2-10-95
BILL NO. SB 292

Mr. Chairman and Members of the Committee:

My name is Christine Phillips and I live and work here in Helena.

SB 292 is not about a "woman's right to know" but rather "society's right to impose". It is clear from the opening of the bill that the intent is to impose certain moral dictates on the women of Montana. It is meant to intimidate and shame women for making a decision that a minority do not approve of.

This bill is demeaning to women. The proponents view women who have an abortion as being one of two extremes:
- either we are victims of evil doctors and an "abortion industry" that seek to prey upon our weakness, or,
- we are callous, amoral women who make the decision glibly and never consider options or implications.

We are neither. I have had an abortion and I did not decide to do so without carefully weighing physical, medical, financial and emotional implications as well as my religious and spiritual beliefs.

The care I received was excellent. The counseling was thorough. In fact, I was asked at several different points if I was clear in my decision, did I want more time, did I want to think about it some more. In all, this was very far from coercion.

My decision was fully informed and well thought out. I accept, fully, the responsibilities for my actions. I do not need, nor do I want, mandated waiting periods, pictures of fetal development, nor any other state imposed obstacles.

There is a lot of discussion of what our "founding fathers" deemed important in our country's formative years. I would like to point out that our founding mothers had full access to legal abortion.
- In fact, abortion was not banned nationwide until the 1880's.
- And, the Catholic Church had only recently banned abortion, in 1869.

As leaders in your communities and of this state, you have the responsibility to determine how this issue is dealt with. The rhetoric in this bill is perhaps more significant than the specific actions that it will mandate. You can choose to add to the escalation by endorsing inflammatory, deragatory and misleading language, or you can choose to protect what is constitutionally guaranteed.

Respectfully Submitted,

Christine A. Phillips
553 Spencer
Helena, MT 59601

BLUE MOUNTAIN CLINIC

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 23
DATE 2-10-95
BILL NO. SB 292

February 9, 1995

Honorable Members of the Senate Judiciary Committee
Montana State Legislature
Helena, Montana 59620

Ladies and Gentlemen of the Committee:

I write in opposition to Senate Bill 292.

First, I want to be clear that counseling, with clear and objective information, has always been an integral part of abortion services at Blue Mountain Clinic. In fact, women who do not want to go through counseling have not been accepted as clients.

This bill appears to be aimed more at limiting access to a legal medical procedure than strengthening the quality of medical practice in Montana.

In fact, I find the language in parts of the bill offensive and the content inaccurate. If the authors of the bill would do their homework to gather the facts rather than concentrate on trying to control the most private decisions of Montanans, they would know better than to include sections which make wild assumptions about what occurs in abortion facilities.

There are a good many women who have come to us for services who gave birth rather than have abortions because, through the counseling they received, they became clear about what they--not their parents, not their partner, not a legislative body--believed would be the best decision.

Where I grew up in eastern Montana, we referred to making this kind of decision as taking personal responsibility and exercising individual rights, and we somehow thought it was nobody else's business. Montana's history of respect for privacy was something to be proud of, not something to treat with contempt.

It saddens me to think that we have become a community divided over this very private issue, that we treat one another with disrespect because we disagree about something so personal.

1916 Brooks, #136 • Missoula, MT 59801

Life is a series of complex decisions, and we all come to those decisions with different values, tools and resolve. I urge you to give credit to the people of Montana for being competent to make their own decisions.

Please, indeed, do work to keep government out of people's lives. Keep it out of our doctor's offices, too.

I encourage you to oppose Senate Bill 292.

Sincerely,

Sally Mullen
Executive Director

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 24
DATE 2-10-95
SB 292

Hi my name is Danni,

There are a few things about the new abortion bill that I feel is very wrong. One of them being how just about anyone can sue the doctor. I really feel that this is wrong! Why should someone get sued for something someone asks from them. The doctors don't go out searching for women to give abortions to, we go them. I also don't feel other people have the right to sue them either. It's not there body nor is it there choice. I use to feel that abortions were wrong and definitely not for me, until a situation happened to me. Then I felt it was right for me. It was my choice and to sue the doctor would be crazy! It was my body and no one else should be able to sue the doctor from my decision with my body.

I also feel the clinic I went to was really great. They didn't try to talk me into something I didn't want, they worked with me. They really explained everything to me, they wanted to make sure this was the right choice for me. And it was! I don't feel they are just out to get women to have abortions. They explained things just like any other doctor would.

I just really feel that we women should have the right to do what we choose to do with our bodies. It's our body and nobody elses! And someone we ask to help us should not be condemned for what we asked for, and chose to do.

Thank you for hearing me.

No on SB292

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 25
DATE 2-10-95
SB 292

February 10, 1995

To: Chairman Crippen, members of the Senate Judiciary committee

I am writing to voice my strong opposition to SB 292.

As a woman who has recently undergone an abortion, I am addressing the process involved in the decision to terminate an unplanned pregnancy.

1. Any government mandated waiting period is insulting. From the moment a woman receives a positive pregnancy test result to an unplanned pregnancy, her mind is weighing out her options, weighing out their benefits and consequences, and evaluating her capacity to provide for a child. This comes from her own conscience before she ever meets with a counselor. A decision to terminate a pregnancy is far from spontaneous.

No one will understand the turmoil involved in deciding the future of an unplanned pregnancy until it is personally experienced. Furthermore, having experienced it, you would not want to take responsibility for interfering or further complicating another woman's decision. It is extremely personal and sensitive.

2. Physicians are trained as scientists not as counselors. Therefore, physicians are not necessarily the best choice for communicating medical information in sympathetic, laymen's terms. Women's health clinics are undeniably the experts in meeting women's health care needs medically and psychologically. Because of the influx of women who use these clinics, the staff, whether medically accredited or not, is adept in dealing with the multiple facets of women's health care needs.

3. The progression once a medical facility is involved:
A. Discussion of options with empathetic **counselor** including guidance on where to seek further information for any/all pregnancy options; 'SELLING AN ABORTION SERVICE' WAS NEVER AN OBJECTIVE OF THE MEDICAL FACILITY!
B. Leave facility for time to think, evaluate, call or drop-in for **further questions;**
C. Schedule of procedure
D. Second **counseling** session, detailed discussion of procedure;
E. Leave facility with opportunity to call with **further questions/concerns** at any time;
F. DAY OF PROCEDURE- **counseling,** procedure, recovery with supportive staff, **receive 24-hour, 7/day/week support phone number** with prompt, receptive answers and physician accessibility.

The staff also provided me on-going support with a staff person's ***home phone number*** to call at any time. Furthermore, I was provided with names and numbers of more **counselors** in the community who were willing to assist my recovery kindly taking into consideration my limited financial resources. The clinic bent over backwards to accommodate my needs.

I hope that you will recognize the quality, unbiased, informative health care that was provided to me throughout my decision-making process to terminate my unplanned pregnancy with an abortion.

Respectfully submitted,

Sara Holmes

Sara Holmes

ACLU OF MONTANA
AMERICAN CIVIL LIBERTIES UNION
P.O. BOX 3012 • BILLINGS, MONTANA 59103 • (406) 248-1086 • FAX (406) 248-7763

February 9, 1995

Mr. Chairman, Members of the Committee:

For the record, my name is Scott Crichton. I am here today as Executive Director of the American Civil Liberties Union of Montana, celebrating 75 years of defending traditional American values as represented in the Bill of Rights. I am also here as a husband and parent, a person, probably like all of you whether you realize it or not, who has friends and/or relatives who have had an abortion.

I am here to oppose SB 292. It is an affront to women, their intelligence, their ability to make decisions, and fundamentally to their rights to the enjoyment of life, liberty, and privacy. SB 292 is also an affront to medical professionals, deliberately placing hurldes and hinderances aimed at discouraging and detering doctors from exercising their professional judgement and constitutional right to perform abortions.

The ACLU asserts that a woman has a right to have an abortion -- that is, termination of pregnancy prior to the viability of the fetus -- and that a licensed physician has a right to perform an abortion, without the threat of criminal sanctions. This bill oozes with criminal sanctions and government intervention into what rightfully should be a private matter. The decision of whether or not to continue a pregnancy should be one of the woman's personal discretion and the doctor's professional judgement.

