

MINUTES

**MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION**

COMMITTEE ON JUDICIARY

Call to Order: By **CHAIRMAN BOB CLARK**, on March 20, 1995, at
8:00 AM.

ROLL CALL

Members Present:

Rep. Robert C. Clark, Chairman (R)
Rep. Shiell Anderson, Vice Chairman (Majority) (R)
Rep. Diana E. Wyatt, Vice Chairman (Minority) (D)
Rep. Chris Ahner (R)
Rep. Ellen Bergman (R)
Rep. William E. Boharski (R)
Rep. Bill Carey (D)
Rep. Aubyn A. Curtiss (R)
Rep. Duane Grimes (R)
Rep. Joan Hurdle (D)
Rep. Deb Kottel (D)
Rep. Linda McCulloch (D)
Rep. Daniel W. McGee (R)
Rep. Brad Molnar (R)
Rep. Debbie Shea (D)
Rep. Liz Smith (R)
Rep. Loren L. Soft (R)
Rep. Bill Tash (R)
Rep. Cliff Trexler (R)

Members Excused: None

Members Absent: None

Staff Present: John MacMaster, Legislative Council
Joanne Gunderson, Committee Secretary

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

Committee Business Summary:

Hearing: SB 292, SJR 16
Executive Action: None

{Tape: 1; Side: A}

HEARING ON HJR 16

Opening Statement by Sponsor:

SEN. JOHN "J.D." LYNCH, SD 19, made the opening statement that SJR 16 was a resolution which came as a result of his attempt to correct the problem of the delay in the appeals process. He explained that the Congress was going to enact reform to the appeals process. He felt that the states should be letting Congress know their frustration in the process and to encourage progress in making meaningful reforms. He quoted, "Justice delayed is justice denied."

Proponents' Testimony:

Chris Tweeten, Department of Justice, testified in support of SJR 16. He reiterated the proposed legislation before Congress and stated the reasons behind the current delays which need to be corrected. He supported the resolution as a message from the population of the state of Montana to encourage the passage of the reform of the appeals processes.

Opponents' Testimony:

None

Questions From Committee Members and Responses:

None

Closing by Sponsor:

SEN. LYNCH closed.

{Tape: 1; Side: A; Approx. Counter: 7.7}

HEARING ON SB 292

CHAIRMAN BOB CLARK limited testimony to 30 minutes for each side of SB 292. He cautioned the witnesses to be brief and respectful of the rights of others to speak without hinderance.

Opening Statement by Sponsor:

SEN. ROBERT "BOB" BROWN, SD 40, called this bill the "Women's-Right-To-Know Act." Because the decision to have an abortion is a major one with ramifications not only for the physical and psychological health of the mother and for the life of the unborn child, he said it was only right and proper that the state guarantee the mother access to all information relevant to her

decision. He said it was consistent for anyone who wanted to uphold the woman's right to choose to show equal vigor in ensuring that every woman considering abortion be provided all the information necessary to enable her to make a truly informed decision. He informed the committee that this rationale was upheld by the U. S. Supreme Court in the 1992 Southern Pennsylvania v. Casey case decision. He quoted directly from that decision, "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 ensure that a woman apprehend the full consequences of her decision, the state furthers the legitimate purpose of reducing the risk that women may elect an abortion only to discover later the devastating psychological consequences that her decision was not further informed. Requiring that a woman be informed of the availability of information 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 ensure an informed choice, one that might cause the woman to choose childbirth over abortion."

He thought it was clear that the Casey decision upholding a similar statute to the one being presented made it clear that it was within the purview of legitimately protecting the public's interests and the state's powers to do so, to provide information for informed consent such as provided in SB 292. He stated that opinion research proved that the American public overwhelmingly approved of the informed-consent concept. He said that eight states had enacted legislation based on the model of SB 292 following the Casey decision. He then reviewed the bill section by section beginning with the stated legislative purpose and findings on page 1 and then stated that beginning on line 8 of page 2 the purpose of the bill was outlined.

{Tape: 1; Side: A; Approx. Counter: 14.6}

He read the new section 4 and said section 5 basically provided that the act would not apply in case of a medical emergency. He said that section 6 was probably going to be amended but read beginning on line 23 which provided for flexibility in reporting. He read portions of sections 7 and 8. He explained that section 9 dealt with a case where the court would not allow briefs to be submitted in a dispute involving the constitutionality of this act. He reviewed section 11 and said it was a revision of the 1974 Abortion Control Act. He said the courts didn't find it constitutional until the Casey decision or perhaps the Webster decision. The Webster decision said it was reasonable for a state to place conditions on the right to choose an abortion and the Casey decision was more specific about what those conditions could be. The Pennsylvania law upon which the Casey decision was based is the model for the bill being presented. He said that section 12 was the penalties section and was the existing law and pointed out the underlined portion being added. The idea of section 13 was to leave the status quo alone as far as any other aspects. He stated that this bill would only

provide for informed consent and would not add or detract from the law other than that.

Proponents' Testimony:

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Linda Rykowski, Montana Right to Life Association, submitted written testimony in support of SB 292 as well as supporting documents. **EXHIBITS 1 and 1A through 1J**

Dr. Robert Whitesitt, Helena, Obstetrics and Gynecology (OB/GYN), stated that SB 292 would provide a waiting period to ensure that the woman contemplating an abortion would not be pressured into it without full realization of what she was doing and without knowledge of alternatives and without full knowledge of the procedure itself. He said that in Montana informed consent was composed of three elements: 1) information about the current condition and planned procedure, 2) discussion of alternative choices, and 3) information about the possible risks and complications.

He said that the first part must include an accurate portrayal of the stage of her current pregnancy including the size, development, etc. of the fetus. It needed to include the understanding that this was not just a tumor being removed and information about the procedure itself whether it was a dilatation and curettage, suction and curettage, lethal salt solution to kill the fetus or the new abortion pill being tested from Europe or the chemotherapy of methotrexate. The information should relate the method to the stage of the pregnancy as planned for the patient. In regard to alternative choices, the information provided should include other resources available such as adoption services, counseling or referral for financial help.

He said that he does not perform abortions but is often called upon to take care of patients who have suffered from complications from abortion and that he would only address those risks and complications he had personally seen. He described hemorrhage or infection as common complications which could lead to infertility or could be life threatening. He said that surgical complications can include perforation of the uterus, damage to the bowel, damage to the bladder, tearing or overstretching of the cervix causing incontinence of the cervix. Death or serious damage to the central nervous system complications could occur from shock, hemorrhage or septic shock, anaphylactic shock from anesthetic or drug-related causes. Psychological trauma often follows abortion, he asserted, in over 50% of the people undergoing abortion. Many are depressed and it is a much more prevalent result that was formerly recognized. There is a situation called the "anniversary syndrome" in which subsequent pregnancies will spontaneously abort at the time of

the therapeutic abortion or termination. He said that he had seen this happen.

He said a waiting period is the least that could be done to allow women to make intelligent decisions in this matter.

Kathrine Keller, Mrs. Montana 1994, presented written testimony urging support of SB 292. **EXHIBIT 2**

Dara Heck submitted written testimony in support of SB 292. **EXHIBIT 3**

Cheryl Wilke shared her testimony in support of SB 292. **EXHIBIT 4**

Peggy Blumhagen, RN, gave her personal testimony as a recipient of an abortion and the lack of information provided at the time of the procedure. She said she had no knowledge of fetal development, the birth process and had no experience in a problem solving process with a competent adult and no alternative options were presented. She said the potential complications were explained, but she did not know what a cervix was. She did not meet the doctor before the procedure which was explained by the woman who talked to her and explained the procedure while in progress. She said it was the greatest pain in body and soul that she had ever known and described the results of seeing the dismembered body of the baby after the procedure. She was given only some information about how to deal with possible physical after effects and she described the psychological consequences and physical consequences for which she was not prepared. She said that through her healing process from these consequences she realized that her abortion had affected herself, her family, and members of the community as a whole because it is a violation of public trust placed in the expectation that a mother would protect and nurture her baby rather than violence which result in the baby's death. She publicly asked for forgiveness and urged the committee to participate in enacting a law that would save many lives.

The time for the proponent's testimony had expired and the following proponents were asked to state their names and support of the bill.

Dr. St. John, Butte Obstetrician and Gynecologist, offered to answer questions during that portion of the hearing.

Sharon Hoff, Montana Catholic Conference, offered written testimony in support of SB 292. **EXHIBIT 5**

Laurie Koutnik, Executive Director, Christian Coalition of Montana, asked the committee to pass the bill so that women would really understand before they choose.

Arlette Randash, Eagle Forum, urged passage of SB 292. EXHIBITS 6 and 7

Charles Lorentzen presented written testimony and a petition in support of SB 292. EXHIBITS 8 and 9

Andy Klein offered written testimony in favor of SB 292. EXHIBIT 10

{Tape: 1; Side: B}

David Jachida, Kalispell, rose in support of SB 292.

Informational Testimony:

EXHIBITS 11 through 18 are letters in support of SB 292.

Opponents' Testimony:

Eliza Frazer, Executive Director, Montana Affiliate of the National Abortion and Reproductive Rights Action League (NARAL), said that NARAL was strongly opposed to the bill which she characterized as unnecessary and misleading. She said it purported to address a problem that women are at risk for abortion trauma syndrome and that they are vulnerable and do not have information causing them to be unable to make their own decision. She said that made her angry. She said that all who opposed the bill were in favor of complete and unbiased information. She said the bill did not contain findings but rather suppositions. She said it put the government squarely in the middle of a most private decision. She said there was no medical or psychiatric evidence that there is a post-abortion syndrome. However, she stated that there is evidence that waiting periods, in fact, increase medical risk as well as financial and personal problems for women to face. She stated that post-abortion trauma was a myth based on anecdotes.

She referred to an American Medical Association (AMA) article to support her position, **EXHIBIT 19**, and said that the AMA is opposed to waiting periods. Despite these facts, she said that proponents were asking for state "scripted" information to be provided though she believed that women were already well-informed. She said that this one procedure was being singled out for government intervention in provision of information where information on other procedures was not mandated, including the risks and complications of childbirth. She felt this legislation was promoting one side of the debate and decision and was therefore not unbiased. She believed it was taking a non-problem and creating medical problems. She also distributed an article for the committee's information as well as other supporting documents. **EXHIBITS 19A - 19C**

Deborah Frandsen, Planned Parenthood of Missoula, spoke in opposition to SB 292. **EXHIBIT 20** She provided the committee with written testimony from **Joan McCracken, Executive Director of InterMountain Planned Parenthood** and a special report. **EXHIBITS 21 and 22.**

Christine Phillips submitted written testimony to oppose SB 292. **EXHIBIT 23**

Kate Cholewa, Montana Women's Lobby, opposed the bill. **EXHIBIT 24**

Ann Broadsky testified in opposition to SB 292. She reported that she had had two abortions and that in both situations she had received more information from the provider than she had received from her doctor before she gave birth to her child. One of her pregnancies had been wanted and she spoke to the affect of this bill in similar situations where the abortion was chosen because of abnormalities in the fetal tissue. She did not feel that all the information which was given was necessary and was irrelevant to that situation nor did she believe it was necessary to wait 24 hours.

She strongly objected to the provision of the bill which would allow for legislative intervention in abortion. As a previous bill drafter and member of the legislative council, she felt this was the most inflammatory piece of legislation proposed. She believed it would extend government regulation where it was unneeded.

Sandra Hale represented **Dr. C. H. McCracken** of the Billings Clinic and read his testimony in opposition to SB 292 into the record. **EXHIBIT 25**

Melody Reynolds read letters from a group of physicians objecting to SB 292. **EXHIBIT 26**

Sara Holmes read a letter from **Scott Crichton, ACLU**, **EXHIBIT 27**

Questions From Committee Members and Responses:

REP. SHIELL ANDERSON asked the sponsor to provide copies of the Casey decision to the committee and the sponsor agreed to do so. He asked the sponsor to address page 3, line 23 of the bill and asked him to explain how the department would outline and draft objective psychological effects and from where they would draw their information.

SEN. BROWN said that would amount to giving some descriptions and possible psychological effects by using specific examples. He outlined some of those and drew from testimony in both this hearing and the Senate hearing on the bill.

REP. ANDERSON asked if the department would hold hearings for input to develop this information.

SEN. BROWN did not think that would be necessary.

REP. ANDERSON said he still would like to know who they would look to compile the information. He wanted to know what guidelines they would have.

SEN. BROWN answered that former Surgeon General, C. Everett Koop, [MD], would be a good source, contrary to the testimony of the opponents. He quoted Dr. Koop who said, "I've counseled women with this problem over the last 15 years." The quote included an anecdote about a woman who had a breakdown several years after having an abortion.

REP. ANDERSON asked if they would look to C. Everett Koop's analysis.

SEN. BROWN said they could and also referred to Dr. Whitesitt's testimony and also thought Dr. St. John could elaborate on the issue. He said there was ample evidence to support the existence of post-abortion syndrome.

REP. ANDERSON said he thought then that whatever the department deemed to be adequate would be what they would include as possible psychological effects.

SEN. BROWN answered that would be the case and they had information from eight different states which had enacted this type of legislation to draw from. He referred to an information booklet from the state of Pennsylvania as an example which might be drawn from. **EXHIBIT 28**

REP. ANDERSON referred to the inclusion of adoption agencies to be provided in the materials to be published and asked if it would be proper to also include abortion providers in the pamphlet.

SEN. BROWN replied that it would not be proper in his view because the bill stated that the printed materials "must be objective, non-judgmental and designed to convey only accurate scientific information about the unborn child at various gestational ages. The materials must contain objective information describing the methods of abortion procedures commonly employed, the medical risk commonly associated with each procedure, the possible detrimental psychological effects of abortion, and the medical risks associated with carrying a child to term." He felt that would adequately cover the issue.

REP. ANDERSON requested the sponsor turn to page 6 and asked for an explanation for including grandparents under the civil remedies section.

SEN. BROWN answered that the person having the abortion could be a minor or incompetent (perhaps even dead) to bring legal action and that this provision would give legal standing to her parents to bring the action.

REP. ANDERSON said that it also allowed the grandparents or parents to bring the action even if the person who had the abortion was competent but had no intention of bringing action.

SEN. BROWN did not read it that way, but provided for the case where she could not bring the legal action. If she was of the age of majority, the parents could not bring the action.

REP. ANDERSON asked why on line 7 there was a requirement for ten or more citizens to seek an injunction.

SEN. BROWN did not know and asked to refer the question.

Tim Whalen, Montana Right to Life, said the reason was to reflect public interest.

REP. ANDERSON asked if the department was not doing its job, would it not be adequate to have just one person raise the issue.

Mr. Whalen said that could certainly be the case. The intent was to prevent frivolous law suits against the department.

REP. DUANE GRIMES asked **Dr. St. John** to address the discrepancy in testimony regarding post-abortion syndrome.

CHAIRMAN CLARK relinquished the chair to **VICE CHAIR ANDERSON**.

Dr. St. John stated that he was an obstetrician and gynecologist in Butte and had also been in practice for 30 years. Besides delivering babies, he also said he took care of the risks, side effects and complications of abortions. He said he trained in an abortion-providing facility and it was one of his primary jobs to take care of the abortion problems. He said that at one time there were abortions performed in Missoula and Billings, but the complications were treated in Butte. He said that included at least one admission to the hospital there per week usually for infection or hemorrhage.

He refuted what was purported to have been said by C. Everett Koop. He said that what was actually said was, "when he [Koop] had reviewed all of the literature in the United States that was generated by the abortion industry pertaining to the risks of abortion and when he went back to President Reagan, he had to make the statement that he could not make a decision based on that research because the research was so biased and so unscientific that no good scientific decisions and conclusions could be reached." The witness said that to get good research conclusions, it was necessary to go out of the United States to

countries which had had abortions for years without the built-in biases here and which use good scientific research. He stated that most of those countries are behind the Iron Curtain. The reason was that they had a police state and socialized medicine. Under those circumstances, when a woman had an abortion she had to go to certain physicians and if they told her to come back, she had to go back. Their research showed that at least 25% of women suffered severe significant physical complications, he said. The health minister of Czechoslovakia had reported, "After one abortion a woman had a 25% less chance of ever carrying a baby to term than she had before the abortion."

He said that on top of that the psychological effects provide severe complication rate of 30% which they see in their office. He gave the following statistics:

25% of women show signs at sometime in their lives that they were infected at the time the abortion occurred.

2% - 15% of women suffer severe enough hemorrhage to require a blood transfusion (2% if the doctor is good, 15% if he doesn't know what he is doing).

up to 1% of women suffer from a perforated uterus at the time of the surgery. If the perforation is recognized at the time of the surgery, they might get away with it, but if not when the suction machine is turned on, other organs could be extracted.

recent research has linked a higher risk of breast cancer with abortions in very high numbers: abortions on persons below the age of 18 leave the person with the chance of developing breast cancer at some time in their life increased at 800%.

REP. GRIMES asked about the opponent's testimony about the risk of dying in comparison to childbirth.

Dr. St. John answered that in those statistics cited the maternal death rate is deaths occurring in pregnant women from the time that they conceive until 28 days after the baby is born. That maternal death rate included deaths from everything including car wrecks, heart disease--anything that kills the woman during that period--including death from abortion. He said that if they took deaths from abortion out of the statistics and compared it to the maternal death rate, the maternal death rate would obviously be higher. Ten to twenty women die every year in this country from abortion. In 1966 there were 289 deaths from abortion (statistics from the Center for Disease Control (CDC)). The death rate was coming down rapidly due to good medical care and antibiotics and blood transfusions. In 1941 there were 1,400 deaths in the U. S. from abortion. This included spontaneous abortions and criminal or induced abortions and ectopic pregnancy. The death rate fell precipitously after that date

with the introduction of sulpha and then penicillin. At the end of the 1940's there were 300 deaths and the rate continued to fall. After Roe v. Wade the death rate went up for a short time because the number of abortions increased from 100,000 per year to 1,600,000 per year. Then it continued to drop to the current level of 10 - 20 per year.

REP. GRIMES asked **Mr. Whalen** to address the confidentiality issue raised by the opponents saying the keeping of the records might somehow jeopardize doctors. He asked if it was a fact that they were trying to seek opportunity during this legislature to advertise in the yellow pages.

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Mr. Whalen said that was correct. He said there was a bill which displayed part of the abortion control act, a portion of which was held to be unconstitutional having to do with outlawing the advertising of abortion services. During the course of that hearing in the House Public Health Committee, the ACLU proposed an amendment to take out of the current provisions the prohibition of advertising the procedure because it was unconstitutional.

REP. GRIMES asked for an explanation for the right to intervention section on page 6.

Mr. Whalen said the sole purpose of that provision being included was two other pieces of major litigation in the state dealing with the issue of abortion in the last two years involved asking permission from the federal court to file an amicus brief so that a different perspective could be offered to the court with respect to the constitutionality. One particular case dealt with the Medicaid funding issue. On both occasions the court refused to allow those briefs to be filed and therefore there was no pro-life representation to the court.

In addition, litigation was filed by Planned Parenthood and NARAL asking that the "physicians only" portion of the Abortion Control Act not be enforced because the board of medical examiners had administratively allowed physician assistants to do abortions. The Attorney General entered into a stipulated agreement with the plaintiffs in that case, Planned Parenthood and NARAL, saying he would not enforce the provision of Montana law which is that only physicians can perform abortions. The result was that the candidate for attorney general ran on a pro-abortion plank and then entered into a stipulated agreement with Planned Parenthood and NARAL saying he wouldn't enforce the law. He asserted that it created a situation where people from the pro-life community could not get into that litigation and advance their perspective as well it prevented the potential of saving the state \$30,000 which the attorney general agreed to pay the plaintiffs. He doubted that would have been paid if the case had been litigated.

The purpose of the intervention provision in the bill was to ensure that some pro-life representation would get into those cases when the constitutionality is litigated. He said that the opponents of every abortion bill in this legislature would oppose anything that was passed. The provision was needed to defend what the legislature does in passing these bills, he said.

{Tape: 1; Side: B; Approx. Counter: 58.0}

REP. DEBBIE SHEA referred to **Dr. Whitesitt's** testimony about patients with complications which he had cared for. She asked if these complications were from legal abortions.

Dr. St. John said that since 1972 they were.

REP. SHEA asked if they see any patients who have self-induced abortions.

Dr. St. John had not seen many.

REP. SHEA asked if there were limits to abortions or if they were made illegal, would they be seeing a great deal more complications from abortions, self-induced or otherwise.

Dr. St. John replied they would see fewer because of numbers. The best estimate of the numbers of abortions before they were made illegal was 100,000. Now 1,600,000 abortions are performed and there is a complication rate with either kind. They see many more now than before.

REP. SHEA asked if he was saying there were more complications with legal abortions than with illegal abortions.

Dr. St. John said that in 1964 in Milwaukee, Wisconsin, he spent two years in the Milwaukee County Hospital where they took care of the complications from the so-called "back alley" abortions. They were not very common. The complications were common, but the numbers of abortions were so low and spread over the whole country that none of them saw very many in spite of what the representative had heard, he asserted.

REP. SHEA asked if that meant if they were to go back in time, they would not have the problems if they would make abortions illegal and that women would just choose not to have them.

Dr. St. John reiterated that there were 100,000 before and 1,600,000 now.

REP. SHEA asked how many years ago.

Dr. St. John said that it was before any abortions were legal in the United States. In 1967 the first legal abortion was performed in Colorado while the supreme court made them legal in 1972.

REP. SHEA asked if there was written documentation on the information he had provided.

Dr. St. John said he could give the information on the numbers of abortions as provided by the CDC.

REP. SHEA referred to the testimony where the remains of the fetus were displayed to the patient and asked if **Ms. Frandsen** had ever heard of such a thing.

Ms. Frandsen said she was reluctant to speculate on someone else's experience. She said the procedure at Planned Parenthood in Missoula is that they are not shown to the patient unless the patient specifically requested to see them.

REP. SHEA asked if she had ever heard of someone being forced to have the abortion when they requested to go home to think about it.

Ms. Frandsen answered, "No."

REP. SHEA asked about an amendment which had been mentioned regarding privacy in section 8.

Ms. Frandsen described the amendment that dealt with the reporting requirements which addressed her concern and the physician's concern that if the information were available as to what abortion providers performed the largest numbers and where they were performed that this would target a great deal of attention on those physicians. They believed that it opened up unnecessary attention particularly since there had been more murders of abortion providers lately and felt that this information should be privately held by the department.

{Tape: 2; Side: A}

REP. SHEA asked the sponsor for expansion on his concerns about physicians' anonymity.

SEN. BROWN replied that most of the physicians advertise in the yellow pages anyway and therefore don't keep what they do a secret. He said that he was aware that the discussions held between the AMA and **Mr. Whalen** pertained to anonymity and felt he could respond to that better.

REP. SHEA asked **Mr. Whalen** to respond.

Mr. Whalen said that there was a meeting following the hearing in the Senate between the Right To Life Association and the Montana Medical Association (MMA) to discuss that issue. The representatives of the Right to Life Association had expressed that they were not interested in creating problems for physicians in the release of their names if they did not want them published. Their main concern was that reporting requirements

were carried through by the department of health for development of statistical information. They then worked out language that the MMA was comfortable with on that issue and he had given that language to **REP. MC GEE**, who would carry the bill.

REP. SHEA asked if it had been discussed with Planned Parenthood. **Mr. Whalen** answered that he did not discuss it with them because the concern was brought to his attention through **SEN. BROWN** and then he was approached by **Jerry Loendorf** of the MMA. At the senator's request, he then met with the MMA where a letter was introduced from the president of the Montana group which is the counterpart of the American College of Obstetricians and Gynecologists who had expressed the identical concern. He said he did not see a need to go further.

REP. DANIEL MC GEE asked **Ms. Wilke** to speak to the committee about her awareness of post-abortion syndrome as to whether or not it is real and whether she has seen any evidence of it.

Ms. Wilke said that she had gone through it herself and had not known of its existence until she went through the severe depression afterwards [following an abortion]. She had sought counsel through the Blue Mountain Women's Clinic where she was urged to go. They had said they counseled for post-abortion syndrome and so she went and was charged \$60 per hour. She stated that she also works with several other volunteers at crisis pregnancy centers who had gone through the same type of trauma. As far as counselors dealing with women who had had abortions, she reported that they had all had similar cases and had not met one woman who had not gone through some sort of grief or trauma following the abortion. She also was affiliated with another organization, Women Exploited By Abortion (WEBA), which two years ago had 10,000 members. With the evidence she had read in addition to her personal experience and experience with other volunteers she had seen much of it.

REP. MC GEE asked how many crisis pregnancy centers there are in the state of Montana.

Ms. Wilke said she was not qualified to answer that.

REP. MC GEE asked how many people contact the crisis pregnancy center.

Ms. Wilke said that varies and that she does a lot of counseling personally out of her home as well.

REP. MC GEE asked **Dr. St. John** to speak to the concept of post-abortion syndrome.

Dr. St. John said that post-abortion syndrome was equivalent to post-traumatic syndrome which was defined after the Vietnam conflict and went back to at least the second world war where

people were called shell-shocked. He said that it takes a while after the trauma for the syndrome to develop. Therefore, it took a while after abortion became a reality for the syndrome to show up and for psychiatrists to relate it to the same kinds of symptoms that the Vietnam veterans had. The information from WEBA spells out the kinds of symptoms dramatically and he said that it is not just depression, but it is a syndrome which includes lack of self-worth, self depreciation, problems with suicidal gestures, suicidal intent and suicide eventually, drug use, breakup of families and inability to form relationships with future spouses and future children. The syndrome of the inability to relate to a replacement baby is common and there are problems with child abuse before they recognize it and get treatment.

REP. MC GEE asked if he was able to give the committee any statistics from his personal practice related to persons who deal with post-abortion syndrome.

CHAIRMAN CLARK resumed the chair.

Dr. St. John said that he and his partner deliver about 250 babies per year. He said that about one-half of the younger women they are presently seeing have had an abortion. He said that 10% of those have suffered some significant post-abortion syndrome and needed counseling and treatment and that another 30% to 40% relate history of depression and have been treated by their family practitioner or obstetrician with some minor drugs used [for depression]. In his practice, he would say that a number, 40% or 50%, suffer in different gradations of that syndrome.

REP. MC GEE asked him to address the statement by the AMA regarding the informed consent which was read by the opponents.

Dr. St. John said he was a member of the AMA and a past alternate delegate to the AMA as well as past president of the MMA. He said that he is a past alternate delegate because the AMA and the American College of OB-GYN over the past 15 years have become very pro-abortion organizations. He said it has happened because of a few abortion decisions which were made and some of the more pro-life doctors had become disgusted and dropped out. Therefore, their voice was lost. The particular study referred to by the opponents had come out of one of the councils which are hand-picked. Not all of the council findings are debatable on the House of Delegates floor or voted on. The study presented was based on the same abortion research which Dr. Koop said he couldn't rely on. It was a biased report and put in the *AMA Journal* which is controlled by the AMA.

{Tape: 2; Side: A; Approx. Counter: 11.5}

REP. DEB KOTTEL directed **Mr. Whalen's** attention to the rules of civil procedure 24 and the rules of appellate procedure 24 and

asked to clarify the difference between rule 24 under the appellate rules for filing an amicus brief and rule 24 of civil procedure for intervenor action. She asked if amicus meant "friend of the court" and he agreed. Then she asked if under the rules of civil procedure he could file the amicus brief with the written consent of both parties or by leave of court when granted on motion. She recalled from his testimony that he had made that motion and the court

Mr. Whalen interjected that he had made that motion on behalf of two separate organizations, one being the National Right to Life, on Medicaid funding, and Judge Hatfield declined to grant permission on both of them as that is discretionary by the court.

REP. KOTTEL asked if instead of writing the statute to change rule 24 and perhaps take away judicial discretion on filing an amicus brief, they could write the statute to give them a right of intervention. Under the civil rules in 24(a), Intervention as a Matter of Right, an intervenor is a party.

Mr. Whalen agreed that an intervenor is a party under that section and they had written it under that provision of the law because they have a situation where, "**Joe Mazurek** before you could even become a party to the action enters into a stipulated settlement with what was then the plaintiffs in that case. If we were in fact a party, we would also have to enter into that stipulation and so we could prevent the type of action that **Joe Mazurek** entered into with respect to that litigation."

REP. KOTTEL said they were asking for more than just the right to file amicus brief, but were also asking for the right to be a party. Then as a party they would have a right to have an attorney present and a right to be motioned on all events as well as a right to participate in the lawsuit itself and as a party the right to state their defense or claim. She said they were asking for a much broader involvement than just the right of an amicus.

Mr. Whalen replied that that was absolutely correct and this is limited to the cases where the constitutionality of these statutes are challenged. In that kind of situation they want the ability to fully participate and not just file a brief. The court may even limit what issue they can address with respect to the brief filed. But by actually being a party, there is the full participation which is absolutely critical in challenging the constitutional basis of the statute in question.

REP. KOTTEL asked if he knew of any other statute in Montana code which would give legislators a right to intervention when a party challenged the constitutionality of a statute.

Mr. Whalen said he did not because he had not researched it.

REP. KOTTEL referred to **EXHIBIT 28** and asked if that booklet would be sufficient in the state of Montana.

Mr. Whalen answered that he would be inclined to say it was not because it has information relative to Pennsylvania, but they would want to include with the fetal development of the child some specific Montana information.

REP. KOTTEL thought it was interesting that there were three pages on the medical risk of abortion, but only one half page on the medical risk of childbirth. She said she was curious about the balance.

Mr. Whalen replied that he was not present when the Pennsylvania department of health put that together, but that it was consistent with his knowledge of medical risks of abortion visavis the medical risks of childbirth.

REP. KOTTEL stated that a physician under the law would have to give out government-approved materials as part of the physician's package on informed consent as she read the statute and asked if that was correct.

Mr. Whalen said that was incorrect. The physician would have to let the woman know the material was available and then it would be at the option of the woman whether or not she chose to avail herself of the information.

REP. KOTTEL asked if he saw that the booklet did not warn a woman that there is an increased risk of breast cancer from abortion as was testified. She said it did not inform a woman about sympathetic spontaneous abortions. She asked if he saw a cause of action against the state of Montana for putting together materials which were not complete and asked if they would have to hire physicians to make sure to research all the data to be sure the informed consent was complete.

Mr. Whalen said he thought the only way the state of Montana could be liable was if they were somehow remiss in putting together the objective material which they were required to put together in terms of this bill. He said he would think that in order to avoid liability, they would want to take a look at whatever competent resources and medical literature might be available in putting together the material. As an aside, he said that as a lawyer, because of the numbers of court decisions which had been handed down in the last five to six years, it was virtually impossible to sue the state no matter what they do with it. He said it was called quasi judicial immunity and anytime a bureaucratic agency such as the department of health acts, the court is clothed under a quasi judicial immunity because they act in an administrative proceeding and the courts have characterized that as quasi judicial and given them immunity from suits. He thought, therefore, that any potential for liability regardless of what the state did was virtually nil.

REP. KOTTEL said, "Although you say the state would have to review all medical research to make sure the date was correct, it probably wouldn't make any difference because the state will be immune from lawsuits even though they don't give full information to the woman, correct...as I understand it."

Mr. Whalen answered, "What I would say is that if you are just talking about the possibility of litigation, my own view is they can do whatever they want and they are not going to be sued under the current state of the law. But with respect to your question as to what they should do under the terms of the bill, I think they certainly ought to survey competent medical studies that are available to make sure women are getting objective information."

REP. KOTTEL asked if a minor child were injured in any tort action by any tortfeasor and died or became incompetent, would the parent under current law have a right of action on behalf of the child.

Mr. Whalen answered that generally those kinds of actions are brought by a guardian ad litem and that was correct. In this particular case, they were specifically designated to be sure that would be allowed -- that the parent could bring that action. He said that it also provided that a spouse may do that.

REP. KOTTEL asked if later on page 6, line 3 or anywhere in subsection 7 that the woman must be a minor for the parent to bring the action.

Mr. Whalen said that it did not specifically say that, but **SEN. BROWN** had indicated that the purpose for that kind of provision was to make sure that it was made clear in the law that those individuals would have standing in the event of the incapacity of the person and would not have to be a minor, but could be someone otherwise incapacitated to where they could not make decisions on their own.

REP. KOTTEL asked if it said anywhere in the section that the woman had to be incompetent for the parent to bring the action on her behalf.

Mr. Whalen replied that it did not and that he did not think it needed to say that.

REP. KOTTEL stated that she read it to give an independent cause of action to the grandparents of the minor and asked if he wanted to state for the record that this does not in his mind do that.

Mr. Whalen asked her to repeat the question.

REP. KOTTEL said, "I read the statute to give an independent cause of action to the grandparents of the fetus, the unborn child. Would you like to state for the record that it is not your intent for this provision to do that?"

Mr. Whalen answered, "No, that's what the intent of the provision is in the event that the mother of the unborn child cannot act on her own; and I think that pretty clear from the legislative history that has been developed here so far."

REP. KOTTEL said, "I said an independent cause of action when a parent acts on behalf of the child, a minor, or a parent acts on behalf of an incompetent adult, the parent does not have an independent cause of action, the parent files as guardian of that person or guardian of the estate of the person, but it is that person's action."

Mr. Whalen answered, "I apologize, it would be a derivative action."

REP. KOTTEL asked, "No problem here if the grandparent was the father of the child?" She restated it, "In an incestuous relationship, any problem if the grandparent is the father of the child that you have given the grandparent an independent of action?"

Mr. Whalen replied, "First of all, I don't think that could ever be established because I don't know that you can establish paternity that no longer exists."

REP. KOTTEL asked, "You don't believe you could establish paternity on fetal matter."

Mr. Whalen answered, "Not in my understanding."

REP. KOTTEL questioned **Dr. St. John** about the physician training in scientific methods and asked if there was a difference between being pregnant and conceiving.

Dr. St. John answered that conceiving is the act of getting pregnant.

REP. KOTTEL asked how birth control pills work and if they stop conception or if they stopped the implantation.

Dr. St. John said that the information they have is that they stop conception and that they probably have an affect on cervical mucous to prevent the actual penetration by the sperm so that pregnancy never occurs.

REP. KOTTEL asked how IUDs work.

Dr. St. John replied, "Probably by causing the same kind of thing, they also cause some trouble with the cervical mucous so that the sperm don't penetrate and if the pregnancy does occur, they probably prevent implantation of the fertilized ovum."

REP. KOTTEL referred to page 7, subsection 1 under 50-20-104, MCA, and said she saw a significantly different definition of the

word, "abortion," and asked him to help her understand from a medical point of view why they had deleted, "the performance of, assistance or participation in the performance of, or submission to an act or operation intended to terminate a pregnancy without live birth" and had instead broadened it to the prescription of any medicine or drugs.

Dr. St. John answered that he did not know since he had not written the bill nor had participated in writing the bill. He said that he could address it from the perspective that abortions are caused by many more things than just doing a suction curettage.

REP. KOTTEL restated that she wanted to know from a medical perspective why it needed to be broadened to include medicine or drugs.

Dr. St. John answered that there were two medicines currently under research in this country which would cause abortion and he assumed that was what they referred to in medicine or drugs.

REP. KOTTEL asked, "So, by using the words, "medicine or drugs," those two, if approved, by the FDA would become illegal in Montana? (She amended so add "subject to this act.")

Dr. St. John replied that he was not a lawyer and would have to ask someone else.

REP. KOTTEL referred to various medical journals and asked if they were all reputable.

Dr. St. John answered that he assumed so, but did not know.

REP. KOTTEL stated, "These journals, using scientific methods, not anecdotal information or biased information from physician's practice, state in studies of British population, studies of U.S. population, that the incidence of post-abortion syndrome either occur at such a rate of 0.03 in 1,000 compared with 1.7 cases of postpartum depression after pregnancy....." She then quoted directly from one journal which concluded that the experience of abortion did not have dependent relationship to women's well-being and that there was not evidence of wide-spread post-abortion trauma. She asked if all those journals were wrong.

Dr. St. John said that she would have to provide him with the article and that he had no idea of what she was referring to and that she was taking it out of context. He therefore could not answer her question. He said that he did know that C. Everett Koop, MD, had problems with those kinds of reports just for that reason--they were biased.

REP. KOTTEL asked the sponsor about the two times in his opening which he referred to a guaranteed right of access. She asked,

"People just tell the woman the material is available, they don't actually give it to the woman?"

SEN. BROWN answered, "Yes, when she requests an appointment to possibly have an abortion and the information is available to her and she is given 24 hours to consider it. But obviously, she doesn't have to consider it and doesn't even have to accept it if she doesn't want to. But when she comes in for the abortion, if that is her decision, has to sign a statement indicating that the information was made available to her."

REP. KOTTEL asked why the statute did not allow the referring physician to give the information and allow her to consider it in the privacy of her home with her family and then sign the consent form as long as that informed consent form was signed 24 hours prior to obtaining the abortion.

SEN. BROWN responded that it did not even need to be signed 24 hours prior to the abortion, it could be signed when she came in to obtain the abortion and she could even receive the information in the mail by calling on the telephone and she could consider it in the privacy of her own home and then go in for the abortion if she chose.

REP. KOTTEL noted that the fiscal note included \$35,250. She further noted that the House had turned down \$50,000 which would provide contraceptive information to poor women. The statement on the floor of the House was that it was not the role of government to be involved in those issues. Even though it involved federal funds, it had an impact on the general revenue fund. Therefore, she had a hard time understanding the difference.

SEN. BROWN answered that he probably would share her problem with that. He said that if they would take the number of women who obtain abortions in Montana from statistics in 1993 or 1994 and divided it into the \$35,250, would result in something less than \$13 per woman invested in that information.

REP. KOTTEL said that the House had turned down the program on family preservation amounting to \$120,000 of state money to be matched by federal money which would reach out to young women in high risk situations and that the statement was made that government had no right to be involved in family issues. She asked how he reconciled that to this bill.

SEN. BROWN said he was not familiar with the issues and was not sure he could competently reconcile them. He said that if she would look at the information contained in the bill under section 4 which enumerated the information available to women considering abortion, it was clear that if the decision is made to go ahead and not have an abortion there ought to be information provided so that she would have the best information available on how to take care of the child.

REP. KOTTEL stated that she like informed consent, but would like to see it across the board. She asked if this were a statute brought which required physicians to give informed consent to outline terms on all serious conditions, she would approve it. She asked why on another bill heard in a different committee it was stated that physicians did not have to give informed consent and why there was nothing in any statute requiring a patient to be informed of the ramifications of other conditions and surgeries. She asked why the legislature was being involved here when they were not involved in any other medical situation.

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SEN. BROWN answered, "If you will go back in history, you will see that abortion has been legal and not legal at different times in history in ours and other countries unlike most other medical procedures. So it is a more litigious area of medicine or surgery than any other that I'm aware of and the Roe v. Wade decision, even though there was no specific right to privacy not in the Constitution, essentially made the right to choose an abortion a constitutional right. Since the Roe v. Wade decision, there have been other decisions, most recently the Webster decision and the Casey decision which have modified the Roe v. Wade decision, but they clearly put this kind of medical procedure in the realm of the courts and legislatures and that is why this legislation is needed to specifically address this issue and make it clear that women are entitled to information and an adequate amount of time to consider it before they enter into a decision that could affect them in the way that proponents and myself claim abortions can affect."

REP. JOAN HURDLE said that she had heard a great deal of rhetoric during this session about getting the government out of peoples lives and business and asked the sponsor if he had any qualms about state government putting words in doctors' mouths in regard to this issue when doctors were trained to counsel patients.

SEN. BROWN restated his previous answer that this is an area of the law that requires legislation along those lines which other areas of the law do not require.

REP. HURDLE said that she was offended by the term, "pro-abortion," and considered it a real tragedy and wanted to know what other legislation he had considered to prevent unwanted pregnancies.

SEN. BROWN said he did not know what that had to do with this legislation. He did not recall using that term and suggested she refer the question to someone whom she had heard use that term. He said he thought those who use the term are some of the opponents to this legislation.

REP. HURDLE said that Mr. Whalen used the term and that the accusation was made that our attorney general had run on a pro-abortion platform and that she found that very offensive.

SEN. BROWN repeated that he had not made that statement and suggested she question that person.

REP. HURDLE asked him if they could count on him to put the \$50,000 federal funds back in for family planning.

SEN. BROWN answered, "No, you certainly can't, the two bills _____ (inaudible)."

REP. LINDA MC CULLOCH asked for clarification if there was no place else in Montana law which mandated how pre-operative counseling must take place.

SEN. BROWN said he was not aware of any but he did not know that.

REP. MC CULLOCH said that she knew from a medical standpoint that usually the term in these situations for an unborn child is "fetus."

SEN. BROWN said he was aware of that.

REP. MC CULLOCH asked if he would have any problem with changing the term in the bill, "unborn child," to "fetus."

SEN. BROWN said he would because the term, "unborn child," was a more accurate description. The term, "fetus," he said, was a less personal term and did not accurately describe what they were talking about when they talk about an unborn child.

REP. MC CULLOCH stated, "Then in order to make this bill a little more personal, they would use the term, 'unborn child'."

SEN. BROWN responded that he thought it was more accurate and that they were talking about human beings. The term, "unborn human being," accurately described what they were talking about when others talk about it less personally as a "fetus."

REP. MC CULLOCH said she was curious about the fiscal note and wanted to keep in mind that the legislative body would bring less government. She discussed the 24-hour telephone number and in distributing the expenses for the various printed materials, and did not see a listing for the costs of the employees who would man the 24-hour number.

SEN. BROWN said he thought it was presumed that the information could be provided probably not by a person, but electronically.

REP. MC CULLOCH asked if it would list all the information across the entire state.

SEN. BROWN did not think it had to be lengthy and that this was in line with what is being done in Pennsylvania.

REP. MC CULLOCH said the bill provided that pre-operative counseling would be done by the physicians at the provider center and was concerned that the physician would not be as well-trained as a professional counselor. From her knowledge, a doctor's services are often much more expensive than a counselor and saw that this would increase the cost of the service. She asked why a doctor, and not a counselor, would provide the counseling.

SEN. BROWN outlined the procedure to include the woman contacting the clinic or the abortion provider and be told that printed information would be available to her and prior to actually having the abortion, the physician who would conduct the abortion would review with her the procedure and what it would involve as well as the affects it would have on her. If the abortion clinic had a counselor, they could have the counselor rather than the receptionist provide the initial material and go over it with the person and he thought that would be appropriate. He believed that the person who conducted the medical procedure ought to provide the information to the person who would receive it as is done now for other types of surgery.

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REP. MC CULLOCH said she thought the bill provided that the physician was required to counsel about the materials which were given.

SEN. BROWN said the physician would not be required to go to the reception room and talk to the person initially and introduce the material. But prior to conducting the abortion, he would discuss with the woman the specifics of what that procedure would entail.

SEN. MC CULLOCH said she thought it had been established that there is violence surrounding abortion clinics and that often a person having to go back more than once would afford the opportunity for someone who did not believe they should be having the procedure to have access for harassment. She asked what the sponsor would be doing to prevent this from happening.

SEN. BROWN said he agreed to an amendment proposed in the Senate to take care of that problem. The person would not have to go physically to the abortion clinic twice. She would only have to sign the certification that she had received the information prior to the time of the abortion and she could request it on the telephone or by mail.

REP. MC CULLOCH moved to page 9, line 15 of the bill and asked for an explanation of the provision for homicide.

SEN. BROWN explained that that was existing law as it pertained to premature infancy. The only amendment was the underlined

section beginning on line 20. It made it clear that the woman obtaining an abortion could not be prosecuted as the result of the changes made in the law if this bill were to pass and that the physician could not be prosecuted for not filling out documents they had not received.

REP. MC CULLOCH asked for an explanation about how the department of health would come up with the materials.

SEN. BROWN said that the National Society of Obstetricians, the AMA, the CDC would be some of the resources for the information. He thought that there was an attempt in the Senate to limit it to a few sources and he thought that was a mistake. He said the department of health needed to be given broader latitude to make the determination. He noted in the provision of the bill that the information had to be scientific and objective from whatever source.

REP. MC CULLOCH asked if he also thought they should provide information on psychological and detrimental effects of a woman giving up a child for adoption.

SEN. BROWN felt that in a general way that was covered and that he had addressed that previously and was adequately provided for in the proposed legislation.

REP. MC CULLOCH addressed the issue of child support and asked if it was fair to include in the bill that according to current statistics only 58% of women in single households in the United States are awarded child support and that of that 58% only about one-half receive the child support they are entitled to.

SEN. BROWN said it seemed to him that they would get into an inherent area of subjectivity when those kinds of things are addressed and would come under political philosophy. He did see the pertinence of accurately presenting that information.

REP. MC CULLOCH asked **Ms. Rykowski** to address page 2, line 2 of the bill in terms of statistics.

Ms. Rykowski said that was already provided in **EXHIBIT 1B**.

REP. MC CULLOCH asked if **Ms. Frandsen** could address the medical, emotional, psychological statements which were made in that regard.

Ms. Frandsen stated that she was not a physician, but the director of Planned Parenthood. She had the experience of her clinic and that it had performed 400 abortions last year and of those 400 only one woman was hospitalized and that case was due to an unrelated virus. The average complication rate in the United States was between 1% and 2% depending upon the method of determination of complications and depending upon how the numbers are viewed, between 7% - 14% times safer than childbirth.

Regarding emotional effects of induced abortion, she said that mild transient depression occurs in up to 20% of all women who have had abortions. However, she said that similar depression occurs in up to 70% of women immediately following childbirth. In unmarried women one out of nine experience post-operative depression and one out of four in deliveries. She said that more serious psychiatric disturbances, women who are at risk for enduring severe psychiatric disturbances following abortion, are those with previous psychiatric or abnormal obstetric history as well as those expressing ambivalence toward their abortions. She offered to share those studies with the committee.

REP. MC CULLOCH said the crux of the issue was informed consent. She asked what sorts of things they do now to provide informed consent as an abortion provider.

Ms. Frandsen answered that they given an extensive list of all the possible side effects, consequences, and complications for the procedure in the order of the most likely to the least likely. She thought it was important to note that in the last 23 years since abortion had become legal in Montana that not a single woman had died. She said that the physician's feedback forms regarding the question asking if they felt they had received enough information, almost everyone said they did receive enough information, a few said they received too much information. She said the committee should understand that they are morally, legally and medically obligated to give complete informed consent on every possible thing that could go wrong and said she would be happy to provide the list which is given to the patient. They review the list with the patient and check off that they have heard and understood each of the complications.

REP. MC CULLOCH asked the sponsor if he could look every woman in the legislature in the face and tell them that they are not responsible enough to make a medical decision on their own without interference from the state of Montana.

SEN. BROWN said it was troublesome to him as he imagined it was to other men who were required to have an opinion on the issue which applied only to women, but referred to the testimony from the four women who had indicated that they wished they had had legislation available to them at the time that they made the decision which they felt was very harmful to them. He said he could not say that the legislation would uniformly help all women, but that there was substantial evidence presented which indicated it would be important to some women.

REP. MC CULLOCH retorted that there had been enough testimony to refute that. She said she would have asked the question of anyone bringing the bill and not just because he was a man.

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REP. LOREN SOFT said that an opponent had stated that postponement would increase the medical risks and asked how 24 hours would increase the medical risks.

Dr. St. John said that the only way it would increase medical risks would be if there is an absolute medical emergency. There is a risk if the person waits weeks, but not 24 hours.

REP. SOFT asked if there were other invasive procedures apart from emergencies which were performed on the same day as the initial visit.

Dr. St. John said the only things that were done in the office would be removal of minor lumps and bumps. Any surgeries he scheduled were done days ahead.

REP. SOFT asked what the purpose of that might be.

Dr. St. John said it was just for this purpose; i.e., that the patient would be given the opportunity to understand it and have a chance to ask questions so that they were not left with any surprises and that was what he came over to testify to.

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REP. DIANA WYATT asked the sponsor if he believed that there is a psychological impact to an adoption.

SEN. BROWN replied that he did not see how and did not know where she was going with the question.

REP. WYATT asked him to provide her with statistical information on the psychological trauma to a lady who had given up a live child to an adoption agency and to other parents and the correlation of psychological problems she might have then and later in terms of trying to find the child.

REP. WYATT asked if the health department's research revealed objectively that there are positive ramifications to an abortion, would he accept those positive ramifications.

SEN. BROWN said he would not have anything to say about it, but department of health would obtain the information.

REP. WYATT asked if the data was gathered and it was impartial and it was determined that there are positive ramifications to
....

SEN. BROWN interjected that the bill showed what the requirements were for the scientific information to be included.

REP. WYATT stated that in the past in the United States women had to sign off on their husband's vasectomies and asked if he considered that to be something that women should be able to do.

SEN. BROWN said he saw that as having no relevance whatsoever to the bill.

REP. WYATT disagreed in that when someone can keep a person from having prostate cancer surgery for a couple of days based upon the fact that they do not have the intelligence to investigate nor will they sit down with people who love and care for them and discuss and analyze the consequences of prostate cancer, a vasectomy or a coronary bypass, that those were medical implications which happen to those particular patients. This is a medical implication, she said, that happens only to women and the implication is that they as a group of people don't have the sense to investigate that without the state's determination that they need 24 hours to discuss it and that they can't think of the questions to ask the physician. That was her objection to the bill. She did not want [men] to have to get permission for a vasectomy or a coronary bypass, and did not want [women] to have to gain permission for other surgical activity.

SEN. BROWN responded with the suggestion that she might want to introduce legislation to explore the issue which concerned her. The second response was that the biological fact was that it was within the body of a woman that the process of life begins and that was why women were more directly effected by this legislation than men were. He said he had indicated that he is sensitive to that, but as a man and a member of the legislature and someone who respects life whether born or unborn, he had to exercise judgement on it just as all other members of the legislature had to. Therefore, it was his right to bring it before the legislature just as it would be for her to introduce legislation directed at her concerns.

REP. WYATT commented that there was not objection to anyone bringing forth legislation that represented their constituency, but that when it attacks or looks at one particular group and not across the board in terms of medical procedures and other people were not assumed to not have the intelligence to make and research decisions related to them, it was discriminatory.

REP. AUBYN CURTISS said her concern was about children and asked what percentage of abortions were performed on minors.

Ms. Randash provided the statistics that in 1993 2,644 women aborted in Montana and of those 298 were under 18 years old.

REP. WILLIAM BOHARSKI noted that there were 14 female co-sponsors to the bill and that page 3 clearly indicated information on the medical dangers of live childbirth were also required. He asked the sponsor how closely the publications required by this bill would paralleled the statute in Pennsylvania.

SEN. BROWN said that there were models from Pennsylvania and Ohio and the publications would be fashioned along those lines and that the statute would parallel the Pennsylvania statute.

REP. BOHARSKI asked **Ms. Keller** if post-abortion syndrome exists.

Ms. Keller said it did, that at least she went through it, and that she knew many other women who had gone through it.

REP. BRAD MOLNAR asked **Ms. Frandsen** if her clinic was open seven days a week.

Ms. Frandsen said it was open 5.5 days a week.

REP. MOLNAR asked if she did not want to have people wait 1.5 days to come in to see them.

Ms. Frandsen said they don't perform abortions every day of the week and that they only perform them on one morning a week.

REP. MOLNAR asked which morning.

Ms. Frandsen replied that they alternate Thursdays and Saturdays. Her concern for the 24-hour waiting periods was that if a woman came for a pre-appointment on a Friday and it was determined that she was 13.9 weeks last menstrual period (LMP), they would not have the 24 hours because the following afternoon the physician would not be available. Essentially because there were fewer than 24 hours, they would have to turn her away from the procedure on the following morning and at that point, she would be in the early second trimester which increases the extensiveness of the procedure and the possible complications. Though this was not a particularly common experience, it does happen.

REP. MOLNAR asked what they tell a 14-year-old who is waiting for an abortion.

Ms. Frandsen said they would ask if she had told her parents or if she could tell her parents and they would encourage her to tell her parents and that they would help her do so. If she could not, they would want to know why. Then they would tell her all the other information they tell every other patient. She said that they give a great deal of time to a 14-year-old patient.

REP. MOLNAR asked if they use the term, "fetus," or "unborn child," when discussing the procedure.

Ms. Frandsen said they try to be medically accurate and use the medically accurate term, "fetus." Beyond that, counseling allows latitude and would use the terms that would be appropriate to the individual though they try to use all medically accurate terms, she said.

REP. MOLNAR asked how long the time would be between the 14-year-old entering the clinic saying she thought she was pregnant and that she wanted an abortion and the performance of the abortion.

Ms. Frandsen said it would depend upon her situation. When they have felt a patient was ambivalent they have sent her away to think about it. They never want to perform the procedure on someone who is not absolutely clear that is what they want. It also depends upon the circumstances of the patient such as where she lives and her last menstrual period.

REP. CHRIS AHNER asked if those who counsel in the clinic are licensed professional counselors.

Ms. Frandsen said they are not but are those who are hired and trained specifically to family planning and sexually transmitted diseases and related issues. If they believe they have a patient who has ambivalence or psychological problems where they do not feel adequate, they are referred to a counselor outside of the organization within the community.

REP. AHNER asked if she did counseling.

Ms. Frandsen said she was the executive director and she went through the counseling training but did not do the counseling.

REP. AHNER asked if another bill dealing with licensed professional counselors would affect this bill.

Ms. Frandsen said she was not familiar with that bill but that if it would affect them, they would comply.

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Closing by Sponsor:

SEN. BROWN summarized. He addressed the opponents' assertion that there was no need for this legislation and that procedures identical or very similar to the ones required by SB 292 were already being conducted by people who provide abortions. Therefore he begged the question, "What's the objection to the bill?" He said that if they say that these procedures are already being performed, then they were saying that there is a need to do it. Therefore, he said the opponents' testimony could almost be turned around as proponents' testimony.

He said that one of the opponents had said that post-abortion trauma syndrome was a myth. He reiterated his quote from C. Everett Koop, MD, and also the testimony of Dr. Whitesitt as well as the testimony of Dr. St. John which refuted that statement. But he said that what was really important was that the courts had recognized it. He re-quoted the Casey decision of the supreme court which made reference to "devastating psychological consequences."

{Tape: 2; Side: B; Approx. Counter: 19.4}

The 24-hour waiting period could be satisfied by a phone call or by mail. He said this legislation does not address the idea of choice. He said it is as legal to have an abortion if the bill passed or if it did not. It would not affect choice but only information. The purpose of the bill was to provide women information that they would need to make a very difficult decision and he believed it was unquestionably constitutional and based on the Casey decision which upheld similar legislation in Pennsylvania and eight other states had adopted similar legislation.

Motion: REP. MC GEE MOVED TO ADJOURN.

{Comments: The set of minutes is complete on two 60-minute tapes.}

ADJOURNMENT

Adjournment: The meeting was adjourned at 12:20 PM.



BOB CLARK, Chairman



JOANNE GUNDERSON, Secretary

BC/jg

HOUSE OF REPRESENTATIVES

Judiciary

ROLL CALL

DATE 3/28/95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Bob Clark, Chairman	✓		
Rep. Shiell Anderson, Vice Chair, Majority	✓		
Rep. Diana Wyatt, Vice Chairman, Minority	✓ 10 ⁴⁵	✓	
Rep. Chris Ahner	✓ 10 ⁰⁰	✓	
Rep. Ellen Bergman	✓		
Rep. Bill Boharski	✓		
Rep. Bill Carey	✓		
Rep. Aubyn Curtiss	✓		
Rep. Duane Grimes	✓		
Rep. Joan Hurdle	✓		
Rep. Deb Kottel	✓ 9 ⁴⁵	✓	
Rep. Linda McCulloch	✓		
Rep. Daniel McGee	✓		
Rep. Brad Molnar	✓		
Rep. Debbie Shea	✓		
Rep. Liz Smith	✓ 9 ¹⁰	✓	
Rep. Loren Soft	✓		
Rep. Bill Tash	✓		
Rep. Cliff Trexler	✓		



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EXHIBIT 1
DATE 3/20/95
SB 292

**MONTANA RIGHT TO LIFE TESTIMONY ON SB 292
BEFORE THE HOUSE JUDICIARY COMMITTEE
MARCH 20, 1995**

Mr. Chairman, Members of the Committee:

For the record, my name is Linda Rykowski, and I am the president of Montana Right to Life Association. Montana Right to Life is a state affiliate of the National Right to Life Committee, the oldest and largest Right to Life Organization in the country. The Montana Right to Life Association wishes to go on record in support of SB 292 introduced by Senator Bob Brown.

This bill provides that a woman who is considering aborting her baby be given information on:

1. The fetal development of her baby (in two-week stages);
2. The risks associated with the abortion surgery; and
3. The resources that are available from public and private sources that the woman can take advantage of if she carries her baby to term.

The bill also provides for a 24-hour reflection period to allow the woman time to digest the information she is furnished outside the coercive environment of the abortion facility. I quote from the American College of Obstetricians and Gynecologists' publication Committee Opinion (No. 61, March 1988) discussion on 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." (Emphasis ours.)

I ask you, how can a woman choose among options when she does not even know what her options are?

In closing, I would like you to know that our Association in consultation with our legal counsel and the National Association's counsel drafted the provisions of this bill, to ensure that its provisions were both constitutional and enforceable. Our local counsel worked closely with Greg Petesch in the Montana Legislative Council office in drafting this legislation so that it would properly dovetail with Montana law. Because of the fact that this type of legislation is so heavily litigated by abortion rights advocacy groups, this legislation has had to be carefully crafted to ensure its enforceability. Therefore, we request that you oppose any and all amendments that might be offered by opponents of this legislation, who do not want to see its provisions enforced.

Our legal counsel, Tim Whalen, is available to answer any questions the committee may have with respect to the legal aspects of this bill.

Please give Senate Bill 292 a DO PASS recommendation without amendment. Thank you.

Linda Rykowski, President

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.

ABORTED WOMEN 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.

THE PHYSICAL RISKS OF ABORTION

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

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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

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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 dilation 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, gastrointestinal 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 Rh-Gam 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

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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

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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. Willard 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 artificially 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 curettage

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 parurition 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.

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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 abortively rendered sterile by abortion. Most of these women are aborting a first pregnancy and will later be seeking a "wanted" pregnancy in vain.

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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*

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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."

This "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

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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.

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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, Barbara Lee 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

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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

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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-

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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.

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F O U R

The Psychological Impact of Abortion

Even more so than with physical complications, the psychological damage caused by abortion is practically impossible to quantify. Once again, the lack of comprehensive studies in America is due in part to obstructionism by abortion providers who keep few, if any, records.¹ But even assuming that complete records were kept, psychological complications are never easily quantified. By comparison, it is much easier to count scarred uteruses than scarred psyches.

As with physical complications, there are two distinct levels of dispute. On one level, some abortion proponents have confused the issue with numerous unscientific opinion papers insisting that psychological problems associated with abortion are a myth, but these efforts are so obviously biased that they tend towards the ludicrous.²

But even when more objective studies are done, the biases of researchers may still be evident, particularly in the ways in which they define "significant psychiatric sequelae" (aftereffects). For example, studies done by abortion advocates typically count only women *hospitalized* with mental breakdowns as victims of post-abortion sequelae, whereas anti-abortion researchers will always include women treated on an outpatient basis as well. Thus, while both pro- and anti-abortion researchers agree that some women are not capable of dealing with

post-abortion sequelae, they disagree as to whether psychological discomfort alone, even when bearable or intermittent, should be considered "significant."

Besides the dispute over defining "significant" sequelae, the process of documenting the rate of post-abortion sequelae is further complicated by delayed reactions. A woman that a six-month post-abortion survey declares "well-adjusted" may experience severe trauma on the anniversary of the abortion date, or even many years later. This fact is attested to in psychiatric textbooks which affirm that: "The significance of abortions may not be revealed until later periods of emotional depression. During depressions occurring in the fifth or six decades of the patient's life, the psychiatrist frequently hears expressions of remorse and guilt concerning abortions that occurred twenty or more years earlier."³ In one study, the number of women who expressed "serious self-reproach" increased fivefold over the period of time covered by the study.⁴

Often the delayed trauma from a previous abortion will rise in association with other causes for anxiety, including such incidents as the death of a loved one; the failure to conceive or the loss of a "wanted" child; the birth of a niece, nephew, or grandchild; or seeing a child or young adult who would be about the same age as the aborted child.⁵ Miscarriage of a "wanted" baby is a particularly common occasion for renewal of post-abortion anxieties. If and when the woman learns that the miscarriage may have been due to a previous abortion, the guilt and anguish can be overwhelming. In this sense, physical complications from abortion often contribute to psychological sequelae as well.

On an even longer timescale, it has been observed that latent anxieties over a previous abortion frequently surface only with the onset of menopause.⁶ This may be due to a woman's renewed awareness of her reproductive system and the realization that there will be no more opportunities to replace the pregnancy that was "lost."

Obviously, then, the validity of studies on post-abortion sequelae are heavily dependent on the stage of the post-abortion period which they examine. Surveys which are taken within the first few weeks after an abortion invariably show lower rates of emotional distress than those which are taken months later. One reason for this is that a short-term follow-up may record the patient's temporary relief or happiness at having the dreaded procedure finally over with, or at having the cause of the temporary embarrassment removed.

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A second, similar reason why short-term studies are skewed involves what psychiatrists identify as emotional paralysis, a post-abortion "numbness," which in itself may be an adverse reaction meriting psychiatric treatment.⁷ Like shell-shocked soldiers, many aborted women are unable to truly express their emotions. Their focus is primarily on having survived the ordeal, and they are at least temporarily out of touch with their inner feelings.

Third, short-term studies are of little use because many women, even those who are not "numbed" by their experiences, are simply unwilling to expose their emotional turmoil. The wounds of abortion, at this point, are too fresh, too tender to be probed. For this reason, a superficial post-abortion survey will record only what the patient *wants* to feel rather than what she really feels. As one abortion counselor admits:

Abortion is very emotional for everyone. The women think, Let's get it over with fast. They don't open up in counseling as they should. . . . So the trouble doesn't come out till afterwards and they just keep it all in. Post-abortion counseling doesn't do any good either, because if the woman has any regrets, admitting it will feed her guilt feelings even more. . . .⁸

The tendency to conceal negative feelings can be further accentuated by the desire of the aborted woman to say what she thinks the interviewer wants to hear. If the woman thinks the counselor wants to hear her say she feels "fine," she may say so just to avoid being considered "abnormal" and thus exposed to further probing questions.⁹

These insights were confirmed by a Canadian study, which found that short-term studies using questionnaires or routine post-abortion exams always underestimate the actual rate of negative responses. These psychiatrists found that women who answered the questionnaires responded much differently when professionally interviewed in detail. One reason was that women saw questionnaires as cold, and so they answered coldly, unemotionally, "without reaching down within themselves and searching for their inmost feelings." On the other hand, when women were questioned with psychotherapy techniques, they were encouraged to grasp their emotions, understand them, and express them.¹⁰

Furthermore, no matter how a survey is structured, timing limita-

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tions will always exist. For example, in one study conducted by a university hospital interviews with women four weeks after abortion reported that 94 percent of the women expressed "satisfaction that [the] right decision was made." But a six-month telephone follow-up found that the "satisfaction" rate had dropped to 85 percent.¹¹ No further follow-up interviews were done to see if the downward trend would continue with time. Indeed, the "long-term," six-month follow-up was still extremely short since most of the aborted women had yet to face the original delivery date or the anniversary date of the abortion—both of which, we now know, can trigger latent reactions.

The final difficulty in recording post-abortion sequelae lies in the ability of women to express the root cause of their mental pain. Even assuming a willingness to discuss their post-abortion misgivings, some women are simply not consciously aware of their inner conflicts. This is because denial and suppression of negative feelings is a common reaction to abortion. In one report, a psychiatrist treated fifty women who had come to him for problems which were supposedly *not* abortion-related. But after prolonged therapy, it was discovered that their disabilities stemmed from long-buried reactions to previous abortions. On a conscious level, each of these women believed that she had effectively resolved herself to her previous abortion. Each woman believed that the psychological turmoil which had led her to seek treatment was due to other situations in her life. But in fact, they each revealed under therapy that it was unresolved conflicts associated with their abortions, hidden at a subconscious level, which were precipitating the new problems in their lives. It was only after recognizing their repressed grief that these women were able to make progress towards improving their emotional and mental states.¹²

Women such as these who suffer from abortions at a subconscious level are "walking time-bombs," waiting to explode over situations seemingly unrelated to their previous abortions. In such cases, obviously, superficial surveys or questionnaires investigating abortion sequelae will not reveal this subconscious disorder created by abortion.