Threats of suits by anonymous third parties, potential intervention by moralistic legislators, and cumbersome regulations forcing more government intrusion in medical practises all tell me that this bill is mis named. It is not about "a woman's right to know", rather it is about imposing "the right to life's" agenda on all of Montana's citizenry.

While in my mind this bill does not deserve further consideration, I fear no amount of logic or debate will dissuade this committee from further curtailing privacy rights and eroding liberty in Montana.

February 10, 1995

The Honorable Members of the
Senate Judiciary Committee
The 54th Montana Legislature
The Capitol
Helena, Montana 59620

Dear Ladies and Gentlemen of the Committee:

I am the Executive Director of InterMountain Planned Parenthood. I am responsible for seven clinics in Montana, two of which are clinics that provide abortion. Less than 5% of all the medical visits to these seven clinics involve abortion services. However, each time the legislature meets, bills are promulgated to try to affect this 5% of the medical care we provide.

At no time have I ever staffed a clinic with untrained or unprofessional counselors. contrary to the allegations made in the legislative purposes and finding s of Senate Bill 292, no one is ;hired to "sell" any service. We have been accused often by folks who oppose our efforts to prevent unintended pregnancies or to support women in their choices to continue or end a pregnancy that we don't tell them what to do. That is true. We have faith that men and women who receive enough information that is accurate and unbiased will make good choices. We do not "coerce"; we do not persuade; we do not sell.

I can testify that every woman who has had an abortion at any of the clinics that I have directed knows that there are risks to having an abortion just as there are risks to continuing a pregnancy. I can testify that women who choose to have an abortion at our clincs, have at least a 24 hour period of time before actually receiving abortion services. It is usually at least a week, unless her pregnancy is so far along that postponing the abortion would put her at higher risk.

I believe this bill, Senate Bill 292, is not about protecting women, I believe it is about putting obstacles in their way. I could not be here today because of the change in the scheduling of this hearing. I am happy to answer any questions you may have.

Sincerely,

Joan McCracken

Joan McCracken

Kenneth V. Eden, M.D., F.A.C.P. 27
Gastroenterology

V. Lee Harrison, M.D.
Geriatrics

INTERNAL MEDICINE ASSOCIATES
121 North Last Chance Gulch
Suite G
Helena, Montana 59601
(406) 442-1994

Fred C. Olson, M.D., Ph.D.

Jean M. Justad, M.D.

Jay L. Larson, M.D.

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 28
DATE 2-10-95
SB NO. SB 292

February 9, 1995

Members of Senate Judiciary Committee

I am writing to you to voice my strong opposition to Senate Bill No. 292, "An act clarifying a woman's right to certain facts prior to an abortion ...".

I am a physician in Helena, Montana, and have served as one of the medical directors for Helena Family Planning for the last five years. My objections to Bill No. 292 are as follows: A careful reading of the bill reveals that it is written on the following assumptions:

(1) That pregnancy alternatives to abortion are not mentioned or encouraged at Family Planning and Planned Parenthood clinics or between a doctor and his/her individual patient. At all of the family planning and women's clinics which I have ever attended or to which I have referred my patients, the entire range of pregnancy alternatives has been made available to clients without emphasis or pressure to choose any one. This includes discussing social services which are available to pregnant women of low income and referrals to appropriate services if a woman chooses to continue her pregnancy.

(2) There is an unstated assumption in this bill that Family Planning and Planned Parenthood clinics pressure their clients to choose abortion. This is simply not true. The professionals whom I know and with whom I have worked have always felt that a woman's decision regarding her pregnancy was a very personal one and that their role was to provide her with full knowledge of her options from abortion to adopting out her child or keeping her child.

(3) There is an assumption that deep psychological trauma is an outcome of abortion. The myth of the postabortion trauma syndrome cannot be verified in either medical or psychological studies which have attempted to document it. While it is certainly true that someone might later regret having had an abortion, this is not the feeling of most women who have undergone that procedure.

(4) There is an assumption that the decision to choose an abortion is one easily made and readily changed by receiving counseling regarding "a father's liability" and "medical assistance benefits available for prenatal care, childbirth and neonatal care". No woman chooses abortion gladly or lightly nor is her decision likely to be changed by the statement that she can sue her partner for child support or compete for increasingly scarce resources from the social services system.

The Legislative Intent of Senate Bill 292

Sen. Steve Doherty

2/14/95

Steve Doherty

I have carefully reviewed SB 292. I believe that it is seriously flawed in many respects. Practically, it will not work- it invades the current privacy of the doctor/patient relationship and it creates unlimited opportunities for harassment. In its application, it will place undue burdens on women exercising rights guaranteed by the U.S. and Montana constitutions.I further believe that it is directly contrary to several provisions of the Montana constitution.

Montana's constitution is unique in it's specific written recognition of the fundamental right to privacy. In this regard, Montana's constitution clearly exceeds the U.S. Constitution in according rights to individuals. Montana is different and in our federal/state framework, Montana has properly reserved to itself the authority to further guarantee individual rights and freedoms.

SB 292, while attempting to tiptoe across the intracacies of the federal court decisions on abortion, wholly neglects and ignores the Montana constitution. This bill directly attacks rights guaranteed Montanans in our constitution.

This bill certainly presents no rational basis for its onerous restrictions. It does not even approach a threshold for any compelling reason for the state to inject itself into one of the most private and agonizing decisions a woman can make.

Further, it became clear to me that the intent of the sponsors is not to provide unbiased information, but to place obstacles in the way of women seeking medical treatment. In responding to questions during the hearing, it became clear that there is no basis in fact whatsoever for the so-called legislative findings. The "findings" are nothing more than conjecture and in fact are based on the sponsor's personal beliefs, suppositions, and prejudices.

I am saddened that this bill has been used as a vehicle to enact certain religious beliefs into our statutes. The separation between church and state is no more.

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 30
DATE 2-10-95
BILL NO. SB 292

February 9, 1995

Senator Bruce Crippen
Chair, Senate Judiciary Committee
Montana State Legislature
Capitol Building
Helena, MT

Dear Senator Crippen:

A bill was recently introduced by Senator Bob Brown entitled SB292 The Woman's Right to Know Act. I am writing in oppositon to this bill for the following reasons.

First, the law presently provides for informed consent to be given prior to the performance of any medical or surgical procedure. Requiring physicians to provide the materials and documentation stated in sections 4 and 6 places unnecessary and costly paperwork and labor on the medical providers, and raises the probability that costs for the procedure will be increased and/or the number of facilities providing abortion services will decrease. This would restrict access to care for a service that is already difficult to obtain due to the few abortion facilities in operation in Montana.

Secondly, in reference to Senator Brown's statement that "(this decision) ought to be made carefully and with as much thought as possible.", this bill smacks of paternalism, that women are not capable of making life or death decisions on their own, that it is necessary for the state to intervene for their protection. When a woman becomes pregnant, she is aware of her condition and the decisions she must make. She is capable of contacting a health care provider and obtaining the information she needs to make those decisions. If Senator Brown's bill were to apply to this "life and death" decision, then it must apply to all life and death decisions in medical care.

Thirdly, Section 2, subsections f and g, implies that the health care provider is dispensing substandard care with "limited and impersonal counseling" given by "untrained and unprofessional counselors whose primary goal is to sell abortion services". Where is the documentation for those statements? The law states that abortions must be performed by physicians who, in turn, must meet the standards and licensing requirements both from the state and their respective licensing boards. In any type of medical or surgical procedure, counseling is provided by the physicians and the nurses directly involved in the patient's care. The law does not require a that professional psychologist provide this service. It does state that physicians, nurses, clergy and other licensed personnel may counsel patients regarding their health care decisions. It is purely opinion that abortion facilities give "limited or impersonal" counseling to their clients.

Finally, this bill creates an unnecessary intrusion by the government into the private lives of its citizens. What a woman and her health care provider decide is not the business of the state as long as

it is a legal procedure. When a woman makes the decision to terminate a pregnancy, who is the state to say that she has not given enough thought to the possible consequences, both physical and psychological?