Given all these variables and uncertainties, a complete quantification of post-abortion sequelae is virtually impossible. But though it can be debated as to how frequently the impact of abortion is "severe," the personal testimony on both the pro-choice and pro-life sides demonstrates that the abortion decision and its aftermath are seldom, if ever, trauma-free. Doubts, discomfort, ambivalence and tears are the rule rather than the exception, as even many pro-choice advocates admit.¹³

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Psychologically, the ideal abortion is at best a neutral experience. No one looks forward to having an abortion, and even those who claim to be untroubled by it are generally anxious to avoid repeating the experience. The only positive feeling commonly expressed after abortion is an overwhelming feeling of relief. But even then, the relief which is felt is often as much relief at having the "ugly" abortion procedure over with as it is relief at no longer facing the "unwanted" pregnancy. Indeed, studies show that many women who express relief after abortion are simultaneously experiencing the mixed reactions of guilt, shame, fear, loss, anger, resentment, depression, and remorse.¹⁴ Women experience so many emotions following an abortion that the only safe thing to say is that it takes a long time for a woman to sort through them all.

With these points in mind, it should be indicated again that the figures from the studies which follow are *minimum* rates of psychological distress among aborted women.

Statistical Reports

As we mentioned earlier, the reported ranges for "severe" post-abortion sequelae vary by a wide degree. In a survey of available studies, the Royal College of Obstetricians and Gynecologists in England observed that, "The incidence of serious, permanent psychiatric aftermath [from abortion] is variously reported as between 9 and 59%."¹⁵ Naturally, the percentage is higher if one includes the "non-serious" and "non-permanent" aftermath.

The following is an assortment of figures given in various studies. The standards and definitions used in each study were different, and so the results cannot be added together or compared in any meaningful way. But the general trend strongly supports our own survey findings which show that significant post-abortion sequelae are common.

- A European study reported negative psychiatric manifestations following legal abortions in 55% of the women examined by psychiatrists.¹⁶
- In the *American Journal of Psychiatry*, researchers reported that of 500 aborted women studied, 43% showed immediate negative responses. At the time of a later review, approximately 50% expressed negative feelings, and up to 10% of the women

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were classified as having developed "serious psychiatric complications."¹⁷

- In one of the most detailed studies of post-abortion sequelae: "Anxiety, which if present after an abortion is felt very keenly, was reported by 43.1% . . . Depression, one of the emotions likely to be felt with more than a moderate strength, was reported by 31.9% of women surveyed . . . 26.4% felt guilt, . . . [and] 18.1% felt no relief or just a bit. They were overwhelmed by negative feelings. Even those women who were strongly supportive of the right to abort reacted to their own abortions with regret, anger, embarrassment, fear of disapproval and even shame."¹⁸ In another paper, the same group of psychiatrists reported that when detailed interviews were performed, every aborted woman, "without exception" experienced "feelings of guilt or profound regret. . . . All the women felt that they had lost an important part of themselves."¹⁹
- Another study of aborted women observed that 23% suffered "severe guilt." An additional 25% were classified as suffering from "mild guilt" and exhibited symptoms such as insomnia, decreased work capacity, and nervousness.²⁰
- One research project contacted 84 women who had received legal abortions two years previously and visited them in their homes. Four of the women were embarrassed and distressed and were unwilling to talk about it, 22 expressed open feelings of guilt, 9 were classified as consciously repressing guilt feelings, and 10 were classified as having suffered "impairment of their mental health."²¹
- One doctor reports: "Since abortion was legalized I have seen hundreds of patients who have had the operation. Approximately 10% expressed very little or no concern . . . Among the other 90% there were all shades of distress, anxiety, heartache and remorse."²²
- In a Canadian study it was found that up to 14% of aborted women later seek psychiatric help to cope with the abortion, and up to 10% of these were hospitalized.²³

Even the most biased pro-abortion surveys admit that severe post-abortion psychological trauma does occur. But these investigators insist

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that disabling sequelae are rare, occurring in only five percent of all aborted women. One researcher even claims that "disabling" psychiatric problems occur in "only" one percent of aborted women.²⁴ But dismissing even a one percent rate of disabling sequelae with an "only" is obviously unjustifiable when the number of women undergoing abortions each year has reached such large proportions. If "only" one percent of 1.5 million women suffer severe disabling psychic trauma from abortion, that means that each year 15,000 women are so severely scarred by post-abortion trauma that they become unable to function normally. Since this one percent figure is by far the lowest claimed anywhere in the literature, the actual rate of disabling sequelae is probably much higher.

An Inside Look

Statistics can be looked at and argued about ad infinitum. But they are really valid only as indicators. The real issue is not exactly how many women suffer, but that they *do* suffer. The first several chapters of this book revealed how women themselves feel they have been affected by abortion. In this section we will take a closer look at some of the major categories of post-abortion sequelae, and at how these reactions are analyzed by psychiatrists.

Guilt and Remorse

Feelings of guilt are among the most common reactions to abortion. Sometimes the feelings of guilt are vague. Other times they are quite specific, as when a woman states, "I have murdered my baby." Often the belief that abortion is murder exists even before the abortion, yet the woman proceeds despite her qualms.²⁵

Many studies have shown that unapproving attitudes towards abortion are very prevalent among aborters. Zimmerman's study, as discussed earlier, found that fully 70 percent of aborting women expressed general disapproval of abortion.²⁶ Another study which concentrated on unmarried adolescent aborters found that 34 percent believed abortion was wrong except for the "hard" cases such as rape, incest, or saving the mother's life. Yet despite their moral disapproval of abortion in general, many young women tend to rationalize themselves as "exceptions" to the rule.²⁷ This "exception" clause was enunciated by one girl who after an abortion said: "It's murder, but it's justifiable murder."²⁸

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Cases like these demonstrate a conscious awareness of a moral compromise. Those who submit to an abortion, even though it violated their consciences, feel that they have "copped out," betraying their values and themselves.²⁹ As one woman said: "We were convinced that the abortion was the best thing rather than the right thing. If you asked me how I felt about abortion, I would say I was against it. I feel very hypocritical."³⁰ All of this, of course, represents a severe attack upon the self-images of aborted women. It makes them feel that they are "too weak" to live the way they would want to.

Traumatic feelings of guilt from abortion have been recorded decades after the fact. Such "blood guilt" does not easily dissipate with time. Those who mention God in speaking of their guilt express two points of view. Some believe that they are forgiven by God but cannot forgive themselves. Others believe that God is punishing them through infertility, miscarriages, or through other emotional conflicts in their lives.³¹

This view that guilt feelings arise from within runs counter to the claim by some abortion advocates that guilt over abortion occurs solely because of the Christian "hang-ups" of Western civilization. If society approved of abortion, they claim, women wouldn't feel guilty. But this claim is hard pressed by the evidence from Japan, which is not a Christian culture and has had abortion-on-demand for several decades. Yet surveys there show that guilt feelings are still prevalent. According to one survey, 73.1 percent of Japanese women who have had abortions report "anguish" about what they have done.³² Furthermore, 59 percent felt that abortion is something "very bad," 16 percent felt it was considerably bad, 17 percent felt it was somewhat bad, while only 8 percent thought it could not be considered bad. Repeated Japanese surveys showed that slightly over half believed that abortion "is bad, but cannot be helped."³³

Guilt, it would seem, is crosscultural, rising from interior discomforts rather than from exterior expectations. Though abortion proponents will continue to claim that guilt is a social "hang-up," such claims do nothing to alleviate the pain and doubts of those who are afflicted by remorse.

Finally, it should be noted that psychiatrists believe that feelings of post-abortion guilt may eventually cause psychotic conditions if the woman's personality is not well enough integrated to handle the stress.³⁴

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Broken Relationships and Sexual Dysfunction

Abortions almost always result in changed attitudes toward sexual partners, usually for the worse. This fact, though never mentioned in abortion counseling, is recognized by both sides of the controversy. Pro-choice advocate Linda Bird Francke notes that almost every relationship between single people broke up either before or after the abortion.³⁵

Women who have abortions, if not actually abandoned by their partners, often *feel* abandoned. This results in anger at boyfriends or husbands whom they feel failed to support or help them continue with the unplanned pregnancy. They may resent their partner for his unwillingness to "want" the baby.³⁶

Women frequently feel that their partners forced them to have their abortions. Sometimes this is literally true; often it is more symbolic. Any hesitation on the part of the father to accept the pregnancy, or a statement such as "I'll go along with whatever you decide," is perceived to imply a preference for abortion, if not an insistence on abortion. Indeed, any failure on the male's part to be happy about the pregnancy may be interpreted as negativism. Since the father's attitude is a leading determinant in a woman's abortion decision, such negativism, whether real or imagined, may be the decisive factor in the abortion decision, and thus a continuing source of resentment within the relationship.

Confusion and resentment, on the other hand, can also develop on the male side of the equation. Conditioned to believe that abortion is solely the "woman's choice," many men hesitate to express their doubts about abortion, or even their excitement about being a parent. They believe that to be good partners and "liberated" lovers, they should express only support for her decision, no matter what she decides.³⁷ In such cases, the man may unwittingly add to the pressure to abort. Failing to urge childbirth, the man leaves the woman feeling isolated or forced to bear the weight of the decision alone. In the meantime, the man himself may inwardly feel frustrated and angry about being "helpless" to prevent the abortion.³⁸ Such failures to communicate openly about the abortion decision are due in part to the pro-choice rhetoric of our age. When either partner remains silent about his or her ambivalence, seeds of resentment are planted which will later emerge as a severe strain on the relationship.³⁹

Sometimes women interpret the post-abortion silence and withdrawal of their partners as coldness and insensitivity, when in fact the male, too, is suffering from feelings of remorse, guilt, and loss.⁴⁰ Though each partner may have anticipated grief over the abortion, each becomes determined to accept the abortion and overcome their grief for the sake of the other. Suffering separately, they are unable to share their remorse openly without falling into accusations. One suspects that if these couples had been able to freely communicate their mutual doubts about abortion in the first place, many would have decided against it. But the choice of abortion is not an easy topic to talk about. Indeed, many deliberately hide their feelings simply because they don't want to talk themselves out of "the practical thing to do."

Another seed for future conflict is planted when a man deliberately thrusts the weight of the decision upon the woman because he is unwilling to accept responsibility for it. This may be done because the man feels that abortion would be "convenient," even though he consciously believes it to be morally wrong. In such cases, the male may want to "wash his hands" of responsibility by insisting that it is "her body and her decision." By abandoning her to make the decision alone, he can rationalize his own innocence on one level, while on another level his isolation pressures her towards the abortion—pressure which might be increased by complaints about how *she* became pregnant. In other words, he wants the abortion, but he wants to deny responsibility for it, too.

In cases like these, however, the woman is usually aware of the duplicity, at least on a subconscious level. Though the feeling of isolation may drive her into the abortion option, she will seldom emerge without resentment towards the person who forced her to make the decision alone.

The overwhelming weight of evidence indicates that abortions performed with the hope of saving a relationship seldom succeed. If either person is unhappy with the abortion choice, or if either accepts it merely out of compromise, bitterness and resentment inevitably develop.

Abortion, it seems, always underscores the weaknesses in a relationship. As an act of conditional love which reflects an unwillingness to accept an inconvenient child, abortion also implies that the love between the adults, too, is conditional. It implies that the relationship is viable only as long as each partner is *convenient* to the other, only as long as their separate aspirations and careers are compatible. Thus the

question of "should we have a child?" slips quickly into "should we continue this relationship?" (Choosing to keep the child reaffirms the relationship; choosing to abort calls the relationship into question. Especially when it is the first child of a couple's union which is being aborted, the abortion symbolically represents an unwillingness to make a deeper commitment to each other. By denying the union of their flesh, the couple denies any long-range commitment to each other.)

One woman, very conscious of how a child increases the bond between parents, deliberately chose abortion as a means of keeping open the possibility of divorce, even though she actually wanted a child.⁴¹ And in still another case, a woman chose abortion out of spite for her partner, not because she was unwilling to bear the child.⁴² In a case like this, the fetus is not seen as part of her body, but as a part of *his* body which is to be punished, destroyed, and expelled. Abortion is used not as a tool for liberating herself, but for wreaking vengeance on him.

Sometimes resentment is aroused over who "caused" the pregnancy, with each blaming the other for having failed to take proper contraceptive measures. Or if contraceptives were used, the couple may blame the failed contraceptive. In either case, abortion is something they feel compelled to undertake because of the contraceptive failure. Again, the abortion is not seen as an act of free choice, but as an unwanted "necessity." Abortion thus makes both man and woman feel like victims of the system, rather than liberated human beings.

In short, some level of discontent about the abortion decision always exists. And once it enters a couple's lives, its memory is a source of conflict within the relationship which can be renewed at any time. Particularly when one knows that the abortion is a sore point for the other, references to it and accusations become a weapon to belittle and hurt the spouse in later conflicts, months and even years later.⁴³

Abortion strains relationships on a sexual level too. Frigidity is a common problem following an abortion, possibly because avoiding sex seems like the best way to avoid repeating the abortion experience. According to two studies, sexual coldness was expressed by 33 percent of aborted women within nine months after their abortions, and an additional 14 percent developed sexual coldness four to five years later.⁴⁴ Post-abortion shock may also result in impotence on the part of the male, sometimes only with the woman he had impregnated, other times with all women.⁴⁵

Because abortion disrupts the woman's natural reproductive cycle,

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it may cause her to experience confusion about her sexual identity. Fears of infertility are common, and many women feel compelled to "prove" their sexual femininity. In these cases, rather than becoming frigid, aborted women may become promiscuous, even to the point of seeking replacement pregnancies. But even the replacement pregnancies may be aborted in a cycle of approach-avoidance conflict, causing still greater inner conflict, anger, and a sense of self-destructive martyrdom.⁴⁶

Psychiatrist Theodore Reik has suggested an analogy for understanding the psycho-sexual trauma of abortion. For the woman, Reik suggests, abortion has an unconscious meaning comparable to that of castration for a male. It is an assault on her fertility and sexuality which may embitter her towards her partner.⁴⁷ This analysis would seem particularly accurate in the case of a woman who contacted the Pregnancy Aftermath Hotline in Milwaukee, Wisconsin. Distressed about a previous abortion, she told the hotline counselor that she felt the abortion had "castrated" her, leaving her with the feeling she was an asexual "amputee."⁴⁸

Depression and a Sense of Loss

Depression and a sense of loss are extremely common after abortion. These "post-abortion" blues generally fade within a few months, but prolonged, deep depressions are not uncommon. Some of these deeper depressions may be unmanageable, causing an inability to concentrate or work. Some women report feeling completely immobilized by their emotional state and unable to "get interested in anyone or anything since the abortion."⁴⁹

Uncontrollable crying is often part of post-abortion depression. Daily crying may continue for years, sometimes lasting for hours or days at a time.⁵⁰

Most women report a "sense of loss" following their abortion. They feel empty. They feel they have lost the "family I could have had." Those who report this symptom describe a number of related reactions such as the inability to look at other babies or pregnant mothers, or a jealousy of mothers. Many consciously seek a replacement pregnancy. This sense of losing a child may be exasperated by the perception of lost relationships, either the loss of a boyfriend or a deteriorating marriage.⁵¹

One study into the factors which motivate women to become surrogate mothers found that a disproportionate number of these vol-

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unteer mothers had previously been aborted. According to the author of the study, Dr. Philip Parker, "Some women said they wanted to be surrogates to atone for the guilt associated with previous abortion. . . ."⁵²

Another psychiatrist has noted that the frequency and degree of severe depression associated with abortion is far higher than with miscarriage, even though the loss in each case is comparable. He suggests that while a miscarriage is regarded as an unfortunate accident resulting in disappointment, regret, and a sense of loss, an abortion is the result of a premeditated choice. He adds, "Even more important is the woman's realization that she is responsible for a decision which must sacrifice some important goals and values (motherhood and the value of life) in order to sustain or attain other beliefs or achievements (career, self-determination, independence.)" Though legalization has reduced the sense of guilt coming from society, it has been "at least partially replaced by an intrinsic awareness of responsibility" which increases self-accusation and self-guilt in making this compromise between conflicting values.⁵³

Deterioration of Self-Image and Self-Punishment

Abortion often creates feelings of low self-esteem, feelings of having compromised values, having "murdered my child," and so on. The damage abortion inflicts on a woman's sense of confidence and self-respect is even worse when these traits are already weak. For such an "unaffirmed woman," the "consequences of induced abortion . . . consist always of a deepening of her feelings of inferiority, inadequacy, insignificance, and worthlessness."⁵⁴

Rather than having their egos strengthened by a society which says "You can be a good mother—you can succeed," many women are encouraged to abort by a society which insists "You can't afford a child. You're not mature or stable enough to raise children. It is better to abort the child than force it to live under your inadequate care." Thus the offer of abortion becomes an implied criticism that deflates an already weakened ego. According to psychiatrist Conrad Baars, encouraging such women to abort "constitutes psychic murder."⁵⁵

If we seek to protect and promote the mental health of women facing problem pregnancies, Dr. Baars points out, we should concentrate on offering positive, affirming support, not abortions. To affirm an unaffirmed woman, he argues, "means to accept her in her helplessness and thus also to recognize that she is not guilty of her psychic

inability to welcome the child in her womb." True acceptance and love allows her to be dependent; it does not force her to feign independence or self-sufficiency. The offer of positive, life-affirming aid (affirming the value of the mother's life as well as that of her unborn child) can often be the beginning of new psychic strength and freedom. With such optimistic support, a woman faced with a problem pregnancy will no longer feel trapped by her situation and condition, no longer feel threatened by her unborn child. "But to advise her, or to insist, that she have an abortion," he concludes, "is tantamount to conveying to her that she is indeed the inferior, inadequate, and worthless person she had always felt she was, a person who could or would not even give the child within her its own life. . . ." ⁵⁶

Psychoanalysis of women experiencing post-abortion trauma has in some cases found that a woman's perceptions of parental rejection during her own childhood, particularly rejection by her mother, may prompt her to re-enact that rejection towards her own unborn child. Thus, believing that her own mother harbored infanticidal desires towards her, the woman acts out these fears by aborting her own child (a substitute victim with whom she subconsciously identifies). Abortion, in this type of case, represents a form of self-punishment by which the "rejected" woman confirms the feelings of her own rejection and low self-esteem. ⁵⁷ Ironically, young women from a home environment in which they felt rejected may have sought a pregnancy in order to prove their self-worth, express their maturity, or to produce a person whom they could love and who would love them in return. But once the pregnancy is achieved, the cycle of self-punishment and self-rejection is directed at the unborn child and leads to a desire for an abortion, further self-rejection, lowered self-esteem, and so forth.

Whether it is the result of having compromised their own values or having further weakened their poor self-images, many aborted women develop patterns of self-destructive behavior in order to punish themselves for their "unworthiness." Such self-destructive behavior, called symbolic suicide, may include abuse of alcohol and drugs. Some may become obsessed with food and try to "eat their way into oblivion" or "to fill" the great emptiness they feel inside themselves. Still others may develop anorexia nervosa in a subconscious attempt to starve or "fast" themselves to death. ⁵⁸

Sometimes, accepting the frightening ordeal of abortion may itself be an act of self-punishment by the young woman seeking to atone for feelings of guilt about becoming pregnant. Pregnancy resulted from a

desirable "sin," and so abortion is seen as the "pain payment" owed as penance for the illicit pleasure of intercourse. In a study of the decision-making process of abortion, Dr. Howard Fisher, a professor of psychiatry at the University of Minnesota, concludes that there is substantial evidence to believe that abortion is a symptom of underlying emotional disturbances, and a "symbol of failure." In such cases, he adds, the "physicians [may be] merely accomplices in self-destructive behavior." ⁵⁹

Suicide

Feelings of rejection, low self-esteem, guilt and depression are all ingredients for suicide, and the rate of suicide attempts among aborted women is phenomenally high. According to one study, women who have had abortions are nine times more likely to attempt suicide than women in the general population. ⁶⁰

The fact of high suicide rates among aborted women is well known among professionals who counsel suicidal persons. For example, testifying in support of parental notification prior to abortion for teenagers, Meta Lehman, Regional Director in Ohio of a national organization called Suiciders Anonymous, reported that in a thirty-five month period the Cincinnati chapter of Suiciders Anonymous worked with 4,000 women, of whom 1,800 or more had abortions. Of these, 1,400 were between the ages of 15 and 24, the age group with the highest suicide rate in the country. She also pointed out in her testimony that there has been a dramatic rise in the suicide rate since the early 1970s when abortion was first legalized. Between 1978 and 1981 alone, the suicide rate among teenagers increased 500 percent. ⁶¹

Other Sequelae

The ways in which post-abortion sequelae are manifested are as numerous as the number of women who are aborted. Symptoms of inner distress are filtered by individual personalities and thus are displayed in personalized manners. We have explored some of the most common reactions and attempted to explain some of the underlying psychologies. We will now briefly mention some of the most commonly reported "minor" symptoms.

Many aborted women express extreme anger and rage. This may be directed at family, husbands, boyfriends, or even other children; the latter may result in child battery. In the case of Renee Nicely of New

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Jersey, post-abortion trauma triggered a "psychotic episode" which resulted in the beating death of her three-year-old son, Shawn. She told the court psychiatrist that she "knew that abortion was wrong" and "I should be punished for the abortion." Unfortunately, Shawn became the second victim of her frustrations.⁶²

Similarly, abortion may sometimes distort maternal bonding with later children. For example, WEBA member Terri Hurst reported that after her first child was born, "I did not understand why her crying would make me so angry. She was the most beautiful baby, and had such a placid personality. What I didn't realize then was that I hated my daughter for being able to do all these things that my lost [aborted] baby would never be able to."

Post-abortion anger is often directed towards the abortionists or abortion counselors "who didn't give me the other side of the picture." Women are angered that they were not forewarned about the emotional problems they would face.⁶³ Feeling that they were misinformed or deceived by abortion clinic personnel, many women feel that they have been "used" for the profit of others.

Sleeping problems are often reported. Some women complain of nightmares concerning the abortion, often involving the "return" of the aborted child. Others experience insomnia, often mixed with depression and crying.⁶⁴

The experience of a "phantom child," is not uncommon when a woman imagines her aborted child as old as it would have been if it had been born. This may include seeing "her baby" whenever viewing other children of that age group.⁶⁵ Similarly, some women become obsessed with the "would have been" birthdate, or the date of the abortion itself; and others report frightening "flashbacks" of the abortion procedure as late as six years after the fact.⁶⁶

General feelings of helplessness, isolation, loneliness, and frustration are expressed. Some describe their situations as "hopeless."⁶⁷ Others claim they are "going crazy." Still others express fear of or a preoccupation with death. Many report they are unable to escape or resolve their conflicts. One woman told an abortion crisis center that she wanted "to get in a car and drive and drive and get out and start life over again."⁶⁸

Suppressed feelings of remorse over abortion cause some women to suffer from psychosomatic illness. One study found that self-induced diseases among aborted women included abdominal discomfort, vomiting, pruritis vulvae, dysmenorrhea, frigidity, headaches, insomnia, fatigue, and ulcers.⁶⁹

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Abortion has also been identified as the cause of psychotic and schizophrenic reactions. Symptoms frequently include extreme anxiety and feelings of paranoia.⁷⁰

Who Is Most Likely To Suffer?

Though it is impossible to predict what type of post-abortion psychiatric illness any particular woman is likely to face, there are general guidelines for identifying women who may be most susceptible to severe post-abortion syndrome. These guidelines have been developed by many psychiatrists who have done extensive work in the treatment of post-abortion sequelae.

According to a report by a group of psychologists headed by Dr. C. M. Friedman:

The literature on abortion and our clinical experience both indicate that there is a greater likelihood of postabortion psychiatric illness in situations in which any of the following elements are present: coercion, medical indication [including abortings to save the life or health and eugenic abortion of a possibly handicapped child], concurrent severe psychiatric illness, severe ambivalence [i.e. when the woman wants a baby, sees this preborn as her baby, or feels she is its mother], and the woman's feeling that the decision is not her own [i.e. is required by needs and circumstances outside of her control].⁷¹

Note that this list of "worst candidates for abortion" includes women who would need abortion for the "hard" cases: to save her life or health, in cases of rape and incest, and to prevent the birth of a handicapped child. These specific categories, representing less than three percent of all abortions, will be discussed in detail in the next chapter. But their inclusion here demonstrates what can be considered a general principle: *The more difficult the circumstances prompting abortion, the more likely it is that a woman will suffer severe post-abortion sequelae.*

In other words, the more one sympathizes with the conditions surrounding a woman's problem pregnancy, the more one should discourage the "easy" escape of abortion, if only for the woman's own mental well-being. Why these rules-of-thumb are valid will become clearer during the following discussion.

Excluding the "hard" cases, Dr. Friedman's "worst candidates for abortion" list includes any woman who feels pressured into the abortion, whether by her sexual partner, her family, social norms, or eco-

nomic hardship. Second, any ambivalence, any desire to keep the child "if things were better" is also a strong warning flag for future problems. The common link between these two categories is the woman's feeling of having compromised herself. In the first case, she aborts not because *she wants to*, but because abortion is the compromise solution demanded by circumstances or the "needs" of others. In the second instance, abortion compromises her own values or desires. She aborts despite her desire to keep the child, despite her moral uncertainties, and in so doing she betrays herself.

A team of psychiatrists which followed over 500 case histories of post-abortion sequelae observed that, "In all of the cases of post-abortion illness we have presented, there were compromises in the decision-making process."⁷² Writing in the *American Journal of Psychiatry*, these authors report that whenever a woman makes the decision to abort, *any compromise*, whether the compromise is in complying with the wishes of others or in setting aside one's own values, *opens the door to later psychiatric problems*. Thus anyone who encourages a woman who is showing signs of uncertainty to choose abortion may unwittingly be pushing their loved one toward self-compromise and a subsequent loss of self-respect.

All of the above warning signs for post-abortion sequelae hold true for young women and especially for teenagers. Because of their limited experience, their greater dependence on others, and their youthful idealism, teenage women are extremely vulnerable to coercion, deceit, and compromised decision-making.

The greater psychological impact of abortion on young women was disclosed in a study which found that nearly one of every three young women who aborted "showed moderate to considerable decline in psychosocial functioning five to seven months post-abortion, as measured from the base-line of reported adequate pre-pregnancy status." Describing the psychic deterioration which teens experience after an abortion, the authors write:

These young women, at initial follow-up, were suffering with a variety of specific symptoms of maladaptive behavior including mild to moderate depressive episodes, a variety of new physical complaints for which medical attention had not been sought, . . . difficulty in concentrating in school, withdrawal from previous social contacts, lower self-esteem explicitly related to the pregnancy and abortion experience, a newly begun promiscuous pat-

tern in relationships with men, and regression to more infantile modes of relationships with parents. These difficulties did not predate the pregnancy.⁷³

A similar study has found that less than one-fourth of aborted teens were able to achieve a healthy psychological adaptive process. Many of the remaining three-quarters who faced prolonged disturbances fell into a vicious cycle of "replacement pregnancies."⁷⁴ Many of these young women will complete the cycle by undergoing a second abortion, then another pregnancy, and another abortion, and so on, reenacting their own torn emotions, the conflict between the desire for a child and their desire to be unburdened.

Unfortunately, the problem of post-abortion sequelae among young women is increased by their greater tendency to "bottle-up" their emotions after an abortion experience.⁷⁵ Thus, even though teens are likely to be most deeply affected by abortions, they are also likely to be the least expressive about their doubts and pains. Some are emotionally "numbed," others conceal their inner pain as part of the veil of secrecy surrounding the abortion. Others strive to conceal their grief, especially from parents who might have encouraged or pressured them to choose the abortion, out of fear that expressing any complaint afterwards would only drive a further wedge between them and their parents.

It must also be remembered that when a young woman (or man) engages in intercourse, she is seeking much more than just physical pleasure. (Indeed, young women frequently complain that such intercourse is pleasureless and "done only for the guy.") In the broader perspective, intercourse is just a symptom of the young woman's search for love, fulfillment, and maturity. Abortion destroys not only the consequences of intercourse, but also disrupts this larger search for meaning. When a young woman is encouraged by her boyfriend, friends, parents, or society to abort rather than to give life to her child, she is being told that her search for love was wrong. Instead of receiving support to act with courage and compassion, she is told to "do what is best for yourself," meaning to place selfishness ahead of love. Instead of being encouraged to accept the consequences of her choices and to mature through the responsibilities of parenthood, she is encouraged to "mature" through infantile destruction. Thus she is made to participate in desolation rather than growth; she is exposed to the fear of death rather than the joy of life.

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Dr. Baars echoes these concerns, noting that the psychological threat of abortion is greatest for the uncertain, unaffirmed "girls who are in a desperate search for someone to love them." He writes:

When they [the unaffirmed women searching for love] learn from personal experimentation that this cannot be found in sexual promiscuity, they often desire to have a child of their own, in the expectation that the child will give them what their parents failed to provide. No one can be blind to what must happen, and is happening these days all too often to unaffirmed youngsters, when other grown-ups prove to be just as pseudo-affirming or denying as their own parents, in their eagerness to persuade or force them to have an abortion. Such conduct constitutes psychic murder of these already deprived girls, and unless they are so fortunate to be helped by affirming persons, they will become the victims of malignant depression.⁷⁶

Aborted Women: The Destruction of Self

Very few women can approach abortion without qualms or walk away from it without regrets. It is this ambivalence towards abortion, to use Francke's title term, which is the gateway to post-abortion sequelae. For most women, abortion is not just an assault on their womb; it is an assault on their psyche.

As we have seen, some women are literally forced into abortion by lovers, families, friends, or even by their physicians. Others slip into the abortion decision, restraining their doubts and questions, simply because it is the most visible and presumably the "easiest" way out of their dilemma. For these women, pro-abortion clichés replace investigation; blind trust supplants foresight. They assume abortion is safe because that is what they are told, and that is what they want to believe. They naively hope that they will have the strength to deal with the aftermath of abortion—even though they are choosing abortion because they feel they lack the strength to handle an unplanned pregnancy.

Unfortunately, abortion does not build psychic strength; it drains it. And so the aborting woman is even less able to handle post-abortion sequelae than she would have been able to handle the unplanned birth. The abortion mentality, the institutional system of birth control

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counselors, abortionists, and clinics, all contribute to this faulty decision-making. As we will see later, abortion counselors are cosmetic figures who only reinforce the abortion choice, acting to support the woman's decision against the rebellion of her instinctive fears against such an unnatural procedure. Rather than urging the woman to confront her decision, reconsider it, and be prepared for its consequences, the counselors work to maintain the "safe and easy" myth and encourage the woman to believe in abortion's tempting lie: "Soon it will all be over."

In response to the many pressures they face, most women tend to rush their abortion decision in an attempt to avoid becoming "too attached" to the idea of having their baby. Unfortunately, this rush to decide frequently occurs during the period in which most women, even those whose pregnancies are planned, experience some ambivalence toward childbirth.⁷⁷ This ambivalence occurs in part because it always takes time to become accustomed to a major change in one's life. But also, there is always a downswing in a woman's hormones during the early months of pregnancy. Because a pregnant woman is experiencing a major hormonal disturbance, "depression is to be expected during the 2nd and 3rd months [of pregnancy], often the time the pregnancy is verified and a decision made."⁷⁸ This natural, hormone-induced depression may be easily misinterpreted to mean hostility towards childbirth, parenting, or even one's sexual partner.

The shock of an unplanned pregnancy, combined with the swinging moods caused by the woman's shifting hormones, may make a woman particularly vulnerable to outside pressures. According to one study:

Her ambivalence [towards her pregnancy] may lean one way or the other according to the attitudes she perceives: with love, help, and support she is more likely to overcome her negative feelings to accept and love her child. But the reverse is also true: the perception of hostile reactions towards her pregnancy may reinforce her negative feelings and push her towards abortion.⁷⁹

The authors add that these negative pressures may come not only from spouses and family, but from those subtle social campaigns against the poor:

Unfortunately, hostile attitudes towards women with problem pregnancies are currently being reinforced . . . by antinatalist

campaigns. Such campaigns encourage a sense of shame and guilt about procreation, especially among the poor, and, in their haste to lower the birth rate, promote an antichild attitude. This attitude in turn contributes to the withdrawal of previously existing forms of social support for pregnant women.⁸⁰

Thus we see again that a woman may choose abortion in an attempt to please others rather than herself. This view is supported by the theories of Harvard psychologist Carol Gilligan, a pro-choice feminist specializing in the moral decision-making processes of women. According to Gilligan, the conventional theory of moral development which says that moral consciousness is formed by a process of rejecting peer pressure in favor of one's own vision of right and wrong, is not applicable to women. Instead, she argues, women "base moral decisions on what will please others—a kind of moral development no worse than the 'independent' male version."⁸¹

Gilligan strains in her attempt to use this model as a justification for abortion; but if true, her theory only shows how easy it is to pressure a woman to abort "in the best interest of everyone concerned." In one of her examples, she praises a woman who after evaluating the desires of her boyfriend and parents (who all want the abortion) decides that the "loving" thing to do is to have the abortion even though she personally wanted to keep the baby very much.⁸² Only Gilligan's pro-abortion bias can account for her blindness to the fact that this girl is submitting to a compromise against her own best interests, her own desires, and her own preferred choice. What she has been given is not the freedom to choose, but the "freedom" to be pushed.

But the knowledge that one is being pushed into an abortion is no defense. Indeed, it can simply become another excuse for the woman to shift responsibility for the choice onto those who urge it. Like a hot potato, everyone passes off the responsibility. Parents and boyfriends believe the final choice is the woman's responsibility; the woman thinks it was theirs: "They forced me to do it." From within all these mind games, the woman may view herself as the "martyr," giving in to the wishes of others, accepting the undesirable. Thus many women accept abortion not only as self-punishment, but as a means of gaining virtue (martyrdom) through submission.⁸³

In sum, the choice for abortion is usually an unwanted choice made in despair. It is a "fight or flight" reaction to a seemingly

insurmountable problem, a reaction which curiously combines the destructive violence of the fight instinct and the denial/avoidance attributes associated with the instinct to flee. These observations were confirmed at a symposium on the psychological aspects of abortion held on October 31, 1978 in Chicago. By the end of the conference, the psychiatrists who had gathered there concluded that:

Without question, abortion is psychologically a symbol of the despair which seems to be endemic to modern society. It is a totally negative response to environmental pressures. Without benefit of an affirming love, abortion is always an empty response—a gesture of denial.⁸⁴

They continue by pointing out that "carrying an unwanted child to term" is far less traumatic than abortion, and they imply that helping a disturbed woman give birth to a child is often an aid to overcoming her emotional or mental problems. They conclude by saying, "In the final analysis . . . life is better than death, and that psychotherapy which affirms life is by far the best. Abortion is a defeatist answer, a psychic retreat for those who have given up looking for answers."⁸⁵

Abortion is an act of despair not only on the part of women, but also on the part of the society which has given up trying to give them authentic help. What began with the abortion of unwanted children,

. . . before long becomes de facto "social abortion." Women who seek abortion . . . find themselves "socially aborted" long before they seek the medical abortionist. They are aborted, rejected and unwanted by those close to them—their husbands, parents, and friends. By the time these women reach the abortionist (who at least identifies himself), they are already isolated and afraid; they feel literally trapped.⁸⁶

It is these feelings of isolation and abandonment which cause despair, which cause the abortion alternative to appear to be the *only* alternative. For these women the feelings of loss and abandonment do not end after they have given in to the "practical need" for abortion. Instead, for many, the experience prompts the final and most wrenching of abortions—"self-abortion," that is, the loss of their self-worth, the loss of their dignity. Instead of giving birth to life, their abortions give birth to feelings of self-hatred and self-punishment. For many

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women, the destruction of their "fetuses" marks also the destruction of their self-respect. Abandoned by others, the aborting woman feels forced to abandon her child, and finally even her self.

Who Is Least Likely To Suffer?

Because the list of those most susceptible to the psychological impact of abortion is so long (including the youthful, the dependent, the coerced, the ambivalent, the frightened, the poor, the emotionally unstable, and the ill-informed), it may in fact be easier to describe the smaller category, the opposite set: those who are in the least danger of suffering from post-abortion sequelae.

According to Professor Peter Peterson of the Hannover Medical School, while those who are most likely to suffer psychological disturbances are "motherly women," those with the least chance of becoming disturbed, he notes, are women "with little motherliness."⁸⁷

All the published evidence seems to agree with Dr. Peterson's assessment. More precisely, the women least likely to experience post-abortion sequelae are aggressive rather than nurturing. They are likely to be self-centered and property-oriented rather than people-oriented. For such women, abortion is not experienced as something which is "forced" upon them by circumstances. Instead, abortion is truly an act of self-determination for these women, simply the cutting down of another obstacle on the road to success.

In his treatise "Psychic Causes and Consequences of the Abortion Mentality," psychiatrist Conrad Baars explains that such women with "little motherliness" have never truly believed that they themselves were loved or "affirmed" for who they are. Instead, these women feel that parents and friends "love" them for their actions rather than for themselves. Not having experienced and internalized love from others, such a person seeks to become "self-affirmed" by proving:

... to the world and to himself that he is significant, worthwhile and equal. This self-affirming person does this by using his "mind" to plot and manipulate others in trying to amass material goods, riches, power, fame, status symbols, and the like, which he expects will give him the feelings his parents failed to give him.⁸⁸

Lacking the confidence of a person who feels loved, the self-affirmed rely on pseudo-confidence which they display as aggressiveness—an aggressiveness born of inner doubts and an exagger-

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ated need to "prove" themselves. The result is that the self-affirming person struggles on an unending treadmill, blindly trying to gather more and more pseudo-happiness (material success) as a substitute for true happiness (affirming relationships outside of his or her self). The self-affirming person is thus trapped in a cycle of accumulating rather than giving, practicing self-love rather than love of others.

Depending only on self-love is self-consuming, and thus the self-affirmed person is unable to truly affirm (love) others. Since all they do and think is centered around affirming their own self-worth, the self-affirmed are extremely manipulative of others. Other people become objects for manipulation rather than persons honored for their own sake. For example, in sexual encounters the focus is always on the self rather than the other. Thus intercourse becomes an act more of mutual masturbation than of mutual love. Since each concentrates on proving themselves in such intercourse, the self-affirmed frequently prey upon each other, often by mutual consent.

According to Dr. Baars, these self-centered, self-affirming men and women are incapable of truly loving and affirming each other or their children. Their children, like all other persons, are only objects used to prove themselves to the world. Their children exist only to please them, and they have no claim to more than the self-affirmed parent is willing to give. Coming from this perspective, then, the self-affirmed "are the first to demand the right to abort the child they know or sense they are incapable of loving."⁸⁹

Thus it is these self-affirmed women (and men) who find it easiest to choose abortion when it advances their self-interests. But even then, many self-affirmed women will suffer post-abortion ambivalence.⁹⁰ But although many, or even most, of the self-affirmed will be troubled by ambivalence or guilt, at least some of this group will emerge from an abortion relatively unscathed.

As a class, then, the self-affirmed represent those with the best chance of being unaffected by abortion. They suffer least not because they are more psychologically stable, but because they are already so psychologically crippled. The abortion experience is unlikely to breach their defenses precisely because those defenses have been in place for so long.

Rather than denying the humanity of the unborn, self-affirming women might accept that a human life is destroyed, but they simply rationalize the death as "necessary" or justified. As one woman put it: "No one shrinks from what abortion means: the irrevocable ending of

... [a] unique human being. To be unequivocally, all-out for life, any life, is quite satisfying to the soul, but it's an ethical indulgence I cannot afford. The bottom line is, someone's rights are going to take precedence. I vote for the woman."⁹¹

Similarly, another feminist philosopher insists that women should never agree to be the "victim" in an unwanted pregnancy. If there must be a "victim," and she agrees there always is, then it might just as well be the unborn child, who by virtue of its lower social standing is logically less valuable.⁹²

Self-affirmed women such as these are simply unwilling to sacrifice any of their own immediate ambitions or their own material possessions for the sake of an unwanted responsibility. They are addicted to the pseudo-happiness of their own plans, careers, and possessions—the "things" in their lives upon which they depend for their self-affirmation. Like all addicts, they are unable to trust that there is a greater happiness to be found in a human relationship, particularly a future relationship with an unseen child.

In sum, the women least likely to suffer from post-abortion sequelae are those for whom most people have the least sympathy. They are the self-affirmed women for whom abortion is not a dire necessity, but an act done purely for the sake of convenience. They abort not for health reasons, nor out of economic necessity, nor even to avoid social embarrassment. (Indeed, since she is self-affirmed, such a woman would be the first, if it suited her, to deliberately seek a child out of wedlock, through artificial insemination, or by a "one night stand.") She cares not for social norms, or for the well-being of a child raised without a father, only for her own desires.) Instead, the self-affirmed woman aborts to prevent a disturbance in her lifestyle or career. If married and with children already, abortion is chosen simply because "We don't want any more." The self-affirmed woman may abort simply to avoid being "tied down."

It is circumstances such as these for which most people have the least sympathy, but it is the women and men who abort for these reasons who are the most active and vocal in demanding "freedom of choice" in order to protect their lifestyles. Conversely, it is the women who feel compelled by necessity to abort who are least active in demanding the right to abortion. Indeed, the latter abhor abortion (that's what makes it traumatic for them,) and submit only because they see no other alternative. To them abortion is "ugly" and "dirty." It is not a convenience or a "right" which they cherish; it is an awful

"necessity." But it is these latter women, those with whose circumstances we all sympathize, who are most likely to experience post-abortion trauma. By allowing and even encouraging them to compromise themselves, society abandons these women to the "ugly necessity" of abortion which carries with it guilt, despair and loss.

In the final analysis, then, every woman pays a psychological price for abortion. Those who abort out of "necessity" pay through post-abortion trauma. Those who abort for the sake of convenience have already paid by buying into the abortion mentality, the "me first" philosophy which has crippled their ability to affirm others and to recognize or accept unconditional love when it is offered to them.

This observation is substantiated by the testimony of Dr. Julius Fogel, a psychiatrist and obstetrician who has been a long-time advocate of abortion and has performed hundreds of abortions himself. Although he approaches abortion from a "pro-choice" perspective, Dr. Fogel is deeply concerned about the "psychological effects of abortion on the mother's mind." According to Dr. Fogel:

Abortion is an impassioned subject. . . . Every woman—whatever her age, background or sexuality—has a trauma at destroying a pregnancy. A level of humanness is touched. This is a part of her own life. She destroys a pregnancy, she is destroying herself. There is no way it can be innocuous. One is dealing with the life force. It is totally beside the point whether or not you think a life is there. You cannot deny that something is being created and that this creation is physically happening. . . . Often the trauma may sink into the unconscious and never surface in the woman's lifetime. But it is not as harmless and casual an event as many in the proabortion crowd insist. A psychological price is paid. It may be alienation; it may be a pushing away from human warmth, perhaps a hardening of the maternal instinct. Something happens on the deeper levels of a woman's consciousness when she destroys a pregnancy. I know that as a psychiatrist.⁹³

Clearly, if a psychological price is not paid after the abortion, it was probably compromised away long before.

Summary

Abortion is never simply "over and done with." The experience is always tainted by a lingering ambivalence and is often the source of

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severe psychiatric disabilities. Pro-abortionists do not deny that post-abortion sequelae occur, they simply insist that they are usually bearable. Several sources place the rate of severe post-abortion sequelae, defined as requiring psychiatric hospitalization, as high as 10 percent. Observable sequelae of a less serious nature occur in 55 to 90 percent of all aborted women.

Not surprisingly, most reactions include aspects of guilt, depression, self-punishment, and feelings of loss and emptiness. Many women deny their inner doubts, but psychiatric evidence indicates that all aborted women continue to face unresolved conflicts about the abortion, at least at some subconscious level.

The women most likely to suffer post-abortion sequelae are those whose situations are most sympathetic, those who are "forced" by social or economic conditions, or those who want a child some day but "not just now." Those least likely to suffer are those with "little motherliness," who abort purely for convenience and have no doubts about what they are doing. These "self-affirming" women are chronic exploiters, used to manipulating people as objects, and so are easily inclined to think of the unborn as disposable property. These self-affirmed women may recognize the humanity of the unborn child, but their worldview is self-centered, and so is insulated from compassion for the child or for anyone else.

Given the great psychological and physical risks posed by abortion, it is clear that the responsible physician, one interested in his client's overall health, would be extremely reluctant ever to recommend or perform an abortion.

EXHIBIT 10
DATE 3/20/95
SB 292

Informed Consent

INFORMED CONSENT

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I. Rationale

Those who fight in the name of "freedom of choice" say they are not promoting abortion, but a woman's "right to choose." If a woman considering an abortion is to have any real choice, she must be allowed to have access to all the facts about her situation. Otherwise, "choice" is only a political slogan, which really means nothing more than subjecting a woman to the control of others -fathers who want to avoid responsibility, families more concerned about their reputations than potential physical and psychological repercussions, friends who don't really know about realistic alternatives, and abortion industry counselors and doctors more concerned about making a sale than helping a woman make a considered decision about her real interests and the interests of her unborn child.¹

Because the decision to have an abortion is such a major one, having potential ramifications not only on the physical and psychological health of the mother, but also on 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. Since current abortion procedures are often hurried and impersonal, and the physician-patient relationship almost nonexistent, the state is justified in taking such measures to protect the rights and interests of the patient.

Informed consent legislation is intended to ensure that women considering an abortions are informed about the medical risks associated with the procedure and given an opportunity to read information about agencies that provide alternatives to abortion, as well as non-inflammatory, scientifically accurate information about the development of the unborn child.

¹ It can never be ignored that abortion destroys a human life. See Willke, Abortion: Questions and Answers 33 (Rev. ed. 1988), APP S.

II. Why Informed Consent Legislation is Needed

A. Neither uninformed choices nor forced choices are really free choices

Those who argue for a woman's right to abort her unborn child emphasize the woman's "right to choose" an abortion based on her own personal evaluation of her obligations and interests. A woman who is denied information relevant to her decision is not able to make a free choice. Rather than being treated as a rational, responsible adult, she is misled into believing that she has no realistic alternatives, that the unborn child she carries is no more than a clump of tissue, and that abortion is an easy solution with no potential drawbacks or dangers. A woman who decides to have an abortion under these circumstances is not "choosing" anything, but merely being manipulated by social pressure and a paternalistic medical system.

Anyone who consistently wants to uphold a woman's "right to choose" must show equal vigor in attempting to insure that every woman considering an abortion is provided with all the information necessary to enable her to make a truly informed decision. Only in this way can a woman make her own decision, a decision she can live with, a decision she will not later regret after events can no longer be altered.²

B. Abortion clinics frequently fail to provide adequate and accurate information to women considering abortion

Opponents of informed consent legislation frequently say that what information a woman is told should be left to the discretion of the individual doctor. But according to a study published by Planned Parenthood's research affiliate, the Alan Guttmacher Institute, in 1987, only 4-8% of all abortions are performed in doctor's offices. 75% are done in abortion facilities that perform at least 1,000 a year, while 20% are done in facilities performing at least 5,000 a year.³ In Roe v. Wade, the Supreme Court appears to have envisioned the woman and her physician consulting together to consider carefully all the factors relevant to her decision, looking at not only potential medical complications, but also psychological harm, and possible impact on her life, her family, and her future.⁴ Under the kind of assembly line conditions mentioned by Guttmacher, doctors would rarely have the time to

² In Wood & Durham, Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship, 1978 B.Y.U.L. Rev. 783, 786 (see APP A), the authors point out that autonomy, or the ability to control one's life according to one's own choices, can only be supported by informed consent. They write, "A woman's autonomy, after all, is protected not by ensuring her ability to make any choice she wishes, but by protecting her right to make an informed, calm, and rational choice."

³ Henshaw, Forrest, & Van Vort, Abortion Services in the United States, Family Planning Perspectives, Mar./Apr. 1987, at 68. APP I.

⁴ See Wood & Durham, supra, at 784, referring to the court's decision in Roe v. Wade, 410 U.S. 113, 153 (1973). APP A.

personally inform or counsel the patients. Here there could be little or no real physician/patient relationship. The doctor is likely to be a total stranger, not someone who knows the patient's personal medical history and background. The only personal contact the patients might receive is from nonmedical "counselors" who talk with the women, often in groups, and sometimes for as little as only three minutes. Pamela Zeckman and Pamela Warrick of the Chicago Sun-Times report,

Under [Illinois] state regulations, clinics are required to counsel abortion patients. Some clinics take time with patients to probe their motives, fears, and misgivings. But some of the Michigan Ave. clinics make a mockery of the mandate. At least one offers no counseling at all. Others make feeble attempts at counseling groups of 10 or more in three minutes or less.⁵

Obviously, this is hardly the time or attention necessary for such a serious decision. Even when such "counseling" takes place, it is often deceptive and misleading. Shelly Banda of Menasha, Wisconsin offers the following account of her "counseling" experience.

The abortion chamber provided counseling only on the day of the abortion and in a group of 3 other young women. I told the counselor that I felt abortion was murder and she quickly enlisted the aid of the other girls to apply pressure and I was bombarded with remarks such as, "What would you do with a baby[?]," and "Where would you go?" I had no answers so I sat silently during the remainder of the session. A uterine model was brought in which contained only a nucleus of cells with protons and neutrons revolving around it - not at all an 8-10 wk. fetus which was really there. The fetus was only referred to as a "by-product" of conception and no possible side-effects or alternatives were even discussed with us. If someone had offered me an alternative such as a "shepherd home" I would not have had the abortion and I would be at peace now instead of the hell I live in knowing I allowed my baby to be killed."⁶

In Planned Parenthood v. Bellotti, the Massachusetts District Court found that "clinics and counselors avoid discussion of the stage of development," and that "there is a deliberate effort to shield the woman from this information about fetal development."⁷

⁵ Zeckman and Warrick, The Abortion Profiteers, Chicago Sun-Times, Nov. 12, 1978, at 4, col. 1. APP K.

⁶ Letter from Shelly Banda to Senator Gordon Humphrey, June 10, 1986.

⁷ Planned Parenthood v. Bellotti, 499 F. Supp. 215, 219 (D. Mass. 1980).

Karen Yates, director of the Southeast Crisis Pregnancy Center in Washington, D.C. says she is amazed at the number of women who have had one or two abortions and still don't know the facts about fetal development. She says some of the women have "really freaked out" when they realized they had killed their developing baby through a previous abortion.⁹

Zekman and Warrick relate.

One patient, who said she underwent a horribly painful abortion at Biogenetics [a major Chicago abortion clinic], recalled she had many questions to ask her counselor. "But I was afraid to ask them with all those people around."... Another Biogenetics patient told the Sun-Times she might not have gone through with her abortion had someone taken the time to counsel with her. "I wasn't counseled at all," she said. "The nurse just took my name down and filled out the application. She gave a quick explanation of the procedure, but that's not counseling. I wasn't sure I wanted an abortion. I really wanted to talk to somebody about it."⁹

There are flaws even in the most idealistic self portraits provided by abortion counselors. According to one account,

At a 1971 conference of abortion providers, hospital clinical social worker Martha Skibitzki said she saw the role of the abortion counselor as no more than a "facilitator and participant" in problem solving. The counselor was to give the client any information she requested, and help her reevaluate her attitudes, but always operate on the assumption that the woman did not want to be talked out of an abortion. The decision made, the counselor was to give the woman emotional support, cut any red tape, explain in advance the frequently bad logistical conditions like the lack of rooms and operating facilities, explain the procedure and - if the doctor approved - warn the patient about possible future sterility. Finally, the counselor was to try to counteract the conviction that the unwed mother-to-be should suffer for her mistake.¹⁰

Notice how this idealized counselor provides only the information "requested" by the patient. If a woman doesn't know enough to ask, or is too afraid to ask (as many of those patients quoted above said they were), she will not be offered any information

⁹ Braun, Nation's First Black Crisis Pregnancy Center Stresses Family Involvement, National Right to Life News, Jan. 12, 1984, at 4, cols. 1-4. APP L.

⁹ Zekman and Warrick, Hot Line Deceptions Sell Most Abortions, Chicago Sun-Times, Nov. 25, 1978, at 50, col. 1. APP K.

¹⁰ Marx, The Death Peddlers: War on the Unborn 18 (1971).

about the development of the unborn child she is carrying or about possible alternatives to the abortion. The mother is not even to be told about "possible future sterility" unless the doctor "approved." Though this counselor is said to be prepared to help the mother "reevaluate her attitudes," the actual decision regarding the abortion appears to be off limits. The counselor assumes the question is already settled and just helps the process along, cutting administrative "red tape" and quieting whatever fears or pangs of conscience may be giving the mother second thoughts. This is not a neutral stance.

Do women feel they are given enough information by abortion counselors to make their decisions? Have women already made up their minds before arriving at the abortion clinic? In one study of 252 women who had abortions, 221 said they did not feel that at the time of their abortion they had all the information necessary to make their decision. Only 78 of those 252 said they felt "firm" about their decisions when they went to the clinic.¹¹ Whether this sample is representative or not, it is obvious that there is a significant group of women who never received adequate counseling during the time of their crisis.

David Reardon offers a more realistic account of what abortion counseling is all about.

At one clinic...when a woman voiced her concern that abortion might be killing, the counselor said, "don't think of it as killing. Think of it as taking blood out of your uterus to get your periods going again."... Once counselors decide what is "best" on behalf of their clients, it is an easy matter to influence their final decisions toward the predetermined outcome. Counseling in such cases downplays or even denies the availability of support resources and instead concentrates on the "tremendous burdens" involved in raising a child. Such counseling sessions encourage women to believe that abortion is not only the "safe and easy" solution, but it is in fact "the only practical thing to do." Explaining how she handles such cases, abortion counselor Betty Orr says, "I ask them who is going to take care of the baby when they're in school. Where are they going to get money for clothes?" Faced with such questions of antagonism rather than offers of confirmation and support, frightened and vulnerable young women are easily convinced that abortion is their only choice - even when it is contrary to their real desires.¹²

Why is there such pressure placed on the mother to abort her baby? Why is information about alternatives kept from her? Why is the patient not warned about potential physical risks? Why is the mother not told the facts about the developing child inside her? The answer must be this: because every woman who changes her

¹¹ Reardon, Aborted Women: Silent No More 334, 335 (1987). APP T.

¹² Id. at 251-252 (1987). APP M.

mind represents lost income for the abortion providers. Abortion is a multi-million dollar a year industry and abortion providers aren't about to let anything stand in the way of profits. For example,

Carol Everett, at one time director of four Dallas/Ft. Worth abortion clinics, owner of two, says. "Each time I sold an abortion to another woman, I justified my own abortion all over again. I was really quite good at abortion marketing, and soon watched my employer's abortion business more than double. When I realized how profitable the "business" was, I wanted more money. Because my employer would not give me an equity interest, I negotiated a more lucrative arrangement with the next clinic, I was paid \$25.00 for each abortion that was done. The first month we did 45 abortions and the last month in the abortion business, with two clinics open, we did 545 abortions. Multiply 545 times \$25.00 and I made \$13,625.00 in July, 1983. However, we had much bigger plans. We actually planned to have five clinics, all run out of one yellow page advertising budget and one central telephone counseling center. We wanted to eventually pull patients from a five-state advertising area."¹³

Zeckman and Warrick of the Chicago Sun-Times give the following report of abortion counseling in one clinic. "When staff members do have time to talk to patients, they are under orders to say nothing to scare women away. 'Don't tell them it hurts,' our undercover counselor was told. 'Don't answer too many questions because the patient gets too nervous, and the next thing you know they'll be out of the door.'"¹⁴

Under circumstances that more closely resemble assembly lines than personal medical care facilities, counseling is little more than a byword; since the object is not patient care, but turning a profit, this should not be surprising. More abortions mean more money. A woman who changes her mind represents lost profit, so the less said, the better.

The only way to insure that the rights of the woman are upheld is for the state to guarantee her access to the information essential to her making an informed decision, particularly to counter the social and selling pressure exerted upon her by those representing the interests of the abortion industry.

¹³ Everett, What I Saw in the Abortion Industry, USA Today, Apr. 26, 1989 (Special Advertising Insert). APP J.

¹⁴ Zeckman and Warrick, The Abortion Profiteers, supra note 5. APP K.

C. The burden of pain and regret

The story told by the abortion industry is one of quick, safe and easy solutions. Yet many of those undergoing abortions are scarred for life.

Judy Oulliber writes, "After my abortion in 1976, I experienced seven and one half years of spiritual, emotional, and physical side effects, including the premature birth of my son James Michael, four years after my abortion. He died when he was 23 days old. Premature birth of subsequent pregnancies is a growing concern of women who unknowingly choose abortion as an alternative in a crisis pregnancy. I use the word "unknowingly" because I was not counseled at the time that I would be under a doctor's care for three years to heal atypical vaginal cells following that abortion, or that I would become so overwhelmed by guilt and remorse that I would struggle for seven and one half years with fears and anxieties to the point of becoming agoraphobic, an emotional condition that not only put a strain on my marriage but also contributed to its eventual failure."¹⁵

Physical risks like scarring, infection, and sterility are only part of the story. Shirley Foster of Brookeville, Maryland wrote a letter to the clinic which performed her abortion, saying, "Please realize your counseling does not inform women of the years of guilt, shame, pain and deep regret that follows an abortion."¹⁶ A Los Angeles Times survey taken in March of 1989 shows that Shirley Foster is not alone. The Times survey revealed that 56% of women who stated that they had abortions felt a sense of guilt about it, and 26% now "mostly regret the abortion."¹⁷ Seeing as how half of the women who have abortions every year are ashamed to admit it even in a confidential survey, the numbers are likely to be even higher than that.¹⁸ Even if the survey underestimates the amount, it means there are thousands and thousands of women for whom abortion has been, not a benefit, but a heavy, heavy burden. Many echo the pain of Shirley Foster.

¹⁵ Letter from Judy Oulliber to Senator Gordon Humphrey, (June 5, 1986).

¹⁶ An open letter from Shirley Foster to Cygma Abortion Clinic (July 12, 1989).

¹⁷ Skelton, Abortion often causes guilt, regret, poll finds, The Sacramento Bee, March 19, 1989, at A-7, col. 2. APP H.

¹⁸ See Whitehead and Patrick, Exclusive Interview: U.S. Surgeon General C. Everett Koop, Rutherford Journal, Vol. 6, No. 1, at 30, 31 (Spring 1989).

Sandra D. Walton of Silver Spring, Maryland, says,

I didn't receive any formal counseling at the clinic. They simply described the suction abortion procedure and said it would only take a few minutes. Those few minutes scarred me for the rest of my life. If only someone had been there to give me the facts about the child inside of me. If only someone had been there to point out alternatives that would help me and accept the responsibility instead of escaping it at the expense of my baby's life. I could have been spared the haunting grief and guilt.¹⁹

Teresa L. Wibblesman says,

When I was 16 I was shuffled through an assembly line abortion. I was number 13 of 17 who went through the morning session at one abortion clinic...I'm not sure the tears will ever stop...If I had known then that it would be difficult to sleep at night and that every time I saw a child about the same age as the one I got rid of my insides would flinch, or that I would feel I had to have another child to 'justify' my actions as a teenager, I hope and pray I would have made another decision.²⁰

Still another account notes,

Before her abortion while three months pregnant, Julie Engel recalls asking an abortion counselor, "What does a three-month-old fetus look like?" "Just a clump of cells," she answered matter-of-factly. Years later she saw some pictures of fetal development. "When I saw that a three-month-old 'clump of cells' had fingers and toes and was a tiny, perfectly formed baby, I became really hysterical. I'd been lied to and misled."²¹

Not every woman who has an abortion experiences life-long trauma. Many people do not experience the pain and remorse until several years later.²² But, if these

¹⁹ Sandra D. Walton, Letter, 133 Cong. Rec. S 12,326 (daily ed. Sept. 17, 1987).

²⁰ Teresa L. Wibblesman, Letter, 133 Cong. Rec. 17,371 (daily ed. Dec. 4, 1987).

²¹ Rockmore, Are You Sorry You Had an Abortion?, Good Housekeeping, July 1977, at . APP M.

²² Washington Post columnist Colman McCarthy recounts the words of Dr. Julius Fogel in an article entitled The Real Anguish of Abortions, Washington Post, Feb. 5, 1989, at F-2, col. 4. Dr. Fogel, an Ob-Gyn and a psychiatrist, says,

There is no question about the emotional grief and mourning following an abortion. It shows up in various forms. I've had patients who had abortions a year or two ago - women who did the best thing at the time for themselves - but it still bothers them. Many come

testimonials and the L.A. Times survey are to be believed, a significant number of those having abortions will suffer years of guilt and anguish, something counselors working for the abortion industry never told them about, and something the counselors currently have no legal obligation to warn them about. Isn't it time the rights of women were protected from the exploiters of the abortion industry?

D. Letting patients, not physicians, decide

At one time in our history, physicians had both the legal right and the social approbation to decide what was in the best interest of their patients, including what patients were to be told about their conditions. Things have changed. Though this paternalistic attitude continues to pervade the medical profession, it no longer goes unchallenged either in the law courts or in the court of public opinion.

In 1972, in the landmark case of Canterbury v. Spence, a federal Court of Appeals held that "every human being, and thus every medical patient, of adult years and sound mind has the right to determine what shall be done with his [or her] own body."²³ The court further held that the "[m]edical patient's true consent to what happens to him [or her]self is informed exercise of choice, entailing opportunity to evaluate knowledgeably the options available and risks attendant upon each."²⁴ The court stated "It is the prerogative of patient, not physician, to determine for him [or her]self the direction in which his [or her] interests seem to lie."²⁵ The physician has a duty to tell the patient of risks and alternatives, and failure to disclose such information may be grounds for a suit.²⁶ The physician is not to impose his or her

in -some are just mute, some hostile. Some burst out crying...There is no question in my mind that we are disturbing a life process.

McCarthy goes on to say that in 1971, when Fogel and others were legally performing "therapeutic abortions," Fogel had made the same type of observations.

Often the trauma may wink into the unconscious and never surface in a woman's lifetime...[But] a psychological price is paid. I can't say exactly what. It may be alienation, it may be pushing away from human warmth, perhaps a hardening of the maternal instinct. Something happens on the deeper levels of a woman's consciousness when she destroys a pregnancy. I know that as a psychiatrist.

²³ Canterbury v. Spence, 464 F. 2d 772, 780 (D.C. Cir. 1972). APP O.

²⁴ Id.

²⁵ Id. at 773.

²⁶ Ibid.

own beliefs on the patient.²⁷ Finally, "Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves".²⁸

More and more emphasis is being placed on the importance of patient autonomy - the right of the patient to decide for him or herself what treatment is in his or her best interest - as a basic, if not primary consideration in physician disclosure. The outgrowth of malpractice suits,²⁹ as well as the establishment of documents such as "living wills" testify to the increased public insistence on the patient as the decision maker in any medical decision. More and more often, the public is demanding the right of informed consent.³⁰

Even those in the medical profession are beginning to recognize the doctrine of informed consent. In a recent article in JAMA, the authors admitted that a paternalistic bias had long permeated the profession.³¹ They said, "some factors that

²⁷ Id. at 774.

²⁸ Id. at 784.

²⁹ See Lawyer Says MD Has a Duty to Give Sufficient Information to Patient When Securing Informed Consent, 19 Ob.Gyn News 34 (1984). According to this article, Douglas Danner, J.D., at a conference sponsored by the American Society of Law and Medicine, warned physicians that they are susceptible to possible legal action if they ignore the basic principles of informed consent. Among his warnings: recognize that the prerogative belongs to the patient; don't delegate the job of getting consent to staff members; just answering questions is inadequate; never call any procedure "routine;" and get written consent whenever possible. APP P.