For these reasons, I urge you to oppose this bill, and any other that attempts to restrict a woman's choice and access to legal and competent health care.

Sincerely,

Patricia Goudie, R.N.
31 Sun River-Cascade Rd.
Sun River, MT 59483
(406) 264-5369

SD 249

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 31
DATE 2-10-95
BILL NO. SB 249

Sen. Bishop

OPENING STATEMENTS ~~(from the Governor's task Force to Study Montana Government)~~

Montana is one of only two states (Montana and Indiana) that elect clerks of the Supreme Court. In most states, the chief justice or the supreme court administrator appoints the position. A number of states require that the clerk be an attorney. In Idaho, Wyoming, and North Dakota, the chief justice, as direct supervisor, assigns the duties of the clerk of the court, in addition to duties statutorily prescribed.

Nationwide, generally the duties of the clerks of the supreme court include: 1) recording the proceedings of the court; 2) keeping the records, files, books, and papers of the court; 3) filing all court papers; 4) attending the terms of the court and administering oaths; 5) entering orders and judgments; and 6) authenticating records.

Montana's statutes generally require the clerk of the supreme court to perform functions 2,3,5 and 6. Section 3-2-402, details the duties of the clerk.

Arguments for appointing this position and shifting the responsibilities to the Supreme Court include: 1) general fund cost savings; 2) unity of command and accountability realized by direct reporting relationship between the clerk and the court; 3) better coordination of the functions of the court; and 4) an increased efficiency and streamlined structure.

The larger issue goes back to the question of the criteria used to determine whether a function should report to an elected or an appointed officer. An elective office should have significant stature to assure that voters know what are the job requirements. Only then can voters judge job performance against those job requirements. Further, an elected office should have high enough visibility (in terms of media coverage) to allow the voters to judge performance of the office holder. This position fails all of these tests.

As it is now, voters are asked to vote for a position which is given no policy discretion under the law. The job is obscure enough that the media generally doesn't provide voters with sufficient information on who's running and what is their platform.

The Montana Judiciary is a separate branch of our Montana government, the justices and judges are all elected in a non-partisan election. To have a partisan elected official holding the responsibility for filings at the highest court of the state is like having the governors legislative liaison elected as a partisan office holder.

Closing Items

(many of the facts and calculations referenced below are from the 1994 Judicial Report on Montana Courts and the Report of the Judicial Unification and Funding Commission, Salary figures and budget amounts are from state accounting records)

- The net result from this bill will be savings of general fund over the biennium of $88,327. In biennium's after the enactment, cost savings of $117,702 would be realized.

- This is a change that can be made now with positive effect to the citizens of Montana. In fact it, probably will result in increased access to the public, the time dictates it as the mood of the people demands less of and more effective government.

- The court will have the tools to operate in more streamlined and productive manner. The branch needs to have control over all functions of it's own operation just like the executive and legislative branches.

- The office will be fiscally responsible. Currently the deputy clerk ($36,894) is paid more than the elected clerk ($35,289), more than the State Auditor ($36,278) and more than the Secretary of State ($36,278). The salary and benefits of the elected clerk and deputy account for $91,179 of a total yearly budget of $179,279, or over 50%. This is not fiscal control or effective government.

- Based on current staffing and case filings, each case that was filed in calendar 1994 (Calendar 1994 cases filed 633) was allotted 13.2 hours of supreme court clerk staff time. In the Yellowstone county District Court each case filed was allotted 6.6 hours of staff time. The average of the five largest counties District Court clerks offices (Yellowstone, Lewis & Clark, Missoula, Cascade, and Gallatin) is an allotment of 7.3 hours of staff time per case. The amount of work involved on a case in district court is considerably more than on an appeal to the Supreme Court. Efficiencies of operation are truly obtainable when the average of hours spent on cases filed in district court is about half that of the clerk of the Supreme Court.

- The Judicial branch will truly be an independent, non-partisan part of Montana government, insuring equal access to the court and it's records.

- The office is not constitutional, in State ex rel. Bonner v. District Court, 122 Mont. 464, 206 P.2d 166 (1949), the Montana Supreme Court stated:

  Except as limited by the Constitution, the term of public officers is a

EXHIBIT 31
DATE 2-10-95
SB 249

matter purely of legislative discretion. Bonner at 467.

In Bonner, supra, the Supreme Court relied on an analysis from State ex rel. Grant v. Eaton, 114 Mont. 199, 133 P.2d 588 (1943), and stated:

> "... With us, public offices are public agencies or trusts, and the nature of the relation of a public officer to the public is inconsistent with either a property or contract right. Every public office is created in the interest and for the benefit of the people, and belongs to them. The right, it has been said, is not the right of the incumbent to the place but of the people to the officer. * * * The incumbent has no vested right in the office which he holds, * * *" 42 Am. Jur., Public Officers, sec. 9, pp. 886, 887. "Public officers, in other words, are but the servants of the people, and not their rulers."

- I urge the committees concurrence with SB 249

February 10, 1995

STATEMENT OF ED SMITH, CLERK OF THE SUPREME COURT

Montanans share a long tradition of grass roots participation within government. Out of this philosophy, a governing structure has evolved which ensures that our citizens are directly involved with the makeup of our government. This means, that in Montana, all branches of government, the executive, the legislative, as well as the judicial branches, are comprised of elected leaders. Within the judiciary, from the justices of the peace, to the clerks and judges of the district courts, through the state supreme court, all positions are elected. This tradition of an elected judiciary provides for a "check and balance" within the Court system. In other words, our citizens want a safeguard against the courts having absolute control over what gets filed or what records are kept.

With regard to our electorate, I believe that Montanans are not too "burdened" or "confused" by the number of choices or issues with which they are faced on election day. Rather, I have great confidence in my fellow Montanan's decision-making abilities. Therefore, I cannot reconcile the idea that if Montanans feel so over-burdened by voting responsibilities, why do they consistently rank number one or number two in the nation in voter turnout. To me, this proud statistic underscores Montanan's desire to be directly involved in their government.

As for my position, the Clerk of the Supreme Court, I work for the people of Montana. I provide a direct service for them. I am a sworn public servant to the people of Montana, not to judges, not to attorneys, or any other entity. I am bound to follow the dictates of the law which sometimes means that my duties require me to take a stand on an issue that is contrary to what the judges or attorneys or others may want. Consequently, I am beholden only to do the job the people elected me to do.

As an elected official, I acutely understand that our citizens have entrusted me to **guarantee** their access to the Supreme Court and its proceedings. It is essential that the citizens have an independent office holder safeguarding their "right to know." Furthermore, the public expects me to efficiently control filings, to protect and to provide access to important official records, to license Montana's attorneys, and to collect important administrative fees and taxes which result in over $165,000 of revenue for this state. I take all of these responsibilities very

seriously as I understand that the public will not tolerate gross inefficiencies or poor service. Therefore, first and foremost, I am responsive to the public and its concern for direct, efficient, quality service.

Additionally, my independent role within the structure of the supreme court is vital to the existence and operation of the court, itself. My duties, mandated by state law, cannot be considered as secondary within the court system. Rather, the Clerk is a requisite part of the working machinery of the judiciary, meaning that the court cannot operate without a clerk of court. This structure is a good design because it ensures that Montana's courts are responsive to the public's needs and desires. In contrast, the Federal system is all appointed and lacks responsiveness to the public. The courts of this state with its elected judges and clerks is far more effective and accessible than the federal courts. An independent clerk of court, operating in the public's best interest, is the structural hub around which this effective, responsive, court system revolves. If you remove the independent nature of the clerk, you are denigrating this effective system which has so efficiently served this state since its creation.

With that said, I would like to point out some serious concerns that I have about this bill. It is my understanding the purpose of this bill is to save money and promote efficiency by putting in place a streamlined chain of command which is supposed to better coordinate the functions of the supreme court. I would like to inform the committee that I was not asked to prepare the fiscal note for my office on this bill. The note prepared, does not provide accurate information concerning salaries and obligations that the State of Montana has if this bill is to become law. Furthermore, It does not provide for adequate staff for the court's work and it unfairly reduces wages for the current staff.