³⁰ According to a study published in Haug & Lavin, Consumerism in Medicine: Challenging Physician Authority 83 (1983), nearly two-thirds of primary care practitioners believe patients are more apt to challenge their authority than previously. Furthermore, one out of six members of the public say they are not as inclined to accept a doctor's opinion as in the past. The authors suggest that this patient mood and behavior may be spreading.

³¹ Forrow, Wartman, & Brock, Science, Ethics, and the Making of Clinical Decisions, J.A.M.A. 3161, 3165-66 (June 3, 1989). APP Q. The authors note:

Some have argued that few patients can understand the risks and benefits of medical interventions accurately enough to make decisions that optimize their own interests. Although this may at times be true for some seriously ill patients, it is much less true, if it is true at all, for many asymptomatic ambulatory patients. Those who doubt the ability of patients to make fully rational medical judgments implicitly assume that the judgments of physicians is significantly more reliable. Many studies have suggested, however, that physicians' decisions are influenced by a wide variety of factors that are unrelated to a patient's specific medical problem. These include practice setting, degree of specialization, and physician age. Other studies have shown that physicians may misunderstand quantitative medical information and that they may manifest some of the same "irrational" biases in decision making to which patients are claimed to be susceptible.

are pivotal in the determination of whether treatment serves a patient's best overall interests may only be understood or known by the patient."³² Rather than a one-sided relationship in which a patient humbly and quietly acquiesces to the physician's wishes, they urge a partnership in which "physician and patient each contribute their own special knowledge to the decision-making process."³³

Yet it is obvious from the accounts we have already recounted that the paternalistic bias still permeates the abortion process. Those who oppose informed consent legislation often do so on the supposed basis of concern for the anxiety of the pregnant woman. Such an attitude is patently paternalistic and degrading, denigrating the maturity and rationality of women. Someone who withholds information from the woman is attempting to make the decision for her, assuming she is somehow incapable of handling or understanding the information. It becomes a decision not by the woman and her doctor, but by the doctor alone, usually a male, and usually employed by the abortion industry.

For those that support a "woman's right to choose," it is entirely inconsistent to assert that women are incapable of making their own decisions in stressful situations, and that someone else must make the decision for them.³⁴ Making a decision about abortion may indeed involve anxiety, but only having access to all relevant information before making that decision makes it truly her decision, rather than that of her doctor or abortion "counselor."

David Reardon writes:

✓ [The desire to "protect" women from the biological facts and moral issues of abortion is all part of the paternalism of abortion providers, which automatically presumes that abortion is the "best" solution for women in trouble... Instead of giving women all the available information and alternatives so they can decide for themselves, counselors screen the information given so as to "guide" their clients to the "best" solution.³⁵

... Too frequently, however, articles about compliance seem automatically to assume that a physician's recommendations do in fact promote a patient's overall interests and well being.

³² *Id.* at 3164.

³³ *Id.* at 3165.

³⁴ See National Abortion Federation, *Twelve Years of Legalized Abortion* (1985). Even this pamphlet, published by the nation's largest organization of abortion providers, touts their member facilities for presumably providing informed consent. The pamphlet claims, "[c]ounseling ensures that a woman is not being coerced into having an abortion, that she has explored all options available to her and that she understands the risks and benefits of the procedure." However, see text accompanying notes 7, 8, 10, 14, and 17 for documentation that few clinics in fact provide counseling that assures truly informed consent.

³⁵ Reardon, *supra* n. 11, at 251. APP M.

To deny women access to the information relevant to their decision is to treat them like children or second-class citizens, perpetuating the oppression and discrimination the women's movement has fought so many years to overturn.

III. Public Support for Informed Consent

Polls have repeatedly shown wide public support for informed consent statutes. A July 1989 Newsweek poll showed that 89% of those questioned agreed that "Women seeking abortions must be counseled on the dangers and alternatives to abortion."³⁶

A study done for the Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical Research found that 94% want to be told everything about their condition and treatment, even if it is unfavorable, and 89% believe the patient's right to information should be protected by law.³⁷

A Boston Globe poll published in December of 1989 showed that by almost a 4 to 1 margin (76% to 16%), Americans favored the adoption of statutes requiring medical personnel to inform a woman considering an abortion about fetal development and abortion risks and alternatives.³⁸ Many state polls reveal similar results.³⁹ In no poll does a majority oppose informed consent legislation.

³⁶ Salholz, 'Informed Consent': Graphic Literature, Newsweek, July 17, 1989, at 20, col. 2. APP C.

³⁷ 2 U.S. Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship 21 (1982). APP B.

³⁸ Boston Globe, December 17, 1989, at A1, col. 1.

³⁹ Baltimore Evening Sun, September 5, 1989, at A-6, col. 1 (72% of Marylanders would require physicians to describe the extent of fetal development); St. Petersburg Times, October 6, 1989, at 1B, (77% (vs. 14%) favor requiring doctors to provide information about the fetus, including his or her health and stage of development); Orlando Sentinel, October 8, at A-1, col. 1 (82% favor a requirement that the doctor offer counseling about alternatives to abortion); Casper Star Tribune, January 6, 1990, at A-1, col. 4 (97% of Wyomingans believe a woman "should be given complete information about the procedure and its physical and emotional risks, as well as alternatives to abortion.").

IV. The Constitutionality of Informed Consent

The majority of the current members of the Supreme Court have indicated they would consider a properly drawn informed consent statute to be constitutional. In Webster v. Reproductive Services, 109 S.Ct. 3040 (1989), the three justice plurality opinion singled out the previous decisions of the Court that had struck down informed consent statutes for criticism. Criticizing the "virtual Procrustean bed" earlier Court decisions had made of abortion law, the plurality wrote,

Statutes specifying elements of informed consent to be provided abortion patients, for example, were invalidated if they were thought to 'structur[e] ... the dialogue between the woman and her physician.' ... As the dissenters in Thornburgh pointed out, such a statute would have been sustained under any traditional standard of judicial review ... or for any other surgical procedure except abortion. ... There is no doubt that our holding today will allow some government regulation of abortion that would have been prohibited under the language of such cases as Akron v. Akron Center for Reproductive Health, Inc.⁴⁰

In the original Thornburgh case, Justices White and Rehnquist explicitly approved of Pennsylvania's informed consent provisions.⁴¹ They were joined by Justice Kennedy in the Webster plurality. Concurring in Webster, Justice O'Connor reaffirmed her dissent in Thornburgh.⁴² In her Thornburgh dissent, Justice O'Connor wrote on behalf of upholding the provisions of the Pennsylvania informed consent statute.⁴³ Together with Justice Scalia, who stated in Webster that he would have reversed Roe outright,⁴⁴ these make a majority of five justices who appear prepared to sustain a reasonably drawn informed consent statute.

⁴⁰ Webster v. Reproductive Health Services, 109 S. Ct. 3040 (1989), 3051 (supporting citations omitted).

⁴¹ Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 798-804.

⁴² Webster, 109 S.Ct at 3063.

⁴³ First Amendment concerns expressed by Justice O'Connor have been taken into consideration in subsequent formulations of informed consent laws.

⁴⁴ Webster, 109 S.Ct. at 3064.

V. Answering Objections

OBJECTION: Isn't this just a backhanded attempt to stop abortion?

RESPONSE: It is an attempt to stop people from making decisions based on incomplete or inaccurate information, decisions many come later to regret.

OBJECTION: Won't all this information just increase the pregnant woman's anxiety?

RESPONSE: The question assumes a paternalistic attitude which denigrates the woman's maturity and rationality. Women are fully capable of making their own decisions, even under stressful situations, if given the relevant information. Any decision-making process may produce anxiety, especially ones such as this, but having access to all relevant information regarding that decision helps the mother feel more confident about her decision, and helps to protect her against the self-doubts that may plague her for years to come.

OBJECTION: This is just torture -- a woman has already made up her mind before coming to the clinic.

RESPONSE: This is not necessarily so. In a survey conducted by Women Exploited By Abortion, only 31% of the women visiting an abortion clinic said they felt "firm" about their decision before going in. Even including those that did feel firm about their decisions, a full 88% of those visiting the clinics believed they did not have the information necessary to make the decision.⁴⁵ These figures indicate that although a small minority may research their condition and alternatives before consenting to a procedure, the vast majority rely on their physicians to give them such information. If the physician fails in this responsibility, most women are never exposed to complete information about their condition, the condition of the unborn child they carry, or the real medical, legal and social alternatives to their dilemma.

OBJECTION: Wouldn't this just make the state a conduit for graphic pro-life propaganda?

RESPONSE: The state, not the pro-life lobby, would have the responsibility for determining the exact nature of the material made available to the woman. The standard would be whatever sort of information about procedures, risks, alternatives, or even fetal development a reasonable individual might request. Descriptions of procedures, statistics on risks, information on alternatives, accounts of psychological effects, clinical photographs of fetal development, may be "graphic" in the sense that they provide a "clear, visual impression" (Webster's New Collegiate Dictionary, 1973), but this need not make them gross or repulsive.

⁴⁵ Reardon, *supra* n. 11, at 328-338. APP T.

OBJECTION: What if someone doesn't want the information?

RESPONSE: No one would be forced to read or view any information they did not want to. The state's only interest is that this information be made available and that the patient express free and unfettered consent in light of the facts at her disposal.

OBJECTION: Wouldn't this intrude on the privacy of the patient-physician relationship?

RESPONSE: In many if not most cases, there is no significant relationship between physician and patient in the abortion context. This legislation would not compel a woman to continue a pregnancy, or force the physician to recommend any particular option. It's only purpose is to insure that the woman has available all materials and information germane to her decision. The confidence and privacy of the physician-patient relationship need not be violated. Though this will encourage the less considerate physician to spend more time with his or her patient, a healthy physician-patient relationship will hardly be affected at all.

OBJECTION: Isn't this punishing responsible physicians for the sake of an unscrupulous few?

RESPONSE: It should not be considered punishment to ask a physician to assist his or her patient in making an informed decision. As most physicians realize, an informed patient is a better patient, more likely to feel comfortable about the chosen procedure, less likely to sue later on for malpractice.

OBJECTION: Why is written consent necessary? Isn't this unnecessary intrusion into a physicians affairs?

RESPONSE: Under current law, a physician or health care facility may be held liable for failure to inform a patient of potential risks associated with or possible alternatives to a given medical procedure. Informed consent laws requiring written consent can help protect health care providers from civil liability by documenting that the patient made a free and informed decision.⁴⁶

OBJECTION: Why frighten a woman with details of physical injury from abortion when the risk is actually so small, in fact, less than the risk from delivery if the child were carried to term?

RESPONSE: The legislation would require only that "medically accurate" risks be revealed. It is entirely appropriate and balanced to tell the mother both the physical risks of abortion as well as the risks of carrying the child to term and then let her make the decision. A mother has a right to know of the specific risks she takes, not only the immediate consequences, but also the possible effects on later

⁴⁶ Southwick, *The Law of Hospital and Health Care Administration* 351, 353-355 (1988). APP R. See also Wood and Durham, *supra* n. 2, at 829 (APP A), and 19 Ob. Gyn. News 34, 35 (1984) (APP P).

pregnancies.

OBJECTION: Why should a physician tell his or her patient about possible physical or psychological risks?" Didn't the Surgeon General say that there was no evidence that there were any serious physical or psychological effects?

RESPONSE: Surgeon General C. Everett Koop never said there were no serious physical or psychological after-effects of abortion. His letter to President Reagan on January 9, 1989 merely stated that all studies done to that date had been methodologically flawed, so that they couldn't prove anything, including the claim that abortion was a medically safe procedure.⁴⁷ Many of the studies focused only on short term results, without following women for more than a few months. In interview after interview, Koop repeatedly emphasized that he had ample anecdotal evidence of women who experienced injury or trauma as a result of their abortions. In an interview published by the Rutherford Journal, Koop said the following about possible physical effects of abortion.

After abortion you can have sterility, you can have an incompetent cervix, so the baby doesn't stay in there and falls out two or three months later. You can have a premature baby. Those things all happen from abortion. How can you say it differently?⁴⁸

Furthermore, Koop says that, as a doctor, he is personally aware of detrimental psychological effects of abortion.

I have counseled women with this problem over the last 15 years. ... Let me give you an anecdote. A woman had a pregnancy at about [age] 38 [or] 39. Her kids were teenagers. And without letting her family or husband know, she had an abortion. At the moment, she said "[The abortion was] the best thing that ever happened to me -clean slate, no one knows. I am all fine" Ten years later, she had a psychiatric break when one of those teenage daughters who had grown up, got married, delivered a baby, presented it to her grandmother.⁴⁹

Short term studies would have termed this a "perfectly fine result of an abortion." There are other examples besides this one.

⁴⁷ Letter from C. Everett Koop to Ronald Reagan (Jan. 9, 1989), and Letter from C. Everett Koop to Jack Wilke (Jan. 10, 1989). APP F.

⁴⁸ Whitehead and Patrick, *supra* n. 18, at 33. For further study, see Wilke, *Abortion: Questions and Answers* 91 (Rev. ed 1988), APP E, and Hilgers and O'Hare, *Abortion Related Maternal Mortality: An In-Depth Analysis*, in *New Perspectives on Human Abortion* 69 (1981), APP D.

⁴⁹ *Id.* at 31.

Karen Cross says "For nine years, I felt my abortions were the best thing I could have done. I didn't realize the impact they would have on my life, and the nightmares that would come. I would leave in tears when I saw a mother cradle her new born child and thought of my own aborted children who would never know my love or feel my arms around them."⁵⁰

Koop says that long term studies would add more credibility to those who claim that there are serious detrimental health effects to abortion. He also says that the mere fact that half of the 1.5 million women every year who have abortions deny it on confidential questionnaires indicates, in Koop's words, "that there is a tremendous psychological problem in the minds of most women just to have said, 'I had an abortion.'"⁵¹

OBJECTION: Wouldn't the state be favoring one particular religious view of personhood in attempting to protect fetal life?

RESPONSE: In providing such information, the state does not take any particular view of when life begins. The courts have ruled that the undisputed fact that "potential life" exists is sufficient to grant the state a legislative interest.

OBJECTION: Aren't you making a special case for abortion?

RESPONSE: No. Informed consent has become an increasingly accepted standard for all areas of medical practice. It is recommended as a standard procedure by the J.A.M.A.,⁵² the Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,⁵³ and the courts.⁵⁴ It has been recommended for anesthesiologists,⁵⁵ Ob-Gyn's,⁵⁶ pediatricians,⁵⁷ doctors practicing internal medicine,⁵⁸ and those performing breast cancer surgery.⁵⁹

⁵⁰ Abortion: A Special Report, USA Today, Apr. 26, 1989, (Special Advertising Insert). APP G.

⁵¹ Id. at 31.

⁵² APP Q.

⁵³ APP B.

⁵⁴ APP O.

⁵⁵ Gild. Informed Consent: A Review, 68 Anest. Analg. 649 (1989). APP N.

⁵⁶ APP P.

⁵⁷ Seek informed consent, pediatricians urged, American Medical News, Nov. 1, 1976, at 18, col. 1.

⁵⁸ APP Q.

⁵⁹ Shearer, MDs Must Level With Women, Parade, Apr. 10, 1983, at 6, col. 1.

VI. Conclusion & Summary

The decision whether or not to have an abortion is often a traumatic one. It is not made any easier by ignorance. The question has too often been framed as a choice between a lifetime of misery and a quick fix. The issue is much more complicated than that, as many women later sadly realize. Many women who undergo abortions later face years of psychological pain and trauma. Several experience physical problems. A woman needs to be aware that abortion does not always offer an easy escape from their problems. Sometimes it only compounds them.

Alternatively, women also need to be aware that carrying a child to term need not lead to a life of poverty or misery. There are legal and social remedies that, were the woman made aware of them, might not only solve many of the mother's immediate concerns, but also save her from a decision she would later regret.

Informed consent legislation is not an attack on personal freedom, but a guarantee of it. It is both constitutionally and legally sound. It safeguards woman's right to know and to make informed decisions. It helps to protect physicians from lawsuits. It is a reasoned and compassionate response to the needs of concerned pregnant women. It is good legislation.

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Reardon, <u>Aborted Women: Silent No More</u> 328 (1987).	APPENDIX T

States Which Have a Woman's Right to Know Law

The following states have informed consent statutes that give women who are considering abortion the right to know the medical risks of abortion, its alternatives, and non-judgemental, scientifically accurate medical facts about the development of the unborn child before making this permanent and life-affecting decision:

Delaware
Idaho*
Kansas
Kentucky
Louisiana

Mississippi
Nebraska
North Dakota
Ohio
Pennsylvania*
Utah

Only the Idaho, Kansas, Mississippi, Nebraska, North Dakota, Ohio, Pennsylvania and the Utah Woman's Right to Know laws are currently enforced. The rest have not been enforced since before the Supreme Court's Casey decision. Casey upheld the Woman's Right to Know law as constitutional saying:

[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 ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed. [R]equiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to insure an informed choice, one which might cause the woman to choose childbirth over abortion. Planned Parenthood of Southeastern Pennsylvania v. Casey, 112 S.Ct. 2791, 2823-24 (1992)

* Law contains exception for "health" of the mother which in practice allows the abortion-performing physician complete discretion to waive the informed consent requirement when he or she claims the emotional health of the woman would be harmed by providing information.

States Which Have Waiting Periods

The states listed below require that information about abortion, and its risks, and alternatives be provided to women a specified amount of time prior to the abortion -- not moments before the procedure. Only the Idaho, Kansas, Mississippi, North Dakota, Ohio, and Pennsylvania laws are currently enforced. The rest have not been enforced since before the Supreme Court's Casey decision which upheld the Woman's Right to Know law as constitutional. The following states provide for a specified amount of time for a woman to review her options before undergoing an abortion:

Deleware - 24 hrs
Idaho - 24 hrs* **
Kansas - 8 hrs
Kentucky - 2 hrs
Massachusetts - 24 hrs*
Mississippi - 24 hrs
Nebraska - 24 hrs
North Dakota - 24 hrs
Ohio - 24 hrs
Pennsylvania - 24 hrs*
South Dakota - 24 hrs

* Law contains exception for "health" of the mother which in practice allows the abortion-performing physician complete discretion to waive the informed consent requirement when he or she claims the emotional health of the woman would be harmed by the waiting period.

** Information must be provided to the woman at least 24 hours prior to the abortion "if reasonably possible."

March 1994

It's not too late to change your mind...

Abortion is not the 'solution.' So many women now regret their abortions, but sadly, abortion is irreversible...it can NEVER be undone. The time to reconsider is NOW.

•If you are sitting in an abortion clinic right now, you can get up and walk out. Don't say a word, just leave!

•If you have already made an abortion appointment, you can break it... or just don't go.

•If you have been considering abortion, we pray you won't.

Take your time...Beware of ANYONE who is pressuring you to have an abortion. YOU will be the one living with your decision.

Consider this...Abortion is a half-billion dollar-a-year industry. And those who are making PROFIT don't always tell the whole truth.

Help is available...Many agencies exist which offer you loving support and practical help...the kind of help that will see you through your pregnancy and many times beyond. This help is offered by people who really care about you and your baby. These agencies are NOT making a PROFIT from your unplanned pregnancy.

Real help is just a phone call away...Please care enough about your baby and yourself to make this simple phone call.

Call this number locally:

Pregnancy Problem Center
40 E. Ninth St
Bozeman, MT 59715

Open Arms cares about you.

Open Arms is a post-abortion ministry primarily made up of people who have personally experienced the tragedy of abortion.

If you have already had an abortion and are hurting, we want you to know your feelings are normal.

If someone you love has had an abortion and you are feeling bad about it, you are not alone.

Abortion effects every life it touches, and for many—it hurts.

If you want to talk with someone who understands, contact us.

Our arms are open to you.

"At the time, I told myself abortion was the right answer even though deep down I really wanted someone to say, 'It's OK, you can have your baby, I will help you.' I wish someone had tried to talk me out of the biggest mistake of my life."
-Darla

*All quotes are from personal testimonies on file. They are used with permission.

Open ARMS

P.O. Box 1086
Bozeman, MT 59715



Have you been told...

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everything you
need to know
about abortion?

We care about you

We have had abortions and want you to know what we found out—too late.

(All quotes are from personal testimonies. *)

Abortion may only make things worse.

"Abortion did not solve anything for me. I ended up quitting school, telling my parents, and having an emotional breakdown...all the things I thought I would avoid!"
-Sue

The relationship with the baby's father usually ends.

"I decided to abort primarily to save the relationship with my boyfriend. It did just the opposite—we broke up and moved apart within eight weeks."
-Rebecca

There is a baby in your womb.

"When I was 11-weeks pregnant, I was told my baby was nothing but a 'cluster of cells.' Grief and guilt over-whelmed me when I later found out he was a perfectly-formed miniature baby, able to feel pain."
-Karen

Abortion is often very painful.

"The abortion was the most painful physical experience of my life. It felt like my entire insides were being sucked out."
-Terri

Abortion could damage you physically.

"My legal abortion led to severe complications. The doctor punctured my uterus, cut an artery, and injured my colon. To save my life, I had to have blood transfusions and a total hysterectomy. I was misled to believe that abortion was a 'simple' procedure with NO complications!"
-Jan'

You may never have another baby.

"After my abortion I had three miscarriages, followed by pelvic inflammatory disease. I had to have a complete hysterectomy...that means no more children, EVER!"
-Cathy

Possible effects on your body

Immediate

Later

- | | |
|----------------------------|-------------------------------------|
| •Intense Pain | •Inability to become pregnant again |
| •Punctured uterus | •Miscarriage/Stillbirths |
| •Excessive bleeding | •Infection |
| •Parts of baby left inside | •Premature births |
| •Shock/Coma | •Pelvic inflammatory disease |
| •Damage to other organs | •Hysterectomy |
| •Death | |

"People do not understand that there are **thousands** of serious physical complications from abortion every year in this country."

-Dr. Bernard Nathanson, OB Gyn.
(former abortionist)

Possible effects on your emotions

The Most Common

- | | |
|----------------------------------|-------------------------------------|
| •Guilt | •Emotional numbness |
| •Desire to become pregnant again | •Sexual problems |
| •Inability to forgive yourself | •Lowered self-esteem |
| •Intense grief/sadness | •Anorexia or other eating disorders |
| •Anger/Rage | •Drug or alcohol abuse |
| | •Suicidal urges |

"Abortion has a painful aftermath, regardless of the woman's religious beliefs, or how positive she may have felt beforehand about her decision to abort."

-Vincent Rue, Ph.D.
(Psychologist)

Our warning to you

Not only can abortion hurt you physically, it can damage you emotionally as well.

"After my abortion I just tried to go on living a teenager's life, but I was really depressed. I dreamed about the baby. I had guilt that would never end. I started **hating myself for what I had done.**"
-Kim'

"After my abortion I became anorexic and nearly starved myself to death."
-Patti

"I had severe depression...I contemplated suicide. I have **horrible nightmares** about babies and people trying to kill me."
-Dee

"I felt so sad and alone after my abortion. I began to **die that day.** I couldn't drink enough...I wanted to be numb. I wanted another baby so badly."
-Marlane

"I was so angry I punched out windows with my fist...I hurt so much inside I had to hurt myself physically to release the pain...I tried suicide twice."
-Nicole'

"After my (suction) abortion I had heavy bleeding and severe cramps...two days later I 'passed' my baby. He had tiny hands and feet and I could make out his little nose. I was horrified! Sorrow overwhelmed me...Years of turmoil followed. The relationship with baby's father dissolved...so did my belief in love. I **drank too much, did drugs, and entertained any man who would look at me.** I was starved for acceptance."
-Kathy

"When I realized what I had done I was **grief-stricken, depressed, guilty, really hysterical.** My self-esteem plummeted and remains low. Abortion is the choice of a frightened woman. We need to help each other...not offer abortion as a cure-all."
-Kathryn

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Abortion: Some Medical Facts



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³⁰Testimonies of Wanda Franz, Ph.D., and Anne Speckhard, Ph.D., "*Hearing on Impact of Abortion, 1989*," op. cit.

"One in four pregnancies now end in an abortion, making it one of the nation's most commonly performed surgical procedures."

The Washington Post, January 23, 1983

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MEDICOLEGAL
FORMS
WITH
LEGAL ANALYSIS



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This is the latest edition of *Medicolegal Forms with Legal Analysis*, a publication first issued almost 35 years ago. The purpose and intention of this edition remains the same as with all previous editions, to be of assistance to the practicing physician.

This publication offers a brief legal analysis of some of the more common issues that confront physicians from time to time in their practice. The legal analysis is supported by court decisions and statutes. The forms presented in this book are very general in nature and must be specifically adapted to the particular facts of the case and to the legal requirements of each jurisdiction. All forms may not be able to be used in all states.

Before relying on the legal principles or the forms in this book, the physician should consult his or her own attorney for specific legal advice.

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**Consent to Operation, Anesthetics, and
Other Medical Services**

Form 21

Date _____ Time _____ A.M.
P.M.

1. I authorize the performance upon _____
(myself or name of patient)
of the following operation _____
(state nature and extent of operation)
to be performed by or under the direction of Dr. _____.

2. I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above-named doctor or his associates or assistants may consider necessary or advisable in the course of the operation.

3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service, with the exception of _____
(state "none," "spinal anesthesia," etc.)

4. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, the possible consequences, and the possibility of complications have been explained to me by Dr. _____ and by _____.

5. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

6. I consent to the photographing or televising of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.

7. For the purpose of advancing medical education, I consent to the admittance of observers to the operating room.

8. I consent to the disposal by hospital authorities of any tissues or body parts which may be removed.

9. I am aware that sterility may result from this operation. I know that a sterile person is incapable of becoming a parent.

10. I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing.

(Cross Out Any Paragraphs Above Which Do Not Apply)

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

**Consent to Operation, Anesthetics, and
Other Medical Services (Alternate Form)**

Form 22

Date _____ Time _____ A.M.
P.M.

1. I authorize the performance upon _____
(myself or name of patient)
of the following operation _____
(state name of operation)
to be performed by or under the direction of Dr. _____.

2. The following have been explained to me by Dr. _____:

A. the nature of the operation _____
(describe the operation)

B. The purpose of the operation _____
(describe the purpose)

C. The possible alternative methods of treatment _____
(describe the alternative methods)

D. The possible consequences of the operation _____
(describe the possible consequences)

E. The risks involved _____
(describe the risks involved)

F. The possibility of complications _____
(describe the possible complications)

3. I have been advised of the serious nature of the operation and have been advised that if I desire a further and more detailed explanation of any of the foregoing or further information about the possible risks or complications of the above listed operation it will be given to me.

4. I do not request a further and more detailed listing and explanation of any of the items listed in paragraph 2.

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

A.M.
P.M.

Date _____ Time _____

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

Witness _____ Signed _____
(name of the institution)
(Patient or person authorized to consent for patient)

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 . . ."²¹

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

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.

1 Hodge v. Lafayette General Hospital, 399 So.2d 744 (La. 1981); LaCaze v. Collif 434 So.2d 1039 (La. 1983). See generally, Miller, L.S., *Informed Consent*, 244 *J. of the American Medical Association*, 2100 et seq. (Nov. 7, 1980); Leonard v. New Orleans Orthopedic Clinic, 485 So.2d 1018 (1986); Hondrouns Schumacher, 531 So.2d 450 (1988); Scels v. Pitman, 499 So.2d 114 (1986); Staff 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); Harbenson v. Parke-Davis, Inc., 656 P.2d 483 (1983); Alexander v. Gonsse 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. §47.137 (1983 Supp.); Ky. Rev. Stat. §304.20-320 (Supp.); Ohio Rev. Code §2317.54 (Page); Me. Rev. Stat. tit. 24 §3905 (Supp.); N.Y. Prob. Health Law §2805-d (McKinney); Pa. Stat. Ann. tit. 40, §1301.103 (P. don) (Insurance Code); Utah Stat. Ann. §78-14-5; Vi. Stat. Ann., tit. 12, §1905 (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

(a) *The Diagnosis*. Because informed consent involves the patient 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 involve in the procedure or treatment should be listed. A risk, it should 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 impractic 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 c

Briggs, 219 Ala. 127, 121 So. 394 (1929); Nelson v. Farris, 143 Minn. 368, 173 N.W. 175 (1919); Urrutia v. Patino, 297 S.W. 512 (Tex. 1927).
6 *Podvin v. Eickhorst, 128 N.W.2d 523 (1964); Nelson v. Farris, 143 Minn. 368, 173 N.W. 715 (1919); Lawson v. Conaway, 37 W. Va. 159, 16 S.E. 564 (1892); Oliver v. Brock, 342 So. 2d 1 (Alabama, 1976); Keene v. Wiggins, 138 Cal. Rptr. 3 (California, 1977); Butlersworth v. Swint, 185 S.E. 770 (Georgia, 1936); Andrews v. Davis, 148 A. 684 (Maine, 1930); Belesh v. United States, 400 F. Supp. 238 (Maryland, 1974); Peterson v. Phelps, 143 N.W. 793 (Minnesota, 1913); Young v. Crescente, 39 A.2d 449 (New Jersey, 1944); Davis v. Tirrell, 443 N.Y.S.2d 136 (New York, 1981); Childers v. Frye, 158 S.E. 744 (North Carolina, 1931); Osborne v. Frazor, 425 S.W.2d 768 (Tennessee, 1968); Lyons v. Greher, 239 S.E.2d 103 (Virginia, 1977); Miller v. Dunnon, 64 P. 804 (Washington, 1901); Nicholson v. Curtis, 452 N.E.2d 883 (Illinois, 1983); Sullenger v. Selco Northwest Inc., 702 P.2d 1139 (Oregon, 1985).*

1.2 Nature of the Relationship

It is clear that the physician-patient relationship is a consensual one, a contract. This contract, however, is usually not a written document setting forth the terms, rights, and responsibilities of the parties. Rather, the contract is implied; the patient requests medical care and the physician agrees to provide it. The contract thus created is one based on a fiduciary, not a financial, relationship.

The Supreme Court of Virginia, for example, has held that in accepting an appointment to treat a particular patient, the physician had an implied agreement to provide a specific medical service at a specific date and time. Consequently, the relationship could be characterized as a consensual one between the physician and patient and gave rise to a duty to perform the services contemplated.¹

In another instance, a patient called to indicate that he would be late for his second appointment with the physician. The doctor indicated that he would not treat the patient and did not refer him to another physician. The court of appeals concluded that the relationship between the patient and the physician was sufficient to impose a duty upon the doctor to conform to the usual standard of care in such a case. The court found that to guard against injury, the physician should have advised the patient of his condition and told him to consult another physician without delay.²

These rulings suggest that a duty of care exists, whether it arises from a formal physician-patient relationship or occurs simply as a result of the acceptance by a physician, or his or her office staff, of an appointment to see a patient with a specific medical prob-

lem. If the physician decides not to see the patient, he or she should notify the patient in writing by registered letter, with a return receipt requested, to seek other medical assistance and offer to help in finding such assistance.³

¹ Lyons v. Greher, 218 Va. 630, 329 S.E.2d 103 (1977).

² Davis v. Hagman, 439 N.E.2d 660 (1982).

³ E.A. Bianco, *Legal Physician-Patient Relationship, legal aspects of medical practice, American College of Legal Medicine, Volume 11 No. 5, May 1983.*

1.3 Creation of the Relationship

The physician-patient relationship is created when a physician responds to an express or implied request for treatment from a patient or the patient's guardian.¹ One issue that arises is whether the relationship may be created even if the doctor never actually sees the patient. Courts have divided over this issue.

In one instance,² the court held that no contract was created when a physician spoke to a nurse over the telephone and advised her to have a patient call the latter's regular doctor. In another case,³ the court held that a physician on call in an emergency room was obligated by medical staff rules to provide emergency treatment to any emergency patient.⁴ A useful rule of thumb is that if the patient is justifiably relying on the physician's advice, a relationship is assumed.⁵

In another instance, it was ruled that a physician-patient relationship did not occur when a woman telephoned a physician who had treated her previously for an unrelated condition. The physician listened to the woman's recital of symptoms, told her to see him the next morning, and recommended that she continue the immediate course of treatment prescribed by another physician.⁶

In another case, no physician-patient relationship was found to exist between the recipient of a donated kidney and the doctor of the donor because the donor's doctor was never the recipient's doctor. That doctor did not have a duty to that patient. The donor's physician owed a duty to the donor and the recipient's physician owed a duty of care to the recipient patient.⁷

- 1 *Stowers v. Ardmore Acres Hospital*, 172 N.W.2d 497 (Mich. 1969); *Greenwald v. Grayson*, 189 So.2d 204 (Fla. 1966); *State of North Carolina v. Hollingsworth*, 139 S.E.2d 235 (N.C. 1964).
- 2 *Childs v. Weis*, 440 S.W.2d 104 (Tex. 1969).
- 3 *Hiser v. Randolph*, 617 P.2d 774 (Ariz.) reh. den. (1980).
- 4 *Id.* at 778.
- 5 *Kaisetos v. Nolan*, 368 A.2d 172 (Conn. 1976); *Johnson v. Vaughan*, 370 S.W.2d 591 (Ky. 1955). See also cases where a relationship was established: *Duprey v. Shane*, 249 P.2d 8 (California, 1952); *Stafford v. Shultz*, 270 P.2d 1 (California, 1954); *Rule v. Cheeseman*, 317 P.2d 472 (Kansas, 1957); *Barttos v. Sara Mayo Hospital*, 264 So.2d 792 (Louisiana, 1972); *Peterson v. Phelps*, 143 N.W. 793 (Minnesota, 1913); *Frazor v. Osborne*, 414 S.W.2d 118 (Tennessee, 1966); *Lyons v. Grether*, 239 S.E.2d 103 (Virginia, 1977). *Relationship not established: Greenwald v. Grayson*, 189 So.2d 204 (Florida, 1966); *Sendjar v. Gonzales*, 520 S.W.2d 478 (Texas, 1975); *Thomas v. Kenton*, 425 So.2d 396 (Louisiana, 1982).
- 6 *Clanton v. Von Haam*, 340 S.E.2d 627 (Georgia, 1986).
- 7 *Moore, et al v. Shah-New York*, 458 N.Y.S.2d, 33, 90 AD 3rd Dept., (December 30, 1982).

1.4 Continuing the Relationship

Once a physician-patient relationship is created, a doctor is under an obligation to provide services as long as the patient requires them or until the relationship is properly terminated.¹ The patient's failure to pay a bill does not end the relationship because the contract that exists is based on a fiduciary, not a financial, responsibility.²

A physician may limit the scope of the relationship to a designated geographic area or medical specialty. In one such case, a woman had a cut treated by a physician's associate. The next day she left for vacation 20 miles away. While there, she decided that she needed additional treatment and asked the physician to come and treat her. Instead, the doctor gave her the name of a local physician. This action was upheld as proper.³

- 1 *Johnson v. Vaughan*, 370 S.W.2d 591 (Kentucky, 1963); *Coughlin v. Christoffer-son*, 431 P.2d 997 (Washington, 1967).
- 2 *Ricks v. Budge*, 64 P.2d 208 (Utah 1937).
- 3 *McNamara v. Emmons*, 97 P.2d 503 (Cal. 1940).

2.1

Physician Discharge Or Terminating The Relationship

A physician-patient relationship may be terminated by the patient, the doctor, or mutually. Once the relationship has ended, the physician is under no obligation to follow the patient's progress.¹ At least one court has held, however, that a duty continued after the relationship ended.

In that case,² the court imposed a responsibility on the doctor to inform the patient of the newly discovered hazards of an IUD. The physician nonetheless stated that he only saw the patient when he inserted the IUD. The court stated that the duty "... would arise by virtue of the confidential relationship between doctor and patient. It is ... a malpractice action from the imposed continuing status of physician-patient when the danger arose from that relationship."³

- 1 *Fleishman v. Richardson-Merrell, Inc.*, 266 A.2d 843 (N.J. 1969).
- 2 *Tressmer v. Barke*, 86 Cal. App. 3d 656, 150 Cal. Rptr. 389 Cal. 2d Div. (1978). See also, *Lee v. Dewbre*, 362 S.W.2d 900 (Lexis 1962); *Johnson v. Vaughan*, 370 S.W.2d 809 (Ky. 1955); *Carroll v. Griffin*, 101 S.E.2d 764 (Ga. App. 1958); *Vann v. Horden*, 47 S.E.2d 314 (Va. 1948); *Bolles v. Kenton*, 263 P.2d 26 (Colorado, 1928).
- 3 *Id.* at 394; *Tressmer v. Barke*, 150 Cal. Rptr. 384 (2nd Div. 1978) (summary judgment review); *Lee v. Dewbre*, 362 S.W.2d 900 (Lexis 1962); *Johnson v. Vaughan*, 370 S.W.2d 809 (Ky. 1955); *Carroll v. Griffin*, 101 S.E.2d 764 (Ga. App. 1958); *Vann v. Horden*, 47 S.E.2d 314 (Va. 1948); *Bolles v. Kenton*, 263 P.2d 26 (Colo. 1928).

2.2

Termination by the Physician

A physician cannot withdraw from a case or discontinue practicing and thereby avoid liability by not seeing a patient without notifying the person of the withdrawal.¹ When a physician wishes to withdraw from a case, he or she must give the patient reasonable notice so that the person may secure other medical attention if that is desired.²

One way to determine what is a reasonable amount of time is to consult other physicians in the area. Factors to be considered include the condition of the patient, the size of the community, and the availability of other doctors.³ The final decision must be made by the physician on the facts of each case. If proper notice is not given, and the patient suffers damages, ... doctor may

Form 1a

To minimize liability exposure and to facilitate termination of a physician-patient relationship, when a physician intends to withdraw from a case, the patient should be clearly notified. The physician should send a letter preferably certified, to the patient explaining the situation. A copy should be kept in the doctor's files. The accompanying examples may be useful.

1 Carol v. Griffin, 96 Ga App 826, 101 SE 2d 764 (1958); Vans v. Horden, 182 Va 555, 47 SE 2d 314 (1968); Boeles v. Kinton, 83 Colo. 147, 263 P. 26 (1928);
 2 Katselos v. Nolan, 368 A.2d 172 (Conn. 1972); Collins v. Meeker, 424 P.2d 488 (Kan. 1967); Norton v. Hamilton, 89 S.E.2d 809 (Ga. App. 1955); Sibert v. Boger, 260 S.W.2d 569 (Mo. 1953); McGulph v. Besmer, 43 N.W.2d 121 (Iowa 1950); Groce v. Myers, 29 S.E.2d 553 (N.C. 1944); Gray v. Davidson, 130 P.2d 341 (Wash. 1942); Baird v. National Health Foundation, 144 S.W.2d 850 (Mo. App. 1940); Ricks v. Budge, 64 P.2d 208 (Utah 1937); Fortner v. Koch, 261 N.W. 762 (Mich. 1935).
 3 Brandt v. Grubin, 329 A.2d 82, 88 (N.J. 1974). See Sendjar v. Gonzales, 520 S.W.2d 478 (Tex. 1975) (coverage was adequate so no abandonment); Medvecz v. Choi, 569 F.2d 1221 (3d Cir. 1977). In Sibert v. Boger, 260 S.W.2d 569 (Mo. 1953), it was held that the physician did not abandon the case when the physician directed the patient to go to somebody else because she was consulting another physician at the time and the city was sufficiently large that medical services could have been obtained any day. See also Urrutia v. Patino, 297 S.W. 512 (Tex. 1927).

Form 1b

Date: _____

Dear _____:

I will no longer be able to provide medical care to (you/your children). If you require medical care within the next _____ days I will be available, but in no event longer than _____ days.

To assist you in continuing to receive medical care for (you/your children), we will make records available to a new physician as soon as you authorize us to send them to that physician.

Sincerely,

_____, M.D.

Date: _____

Dear _____:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you because you have persisted in refusing to follow my medical advice and treatment. Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you desire, I shall be available to attend you for a reasonable time after you receive this letter, but in no event for more than _____ days.

This should give you ample time to select a physician of your choice from the many competent practitioners in this city. With your authorization, I will make available to this physician your case history and information regarding the diagnosis and treatment you have received from me.

Very truly yours,

_____, M.D.

**Letter for Physicians
Discontinuing Practice**

Form 2

Date: _____

Dear _____

Because of _____ (my retirement, reasons of health, etc.) I am discontinuing the practice of medicine on _____, 19 _____. I will not be able to attend you professionally after that date.

I suggest that you arrange to place yourself under the care of another physician. If you are not acquainted with another physician, I suggest that you contact the _____ (local) Medical Society.

I shall make my records of your case available to the physician you designate. Since the records of your case are confidential, I shall require your written authorization to do so. For this reason, I am including at the end of this letter an authorization form. Please complete the form and return it to me.

I am sorry that I cannot continue as your physician. I extend to you my best wishes for your future health and happiness.

Yours very truly,
_____, M.D.

Authorization to Transfer Records

Form 3

Date: _____

To: _____, M.D.

I hereby authorize you to transfer or make available to _____, M.D., _____ (address) all the records and reports relating to my case.

Signed _____

**Acknowledgement of Emergency
Treatment**

Form 4

Date: _____

Time: _____ a.m. p.m.

I acknowledge that the medical care which (was) (is about to be) furnished to (*name of patient*) by Dr. _____ (was) (will be) limited solely to emergency treatment. I understand that it will be necessary to select another physician and make immediate arrangements with that physician for a complete diagnosis and continuation of treatment.

Witness _____ Signed _____ (patient or person authorized to consent for patient)

*If the physician has agreed to provide only emergency treatment, the execution of this form before or immediately after treatment would be valuable as evidence against any later claim that the physician abandoned the patient by failing to continue treatment.

2.3

Termination by the Patient

A patient may unilaterally terminate a physician-patient relationship at any time. Since the patient's withdrawal is often unannounced or unexpressed a dispute may arise as to whether the physician had a continuing responsibility to attend the patient. If no further medical services are necessary for the particular injury or illness the physician was employed to treat, the relationship usually ceases without any formalities.

If a physician is discharged by a patient in need of further medical attention, or if the patient leaves the hospital against the physician's advice, the doctor should be in a position to establish that no abandonment occurred.¹

There are several methods of protecting the physician from an abandonment lawsuit. These include obtaining a signed statement of the facts by the patient, or sending a letter to the person either confirming the discharge or the fact that the patient left against

medical advice. Again, certified mail is preferable and a copy should be retained in the physician's files. The accompanying examples may be useful.

1 Pearson v. Norman, 106 P.2d 361 (Colo. 1940); Muckleroy v. McHenry, 16 P.2d 123 (Okla. 1932); Duke Sanitarium v. Hearn, 13 P.2d 183 (Okla. 1932).

Letter Suggesting Follow-Up

Form 5

Dear _____: _____ Date: _____

As we discussed during your appointment today, I suggest that you make another appointment with me for a check-up in approximately _____ . Although my examination does not indicate the existence of any condition requiring treatment at this time, your condition should be monitored by me or another physician.

Sincerely,
_____, M.D.

Letter to Confirm Discharge by Patient

Form 6

Dear _____: _____ Date: _____

This will confirm our telephone conversation today during which you discharged me from attending you as your physician in your present illness. In my opinion, your condition requires continued medical treatment by a physician. If you have not already obtained the services of another physician, I suggest that you do so without delay. You may be assured that, upon your authorization, I will furnish that physician with information regarding the diagnosis and treatment that you have received from me.

Very truly yours,
_____, M.D.

Letter to Patient Who Falls to Follow Advice

Form 7

Dear _____: _____ Date: _____

At the time you brought your (*daughter/son*), to me for examination this afternoon, I informed you that I was unable to determine without X-ray pictures whether a fracture existed in (*his/her*) injured (*right/left*) arm. I strongly urge you to permit me or some other physician of your choice to make this X-ray examination without further delay.

Your refusal to permit a proper X-ray examination to be made of (*this/her*) arm may result in serious consequences if a fracture exists.

Very truly yours,
_____, M.D.

**Statement of Patient Leaving*
Hospital Against Advice**

Form 8

This is to certify that I am leaving _____ Hospital at my own insistence and against the advice of the hospital authorities and my attending physician. I have been informed by them of the dangers of my leaving at this time. I release the hospital, its employees and officers, and my attending physician from all liability for any adverse results caused by my premature departure.

Signed _____

I agree to hold harmless the _____ Hospital, its employees and officers, and the attending physician from all liability, with reference to the discharge of the patient named above.

(Husband, wife, parent, etc.)

Date _____

Witness _____

* The patient may not be forced to sign this type of statement and cannot be restrained. If the patient refuses to sign the form, it should be filled out, witnessed by hospital personnel, and the statement "Signature Refused" included on the form.

**Letter to Patient Who Fails
to Keep Appointment**

Form 9

Dear _____:

On _____, 19____, you failed to keep your appointment at my office. In my opinion, your condition requires continued medical treatment. If you so desire, you may telephone me for another appointment, but if you prefer to have another physician attend you, I suggest that you arrange to do so without delay. You may be assured that, upon your authorization, I will make available my knowledge of your case to the physician of your choice.

I trust that you will understand that my purpose in writing this letter is out of concern for your health and well-being.

Very truly yours,

_____, M.D.

2.4

Patient Abandonment

Abandonment generally means unilateral severance of the professional relationship between a doctor and a patient without reasonable notice at a time when there is still a need for continuing medical attention.¹ Actionable abandonment, however, occurs only in the absence of reasonable notice or of failure to provide an adequate medical attendant.² When there is evidence that adequate medical care was available within a reasonable time after the physician left the case, or that no damage resulted from the abandonment, there is no cause for action.³

¹ Lee v. Dewbre, 362 S.W.2d 900 (Texas, 1962); Other cases recognizing that a physician has a duty not to abandon the case: Carroll v. Griffin, 101 S.E.2d 76 (Georgia, 1958); Kenney v. Piedmont Hospital, 222 S.E.2d 162 (Georgia, 1975); Magna v. Elle, 439 N.E.2d 1319 (Illinois, 1982); Capps v. Valk, 369 P.2d 238 (Kansas); O'Neill v. Montefiore Hospital, 202 N.Y.S.2d 436 (New York, 1960); Murray v. U.S., 329 F.2d 270 (Virginia, 1964); Conghlin v. Christoffersen, 431 P.2d 997 (Washington, 1976).

² Id.

³ Carroll v. Griffin, 101 S.E.2d 764 (Georgia, 1958).

A physician who administers treatment or performs an operation without a patient's express or implied consent may incur liability for damages. This general rule includes an operation that is different than the one for which consent was given.¹

The patient decides whether to undergo the procedure or treatment the doctor recommends. Expressed or implied consent must, therefore, be given before the physician may proceed.² A competent adult patient who has been informed of the treatment proposed and who knows that it can be refused or accepted, gives implied consent to the treatment if he or she then cooperates with the physician.³

This implied consent is the type of consent usually obtained in routine office practice.⁴

Implied consent to an operation always involves the possibility of a misunderstanding about the purpose and scope of the undertaking. If a controversy does arise, proof is sometimes difficult to obtain.⁵ Implied consent often occurs in emergency medical situations. If a person is, for example, injured or unconscious, and if his injuries require prompt attention, a physician is justified in undertaking treatment to preserve the patient's life or limb without express consent.⁶

Oral consent to a procedure is usually supplemented by implied consent. This would occur, if for example a patient orally consented to a procedure and then cooperated with the physician in its performance. Like implied consent, oral consent is open to misunderstanding and may be difficult to prove.

Written consent to treatment is not required by law, and no particular form is necessary to give a valid consent.⁷ If a form is used, however, it should state the nature of the treatment or procedure authorized, and it should be signed by the person legally qualified to give consent. A surgical authorization, for example, should state who is responsible for administering the anesthetic⁸ and the postoperative care⁹ if these services are to be provided by a physician other than the operating surgeon. The place and date of the document's execution and the signature of a witness¹⁰ should be included to facilitate proof.

The more vague and indefinite the terms of a consent are, the more specifically the agreement will usually be construed by a Court.¹¹ Even if the plaintiff read the form and understood its contents, that act is not considered blanket authority to proceed with treatment other than that which the patient anticipated.¹²

General or "blanket" consent forms purportedly giving a physician unlimited authority and discretion, without specifying the particular treatment or procedure contemplated, are not recommended.¹³ The use of such blanket consent forms has given rise to medical liability claims for the performance of operations different from those orally contemplated. Some courts have construed blanket consent forms to permit only those procedures for which oral consent existed.¹⁴ Others have held that a signed consent form constitutes only limited evidence of valid consent.

A question often arises as to whether a general consent form signed on admission to a hospital will cover all subsequent treatments and procedures. This reliance is not recommended. The general form will allow hospital personnel to provide routine treatment to a patient, but for additional procedures or treatments, a more specific form should be used. This recommendation applies to surgical procedures that involve anesthesia. The administration of anesthesia should be mentioned in the surgical consent form, but a separate form for the anesthesiologist would also be appropriate.

Some states have enacted laws that provide the terms under which a written consent will be presumed valid. Georgia law, for example, states that: "[A] consent to surgical or medical treatment which discloses in general terms the treatment or course of treatment in connection with which it is given and which is duly evidenced in writing and signed by the patient or other person or persons authorized to consent... shall be conclusively presumed to be a valid consent in the absence of fraudulent misrepresentations of material facts in obtaining the same."¹⁵

Furthermore, some states have recently enacted laws that establish additional consent requirements for mastectomies. The Minnesota Statute, for example, states that "every patient or resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment... and the risks associated with each of those methods."¹⁶ These type of laws are intended to prevent "one-step" procedures, that is, after ordering a biopsy and discover-

ing a malignancy, performing a mastectomy!¹⁷

- 1 Cross v. Trapp, 294 S.E.2d 446 (W.Va. 1982); Adams v. El-Bash, 338 S.E.2d 381 (W.Va. 1985); Langy v. Rothman, 540 A.2d 504 (N.J. 1988).
- 2 Perna v. Pirozzi, 442 A.2d 1016 (1982); See 61 AMJUR. 2d Physicians, Surgeons, etc. §158 (1972), leading case absent valid written consent "Risk Case".
- 3 See, i.e., LaCaze v. Collier, 434 So. 2d 1039 (La. 1983). Also see Handronis v. Schumacher 531 S. 2d 450 (La. 1988); Leonard v. New Orleans East Orthoclinic 485 So.2d 1008 (La App. 4 Cir. 1986); Precount v. Fredenck 481 N.H. 2d 1144 (Mass. 1985) **Seals v. Pittman 499 S.2d 114 (La. App. Cir. 1986).
- 4 Seals v. Pittman, 499 So.2d 114 (La. App. 1 Cir. 1986).
- 5 Haywood v. Allen, 406 S.W.2d 721 (Ky. 1966).
- 6 Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905).
- 7 But see footnotes 10 and 11 for presumptions of validity involving consent and footnotes Chapter 5 for informed consent.
- 8 A surgeon usually is not responsible for the negligence of an anesthetist who is not performing those duties under the surgeon's direction. Woodson v. Hney, 216 P.2d 199 (Okla. 1953); Wiley v. Wharton, 41 N.W.2d 255 (Ohio 1941). See generally, Surgeons and Anesthesiologists, Vicarious Liability and the Continued Trend Toward Specialization and Decentralization in the Operating Room, 9 Ohio Northern Univ. Law. Rev. 437 (1982). Also see, 90, A.L.R. 3d 788, Malpractice in connection with Anesthetist.
- 9 See Saunders v. Lischkoff, 188 So. 815 (Fla. 1939); Gross v. Partlow, 68 P.2d 1034 (Iltash. 1937); Reed v. Laughlin, 58 S.W. 2d 440 (Mo. 1933); Hopkins v. Heller, 210 P.975 (Cal. App. 1922); Bateman v. Rosenberg, 525 S.W. 2d 753, 756 (Mo. 1975).
- 10 In Wheeler v. Barker, 298 P.2d 68 (Cal. 1949) and Stone v. Goodman, 271 N.Y.S. 500 (1943), the plaintiff alleged that he signed the consent form while under sedation and that the consent was, therefore, invalid. A witness to the signing testified to the contrary.
- 11 The Court in Valdez v. Percy, 96 P. 2d 142 (Cal. App. 1939), said with respect to a broad, general consent: "However, we do not understand such agreement to constitute a consent to perform operations other than the one for which the operating surgeons were engaged by plaintiff to perform unless necessarily therefore arose during the authorized operation as hereinbefore mentioned." See also Moore v. Webb, 345 S.W.2d 239 (Mo. 1961).
- 12 Moore v. Webb, 345 S.W.2d at 243 (Mo. 1961).
- 13 Rogers v. Lumbermens Mutual Casualty Co., 119 So.2d 649 (La. 1960). In this case the patient signed a vague consent form. The court stated: "We think this so-called authorization is so ambiguous as to be almost completely worthless, and, certainly, since it fails to designate the nature of the operation authorized, and for which consent was given, it can have no weight under the factual circumstances of the instant case--". Also see Karl J. Pizzalotto, M.D. Ltd. v. Wilson, 437 So.2d 859, 865; (La. 1983).
- 14 Pizzalotto v. Wilson, 437 So.2d at 865 (1983).
- 15 Ga. Code Ann. §31-9-6 (1981) See also Louisiana Revised Statutes §40:1299, 40. ---shall be presumed to be valid and effective, in the absence of proof that execution of the consent was induced by misrepresentation of material facts." See also, Florida Medical consent law, Fla. Stat. Ann. §766.103 (4)(a) (1978 Supp). A consent which is evidenced in writing and meets the requirement---shall, if validly signed by the patient or another authorized person, raise a rebuttable presumption of a valid consent. Also see Iowa code Annol. §147.137 (1979-80 Cur. 11).
- 16 Minn. Rev. State. §144.651 (Subd. 9).

¹⁷ Cal. Health & Safety Code §1704.5 (Supp. 1984) requires the physician to inform the patient, through a standardized written summary, of alternative efficacious methods of medically viable treatment. Failure to do so constitutes unprofessional conduct. Cal. Bus. & Prof. Code §2237 (Supp. 1984). Massachusetts law requires that every patient or resident of a facility shall have complete information in non-medical language on all alternative treatment and possible adverse consequences. Hawaii enacted legislation to establish standards for physicians to follow in giving information to patients. Hawaii Rev. Stats. §671-3. Louisiana has adopted a resolution to urge and request all physicians to advise their patients, orally and in writing, of the alternatives to a radical mastectomy prior to performing this procedure. H. Concurrent Resol. 125.

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 intravenously 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

(c) *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

(d) *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

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

2 Gales v. Jensen, 505 P.2d 919 (Wash. 1979).

3 Smith v. Shannon, 666 P.2d 351 (Wash. 1983); In Re Schowler, 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 *Dazel 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); *Laue 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. Hatford*, 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); *Sec. N.Y. Pub. Health Law §3805-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. Vitrnsky*, 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. Clathorn*, 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 *Tuman v. Thomas*, 611 P.2d 902 (Cal. 1980).

Refusal to Submit to Treatment

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 _____

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 responsibility 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

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 *Florentino 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 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

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.H.2d 668 (Mo. 1965).

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

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

⁵ Geichell v. Mansfield, 489 P.2d 953 (Ore. 1971); Berkey v. Anderson, 82 Cal. Rptr. 67 (1969); Brown v. Dahl, 705 P.2d 781 (1985); In Re Schoutler, 723 P.2d 1103 (Wash. 1986).

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 Florentino 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, N.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 *Cantelbury 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.⁵

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

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); Vi. 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); Vi. Stat. Ann. tit. 12, §1909(c)(2)(Supp.).

6 See Chapter 4, *Ins. 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); Vi. Stat. Ann. tit. 12, §1909(b); Wash. Rev. Stat. Ann. §7.70.050(4) (Supp.).

7 Roz... Consent Treatment A Printing Guide §16.4.

9.1

8 See generally, *Lloyd v. Kull*, 329 F.2d 168 (7th Cir. 1964); *Demers v. Gerty*, P.2d 645 (1973) remanded on other grounds 520 P.2d 869 (1974); *Lipson v. The Memorial Hospital*, 733 F.2d 332 (4th Cir. 1984).

Extension of Treatment

As a general rule, the extension of a procedure beyond the scope of the consent may expose a physician to liability for battery. The strict common law rule is that the right of a surgeon to extend an operation beyond the limits that the patient has authorized is confined to emergencies requiring immediate action. Some courts have departed from this common law rule. One approach allows a doctor to extend an operation to deal with any abnormal condition discovered during a procedure when an extension is advisable for the welfare of the patient and follows accepted medical practice.

In an Ohio case, a patient's fallopian tubes were removed during an authorized appendectomy.¹ The physician testified that "I found her tubes in bad shape ... I could have treated them, but the chances were that she might have been in the hospital for two or three months, so I thought I'd better take them out." The Ohio Supreme Court reversed a directed verdict for the defendant doctor and remanded the case for further proceedings on the question of consent.²

In another case, a surgeon found some enlarged follicle cysts on a patient's ovaries.³ Although there was no immediate emergency, the surgeon punctured the cysts. The court noted that where an internal operation is required, both the surgeon and the patient know that no definite diagnosis is possible until the incision has been made. The court said, therefore, that in the absence of proof to the contrary, a surgeon can extend an operation to correct any abnormal or diseased condition in the area of the original incision whenever proper surgical procedure requires such an extension. Under this reasoning, the extension of an operation is not limited to an emergency.

In one critical case,⁴ the plaintiff was told by her family physician that a lacerated uterus was responsible for her frequent miscarriages. Subsequently, she told the defendant surgeon she wanted to be "fixed up" so she could bear children. When the doctor operated on her, he found that her fallopian tubes were sealed and full of pus. Her ovaries were also badly infected, and consequently

could never bear children. The surgeon removed the diseased organs, though immediate removal was not necessary to protect the patient's life or health.

On appeal, the court interpreted the patient's request to be "fixed up" as authority to perform a diagnostic operation and such surgery as might be necessary to cure her ailment. Although the court spoke of consent implied from the existence of an emergency, it appears that the patient had expressly consented to any surgery the physician might find necessary, so long as it did not interfere with her ability to bear children. According to the facts of the case, the woman's conviction before the operation already made it impossible for her to bear children and this condition could not be corrected.

In another case,⁵ an ophthalmologist was held liable for extending a surgical procedure without the patient's consent. The patient's condition was diagnosed as an infection of the meibomian glands on the lower left eyelid. The patient consented to having the eyelid opened and drained. The ophthalmologist administered a local anesthetic, excised some meibomian glands and also removed a freckle from the eyelid. During the operation, the tarsus that supports the eyelid was cut, causing the lid to drop. The Michigan appellate court affirmed a \$12,500 judgment in favor of the patient and noted that no claim of negligence was made. The court held that no emergency existed, and that the removal of the glands and the freckle constituted an unwarranted assault and battery since the patient was conscious, and his consent could have been requested.

In another instance,⁶ a patient complained of a pain in her lower abdomen which the surgeon diagnosed as a tubal pregnancy. The doctor operated, but when he opened the patient's abdomen, he found instead that she had a double uterus, a normal pregnancy but very acute appendicitis. The patient's husband later testified that he was just outside the operating room and presumably could have been consulted, but there was no evidence that the surgeon knew it. The surgeon concluded that the acute appendicitis was responsible for the patient's pain and removed her appendix. The woman had an uneventful recovery and subsequently delivered a normal child. The patient's husband, however, refused to pay the surgeon's fee because the appendectomy was unauthorized. The judgment for the surgeon was affirmed.

The court queried: "What was the surgeon to do? Should he have left her on the operating table, her abdomen exposed, and gone in

search of her husband to obtain express authority to remove the appendix? Should he have closed the incision on the inflamed appendix and subjected the patient, pregnant as she was, to a general spread of the poison in her system, or to the alternative danger and shock of a second independent operation to remove the appendix? Or should he have done what his professional judgment dictated . . . ?"

The court found that the surgeon had operated within the scope of the consent given him by the patient. The surgeon removed what he believed to be the cause of the patient's pain. It was essentially for this reason that the surgeon had been engaged.

A contrasting view was expressed in another case in which a 20-year-old woman submitted to an appendectomy.⁸ During the operation, the surgeon discovered that the young woman's fallopian tubes were full of puss, swollen and sealed at both ends. Fearing that the swollen tubes eventually would break and cause peritonitis, the doctor removed them. It was impossible to obtain the consent of the unconscious patient, and the surgeon did not attempt to obtain the consent of the young woman's stepmother who was in the hospital at the time. At the trial, the surgeon testified that it would have been necessary to remove the tubes "within six months anyway if I was not mistaken."

The Kentucky appellate court ruled against the surgeon. The court ruled that while a surgeon may extend an operation in an emergency, the emergency must exist at the time of the operation and not merely endanger the patient's health or life at some future time. The court said that the evidence did not establish that, as a matter of law, there was an emergency of sufficient urgency to justify the removal of the tubes without the consent of the patient or her stepmother. Although the evidence did indicate that the tubes would have to be removed soon, and that in their infected condition were dangerous, their removal was not established as an emergency. Death was not likely to occur immediately if they were not removed.⁹

In another case, a patient brought an action against her physician for his removal of a vaccination mark without her consent. The court held that the woman's claim that she did not understand or otherwise consent to the removal of the vaccination mark was properly pleaded in battery, under a theory of lack of informed consent.¹⁰

In one such case,⁶ the plaintiff, an adult, expressly prohibited a spinal anesthetic. His mother later consented to the use of any anesthetic. At the start of the operation, sodium pentothal was injected. Because of an adverse reaction, a spinal block was administered. Since the operation had not begun, the jury found that there was no emergency which would justify a violation of the plaintiff's instructions.

Experimental procedures require a patient's consent, and such procedures usually impose greater disclosure responsibilities on physicians. Regulations of the Department of Health and Human Services (HHS) on the protection of human subjects limit the waiver of consent and the release from liability.

The regulations prohibit "exculpatory language through which the subject or the representative is made to waive or appears to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the institution or its agents from liability for negligence."⁷ Additional regulations apply to all research conducted or supported by HHS involving children as subjects.⁸ Any research activity requires more thorough consent procedures than are required for clinical treatment.⁹

Another limitation that arises occurs when parents attempt to describe the type of treatment provided to their children. All states recognize that primary responsibility for the provision of medical necessities rests with the parents, but if the parents fail to provide adequate care, the state may step in to provide services necessary to preserve the life, health and welfare of a minor.¹⁰ In situations where life-saving services are not required, however, or if a delay of treatment would not cause a serious deterioration of a child's condition, courts tend to defer to the parent's decision.¹¹

Cases have discussed how parents should be dealt with in order to successfully treat a child.¹² In one case,¹³ the court held that there was no legal duty on the physician's part to inform the parents of an infant suffering from a life-threatening condition that treatment could be withheld if they wished to let the child die. The court ruled that there were "no alternatives" to which the parents could consent.

¹ Gould, *Linda*, Right to Die Legislation: The Effect On Physicians Liability, 39 *Mercer Law Review* 517 (1988)(article discusses situations in which a physician can withhold treatment, living will statutes as well as proposes a Model Act -

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(1988)(Declaratory judgment sought by husband to remove feeding tube from his wife. United States District Court for Rhode Island recognized the right to terminate nutrition and hydration.) Also see, *In Re: Estate of Prange* 520 N.E.2d 590 (1988).