With regard to efficiency, it must be stated that the Clerk's budget represents roughly $180,000 out of the judiciary's six million dollar budget. The office collects over $165,000 in revenue for the state making it a net cost of roughly $15,000 of taxpayer dollars to operate this office. Moreover, the clerk is providing direct service to the taxpayers in return for their small investment.

It also needs to be stated that this office has not grown in staff size since 1979. In Fiscal year 1991-1992, when our state had too much debt, this office spent less in operating expenses than it in the early 1980s. What other office or agency has done that? More

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importantly, the clerk's office provides direct service to the people of Montana, it does not exist to support or serve government itself. By removing the elected clerk, you will be adding to the bureaucracy of government. The public wants the bureaucracy cut, not the elected offices. Isn't the public crying out against the size of bureaucracy in government? Don't taxpayers want government to be responsive to them? Don't voters want service for their money? I think they do. So why, out of a six million dollar budget, is a small office that has not grown in fifteen years, which provides direct service to the public and protects their rights, and operates on a net cost of $15,000 a year . . . . . Why is it being singled out as the best place to cut so that the judiciary can operate in a more streamlined and efficient manner?. It does not make sense to me.

Additionally, by removing the elected status of the clerk, and installing a "streamlined chain of command," the legislature will add to the administrative duties of an already overworked court? You recently passed legislation to grant permanent statutory authority for the seven justices on the Montana Supreme Court. Again, this office, which must transact all the business for the court, has never had any additional staff added. We are working with the same number of personnel that we had for a five-member court. So why should the court have more administrative work that would take their valuable time away from deciding cases, which is what they are elected to do. Again, if this present structure was grossly inefficient, I could understand the efforts to do something. But this office has run efficiently and effectively through all administrations, Republican and Democrat alike. It should also be stated that through all of the years that both Republicans and Democrats have held this office, there has never been any scent of scandal. Therefore, I cannot see the problems nor the urgency of making such a change as is proposed in this bill..

However, if it is the will of this legislature to change the way this office is filled, I believe that it should be handled in an orderly manner. Over 300,000 Montanans voted for this office in last November's election and over 208,000 of those voters cast their ballot for me. I have a contract with the people of Montana for a term of six years and I think that in the spirit of fair play, I should be allowed to serve my term. You are proposing to eliminate the office of Secretary of State and Superintendent of Public Instruction, but even in those cases the amendments are drafted as to not effect the terms of office for those individuals seeking election in 1996. There is no emergency why this legislation needs to be made effective before the

completion of my term. It also needs to be stated that the Governor's Reinvent Government Commission did not make a recommendation to eliminate the Clerk of the Supreme Court as an elective office.

In conclusion, this bill does not represent the public's best interest. In the name of efficiency and modern centralization of authority, it is attempting to remove the average citizen from a legal system in which he already feels alienated. If this bill is truly about better, more efficient, government, I wish someone would show me where the present system has gone so grossly astray that the legislature feels compelled to concentrate its "streamlining" efforts on the efficient operation of an office that represents less than three percent of a six million dollar budget and provides quality service directly to the people of Montana.

Finally, I believe in the Treasure State's tradition of grass roots participation within our judicial system. I believe in the abilities of our citizens to decide who is guaranteeing their access to the supreme court and protecting their right to know. I believe that this legislature should not look to tamper with offices that provide efficient, direct, service to the people of this state.

MISSOULA COUNTY

KATHLEEN D BREUER
CLERK OF DISTRICT COURT
200 W BROADWAY ST
MISSOULA MT 59802-4292

(406) 523-4780

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 33
DATE 2-10-95
BILL NO. SB249

DATE: 10 February 95

TO: Senator Bruce Crippen, Chairman
Members of the Judiciary Committee

FROM: Kathleen D Breuer, Clerk
President-Montana Clerks of District Court Association

RE: Senate Bill #249

We stand in opposition to Senate Bill 249. The Clerk of The Supreme Court is an extremely important position for the Justices as well as the people of Montana.

This office is the keeper of the Court record as well as the keeper of the Seal for the Supreme Court. The function of the office is to maintain all documents on appeal from every jurisdiction throughout the State. They must be kept properly to preserve that record, to ensure it is handled in a timely and precise manner. This office was established to keep accurate records separate and apart from the Court itself. Not only to protect the Justices, but also those who have deemed it necessary to appeal their cause to the Court.

The Justices are honorable, as we all in public service attain to be, however, as hard as we all try to remain steadfast in our duties, questions can and do arise from time to time, as to behaviors and personalities, in conflict or misunderstanding. To ensure we maintain that dignity of all, the Clerk MUST remain elected by the people of Montana, and be answerable to them. Thus ensuring proper procedures, protection and preservation of the record remains.

The Court already has an Administrator that works at the pleasure of the Court, and handles those administrative tasks such as statistical information (gathered from the Clerk of Court across the State), grants, budget and various duties UN-related to keeping the Court record. These are two very different and distinct positions and should NOT be inter-mingled.

If there is to be one staff person in charge of all positions, those duties of Court Administration should fall to the Clerk of the Supreme Court. The one answerable and ELECTED by the people of this State.

The Clerks of District Court across the State of Montana, thank-you for your attention to this matter and wise consideration this has placed before you.

We urge a DO NOT PASS on this bill and if you do have any additional questions, I would be most happy to answer them for you if I can.

Thank-you again Mr. Chairman and Members of this committee.

Montana State AFL-CIO

110 West 13th Street, P.O. Box 1176, Helena, Montana 59624

Donald R. Judge
Executive Secretary

406-442-1708

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 34
DATE 2-10-95
BILL NO. SB 249

February 10, 1995

Sen. Bruce Crippen, Chairman
Committee on the Judiciary
Montana State Senate
Capitol Station
Helena, Montana 59620

Dear Senator Crippen:

I was unable to attend the committee's hearing this morning on SB249 to eliminate the voters' right to an elective office of Clerk of the Supreme Court, replacing it with a political appointment. I would appreciate you entering this letter into the committee's hearing record on SB249.

Just last summer, delegates to the Montana State AFL-CIO Convention adopted a convention position against "attempts to reduce the direct accountability of government to voters by eliminating Montanans' right to elect their representatives." That same convention voted unanimously to oppose making our current elected offices appointive positions.

At a time when Montanans are demanding more accountability from their elected officials and more access to government, it is ironic that the Montana Legislature is entertaining constitutional changes that would eliminate the voters' right to directly elect their officials.

SB249 would remove the elected Clerk of the Supreme Court from the scrutiny of the voters and replace him or her with a political appointee, a friend of a politician, who would serve at the pleasure of politicians. The citizens of Montana would lose the right to pass judgment on the performance of the Clerk of the Supreme Court because, unlike elected officials, political appointees are answerable only to the politician who appointed them, not to the voters. Consequently, political appointments are occasionally used to reward political favors, to scapegoat for a political blunder, or to hide political activity that can't stand the bright light of public knowledge. We cannot guarantee that future Chief Justices will have the integrity and ethics of our current Chief Justices which is exactly why the office of Clerk was made elective by our forefathers: to protect the public access to the courts.

Furthermore, it is clear that any projected savings in tax dollars would evaporate when a future legislative session faces the cold, hard, documented fact that elected officials work for far less in pay and benefits than professionals, technicians or even qualified political appointees, all of whom can demand far better compensation in the private sector.

Montanans are demanding more openness in state government and the legislature should respond by providing them with more, not fewer, opportunities for public participation in government. For that reasons, we respectfully request the members of the committee oppose SB249.

Thank you.

Don Judge, Executive Secretary
Montana State AFL-CIO

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 35
DATE 2-10-95
BILL NO. SB 249

Legislative Fiscal Analyst
CLAYTON SCHENCK

Room 105 - State Capitol
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Helena, Montana 59620-1711
(406) 444-2986
FAX (406) 444-3036

STATE OF MONTANA
Office of the Legislative Fiscal Analyst

January 18, 1995

SENATE BILL 249

Representative Ed Grady
Montana House of Representatives
Seat #95
Helena, MT 59601

Dear Representative Grady,

As per your request, I have estimated the cost savings associated with elimination of the Clerk of Court, and transfer of that function to the Office of the Supreme Court Administrator.