² *Alabama*: Ala. Code §§22-8A-1 to 10 (Supp. 1992); *Arizona*: Ariz. Rev. Stat. Ann. §§36-3201 (West, 1985); *Arkansas*: Ark. Stat. §§ 82-3801 to -3804 (Supp. 1981); *California*: Cal Health & Safety Code §§7183 to 7195 (Supp. 1987); *Colorado*: Colo. Rev. Stat. §§ 15-18-101 to -113 (Supp. 1986); *Connecticut*: Conn. Gen. Stat. Ann. §§ 19a-570 to -575 (Supp. 1987); *Delaware*: Del. code Ann. tit. 16, §§2501 (1983); *District of Columbia*: D.C. Code Ann. §§6-2422 to -2430 (Supp. 1987); *Florida*: Fla. Stat. Ann. 765.01-765.15 (West Supp. 1986); *Georgia*: O.C.G.A. §§ 31-32-1 to -12 (1982 & Supp. 1987); *Idaho*: *Idaho Code* § 39-4501 to -4508 (1985); *Illinois*: Ill. Rev. Stat. Ch. 110 1/2, §§ 701-710 (Supp. 1987); *Indiana*: Ind. Code §§ 16-8-11-1 to -22 (Supp. 1986); *Iowa*: *Iowa Code* Ann. §§144A.1-144A.10 (Supp. 1987); *Kansas*: Kan. Stat. Ann. §§ 65-28,101 to -28,109 (1985); *Louisiana*: La. Rev. Stat. Ann. §§ 40-1299,58.1-40-1299,58.10 (Supp. 1987); *Maine*: Me. Rev. Stat. Ann. tit. 22, §§ 2929-2931 (Cum. Supp. 1986); *Maryland*: Md. Health-Gen. Code Ann. §§ 5-601 to -614 (Supp. 1986); *Missouri*: Mo. Rev. Stat. §§ 459.010-459-055 (Supp. 1987); *Nevada*: Nev. Rev. Stat. §§ 449,540 to 449,690 (1986); *New Mexico*: N.M. Stat. Ann. §§ 24-7-1 to -10 (1978); *North Carolina*: N.C. Gen. Stat. §§ 90-320 to -323 (1985); *Oklahoma*: Okla. Stat Ann. tit. 63, §§ 3101-3117 (Supp. 1987); *Oregon*: Or. Rev. Stat. §§97,050 to -090 (1983 & Supp. 1987); *South Carolina*: S.C. Code Ann. §3-44-77-10 to -160 (Supp. 1986); *Tennessee*: Tenn. Code Ann. §32-11-101 to -110 (Supp. 1986); *Texas*: Tex. Civ. Rev. Stat. Ann. art. 4590h §1 to 11 (Vernon Supp. 1987); *Utah*: Utah Code Ann. §§ 75-2-1101 to 1118 (Supp. 1987); *Vermont*: Vt. Stat. Ann. tit. 18, §3 5251 to 5262 (Supp. 1986); *Virginia*: Va. Code §§ 54-325.8.1 to 54-325.8-12 (Supp. 1987); *Washington*: Wash. Rev. Code Ann. §§ 70.122.010 to 70.122.905 (Supp. 1987); *West Virginia*: W. Va. Code §3 16-30-101 to -110 (1985); *Wisconsin*: Wis. Stat. §3 154.01 to .15 (Supp. 1986).

³ *Schloendorff v. Society of N.Y. Hospital*, 105 N.E. 92 (N.Y. 1914).

⁴ *Markart v. Zeimer*, 227 P. 683 (Cal. App. 1924).

⁵ See, *Malpractice - Liability of Anesthetist*, 90 A. L.R.3d 775.

⁶ *Chambers v. Natchbaum*, 96 So. 2d 716 (Fla. 1967); *Siegel v. Mt. Sinai Hospital*, 403 N.E.2d 202 (1978); (Court held that although signed consent form was evidence of decedent's consent, it was not conclusive because it left open question for jury as to whether the decedent consented to added risk involved in administering anesthesia to an asthmatic).

⁷ 45 C.F.R. §46.116. The information required in the written consent form and the documentation is specified in the regulations. 45 C.F.R. §46.116, §46.117. Each department of the Federal Government that supports research involving human subjects, to some extent, follows the HHS guidelines. *Implementing Human Resource Regulations, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, Ch. 1, March 1983.

⁸ See, e.g., *Bang v. Miller Hospital*, 88 N.W. 2d 186, 190 (1958); *Delgado, Richard*, Informed Consent in Human Experimentation Bridging the Gap Between Ethical Thought, and Correct Practice, 34 U.C.L.A. 67 (1986).

⁹ 45 C.F.R. §346.401-46.409.

¹⁰ There are statutes in some states that authorize the juvenile court to order necessary medical and surgical care for a minor whose parents or guardian refuse to provide it when able to do so. See, e.g., *Mich. Stat. Ann* §§27.3178 (598.2)(b)(1), 27.3178 (598.18)(h)(1980 Rev. Yo.); *N.Y. Unconsol. Laws Tit. I, §52 (17)(6)(McKinney, Supp. 1955)*. The New York statute was held constitutional in *In Re: Revasko*, 263 N.Y. Supp. 552 (1933). The statute was said to be a valid method by which the state could protect its interest in the health of its

6 *Jeffcoat v. Phillips*, 417 S.W.2d 903 (Tex. 1967). This rule applies even when it is likely that the operation will have some effect upon the sexual life of the individual, as for example, with sterilization operations. See *Kritzer v. Citron*, 224 P.2d 808 (Cal. 1950); *Barker v. Heaney*, 82 S.W.2d 417 (Tex. Civ. App. 1935); *Rytkonen v. Jojaco*, 257 N.W. 703 (Mich. 1934); *Barroughs v. Crichton*, 48 App. D.C. 596 (1919); *State v. Housekeeper*, 16 A. 382 (Md. 1889). See *Coleman v. Coleman*, 471 A.2d 1115 (Md. Ct. of Special App. 1984). The Maryland court denied the husband's petition to prevent his wife from having an abortion. The court held that "a woman in her first trimester of pregnancy, in consultation with her physician, may elect to terminate the pregnancy, and neither the state nor the woman's spouse nor the father of the child has any right to intervene so as to prevent her decision from becoming a fact."

7 *Barker v. Heaney*, 82 S.W.2d 419 (Tex. Civ. App. 1935).

8 *Wheeler v. Barker*, 208 P.2d 68 (Cal. App. 1949); *Demers v. Greely*, 529 P.2d 278; *Stone v. Goodman*, 271 N.Y. Supp. 500 (1934).

9 *Arballo v. Nielson*, 166 P.2d 621 (Cal. App. 1946).

10 *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941); *Kozup v. Georgetown Univ.*, 851 F.2d 437 (D.C. Cir. 1988). (Appeals court held as a material fact an issue as to whether transfusion was absolutely necessary to save child's life and thus whether patients gave implied consent for transfusion which resulted in the baby contracting aids).

A patient has the right to withhold consent to lifesaving treatment, and thus can impose terms, conditions and limitations on the consent. A physician, however, does not have to agree to conditions that are incompatible with good medical practice. The prudent doctor will not agree to an arrangement that unduly circumscribes the exercise of a reasonable degree of professional judgment. The physician who does so, particularly in surgery when a patient is to be anesthetized, may later face the dilemma of choosing between poor medical practice or liability exposure for unauthorized treatment.

Any limitations on consent should be included in the consent form for a physician's protection if the limitations could cause an unsatisfactory result. If a patient insists on limitations that are clearly inconsistent with good medical practice, the physician would have justification for declining the case. Physicians should also be aware of the possibility that a patient may have a living will which specifically states that he or she does not want to undergo certain life prolonging techniques.¹ Many states today have legislation authorizing the execution of living wills, and the release of medical personnel from liability for honoring them.²

In a New York case,³ a patient entered a hospital for an examination under anesthetic to determine the nature of a lump in her stomach. She subsequently claimed that she had notified the physician "that there must be no operation." While she was under the anesthetic, however, a fibroid tumor was removed from her abdomen. The court held that if the operation was performed without her consent, in the absence of an emergency, the procedure would be an assault by the surgeon. In another case,⁴ a patient consented to an operation for hernia, but the surgeon also removed a testicle despite the patient's express prohibition. The surgeon contended that conditions warranted the removal, but it was held that this was an unauthorized extension for which he was liable.

A physician who administers a type of anesthetic expressly prohibited by a patient is responsible for damages caused by the anesthetic even though there is no negligence in administration. The frequency of medical liability claims involving the choice of anesthetic indicates the desirability of a statement in the patient's consent form indicating any restrictions on the anesthetics to be used.⁵

As noted previously, a surgeon is entitled to extend an operation when the advisability of additional surgery becomes apparent during an operation. Embolism, infections, anesthesia deaths and paralysis are remote possibilities in modern surgery, but they do occur. Subjecting a patient to a second, separate operation just to obtain a consent the person would give anyway, if awake, is unconscionable. In the absence of specific prohibition by the patient, the physician should be privileged to perform such surgery as is justified by prevailing medical opinion.

When a bad result occurs, a plaintiff, unable to prove negligence, may resort to the theory of assault and battery to seek a recovery. A patient who would expect to be spared from an unnecessary, second operation may, nevertheless, react differently if an extension of the agreed operation proves unsuccessful. To hold a physician responsible under these circumstances may, however, penalize and thwart good medical practice.

The professional instincts of physicians should not be clouded by unreasonable threats of liability. Good surgery frequently requires additional procedures to correct conditions that are only discernible by visual inspection after the surgery has begun.¹¹

1 Wells v. Van Nort, 125 N.E. 910 (Ohio 1919).

2 Also see, Rubino v. DeFratias, M.J.D. 638 (Supp. 182 (1986) (Patient brought a claim that she did not understand or otherwise consent to her physician's removal of her vaccination mark was properly pleaded in battery rather than negligence); Samoilov v. Raz, 536 A.2d 275 (N.J. Super. A.D. 1987).

3 Kennedy v. Parroti, 90 S.E.2d 754 (N.C. 1954). See also Barnett v. Bachrach, 34 A.2d 626 (D.C. 1943); Bennan v. Parsonnet, 83 A. 948 (N.J. 1912).

4 King v. Carney, 204 P. 270 (Okla. 1922). Appellate Ct. affirmed judgment on jury verdict for surgeon who removed facial tumor to recover for a nerve damage. Surgeon was held not to have committed battery; estate of Leach v. Shapiro, 469 N.E. 2d 1047 (1989).

5 Shulman v. Lerner, 141 N.W. 2d 348 (Mich. 1966).

6 Barnett v. Bachrach, 34 A.2d 626 (D.C. 1943).

7 *Id.* at 629.

8 Tabor v. Scobee, 254 S.W.2d 474 (Ky. 1952).

9 Tabor v. Scobee, 254 S.W.2d 474 (Ky. 1952).

10 Rubino v. DeFratias, 638 F. Supp. 182 (D. Ariz. 1986).

11 Samoil v. Raz, 536 A.2d 275 (1987) (Patient brought medical malpractice action against surgeon who removed facial tumor to recover for a nerve damaged. The court held where patient consents to certain treatment and doctor undertakes that course, but undisclosed complications occur and the physician utilizes appropriate procedures there is no basis for claim of assault and battery); Also see Rozovsky, F. Consent to Treatment, Ch. 1 and 1987 Supp.

Who May Consent

The authority to treat or operate usually arises from the valid consent of the patient or someone authorized to consent for the patient. Some state statutes define precisely who this may be: Ohio, for example, provides that a consent must be signed by the patient, or if the patient is unable to sign then by a person who has legal authority to consent on his or her behalf.²

A consent may be invalid if the act consented to is unlawful,³ if it is given by someone not authorized to do so,⁴ or if it is obtained by misrepresentation or fraud.⁵ The patient's consent to an operation is sufficient if the individual has reached the age of majority and, at the time of consent, is competent to understand the nature and purpose of the operation proposed and the risks involved.

The consent of a spouse is not necessary; the patient's consent is sufficient.⁶ Nevertheless, it is advisable to have the spouse join in the consent whenever practicable. Spousal consent is particularly advisable if the operation involves danger to life, or may destroy or limit sexual functions, or may result in the death of any unborn child.

The law presumes patients are competent, rather than incompetent, to consent to care. The presumption may be rebutted, however, by evidence that the patient was drunk,⁷ under the influence of drugs, delirious or comatose,⁸ or otherwise incapable of exercising rational judgment. Whether a patient is treated free or at someone else's expense, consent is still required!⁹

1 For example, Georgia law declines who may give consent. The statute covers adults, minors, and those adjudicated incompetent. Ga. Code Ann. §88-2904. See also Del. Tit. 18, §8852; Idaho Code §39-4303; Iowa Code Ann. 147.137 Me. Rev. Code Ann. §78-14-5(4); and footnote Chapter 5.

2 Ohio Rev. Code §2317.54(c)(Page 90).

3 Hancock v. Hullett, 82 So. 522 (Ala. 1919); Miller v. Byer, 68 N.W. 869 (Wisc. 1896).

4 Moss v. Rishworth, 222 S.W.2d 225 (Tex. Civ. App. 1920); Mohr v. Williams, 104 N.W. 12 (Minn. 1905); Kimkin v. Heupel, 305 N.W.2d 589 (1981); Kohoniek v. Hafner, 383 N.W.2d 195 (Minn. 1986).

5 LaCaze v. Collier, 434 So. 2d 1039 (La. 1983). In Nolan v. Kechjian, 64 A.2d 86 (R.I. 1949), the plaintiff's consent to abdominal surgery was based on the defendant's representation that the operation was intended "to build up the ligaments that hold the spleen in place. The court held that the defendant's representation was so inadequate as to border on deceit. The accidental tearing of blood vessels which required the removal of the spleen was therefore held to be sufficient to sustain an action for assault and battery. See also Birnbaum v. Siegler, 76 N.Y.S.2d 173 (1948); Keen v. Coleman, 20 S.E.2d 175 (Ga. 1942); Fla. Stat. Ann. § (4)(a). N.Y. Civ. Ct. 1754

11 In *Interest of Cooper*, 631 P.2d 632 (Kan. 1981); *Muhlenberg Hospital v. Patterson*, 320 A.2d 518 (N.J. 1974); *State v. Perricone*, 181 A.2d 751 (N.J. 1962)(*Lehovah's Witness*); *Custody of a Minor*, 379 N.E.2d 1053 (Mass. 1978) (Court ordered continuation of chemotherapy over parents' objection). If the child already has been declared a ward of the state, the court may be more willing to authorize treatment. See, e.g., *In Re Karwarth*, 199 N.W.2d 147 (Iowa 1972). But see *In Re: Phillip B. 156 Cal. Rptr. 48 (1979)*.

12 See, e.g., *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 201 A.2d 537 (N.J. 1964) (*Blood transfusion for the mother ordered*); *Jefferson v. Griffin Spaulding County Hospital Authority*, 274 S.E.2d 457 (Ga. 1981) (*Mother order to submit to a caesarean, rather than a vaginal, delivery over her religious objections.*) *In the interest of A.W., a child under the age of eighteen* 740 P.2d 82 (Kan. 1987)(*Court had the inherent power to accept relinquishment of parental rights by natural mother in lieu of a proceeding with an action to sever parental rights where all of the statutory requirements for the protection of the mother were met.*)

13 *Infance v. Luchs*, 501 A.2d 1040, 1048 (N.J. Super L. 1985).

1.1 Minors

The general rule for consent when a minor is the patient is that the operation or treatment requires the consent of a parent or guardian except in an emergency where immediate treatment is imperative and any delay involves serious risk to the patient.

In one such case,¹ two adult sisters took an eleven-year old to a hospital for removal of badly diseased tonsils and adenoids. The child died while under the anesthetic. The court held that the child's father could recover from the operating surgeon for the child's death. Although the operation might have been necessary, no immediate emergency existed to excuse the need for parental consent.

In another instance,² a seventeen-year-old boy, accompanied by his aunt and two adult sisters, consulted a surgeon who recommended surgery to remove a tumor. Preparations were then made for an operation, with apparent knowledge of the boy's father with whom the youngster lived. Subsequently, while under an anesthetic, the boy died and his father sued. Recovery was denied. The court ruled that since the father was aware of the preparations and did not object, his consent could be implied. Furthermore, the operation was not ordinarily hazardous, and the boy was close to the age of majority.

Emergencies remove the need for consent for minors as well as adults.³ The problem arises in defining what constitutes a true emergency. One case stated that: "It is not to be presumed that

competent surgeons will wantonly operate, nor that they will fail to obtain the consent of parents to operations where such consent may be reasonably obtained in view of the exigency."⁴ In that case, the decision to amputate a minor's foot was made after extensive consultation among the physicians involved. Doctors should always attempt, however, to contact the parents.

In one instance, in which a seventeen-year-old boy's arm was crushed by a freight train, efforts were made to reach the parents by telephone, but they failed.⁵ After a consultation among physicians, the boy's arm was amputated. The consent of the parents was implied by the emergency.

In another case,⁶ a seven-year old youngster died while anesthetized for treatment of a broken arm. Before administering the anesthetic, an unsuccessful attempt was made to contact the mother at her place of work. The court held that an emergency existed.

An extremely liberal view of what constitutes an emergency was taken by a court in the case of a twenty-year old man who fractured his ankle during a baseball game. The surgeon told the patient it would be necessary to put him under an anesthetic before the foot could be treated. The patient's response was: "Well, if you think best, go ahead." The young man's father brought suit charging that the anesthetic was administered without his consent. The court said the operation was necessary to stop needless pain and suffering; it held for the defendant.⁷ Since it does not appear that a true emergency existed, the court probably was strongly influenced by the fact that the patient was nearly an adult, and that the operation ordinarily was not difficult.

In a Kansas case,⁸ the court held that a minor who was near the age of majority could consent to a skin graft on her fingertip. The Kansas Supreme Court said that parental consent was not necessary if an emergency existed, if the minor was emancipated, if parental consent could not be obtained in time to accomplish proper results, or if the minor was able to understand the procedure and risks involved. The court found that the girl was conscious, capable of knowing what was taking place, and that no damage or disability resulted from the treatment.

The prudent physician should, as a general rule, obtain the consent of a parent or legal guardian before performing elective surgery or medical treatment for a minor. There are no reported cases which would indicate that the consent of both parents is necessary. In the

absence of a controversy between parents as to whether the physician should provide treatment, the consent of one parent should suffice. If the parents are legally separated or divorced, consent on behalf of the child should be obtained from the parent who has legal custody.

Another exception to the parental consent requirement involves emancipated minors. What constitutes "emancipation" is defined by statute. Some states have enacted laws that relieve the physician of liability for lack of parental consent if the doctor, in good faith, relies on the minor's representation of emancipation.⁹

In one such instance,¹⁰ an eighteen-year-old married man, the father of one child, was suffering from an incurable, progressive muscular disease. He and his wife decided to limit their family. After obtaining the couple's written consent, the doctor performed a vasectomy. When the man reached his majority, he sued the physician for operating without a valid consent.

Affirming the judgment in favor of the physician, the Washington Supreme Court said that the mental capacity necessary to consent was a fact question and should be determined from the circumstances of each case stating that "a married minor, eighteen years of age, who has successfully completed high school and is the head of his own family, who earns his own living and maintains his own home, is emancipated for the purpose of giving a valid consent to surgery."¹¹ Some states have enacted statutes that lower the age of consent to obtain medical care in certain circumstances.¹² The Texas statute, for example, requires that the individual be at least sixteen years of age and reside separate and apart from his parents.¹³

Other exceptions to parental consent requirements are based in public policy. Treatment of venereal disease,¹⁴ drug abuse,¹⁵ alcohol dependency¹⁶ or pregnancy¹⁷ often do not require parental consent. A minor in Minnesota, for example, may give effective consent for medical services to determine pregnancy or to treat pregnancy.¹⁸ Some statutes that eliminate the parental consent requirement add a corollary parental notification requirement.¹⁹ Other statutes however prohibit informing the parents unless the minor consents or authorizes release of the information.

⁴ Luke v. Lowrie, 136 N.W. 1106 (Mich. 1912).

⁵ Jackovach v. Yocum 237 N.W. 444 (Iowa 1931).

⁶ Wells v. McGehee, 39 So. 2d 196 (La. 1949).

⁷ Sullivan v. Monaghan, 279 N.Y.S. 575 (N.Y. 1935).

⁸ Younis v. St. Francis Hospital and School of Nursing, 469 P.2d 330 (Kan. 1970). Also see, Cardwell v. Bechtol, Supreme Court of Tennessee, S/C No. 36 2-6-87; seventeen-year old out on her own to seek osteopathic physician, Tennessee adopts the "mature minor" position.

⁹ N.Y. Pub. Health Law §2504; Pa. Stat. Ann. Tit. 35, §10105; Va. Code Ann. §32-137 (limited circumstances).

¹⁰ Smith v. Setby, 431 P.2d 719 (Wash. 1967). See Planned Parenthood Association of Kansas City, Missouri v. Ashcroft, 103 S.Ct. 2517 (1983). A Missouri statute required either parental or judicial consent prior to performing an abortion on a minor. The Supreme Court stated that the state's interest in protecting immature minors will sustain a requirement of a consent substitute, either parental or judicial. However, "the state must provide an alternative procedure whereby a pregnant minor may demonstrate that she is sufficiently mature to make the abortion decision herself or that despite her immaturity, an abortion would be in her best interest." *Id.* at 2525 citing City of Akron v. Akron Center for Reproductive Health, 103 S.Ct. 2481, 2497-98 (1983). The statute provided that the court would receive evidence about the emotional development, maturity, intellect and understanding of the minor. The provision was held constitutional. Also see, Baird v. Attorney General, 360 N.E. 2d 288 (1977)(minor parents must only consider what is in the best interest of the child in deciding whether to consent to abortion).

¹¹ *Id.* 431 P.2d at 723.

¹² Code of Ala. §22-8-4; Alaska Stats. §§25.20.020 (1978 Supp.); 09.65.100 (1979 Supp.); Ariz. Rev. Stats. §44-132 (1988 Supp.); Ark. Stat. Ann. §82-363; Cal. Civil Code §34.10; Colo. Rev. Stat. §13-22-103 (Supp. 1981); Del. Code Ann. Tit. 13, §707; Fla. Stat. Ann. §743.01; Ga. Code Ann. §74-104.1; Haw. Rev. Stat. §§577-25, 577A-1; Ill. Rev. Stat. Ch. 111, §4501 (Smith-Hurd 1989); Ind. Stat. Ann. §16-8-12-2(2); Kan. Stat. Ann. §38-101 (1987 Supp.); Ky. Rev. Stat. §214.185; La. Rev. Stat. Ann., Art. 379, 366; Code of Md., §30-102; Mass. Gen. Laws Ann. Ch. 112, §12F; Mich. Comp. Law Ann. §722.4; Minn. Stat. Ann. §§144.341, 144.342; Miss. Code Ann. §41-41.3; Mo. Stat. Ann. §§475.010; 431.061; Mont. Code Annotate §41-1-402; Nev. Rev. Stat. §129.030; §129.010; N.J. Stat. Ann. §9-17A-1; 9-17A-4; N. Mex. §24-10-1; N.Y. Pub. H. Law §2504; N.C. Gen. Stat. §§90-21.1, 90-21.1(4); 90-21.1(5); Okla. Stat. Ann. Tit. 63, §§2601, 2602; Ore. Rev. Stat. §109.640; R.I. Gen. Laws. Ann. §23-51-1; S.C. Code Ann. §§44-45-10, 44-45-20; Tex. Code Ann. Family Code §35.03 (1989 Supp.); Wis. Stat. §51.47; Wyo. Stat. §14-1-101.

¹³ Tex. Code Ann. Family Code §35.03.

¹⁴ Code of Ala. §22-8-6; Ala. Stat. §09.65.100; Ariz. Rev. Stat. §44-132.01; Ark. Stat. Ann. §82-1606 (1979 Cum. Supp.); Cal. Civil Code §34.7 (1989); Conn. Gen. Stat. Ann. §19a-216; Del. Code Ann. Tit. 13, §708 (1978 Cum. Supp.); D.C. Code Ann. §6-129, (1973Bd. Vol.); Ga. Code Ann. §874-104.2 to 74-104.4 (1988 Supp.); Haw. Rev. Stat. §577A-2; Idaho Code Ann. §39-3801 (1977); Ill. Rev. Stats. Ch. 111, §4504 (Smith-Hurd); Ind. Stat. Ann. §16-8-5-1; Iowa Code Ann. §140.9; Kan. Stat. Ann. §§65-2892, 2892a; Ky. Rev. Stat. §214.185; La. Rev. Stat. Ann. §40-1065.1; Me. Rev. Stat. Ann., Tit. 32, §2595; Ann. Code of Md., Art. 43, §135; Mass. Gen. Laws Ann., Ch. 111, §117; Mich. Comp. Law Ann. §333.5257; Minn. Stat. Ann. §144.343; Miss. Code Ann. §41-41-13; Mo. Stat. Ann. §431.061; Mont. Rev. Code Ann. §41-1-402; Neb. Rev. Stat. §71-1121; Nev. Rev. Stat. §129.060; N.H. Rev. Stat. Ann. §141.11-a; N.J. Rev. Stat. Ann. §9-17A-4; N. Mex. Stat. Ann. §24-N.Y. Pub. H. Law §2305; N.C. Gen. Stat. §90-21.5; N.D. Cent. Code Ann. §14-10-17; Ohio Rev. Code Ann. §2709.24.1; Okla.

¹ Moss v. Rishworth, 222 S.W.2d 225 (Tex. 1920).

² Baker v. Welsh, 108 N.H. 94 (Mich. 1906)

³ See generally, Kozup v. Georgetown §51 F.2d 437 (D.C. Cir. 1988).

Stat. Ann. Tit. 63, §2602; Ore. Rev. Stat. §109.610, Pa. Stat. Ann. Tit. 35, §10103; R.I. Gen. Laws Ann. §23-11-1; S.C. Code Ann. §44-45-10; S.C. Comp. Laws Ann. §34-23-16; Tenn. Code Ann. §29-31-101 to 105; Tex. Code Ann. - Family Code §35.03; Va. Stat. Ann., Tit. 18, §4226; Va. Code Ann. §§32-137, 70-24-110; W. Va. Code Ann. §16-4-10; Wis. Stat. §143.02; Wyo. Stat. Ann. §35-4-151.

- 15 Code of Ala. §22-8-6, *Alas. Stats. §44-133.01*; Colo. Rev. Stat. §13-22-102; Conn. Gen. Stat. Ann. §19-382; D.C. Code Ann. Regulation No. 74-22, D.C. Register (Sept. 16, 1974); Ga. Code Ann. §§74-104.2 to 74-104.4 (1988 Supp.); Cal. Bus. and Prof. Code §4211.5 *Haw. Rev. Stat. §577-26* (1984 Supp.); Idaho Code Ann. §37-3201; Ill. Rev. Stat. Ch. 111, §4504 (Smith-Hurd); Ind. Stat. Ann. §16-13-6-1-23; Iowa Code Ann. §125.33; Kan. Stat. Ann. §§5-2892, 65-2892a; Ky. Rev. Stat. §214.185; La. Rev. Stat. Ann. §40:1096; Me. Rev. Stat. Ann. Tit. 32, §2595; *Mass. Code of Md. §20-102*; *Mass. Gen. Laws Ann., Ch. 112 §12F* (need two physicians findings); Mich. Comp. Law Ann. §33.6121 (Public Health Code); Minn. Stat. Ann. §144.343; Mo. Stat. Ann. §31.061; *Mont. Rev. Code Ann. §41-1-402*; N.H. Rev. Stat. Ann. §31-B-12-a; N.J. Rev. Stat. Ann. §9-17A-4 (1988 Supp.); N.C. Gen. Stat. §90-21.5 (1988); N.D. Cent. Code Ann. §14-10-17; Ohio Rev. Code Ann. §3719.01.02; Okla. Stat. Ann. tit. 63, §2602 (1989); S.C. Code of Laws §20-7-280 (1976 rev'd 1981); Tenn. Code Ann. §63-6-220; Tex. Code Ann. - Family Code §35.03 (1989 Supp.); Tex. Civ. Stats., Art 4447; Va. Code Ann. §32-137; Rev. Code Wash. Ann. §60A-5-504.
- 16 Code of Ala. §577-26; Ind. Stat. Ann. §16-13-6-1-23; Ky. Rev. Stat. §214.185; Ann. Code of Md., Art. 43, §135; *Mass. Gen. Laws Ann., Ch. 111B §10*; *Minn. Stat. Ann. §144.343*; *Mont. Rev. Code Ann. §41-1-402*; N.C. Gen. Stat. 90-21.5; N.D. Cent. Code Ann. §14-10-17; *Okla. Stat. Ann. Tit. 63, §2602*; S.C. Code Ann. §44-45-10; *Vi. Stat. Ann. Tit. 18, §4226*; Rev. Code Wash. Ann. §69.54-060; *W. Va. Code Ann. §60-6-23*.
- 17 Code of Ala. 22-8-6; Ark. Stat. Ann. 82-363 (not for abortions); Cal. Civil Code §4.5; Cal. Health and Safety Code §25958; Del. Code Ann. Tit. 13, §708 (Cumm. Supp. 1978); D.C. Code Ann. Regulation No. 74-22, D.C. Register (Sept. 16, 1974); Fla. Stat. Ann. §458.215; Ga. Code Ann. §31-9-2; Haw. Rev. Stat. §577A-2; Kan. Stat. Ann. §38-123 (1987) (if no parent or guardian is available); Ky. Rev. Stat. §214.185 (except for induced abortion or sterilization); Ann. Code of Md., Art. 43, §135; *Mass. Gen. Laws Ann. Ch. 112, §125*; Mich. Comp. Law Ann. §§333.5257, 333.6121 (discretionary for covered disease or drugs); *Minn. Stat. Ann. §144.343*; Mo. Stat. Ann. §31.061; *Mont. Rev. Code Ann. §41-1-402*; N.J. Rev. Stat. Ann. §9-17B-1; N. Mex. Stat. Ann. §24-1-13; N.C. Gen. Stat. §90-21.5; Ohio Rev. Code Ann. §§3709.24.1, 3719.01.2 (parents responsible for payment if consent); Okla. Stat. Ann. Tit. 63, §2602; Pa. Stat. Ann. Tit. 35, §10103; S.C. Code Ann. §44-45-10; Tex. Code Ann. Family Code §35.03; Utah Code Ann. §78-14-5; Va. Code Ann. §32-137.
- 18 Also see Tenn Code Ann. 37-10-305 (parental consent to abortion, effective 07/01/89); Minn. Stat. Ann. §144.343.
- 19 Del. Code Ann. Tit. 13, §708 (1978 Cumm. Supp.) (for pregnancy discretion-ary); D.C. Code Ann. §6-119j-1 (Bd. Vol. 1973) for general disease services; Ga. Code Ann. §§74-104.2 to 74-104.4 (1973 Rev.) (discretionary for drug abuse or general disease); Haw. Rev. Stat. §577A-3 (physician must inform parents of minor's pregnancy); §755A-4 (physician's discretion to inform parents of positive general disease test); Ind. Stat. Ann. §61-13-6-1-23 (treatment disclosure within facilities discretion); Kan. Stat. Ann. §§65-2892, 65-2892a (physician's discretion); La. Rev. Stat. Ann. §40:1096 (provider's discretion); Me. Rev. Stat. Ann. Tit. 32, §2595 (practitioner's discretion); N.J. Rev. Stat. Ann. §9:17A-5 (physician's discretion); Ore. Rev. Stat. §109.650 (discretion-ary); Pa. Stat. Ann. Tit. 71, §1600, 112 (discretionary); Tenn. Code Ann. §63-624 (physician's discretion for general disease; also see Shipps, William Medical Trial Technique Quarterly, Interned Consent and the Child in Non-

11.2

Minor Incompetent and Consent

therapeutic Human Experimentation: Evolution to Solution (discusses informed consent and minors generally, also discusses necessity of experimentation and ways to prevent abuse).

When a patient is a minor and of unsound mind and incompetent to understand the nature, purpose and risk of a proposed operation, authority must come from one or both parents or a guardian.¹ If an incompetent patient has attained majority, authority must come from the spouse or legally appointed guardian.²

While some courts have held that if there is no spouse and no legally appointed guardian, the parent may give consent,³ it is important to check the relevant state statute with respect to minors and incompetents since there is variability among the states.