As you can see from the attached worksheet, there would be a 1.0 FTE per year reduction and general fund savings of approximately $117,702 over the biennium if this proposal were approved. The savings calculation was developed assuming a July 1, 1995 effective date (the beginning of fiscal 1996). If the effective date were later than that, the FTE reduction and savings would be reduced proportionately.

If the Clerk of Court were eliminated, it is the opinion of the Supreme Court Administrator that the deputy position could also be eliminated. However, it would be necessary to add a supervisory position (which would also perform clerk duties) in order to oversee and manage that function. The 1.0 FTE reduction would be possible due to the transfer some duties currently performed by the Clerk of Court to the law library, the secretary to the Chief Justice, and through efficiencies achieved through automation already in place in the court administrator's office.

If you have any further questions, please contact me at 444-5834.

Sincerely,

Terri Perrigo
Senior Fiscal Analyst

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Clerk of Court
1997 Biennium Personal Services Budget

	FTE	FY 96	FY 97
Clerk of Court	1.0	44,834	44,834
Deputy Clerk of Court	1.0	46,345	46,707
Clerk	1.0	31,491	31,601
Clerk*	1.0	30,555	30,768
Total Current FTE and Personal Services Cost	4.0	153,225	153,910

*Includes double insurance benefits of 2,760 per year because position filled with two, half-time people.

Personal Services Costs
If Elected Clerk of Court is Eliminated and Function Assumed by Office of Court Administrator

Supervisory Clerk*	1.0	35,188	35,350
Clerk	1.0	31,491	31,601
Clerk**	1.0	27,795	28,008
Total Proposed FTE and Personal Services Cost	3.0	94,474	94,959

*Salary calculated at approximate grade 16 entry level salary of $28,000 with one-half of one percent increase in 1997.
**Less $2,760 per year for additional insurance cost associated with two, half-time employees filling this position.

Projected Savings
Upon Elimination of Clerk of Court Effective July 1, 1995

Total Current FTE and Personal Services Costs	4.0	153,225	153,910
Total Proposed FTE and Personal Services Cost	3.0	94,474	94,959
Total FTE and General Fund Savings	1.0	58,751	58,951

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SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 36
DATE 2-10-95
SB 249

THE SUPREME COURT OF MONTANA

JOHN CONWAY HARRISON
JUSTICE
Retired

JUSTICE BUILDING
215 NORTH SANDERS
HELENA, MONTANA 59620-3001
TELEPHONE (406) 444-5573

January 20, 1995

Senator Al Bishop
Senate District 9
State Capitol Building
Helena, Montana 59620

Dear Senator Bishop:

I am writing in support of LC 1333, an improvemnet for court organization. I regret that I cannot be in Helena to present this testimony in person, but after 34 years on the Supreme Court, I decided to spend some time in Arizona to enjoy the fruits of all the years of public service.

The functions of the clerk of the Supreme Court are indeed a very important part of Supreme Court operations, as the proper filing and processing of appeals, writs, and other matters are critical to the court and the public at large. Whether or not these functions are best placed with an elected clerk given the demands of the day is quite another matter. State government, including the judicial branch, is or should be undergoing progressive renewing, much of it needed to reduce the size and cost of government, and especially to enable government to function more effectively.

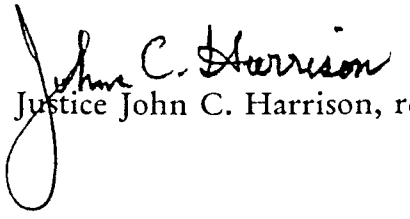
It is for these reasons, and more, that I strongly endorse and offer my support to LC1333. The duties of this office are more appropriately handled by appointment creating an office that is directly responsible to the court by creating an employer-employee relationship. The improvement would promote direct accountability for accuracy, efficiency and budgetary control. My years on the court have convinced me that the court must have direct, daily control over procedures used by the clerk and the flexibility to reorganize or redirect all court staff in all areas when court business demands. This bill gives the court that flexibility, and at the same time, saves money while improving organization.

From information provided by the National Center for State Courts, Montana is one of only two states that have elected clerks of the Supreme Court. This is not a

constitutionally created office, but rather one that may be adapted by the legislature to meet changing organizational needs.

This change is small compared to other consolidations being considered by the 54th Legislative body in the executive and legislative branches, but it is a logical way that the judicial branch can contribute to reinventing government and become more efficient in organization and prudent in spending public funds.

Respectfully submitted,



Justice John C. Harrison, retired

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 37
DATE 2-10-95
BILL NO. SB 249

January 21, 1995

Senator Al Bishop
Senate District 9
State Capitol Building
Helena, Montana 59620

Dear Senator Bishop:

From 1983 to 1988 I served as the elected clerk of the Montana Supreme Court. Reflecting on those fulfilling years of public service, the office underwent many changes and improvements. Always central in my mind was the public's right to have access to the court and the importance of accuracy of court records.

Since retiring, I have maintained an active interest in Montana's legal system and particularly the duties of the Clerk of the Supreme Court. I am aware of LC1333, a proposal to make the clerk an appointed rather than an elected position. Based upon my years of experience as clerk, and recognition of the present necessity to streamline and improve government organization, I offer my support for this bill.

The time has come for this office to embrace what other states decided to do long ago. Professionals, as well as my own common sense, tell me that the Supreme Court should have more daily control over clerical functions of this office. The Clerk of the Supreme Court does not make public policy, but rather performs a ministerial clerical function for the court. Though I have not done any calculations, my past experience would tell me that the improvements made possible by passage of this bill will bring savings to the court's budget and to the state. Additional, this organizational change would provide the court with more direct control over staffing levels, efficiency of operations and work flow.

All organizations, public and private, must restructure and improve with changing times, 1995 is no exception. I encourage the committee to vote for this bill, and thus equip the Supreme Court to work more effectively for the citizens of Montana.

Sincerely,

Ethel Harrison

Ethel Harrison
Clerk of the Supreme Court, retired

Amendments to Senate Bill No. 241
First Reading Copy

Requested by Senator Benedict
For the Committee on Judiciary

Prepared by Greg Petesch
February 2, 1995

1. Page 2, line 8.
Strike: "Prior"
Insert: "Beginning November 1, 1998, and prior"

2. Page 4, line 20.
Following: the first "a"
Insert: "coded marker in the"

3. Page 4, line 21.
Following: "a"
Insert: "coded marker in the"

SENATE JUDICIARY COMMITTEE
EXHIBIT NO. 39
DATE 2-10-95
SB 233

Montana Trial Lawyers ASSOCIATION

Russell B. Hill, Executive Director
#1 N. Last Chance Gulch
Helena, Montana 59601
Tel: (406) 443-3124
Fax: (406) 443-7850

February 10, 1995

Sen. Bruce Crippen, Chair
Senate Judiciary Committee
Room 325, State Capitol
Helena, MT 59620

RE: Senate Bill 233

Mr. Chair, Members of the Committee:

Thank you for this opportunity to express MTLA's opposition to Senate Bill 233, which further regulates the attorney fees paid by claimants--but not insurance companies--in workers compensation.

Background.

1. The attorney fees which claimants can pay in workers compensation cases are *already* regulated--by administrative rules, and unlike the fees by insurance companies to defense attorneys.

2. Since 1987, the fees paid to claimant's attorneys have ***come from claimants themselves, not from the pockets of employers, insurers, or Montana taxpayers.*** (See, for example, the fiscal note for SB 233.) In contrast, every penny of the fees paid to defense attorneys comes from the pockets of employers (who pay premiums directly) or Montana taxpayers (who subsidize Montana's work-comp system). Regrettably, work-comp *insurers are not even required to report the attorney fees which they pay* to defense attorneys, and so no comparison between claimant and defense fees is possible.

3. Claimants pay their attorney fees only when they obtain a recovery. Most

claimant attorneys, however (again unlike defense attorneys) *collect nothing at all if the claimant loses.*

4. Attorney fees paid by claimants are *declining dramatically*--and MTLA expects updated attorney-fee figures from the Department of Labor next week to reflect still further declines:

- Total settlement amounts paid to claimants *declined more than 30 percent* in the five years between 1988 and 1993. As settlement amounts decline, so do attorney fees calculated as a percentage of those amounts.
- Total fees paid to claimant attorneys *declined more than 40 percent* in the five years between 1988 and 1993.
- The number of attorneys involved in workers compensation cases is declining--more than 10 percent in the most recent year for which the Department of Labor has released settlement data. Fewer and fewer attorneys are willing to take new workers compensation cases because of drastically reduced benefits and the increasingly complex and unstable legal environment in workers compensation.

5. The recent closed-claim study of Montana's workers compensation system by Tillinghast demonstrated that *insurance companies treat claimants without attorneys) much worse than claimants represented by attorneys.* According to that study:

- Injured workers who rely on the State Fund average $27,670; injured workers who finally hire an attorney against the State Fund average $66,[illegible]5. (Ironically, whenever the State Fund also resorts to an attorney, the average medical and wage-loss payments climb even higher--above $74,000.)
- The average Montana worker *already waits more than three months* after being injured before the insurance company even admits responsibility. Workers who must deal with the State Fund face an average wait of 106 days, compared to 70 days for workers dealing with private insurers and 41 days for workers dealing with self-insured employers.
- The average Montana worker *already waits nearly five months* after being injured before the insurance company makes its first payment for wage losses or medical treatment. Workers who must deal with the State Fund face average delays of 160 days before their first medical bills are paid, compared to 64 days for workers dealing with either private insurers or self-insured employers.
- On average, the State Fund accepts responsibility for barely 27 percent of its paid claims within 30 days of the injury. In comparison, other work-comp insurers accept responsibility for 60 to 70 percent of their paid claims within 30 days of the injury.
- On average, the State Fund pays injured workers only 25 percent of their wage-loss benefits within 30 days of the injury. In comparison, other work-comp insurers pay 50 percent of wage-loss benefits within 30 days of the injury.
- On average, the State Fund pays injured workers less than 2 percent of their medical benefits within 30 days of the injury. In comparison, other work-

comp insurers pay about 40 percent of medical benefits within 30 days of the injury.

- On average, ***the State Fund takes a year longer than other insurers to close a work-comp claim,*** whether that time is measured from the date of injury or the date the insurer accepts responsibility.
- Despite such delays, and despite enormous financial hardships which pressure many injured employees to settle for cents on the dollar, ***THE AVERAGE MONTANA WORKER ALREADY WAITS MORE THAN 15 MONTHS AFTER BEING INJURED BEFORE RESORTING TO AN ATTORNEY.***
- Fewer than 2 percent of all work-comp claims in the study involved contested hearings. Fewer than 2 percent of all work-comp claims in the study went before the Workers Compensation Court. Fewer than 1 percent of all work-comp claims in the study were appealed to the Montana Supreme Court.
- Insurance companies disputed work-comp impairment ratings at about the same rate as injured workers.
- Not a single injured worker dared to represent herself or himself in a contested hearing or before the Workers Compensation Court. *There's nothing at all "user-friendly" about Montana's cumbersome, unstable workers compensation system.*

Senate Bill 233. In addition to the reasons stated above, MTLA opposes numerous specific provisions of SB 233:

1. By limiting attorney fees payable by claimants but not those paid by insurers, ***the bill severely tilts the playing field*** in disputed workers compensation cases. Although the accompanying amendment leaves intact many objectionable regulations upon claimant attorney fees, MTLA proposes the amendment in order to moderate the unbalanced impacts of SB 233.

2. Section 1, subsection (2), at page 1, lines 19-23, limits both hourly fees and contingent fees which an injured worker can pay to an attorney. It does nothing to limit the hourly fees or even the total fees which an insurance company can pay for attorneys.

3. Section 1, subsection (3), at page 1, lines 24-26, by limiting a claimant's attorney fees to 15 percent of "any benefits obtained, through the attorney's efforts, up to the date on which the claim is accepted by the insurer," ***terribly disadvantages claimants.***

Example: Insurer denies compensability. Injured worker retains an attorney on contingent-fee basis. Attorney researches and works the case for weeks, challenges the denial, and prepares for hearing. At the last moment, insurer admits compensability and agrees to pay full benefits--20 percent of which are already past due and 80 percent of which will become due in the future. Claimant's attorney can only collect fees on the 20 percent of benefits which are past due.

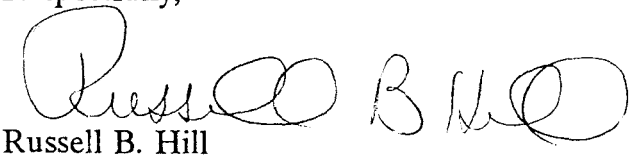
4. Section 1, subsection (4)(b), at page 2, lines 1-2, prohibits attorney fees for "benefits that are received by the claimant when the attorney has only assisted in filling out initial forms." *Ironically, in a workers compensation system which frequently treats claimants quite differently depending upon whether they have retained an attorney, this element of legal representation may be precisely the most important and effective contribution an attorney can make to an injured worker.*

5. Section 1, subsection (6), at page 2, lines 13-14, ***prohibits a claimant attorney from collecting hourly fees in unsuccessful cases*** and from collecting any fees whatsoever in advance of a final resolution.

6. Section 1, subsection (6), at page 2, lines 13-14, requires all claimant attorney fees to be paid out of benefits received by the claimant--even when the insurer has acted unreasonably and would otherwise be punished with a bill for those fees.

If MTLA can provide more information or assistance to the Committee, please notify me. Thank you again for this opportunity to express MTLA's opposition to Senate Bill 233.

Respectfully,



Russell B. Hill
Executive Director

EXHIBIT 39
DATE 2-10-95
SB 233

Amendments to Senate Bill 233
First Reading Bill (White Copy)

Requested by the Montana Trial Lawyers Association
For the Senate Judiciary Committee

Drafted by Russell B. Hill
February 10, 1995

1. Page 1, line 16.
Following: "claimant"
Insert: "or an employer"

2. Page 1, line 18.
Strike: "claimant"
Insert: "party."

3. Page 1, line 19.
Following: "(2)"
Insert: "Fees charged by an attorney representing a claimant are limited as provided by sections [3 through 6]. Fees charged by an attorney representing a party other than a claimant may not exceed $75 an hour, subject to a maximum fee of $7,500 per claim. The fee arrangement is subject to approval by the department."
Renumber: subsequent sections.

4. Page 2, line 13.
Following: "arrangement"
Strike: "and must be paid out of workers' compensation funds received by the claimant"

5. Page 2, line 22.
Strike: "the claimant gained due to the efforts of the attorney"
Insert: "paid"

Reason for the amendments: These amendments would limit fees payable by insurance companies. Although claimants would still be severely disadvantaged in their ability to obtain legal representation, the amendments at least apply some disadvantages to insurance companies as well.

Great Falls TRIBUNE

1993 Great Falls, Montana No. 145 — 109th Year 50¢

Closeup on taxes

Premiums outpace payout for private insurers

Improvements tied to reforms in work comp

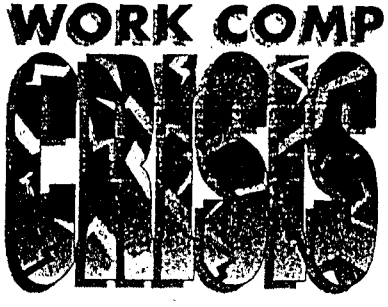
By MIKE DENNISON
Tribune Capitol Bureau

HELENA — In the midst of complaints about the high cost of workers compensation insurance in Montana, many private insurers are expanding work-comp sales here and watching loss ratios decline.

For some private insurers, the growth has been dramatic: Lumbermens Mutual Casualty of Long Grove, Ill., increased its earned premiums in Montana from $82,200 in 1988 to $10.5 million last year; Liberty Northwest Insurance of Portland, Ore., went from $385,000 to $3.2 million.

Their losses also increased, but were far lower than premiums collected in 1992, state figures show.

Insurers and the state's chief work-comp executive say the increase shows that reforms made in 1987 and 1991 are paying off,



reducing the cost of the work-comp system.

"The carriers are being more aggressive; they're coming back into the state, which I'm glad to see," said Patrick Sweeney, president of the State Compensation Mutual Insurance Fund. "You have a better system when you have a competitive system."

But the Montana Trial Lawyers Association and a labor spokesman say the figures aren't necessarily good news for everyone.

Don Judge, executive secretary for the Montana AFL-CIO, says private insurers are reaping returns from reforms that reduced or restricted benefits for injured workers.

"Workers have been hit the hardest by the changes and insurers have benefited the most," he said. "These highly profitable insurance companies reject the higher-risk employers, leaving them to be covered by the State Fund."

Russell Hill, executive director of the trial lawyers' group, says while private insurers — and their customers — are benefitting from reforms, the public has paid ever-higher costs to bail out the financially troubled State Fund.

"You've got to come grips that ... some of these companies are growing like crazy, and some money's being made here," he said.

See WORK COMP, 6A

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Work comp
Changes good?

FROM 1A

"Private insurance companies ... skim the cream off the top of Montana's workers compensation system."

Hill said the State Fund is forced to insure the worst risks in the state. As its financial condition deteriorated in the 1980s, the clamor for reform grew.

Reforms may have helped shore up the State Fund, but they also help private insurers, who don't share the same risks as the State Fund, he said.

The State Fund insures about three-fourths of Montana businesses for work comp, which pays benefits to workers injured on the job.

The rest of Montana businesses either buy work-comp insurance from private companies or are self-insured.

According to figures from the state insurance commissioner's office, premiums earned by private work-comp insurers in Montana increased from $49.8 million in 1988 to $56.5 million last year.

At the same time, losses incurred by private insurers declined from $35.8 million to $30.1 million.

Insurance experts say these figures aren't necessarily an accurate measurement of premiums-to-losses ratios, for they rely on calendar years instead of comparing losses to the year for which the policy was written.

But the figures are a fairly good indicator of the overall trend of work-comp insurance in the state, these same experts say. Loss-ratios in Montana have generally declined since about 1988.

Steve Beckham, director of government affairs for Liberty Northwest Insurance, said his company has increased business in Montana because it sees a good market here.

"We're there for the long haul," he said. "We've established a nice, solid base in the Northwest."

His company has been successful because it works with employers and workers to control losses, through safety programs and good customer relations, he said.

Lumbermens Mutual, part of Kemper National Insurance Companies, has increased its Montana work-comp premiums through national accounts that happen to do business in Montana, said Mark O'Brien, a special risks officer for Kemper.

"It's the policyholders who are benefitting from the reforms," he said of the changes in Montana work-comp law. "When loss experience shows a downward trend, I think everybody's a winner."

Comparing premiums to payout

A look at five private work-comp insurers in Montana.

1992

COMPANY	Direct premiums earned	Direct losses incurred
Lumbermens Mutual Casualty	$10,500,000	$2,400,000
Insurance Co. of North America	$4,000,000	$1,600,000
Liberty Northwest Insurance	$3,200,000	$1,500,000
Employers Insurance of Wausau	$3,400,000	$1,400,000
Standard Fire Insurance	$2,900,000	$1,400,000
TOTAL (for all privates)	$56,500,000	$20,500,000

1988

COMPANY	Direct premiums earned	Direct losses incurred
Lumbermens Mutual Casualty	$80,000	$10,000
Insurance Co. of North America	$540,000	$660,000
Liberty Northwest Insurance	$380,000	$190,000
Employers Insurance of Wausau	$1,520,000	$1,240,000
Standard Fire Insurance	$1,010,000	$1,920,000
TOTAL (for all privates)	$49,820,000	$24,750,000

"Direct premiums earned" are roughly equivalent to the net premiums collected by the company for a given year. "Direct losses incurred" are the anticipated and paid losses on claims submitted for a given year. These figures are for calendar years.

Insurance experts say figures based on "policy years" are more accurate, but that a calendar-year analysis over several years is usually an accurate portrayal of trends.

Source: Montana Trial Lawyers Association, State Insurance Commissioner — Tribune graphic

A primer.

Tribune Capitol Bureau

HELENA — Whoever coined the phrase "Figures lie and liars figure" must have had insurance companies in mind, for the labyrinth of insurance data often seems an impossible path to follow.

Of course, it's not impossible. One needs only to understand a few fundamental terms.

The language of insurance profit-and-loss involves three basic components: premiums, losses and reserves.

Insurers take in money by premiums charged to customers; they incur losses when they must pay claims. Insurers also earn income on their "reserves" — the unspent premiums that accumulate interest and other dividends when they're not being paid out in losses.

An insurer's "loss ratio" is figured by dividing premiums into losses. The lower the loss ratio, the better off the company. For example, if a company's loss ratio is 50 percent, it's paying out 50 cents in losses for every $1 in premiums collected.

Loss ratios can be figured for calendar years, but insurance experts prefer "policy years." The latter method compares losses against a policy for the year it provided coverage, rather than taking all losses in a given calendar year.

Figures on private work-comp carriers in Montana show an increase in premiums from 1988-1992 and a decrease in losses.

Insurance experts say that's a favorable trend for insurers, but it may not present an accurate picture of the future. If companies are writing more insurance now, losses won't show up until later, they say.

Of course, those losses also could be lower than anticipated, creating an even better loss ratio.

Montana State AFL-CIO
Donald R. Judge
Executive Secretary
110 West 13th Street, P.O. Box 1176, Helena, Montana 59624
406-442-1708

Testimony of Helen Christensen
before the Senate Committee on the Judiciary
February 10, 1995

Mr. Chairman, members of the Committee, for the record, I am Helen Christensen of the Montana State AFL-CIO. I am here today to urge your opposition to Senate Bill 233.

This bill suggests the use of a nuclear weapon to resolve a playground dispute, a solution far out of proportion to the size of the problem.

It appears that SB233 was crafted to remedy a single solitary situation involving a single work comp claimant who defrauded the State Fund, and lied to his attorney as well. After the State Fund had investigated, gone to court and lost the claim, they belatedly discovered the fraud. Then they went back to court to recover costs, not only from the fraudulent client, but from the clients' attorney who had no knowledge of the fraud and was only paid for the work he had done. The Supreme Court upheld the attorney's right to payment for his work.

Now we have a bill that would punish every attorney and every work comp claimant who disputes the finding of the State Fund because of that one case?

As with any insurer-client-claimant relationship, disputes will arise over work comp claims to the State Fund and litigation will become necessary. In no other similar relationship, however, does the law allow the insurance company unlimited access to legal representation and funding for those attorneys, yet requires the claimant -- before retaining counsel -- to not only choose from among the small number of attorneys willing to accept a limited fee but also prove that he or she is innocent.

Access to quality representation for an injured worker is already hampered by a law that unfairly discriminates in favor of a multi-million dollar insurance company. The bill before you further restricts access for the average Montanan by, in effect, telling every attorney in Montana that they must investigate any work comp client before accepting his or her case.

Where is the presumption of innocence? SB233 presumes the innocence of the insurance company while the injured worker is presumed guilty of fraud.

Where is the right to legal representation? SB233 gives the right to unlimited legal representation to the insurance company but restricts the right of the injured worker to counsel.

Why is this bill before you? One might see it as an attempt to "shift the blame." The State Fund and the Department of Justice have the responsibility and the resources to fully investigate claims and claimants and to identify those which are fraudulent. It is appropriate that the responsibility remain where it is and not be unfairly shifted to the private sector as another unfunded mandate.

Please vote no on Senate Bill 233. Thank you.

DATE 2-16-95

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: SB 241, 249, 233

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Al Ng. (Rud) Elwell	WSSA / NWAC	SB241	X	
Dave Martin	MT Democratic Party	SB249		X
GARY MARBUT	MSSA GOA CCRKBA WMFGA BSPS	SB241	X	
Bob Davies	self	SB241	X	
Bob Gilbert	MT ASSOCIATION OF Clerks of DIST. COURT	SB249		X
Norm Grosfield	Self	SB233		X
Russell B Hill	MT Trial Lawyers	SB233		X
Carl Swanson	State Fund	233	V	
Ben Everett	Attorney	233		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

SENATE JUDICIARY COMMITTEE

STATE OF MONTANA DEPARTMENT OF LABOR AND INDUSTRY EMPLOYMENT RELATIONS DIVISION P.O. BOX 8011 HELENA, MT 59604-8011	ATTORNEY RETAINER AGREEMENT	EXHIBIT NO. 41 DATE 2-10-95 SB NO. SB 233

INSTRUCTIONS: Complete the form and return all copies to Department for approval. Claim No. _____

Attorney: _____ Claimant: _____

_____ Address: _____

Address: _____ City/State/Zip: _____

City/State/Zip: _____ Date of Accident: _____

Phone: _____ Employer: _____

The above-named claimant hereby employs the above-named attorney and the attorney agrees to represent claimant in his claim for workers' compensation or occupational disease benefits arising out of an industrial accident or occupational disease suffered by the claimant on or about the above-noted day while employed by the above-noted employer, and claimant hereby requests that the Department of Labor and Industry enter the attorney as attorney of record, direct all future correspondence to said attorney and furnish said attorney all pertinent documents in claimant's file upon request.

Check A,B or C as applicable:

☐ A. Claimant and attorney agree to a fee schedule as follows:
For cases that have been settled without an order of the workers' compensation judge or the Supreme Court, twenty percent (20%) of the amount of additional compensation payments the claimant receives due to the efforts of the attorney.

For cases that go to a hearing before the workers' compensation judge or the Supreme Court, twenty-five percent (25%) of the amount of additional compensation payments the claimant receives from an order of the workers' compensation judge or the Supreme Court due to the efforts of the attorney.

☐ B. Claimant and attorney agree that claimant shall pay for services rendered by attorney on behalf of claimant at the rate of $_____ per hour (not more than $75.00 per hour); provided that the total fee shall not exceed the percentages set forth above in subsection "A."

☐ C. Application is made for approval of a variance from the guideline fees to charge at the rate of _____. Documentation for the requested variance is attached. If the variance is not approved, the attorney and the claimant agree to a fee of _____A or _____B, as set forth above.

Where the initial compensability of the claim is not in dispute, no fee shall be charged upon temporary total disability benefits paid during the healing period or upon medical benefits. If the insurer has denied liability, the attorney fee shall apply to all monies, including medical benefits, obtained for the claimant through the efforts of the attorney.

The following benefits shall not be considered as a basis for calculation of attorney fees:

(1) The amount of medical and hospital benefits received by the claimant, unless the workers' compensation insurer has denied all liability, including medical and hospital benefits, or unless the insurer has denied the payment of certain medical and hospital costs and the attorney has been successful in obtaining such benefits for the claimant.

(2) Benefits received by the claimant with the assistance of the attorney in filling out initial claim forms only.

(3) Any undisputed portion of impairment benefits received by the claimant based on an impairment rating.

(4) Benefits initiated or offered by the insurer when such initiation or offer is supported by documentation in the claimant's file and has not been the subject of a dispute with the claimant.

(5) Any other benefits not obtained due to the actual, reasonable and necessary efforts of the attorney.

The claimant agrees to pay or reimburse all costs incurred by the attorney in investigating and prosecuting the claim.

Claimant does hereby authorize the attorney to act on his behalf exercising all powers authorized by the laws of the State of Montana relating to the attorney-client relationship. It is understood by the claimant that the attorney may select co-counsel as the attorney believes necessary and expeditious in handling the claim, and that any payment received by co-counsel shall be made by sharing the above-referenced fee between the attorney and the co-counsel.

In the event a dispute arises between any claimant and the claimant's attorney relative to attorney's fees in a workers' compensation claim, upon request of either the claimant or the attorney, or upon notice of any party of a violation of Section 39-71-613, MCA or ARM 24.29.3802, the Administrator or his designee, shall review the matter and issue his order resolving the dispute pursuant to procedures set forth in ARM 24.29.201, et seq.

The attorney and claimant understand that the Department retains its authority to regulate the attorney fee amount in any workers' compensation case even though the contract of employment fully complies with Section 39-71-613, MCA, and ARM 24.29.3802

DATED: _____ Claimant acknowledges a copy of this agreement and agrees that a copy be filed with the Department of Labor and Industry.

LAW FIRM: _____

_____ CLIENT: _____

By: _____ SOCIAL SECURITY NUMBER: _____

LOWER PORTION TO BE COMPLETED BY DEPARTMENT ONLY

This agreement is hereby: ☐ APPROVED ☐ A ☐ B ☐ C ☐ NOT APPROVED

INITIALS _____ DATE _____

ERD050 (Rev. 12/93)

DATE 2-10-95

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: SB 241 - 249 - 233

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Nancy Sweeney	Montana Association of Clerks of District Court	SB 249		✓
Gary Todd	self	233		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

DATE 2-10-95

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: SB 241 - 249 - 233

< ■ > PLEASE PRINT < ■ >

Check One

Name	Representing	Bill No.	Support	Oppose
CHARLES J. LORENTZEN	SELF	292	✓	
Ann Brodsky	self	292		✓
MARK E. CADWALLADER	SELF	292		✓
Brad Martin	MT Dentists Assn	292		✓
Shirley Johnson	self	292		✓
Judy Sanderson	self	292		✓
Sandi Olsen	BPW	292		✓
Chris Imhoff	League of Women Voters of MT.	292		✓
Andrie Carose	Self & daughter, son & husband	292		✓
Shelly Griffin	self	292	✓	
Devon Hartman	self	292		✓
Holly Franz	self	292		✓
Sara Holmes	self	292		✓
Helen Christensen	MT AFL-CIO	249		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

DATE 2-10-95

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: SB 291 - 249 - 233

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Janice S. VanRiper	self	233		✓
Mary A. Arnold	Self	292		✓
Joe Sutton	Self	233		✗
Jim Hunt	SELF	233		✗
Thomas Sullivan	SELF	233		✓
Glenn Cox	MMIA MSOIA	233	✓	
Jim Stearns	Self	233		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

DATE 2-10-95

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: SB 292 - 241 - 249 - 233

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Cindy Frazer	MT NARAL	SB292		X
Jack Copps	CRLP	SB292		X
Dan Christensen	MT State AFL-CIO	SB233		X
Mark Mozer	Self	SB292	X	
Tim Whalen	Montana Right to Life	SB292	X	
Deborah Frandsen	Planned Parenthood	SB292		X
Anastasia Phillips	self	292		X
Connie Seiger	Self	292		X
Ed Tinsley	Lewis & Clark City Demos	292		X
Kay Foster	self	292	X	
Sandra Boggs	self	292		X
Debbie Lee	self	292		X
Peg Hurdle	women	292		X
Blondee Strayer	Self	292		X

VISITOR REGISTER

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REGISTER.F10

DATE 2-10-95

SENATE COMMITTEE ON Judiciary

BILLS BEING HEARD TODAY: SB292, SB241, SB249, SB233

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Judith Gerrose	DHES	292		
Laurie Koutnik	Christian Coalition of MT	292	✓	
SHARON HOFF	MT CATHOLIC CONF	292	✓	
Michael & Peggy Blumhagen	Self	292	✓	
Darci Heck	self	292	✓	
Cheryl Wicks	self	292	✓	
Robert M. D. Johnson MD	S/f	292	✓	
[illegible]	Self	292		X
Kate Chelan	MT Women's Lobby	292		✓
SCOTT CRICHTON	ACLU/MT	292		✓
Linda Rykowski		292		
Beth Lifeathley	Self	292		✓
Walt Dupea	Self	SB292	✓	
Georgia Blackmore	Self	SB292	✓	

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