- 1 Lester v. Aetna Casualty & Surety Co., 240 F.2d 676 (Cir. 1957); In Re Green, 448 Pa. 338, 292 A.2d 382 (1972); Rothe v. Hull, 180 S.W.2d 7 (Mo. 1944); Barnett v. Bachrach, 34 A.2d 636 (D.C. 1934); Pratt v. Davis, 161, 79 N.E. 562 (Ill. 1906).
- 2 In Faber v. Olkon, 254 P.2d 520 (Cal. 1953), the court held that a parent who has the responsibility to maintain an adult incompetent child may authorize medical treatment where no guardian has been appointed. Also see 88 Harvard Law Review, 1001 (1988) Parental Consent Requirements and Privacy Rights of Minors. The contraceptive controversy.
- 3 Ritz v. Florida Patient's Compensation Fund, 436 So.2d 987 (Fla. App. 1983). Ritz involved an adult who had been mentally retarded since birth. See also Farber v. Olkon, 254 P.2d 520 (Cal. 1953). These courts state that the parents have the responsibility to care for these children. See Matter of Barbara C., No. 21282-82 (N.Y. Sup. Ct., Sept. 23, 1982). Parents of a pregnant, profoundly retarded twenty-five year old woman could consent to an abortion for their legally incompetent daughter. See also Public Health Trust of Dale City v. Valcin, 509 So.2d 596, 598 (Fla. 1982); Superintendent of Belcherown State School v. Salkiewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (court appointed guardian shall make a decision regarding whether an incompetent should be treated, but a hearing is required to review guardian's decision); also see In Re Quinlan, 70 N.J. 10, 355 A2d 697 (1976).

Informed consent requires that a patient understand and be able to weigh the positive and negative features of a proposed medical treatment.¹ An individual can only give valid consent if he or she is competent. The test in terms of mental capacity to consent has been stated as follows: "Does the patient sufficiently and reasonably understand the condition, the nature and effect of the proposed treatment, and the attendant risks in pursuing and not pursuing the treatment?"²

Various methods and theories have been set forth to aid physicians in determining whether a patient is competent to make a treatment decision.³ Many state statutes also establish requirements for determining when an individual is not capable of informed consent.⁴

The state statutes, like the courts, are not uniform in their analysis of a patient's competence to consent to treatment. A doctor should therefore be aware of what the statute in his or her state requires. There are several definitions of incompetency including: (1) lack of capacity to consent to treatment; (2) lack of capacity to be informed of the treatment; and (3) individuals adjudicated as incompetent.⁵

State statutes use various phrases, such as: "unable to care for himself"; "lack of capacity to consent or to make responsible medical decisions for treatment; someone who may endanger himself"; "someone whose ability to receive and evaluate information is impaired"; "someone who because of the reason of illness lacks sufficient understanding or capacity to render a decision"; and, "someone who is in need of supervision."⁶

It is generally accepted by both the courts and the medical community that mental illness may affect only a specific area of function while leaving other areas unimpaired.⁷ There is an almost unanimous consensus by courts that civil commitment does not mean that an individual is incompetent to make treatment decisions.⁸

In one such case, the court was confronted with one of the most common situations involving the right of institutionalized patients to refuse treatment.⁹ The individual in this case was an involuntarily committed mental patient who was being treated with anti-psychotic drugs without his consent.¹⁰ In stating the institution's interest in medicating certain patients despite their objections, spokesmen for the institution acknowledged the right of competent

adults to decide whether they will consent to certain treatment procedures.¹¹ The institution argued that an involuntarily committed mental patient is presumably incompetent to exercise this right. This argument was based on the theory that the court, in ordering involuntary retention, had implicitly determined that the patient's illness had impaired his judgment, and that he could not therefore make appropriate decisions regarding treatment and care. The court concluded, however, that neither mental illness nor the fact that a patient had been involuntarily committed was sufficient reason to deny an individual the opportunity to make his or her own treatment decision.¹²

In a similar case, the court approved the establishment of procedural safeguards to protect a patient's right to refuse treatment.¹³ The court held that an involuntarily committed mental patient is competent to make treatment decisions until the individual is judged to be incompetent by a court.¹⁴

There are also situations in which a patient may be intermittently rational. In these circumstances, and whenever possible, the doctor should wait until the patient can give a valid consent. The physician should also document indications that the patient was competent when giving the consent.

When an immediate operation is imperative and the patient is unable to give a rational consent, an operation may be performed. This is also true when a delay in obtaining the act of someone legally authorized to consent on the patient's behalf would involve serious risk to the patient. The applicable legal theory is that of implied consent.¹⁵ The law implies that the patient would, if competent, consent to whatever might be necessary in his or her own interests.¹⁶

1 Andrews, *Lori R.*, Informed Consent Statutes and the Decision Making Process, *Journal of Legal Medicine*, Vol. 5, Num. 2, 1984; Parry John, *A Unified Theory of Decision-Making*, 11 *Mental and Physical Disability Law Reporter* 378 (1986); Parry John, *Psychiatric Care and the Law of Substitute Decision-Making*, 11 *Mental and Physical Disability Law Reporter* 151 (1986); Solnick, John, *Proxy Consent for Incompetent Non-Terminally Ill Adult Patients*, *The Journal of Legal Medicine*, Vol. 6, No. 1 (1985).

2 In the Matter of William Scheller, 148 N.J. Super. 168, 180-181, 372 A.2d 360, 367 (1977).

3 Andrews, *Lori R.*, Informed Consent Statutes and The Decision Making Process, *Journal of Legal Medicine*, Vol. 5, Num. 2, 1984; Parry John, *A Unified Theory of Substitute Consent: Incompetent Patients Right to Individualized Health Care Decision-Making*, 11 *Mental and Physical Disability Law Reporter* 378 (1986); Parry John, *Psychiatric Care and the Law of Substitute Decision-Making*, 11 *Mental and Physical Disability Law Reporter* 151 (1986); Solnick, John, *Proxy Consent for Incompetent Non-Terminally Ill Adult Patients*, *The Journal of Legal Medicine*, Vol. 6, No. 1 (1985).

4 *Alabama*, Al St. #26-24-20(8); *Alaska*, Ak St. #13-26-0005; *Arizona*, Ar St. #14-5101; *Arkansas*, Ar St. #11-101 (3); *California*, P11 3 #1880; *Colorado*, Unde-

Proxy Decisionmaking

Many state statutes now provide that when a patient is incompetent to consent a proxy consent is required. Designation of a proxy decisionmaker is important because it attempts to assure that the treatment decision will closely resemble the decision the patient would make if competent.¹ Even if a proxy decisionmaker has been appointed, however, it is often beneficial to the patient's welfare to keep him or her as fully aware as possible of the treatment and its consequences.²

A number of states have statutes authorizing proxy decisionmaking; some have done this within their informed consent statutes.³ Some statutes specify a specific person who can consent to treatment for the individual; others mention specific relatives.⁴ It is important, therefore, to consult the applicable state statute rather than simply assuming that someone can validly act as a substitute decisionmaker for a patient.

The standards applied in the decisionmaking process when an individual is incompetent vary according to the test used. Many commentators and courts have attempted to spell out at least two theories.⁵ These are the "substitute judgment" and the "best interest" tests. Both are designed to determine what treatment decision the patient would have chosen if he or she had been competent, and what treatment would be best in the particular instance. There has been much criticism and disagreement about which theory best protects the patient's rights.⁶

¹ Andrews, *Lori R.*, Informed Consent Statutes And The Decisionmaking Process, *The Journal of Legal Medicine*, Vol. 5, No. 2, 1984.

² *Id.* at 211.

³ G.A. Code Ann. §88-2904 (1979); Idaho Code §39-4303 (1977); La Rev. Stat. Ann. §401299.53 (West, 1977); Me. Rev. Stat. Ann. Tit. 24, §2905(f) (Supp. 1983-1984); N.C. Gen. Stat. §40-21.13(a) (1981); Utah Code Ann. §78-14-5(4) (1977); Ark. Stat. Ann. §34-2614(B)(1) (Supp. 1983); Fla. Stat. Ann. §468.663(a)(1)(4)(a) (West, Supp. 1983); Iowa Code Ann. §304.40-320(1) (1981); Nev. Rev. Stat. §414.120(2) (1979); Ohio Rev. Code Ann. §2317.54(c) (Page 1981); Tex. Stat. Ann. A.R. 4590i, §§6.03(a), 6.04(a), 6.05 (Vernon Supp. 1983); Wash. Rev. Code Ann. §7.70.066 (Supp. 1983); Vi. Stat. Ann. Tit. 12 §1909(c)(3), (d) (Supp. 1984); Hawaii Rev. Stat. §671.3(a), (b) (Supp. 1984); Minn. Stat. Ann. §§144.651(2) (West, Supp. 1984).

⁴ For example, these 8 statutes mention relatives, such as a spouse, parent or adult children. Ga. Code Ann. §§88-2904 (1976); Idaho Code §39-4303(a), (b) (1977); La. Rev. Stat. Ann. §401299.53 (West 1977); Me. Rev. Stat. Ann. Tit. 24, §2905(f) (Supp. 1983); Miss. Code Ann. §§41-41-3 (1972); Neb. Rev. Stat. §44-2208 (1978); N.C. Gen. Stat. §90-21.13(a) (1981); Utah Code Ann. §78-14-5(4) (1977). See also Ala. Code Sec. 26-1-2(c)(2) (Repl. 1986); Alaska Stat. Sec.

informed. Connecticut, Undefined; Delaware, Title 12 §3914 (1974); District of Columbia, Undefined; Florida, 744.102 (5); Georgia, 49-601; Hawaii, 560-5-304; Idaho, 15-5-101; Illinois, 110 §112. See also Chap. 111, par. 3, Indiana, §29-1-18-1 (c); Iowa, §229.1 (1972); Kansas, §59-31002; Kentucky, §304-40-320; Louisiana, General; Main, §18-A--§5-101; Maryland, §13-703; Massachusetts, General; Michigan, 700.8; Minnesota, §25.54; Mississippi, General; Missouri, §475.010 (8); Montana, General; Nebraska, §30-2610 (1); Nevada, General; New Hampshire, General; New Jersey, N.J. S.A. 3B:1-2; New Mexico, §38-4-14; New York, E 172-17-A, Mentally Retarded defined; North Carolina, 35A-1101 (7); North Dakota, General; Ohio, E5101.60 (1); Oklahoma, General; Oregon, General; Pennsylvania, General; Rhode Island, Undefined; South Carolina, Undefined; South Dakota, §27B-6A-2; Tennessee, §34-4-102; Texas, Tex. Prob. Code §33(P); Utah, §78-14-5(f); Vermont, 1909 Sect. C4; Virginia, 37-1-128.01; Washington, 11-88-010; West Virginia, General; Wisconsin, §880.01; Wyoming, Undefined.

⁵ Andrews, at 209.

⁶ Kunech, C.I.G. The Competency Component of Informed Consent: Ethical, Legal & Clinical Perspectives Masters Thesis, Loyola University School of Law, May 1989, Appendix.

⁷ Plotkin, Limiting the therapeutic Overt: Mental Patients Right to Refuse Treatment, 72 Northwestern University Law Review 461 (1978).

⁸ Rennie v. Klein, 653 F.2d 836 (1981), vacated on other grounds, 458 U.S. 119 (1982); Rogers v. Okin, 738 F.2d 1 (1 St. Cir. 1984); Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973); Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986); In Re the Mental Commitment of M.P., 510 N.E.2d 645 (Ind. 1987); Scott v. Plante, 532 F.2d 939 (3d Cir.); Winters v. Miller, 446 F.2d 65 (2nd Cir.); Davis v. Hubbard, 506 F. Supp. 915, 935 (Ohio); Master of Anderson v. State of Arizona, 135 Arizona 578, 663 P.2d 570; In Re Boyd, 403 A.2d 744, 747, n5 (D.C. Ct. App.); Gandy v. Pauley, 619 S.W.2d 730, 731 (KY); Rogers v. Commissioner of Dept. of Mental Health, 390 Mass. 489, 458 N.E.2d 308, 314; Matter of K.K.B., 609 P.2d 747, 749 (Okla.); In Re Interest of Brande, 951 S20 N.E.2d 946, (11 App. 1st Dist. 1988); See, 82 Columbia L. Rev. 1720, 1722. A Common Law Remedy for Inevitable Medication of the Institutionalized Mentally Ill, But see, In Re Mental Commitment of M.P., 500 N.E.2d 216 (Ind. Ct. App. 1986) (in which the court allowed forcible medication on a patient who was not adjudicated incompetent).

⁹ Rivers v. Katz, 459, N.E.2d 337, 341 (N.Y. 1986).

¹⁰ *Id.* at 341.

¹¹ *Id.* at 341.

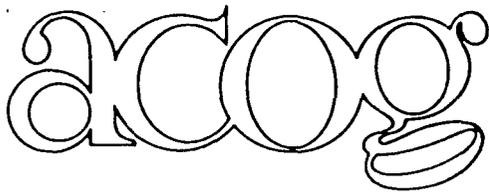
¹² *Id.* at 341.

¹³ Rogers v. Okin, 738 F.2d 1 (1st Cir. 1984).

¹⁴ *Id.*

¹⁵ Wells v. McGee, 39 So. 2d 196 (1a. App. 1949).

¹⁶ Strunk v. Strunk, 445 S.W.2d 145 (K.Y. 1969). The brother of a 27 year old incompetent man was suffering from chronic glomerular nephritis. The incompetent was the only acceptable kidney donor. The guardian petitioned the court to allow the incompetent to act as a donor for a transplant. Noting the incompetent's dependence on his brother, the court ruled that the transplant would be in the incompetent's best interest.



Deception

Deception is the deliberate misrepresentation of facts through words or actions in order to make a person believe that which is not true. Because human interaction and self-determination depend upon use of accurate information, there is a strong presumption that deception either by imparting or by withholding information is unethical.

Deception, even when intended to benefit the patient, always requires justification. The rare cases of justifiable deception are more properly discussed in the context of informed consent. The following opinion is intended to address deceptive behavior which cannot be justified. It is concerned primarily with deception as a means of abusing power in a professional relationship.

The primary duty of physicians is to apply their knowledge in a way that both promotes the health and respects the autonomy of their patients. Insofar as physicians possess greater knowledge about the intricacies of diagnosis and treatment, they have a fiduciary responsibility to patients. While professional knowledge gives physicians an advantage in the relationship, their professional commitment is to use that knowledge on behalf of patients. Unless physicians share knowledge and information, patients cannot exercise autonomy in integrating personal values and concerns. Deception for the purpose of exploiting any imbalance in the relationship in order to benefit physicians at patients' expense, economically or any other way, is unethical.

Exploitative deception can occur in the way physicians represent their expertise to patients and in the way they communicate with patients regarding medical diagnosis and treatment. The forms deception can take include explicit lying, deception by implication, and deception by omission of information that patients need to make decisions in their own regard. Examples of these kinds of deception can help to clarify their seriousness.

DECEPTION BY EXPLICIT LYING

It is unethical for a physician deliberately to misstate facts, for example, to lie about his or her credentials, experience, and/or success rates. It is also unethical to misrepresent facts about conditions or treatments that apply to the patient, such as complication rates for a procedure.

DECEPTION BY IMPLICATION

Deception by implication is a more insidious and more frequent dereliction. An example is citing national experience and success rates in infertility procedures, implying that the same data apply locally as well. Another example of unethical behavior is alarming a patient by implication about abnormal, but relatively innocuous conditions, thereby promoting excessive diagnostic procedures, unnecessary surgery or other over-treatment. Conversely, it is deceptive to imply that a condition or procedure entails fewer risks than actually exist.

DECEPTION BY OMISSION OF INFORMATION

Deception by omission can also be unethical. An example is failure to disclose options or information that might lead a patient to choose a different physician or a different mode of treatment. Similarly, failure to disclose a medical alternative that is therapeutically equal but less advantageous to the physician than a surgical intervention manipulates a patient's choice and may expose her to hazards or expense she would prefer to avoid.

Conflict of interest, or the appearance of conflict of interest, ought to be avoided insofar as possible. When unavoidable, conflict of interest that can be anticipated must be evalu-

ated in advance and discussed with patients. If it arises in the course of diagnosis or therapy, it must then be disclosed and resolved without deception. For example, failure to disclose an interest in an imaging center or laboratory where a referral might result in financial benefit to the physician, is unethical. On the other hand deception may be involved in cases when undisclosed financial arrangements result in under-treatment of a patient. Examples of this could occur when professionals profit from inappropriately limiting care.

THE RISK OF SELF-DECEPTION

When professional prestige or financial gain is involved, self-deception is an ever-present possibility. That is, relevant information poten-

tially detrimental to one's interests may either not be sought or may be consciously or unconsciously suppressed. To maintain professional integrity, physicians need to monitor regularly the motivations that underlie their policies on the disclosure of information to patients.

SUMMARY

Deception is the deliberate misrepresentation of facts through words or actions in order to make a person believe that which is not true. The forms deception can take include explicit lying, deception by implication, and deception by omission of information that patients need to make decisions in their own regard. Deception intended to advantage the physician economically or otherwise at the expense of the patient is unethical.



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The American College of Obstetricians and Gynecologists
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Ethical Issues in Pregnancy Counseling

A Guide to Counseling Prospective Parents in Light of Current Capabilities for Evaluation of Pregnancy Outcome, As Well As for Obstetric Management

Advancing capabilities in prenatal care, diagnosis, and high-risk pregnancy management; new knowledge of factors affecting fetal growth and development; and potential therapies have focused the attention of both physicians and patients on the need for patient counseling in these areas. Much of this counseling is best provided by the obstetrician. The need for special information, however, may require the services of other professionals with expert knowledge. Such counseling should include an exploration of the attitudes, beliefs, and values of each participant as they relate to the issues being considered and their impact on the decisions to be made.

The ethical concerns of those involved can be outlined as follows:

1. The ethical practitioner will recommend counseling for the patient or couple about certain types of potential risks involved in preg-

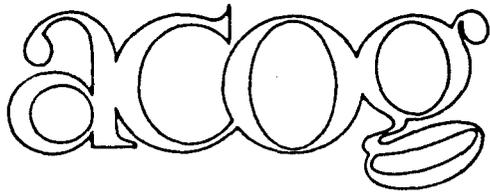
nancy for both her and her fetus. Such counseling should include information that may be required for informed decision-making, including the availability, dependability, and possible hazards of relevant tests, procedures, and therapies.

2. No commitment either to continue or to terminate a pregnancy ought to be a prerequisite for undertaking diagnostic or therapeutic procedures.
3. Potential parents should be advised to seek counseling prior to conception whenever possible, because an existing pregnancy may place a different stress on the decision-making process. If pregnancy has begun before the patient or couple is first seen, counseling should be undertaken promptly to allow as much time as possible for making decisions regarding the management of the pregnancy.



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Journal

committee opinion

Committee on Ethics

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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 medi-

cal 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 pro-

foundly—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 ini-

tial 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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INFORMED CONSENT

TALKING POINTS

Objection: LEGISLATOR INTERVENTION

Answer: 1) Does not allow a legislator to be involved in individual lawsuits under the civil remedy provision of the bill.

2) Only allows a legislator to intervene in a lawsuit wherein the constitutionality of any provision of the bill is challenged. This prevents the situation which has occurred recently in a number of abortion related court cases in Montana whereby Pro-Life organizations were excluded from being allowed to participate in the case.

Objection: FATHER AND GRANDPARENT CAN SUE (new section 7)

Answer: This provision allows the father of the aborted child or the parents of the aborted mother to legally pursue the rights of the aborted mother if she cannot.

- 1) A minor cannot sue on their own behalf.
- 2) The aborted mother is killed or otherwise incapacitated, either as a result of the abortion or some other disability (mental retardation, etc.).

Objection: INSERTS GOVERNMENT INTO A PRIVATE DECISION (privacy rights)

Answer: Not true. - The only government involvement called for by this bill is to publish and disseminate free of charge scientifically accurate and objective information, staff a hot line, and design and collect written reports from abortion providers.

The remainder of the provisions in the bill are enforceable, primarily at the election of the aborted women. (Criminal enforcement takes place upon the complaint of an injured party at the discretion of the local prosecutor.)

Rather than interfere in a personal right of a woman to choose abortion, SB 292 facilitates the making of

a choice by a pregnant woman by arming her with the facts about risks of abortion, childbirth; abortion alternatives; and objective information about the development of her unborn child.

Objection: ALLEGATIONS OF UNCONSTITUTIONALITY

- Answer:
- 1) The United States Supreme Court and Federal Courts have been very liberal in upholding and requiring the enforcement of informed consent provisions similar to those contained in SB 292.
 - 2) The Montana Constitutional provision on privacy was adopted by the 1972 Constitutional Convention before anyone had any idea that the word privacy was actually a code word for legalized abortion on demand through all nine months of pregnancy for any reason whatsoever. Consequently it is doubtful that Montana's constitutional provision on privacy could be construed in such a way as to strike down SB 292. Montana's privacy provision in the abortion context is not tested and its application in the abortion context on the part of opponents to SB 292 is pure speculation.

Objection: REPORTING REQUIREMENT IS TOO BURDENSOME

- Answer:
- 1) More extensive reporting requirements are currently in place and enforced in Pennsylvania than in SB 292 (eg. how many teenagers asked for and were given informed consent and how many women at each of the different stages of pregnancy asked for and obtained informed consent).
 - 2) Reporting provisions similar to SB 292 have been upheld by courts of appeal for the states of Mississippi and North Dakota and are presently on appeal and likely to be upheld with respect to South Dakota.
 - 3) Both the U.S. Supreme Court decisions in CASEY and DANFORTH have upheld reporting requirements in informed consent statutes.
 - 4) The Montana Right To Life Association has absolutely no interest in passing legislation that will not be enforced by the courts.

Objection: INFORMED CONSENT MUST BE CERTIFIED IN WRITING 24 HOURS BEFORE THE ABORTION

- Answer: That provision was eliminated by Senator Bartlett's amendment in committee.

WOMEN'S RIGHT TO KNOW SB 292
Section by Section Analysis

Legislative Findings

- Knowledgeable exercise of woman's decision to abort depends on receipt of sufficient information
- Physician/patient contact in abortion contest is almost non-existent
- Consequences of abortion are serious
- Abortion facilities offer only limited counseling

Definitions

Publication of Materials

1. Geographically indexed information on abortion alternatives (phone numbers and addresses)
 - a. Adoption
 - b. Private & public agencies offering help; prenatal, childbirth and neonatal care
2. Information on Unborn Child
 - a. Anatomical & physiological characteristics of child in 2 week gestational increments
 - b. Information on possibility of child's survival at each stage
3. Information on methods of abortion employed, medical risks of abortion and childbirth
4. Other requirements
 - a. All information to be objective
 - b. Woman to be advised it is unlawful to coerce a person to have an abortion
 - c. Information that adoptive parents can pay costs of prenatal, childbirth & neonatal care
 - d. Materials must be legible

Emergency

Medical emergency defined:

- to avert woman's death or risk substantial & irreversible impairment of a major bodily function

Physician Reporting Requirements

- Department of Health to prepare a form to be used by the physician capturing the following information:
 1. Number of women provided the information on:
 - a. Abortion risks
 - b. Abortion alternatives
 - c. That printed material available for review
 2. Who provided the information in #1 above
 - a. The physician performing abortion
 - b. A referring physician
 - c. An agent of the physician
 3. The number of women who availed themselves of the printed information and the number who did not
 4. The number of women who were furnished any information who went ahead and had the abortion
 5. The number of abortions performed under the medical emergency part of the statute
 - a. Because of imminent death
 - b. Because of substantial risk of irreversible impairment of a major bodily function
- Department to furnish copies of reporting forms to all physicians at time of licensure and again by December 1 of each year
- Physician or his agent to send completed forms to department by following February 28 of each year
- Reports not submitted by March 31 subject to penalty of \$500 per month they are delinquent
- Department to issue public report summarizing statistics gathered from reports by June 30
- Department can change above dates or combine forms to achieve administrative efficiencies

Civil Remedies

- Standard of proof; knowing or reckless violation of bills provisions
- Who may bring action if violation
 1. Actual abortion
 - a. Mother (of aborted child)
 - b. Father (of aborted child)
 - c. Grandparents (of aborted child)
 2. Attempted abortion
 - a. Mother (of aborted child)
 3. Reporting violation
 - a. Department of Health
- Remedies provided
 1. Actual & punitive damages for actual & attempted abortion
 2. Injunction for reporting violation
 3. Attorneys fees to plaintiff in a successful action

Protection of Privacy in Court Proceedings

- By order of court upon findings
- Record to be sealed & exclusion of witnesses from proceedings when necessary to preserve woman's anonymity

Informed Consent

- Means voluntary consent after full disclosure

By Physician:

1. Medical risks associated with the particular abortion procedure
2. Probable gestational age of child
3. Medical risks of carrying child to term

By physician or his/her agent:

1. Medical assistance benefits may be available for prenatal, childbirth, and neonatal care

2. Father is liable to pay child support
 3. The woman has right to review the printed materials
 4. Printed materials are from the Department of Health
- Informed consent to be given 24 hours prior to the abortion
 - Written materials to be furnished at least 24 hours before abortion if requested
 - Oral information can be given over phone
 - Written material can be mailed 72 hours before abortion
 - No informed consent required in case of a medical emergency

Criminal Penalties

- None against woman
- Misdemeanor for violation of act by abortion providers
- None for violation of failure to furnish written materials to woman where Health Department has not made the materials available to the abortion provider

March 20, 1995

EXHIBIT 2
DATE 3/20/95
SB 292

HB 292
Katherine J. Keller

Mr. Chairman, Members of the Committee, my name is Katherine Keller. Mrs. Montana for 1994. I am the mother of a 2 year old son and currently 18 weeks pregnant.

3 1/2 years ago I moved to Montana, within a few months I found myself underemployed, struggling in an abusive relationship, and frightened I was pregnant. Not knowing where to turn, I went to the Missoula Planned Parenthood looking for information and support. Instead of support I was handed a list of names and addresses of ABORTION PROVIDERS. I really hadn't thought about abortion, I just wanted some HELP. I was given no information on ADOPTION. No information on the possible complications of the ABORTION. And no information on how I could KEEP MY BABY. Which is what I really wanted in the first place. But after leaving Planned Parenthood the only viable option presented to me was abortion.

I called Blue Mountain Clinic in Missoula, one of clinics off their list. According to their calculations I was 11 weeks pregnant and since the price goes up after 12 weeks. I was strongly encouraged to come in as soon as possible. I was assured that when I came in I would have counseling that morning and be sent home to think about it. Then come back for the abortion in the afternoon. So I scheduled the appointment October 2, 1991; the day that forever changed my life!

That Wednesday morning I walked into the Blue Mountain Clinic and paid \$350 in cash up front. During the counseling session that morning; I remember asking the counselor if "IT" was a BABY. (I had to call my baby "IT" or I could not have gone through with the ABORTION.) Confidently she said "No it is just a blob of tissue that isn't even alive." Not satisfied with the answer I received I asked her if "IT" had a heartbeat and again the answer was "NO". Trying to ease my conscience I asked her one last question "if "IT" could feel pain?" This time she didn't answer with confidence but instead looked away and said "no." Then as if to reassure herself more than me she proceeded to tell me that she had had an abortion and it was the best thing for HER.

Then instead of sending me home to think about everything that had been said. They escorted me into the operating room. I remember wondering what I was doing there because they had said that I could go HOME FIRST. But who was I to question them, they were the ones in the white coats, the professionals. So I did exactly what they told me. I took my cloths off and put on the gown they handed me. It was so degrading laying there waiting for a doctor that I would never see again. I remember thinking about how rude he was earlier about not wanting me to mess with his machine. I hadn't even thought of touching his machine.

When he came back in he didn't even say a word, he just started dialating me

It's hard to imagine the heaviness and emptiness I and my ~~SB~~ 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 dreamt 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-husband's 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 heavens of horror and torrents of tears. You see, 6 months earlier I, a 23 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 3 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,

EXHIBIT 4
DATE 3/20/95
SB 292

March 20, 1995

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

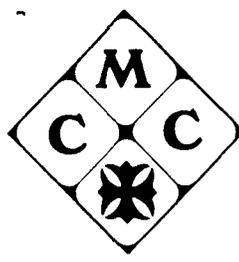
TESTIMONY

My name is Cheryl Wilke. My views stem from an abortion I received on January 23, 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 was not knowledgeable about abortion at all and reflecting back to my own level of maturity at the age of 17 is a scary thought! 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 accentuated on the dyer social situation I was in. The abortion itself was very quick and impersonal, which is sad considering what it's done to my life. I would ask that you keep in mind that the group of women who make up the clientele of Planned Parenthood INCLUDE the 12, 13, 14, and 15 year old girl who most likely DO NOT have the knowledge or maturity to make an informed decision.

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 duress, which makes it even more important to have complete, accurate information and time 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.



Montana Catholic Conference

March 20, 1995

SENATE BILL 292

MR. CHAIRMAN, 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.*

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 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.

I URGE YOUR SUPPORT OF SB292. THANK YOU.

March 20, 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.

Fundamentally, SB 292 is an attempt to guarantee a woman is fully informed and then consenting freely to an abortion. SB 292 recognizes informed consent is an ethical concept that has become integral to contemporary medical ethics and medical practice. **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. Coming to comprehension.....and then freely consenting is a *process*, a process that includes ongoing shared information.....that is why a minimum of 24 hours for reflection is needed. Keep in mind, true informed consent is a *process*, while the form one signs is merely the document which records the process.

Ethics committees in the medical profession have outlined that comprehension requires information, and a *sharing of interpretations of its meaning by a medical professional*. The accuracy and adequacy of disclosure can be judged by various criteria:

- 1) The common practice of the profession.
- 2) The reasonable needs and expectations of the ordinary person who might make a particular decision.
- 3) The unique needs of an individual patient faced with a given decision. (Surely a woman faced with an unexpected pregnancy and considering an abortion has unique needs.)

F.A. Razovsky in Consent to Treatment: a Practical Guide, has said 6 components are recognized as necessary for valid informed consent in any medical procedure:

The diagnosis --the materials developed by the DHES show the woman in 2 week gestational increments the exact size of the developing child. She is aware of her diagnosis.....not just told it is a blob of tissue. Section 4 (4)

The procedure or treatment --the specific abortion to be utilized Section 4, (4) line 15

Montana unless a mother specifically requests that they are recorded under abortion complications. Few women request that due to shame. Furthermore, that method of morbidity compilation permits the abortion advocates to claim abortion is safer than bring a child to birth.

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 defended this issue, to relitigate the issue?

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. There is a 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.

January 31, 1994

Arlette Randash
1941 Virginia Dale
Helena, MT 59601

Re: Testimony regarding Woman's Right To Know Bill

Dear Arlette,

On Labor Day weekend in 1988 I went to a keg at a local park. I had a lot to drink that night and went home with a guy. We were together once that night and did not use any protection. Two months later I found out that I was pregnant. I'll never forget the day that I found out. I went to Planned Parenthood in Bozeman. When the test came back positive, the nurse did a pelvic exam to see how far along I was. She told me that I was 2 1/2 months along. She asked me what I wanted to do and I told her that I did not want to have it and that I was going to have an abortion. All she did was give me the names of doctor's that do abortions. I went home and told my mom that I was pregnant and that I wanted an abortion. She also did not try to stop me. I called Planned Parenthood in Billings and made an appointment for the first part of November. I don't remember much of that day. Today it seems like a bad dream. I had to be there at 6:00 a.m. so they could dilate my cervix. A couple hours later I went back to the Planned Parenthood clinic. The nurse asked me a few questions about my hobbies so she could talk to me while the doctor was performing the abortion. I can't remember what we talked about. All I know is that I was crying and it felt like the suction cup was sucking everything out of me. Then they put me in the recovery room, and handed me a pack of birth control pills. I paid my \$300.00 and that was it.

I was a senior in high school and was working part-time at the public library. One afternoon I decided to see what the fetus looked like at 2 1/2 months. When I found the page that showed me what my baby looked like all I could do was cry. I had no idea that my baby looked to much like a baby. If Planned Parenthood had told me what my baby looked like and

EXHIBIT 8
DATE 3/20/95
SB 292

Charles J. Lorentzen
418 4th St. East
Kalispell, MT 59901

The Honorable Bob Clark, Chairman
Capitol Station
Helena, MT 59620

SB 292

March 20, 1995

Chairman Clark and Members of the House Judiciary Committee,

I am a board member and passed president of Flathead ProLife. In recent years a growing number of disturbing accounts have come to my attention, so I support fully SB 292 and urge you to do so for the following reasons:

- 1) Very few decisions we make in our lifetimes are life or death decisions, but abortion is that to unborn children.
- 2) The full impact of having decided to end her unborn baby's life is often devastating to the mother, even years later.
- 3) Physical and mental complications often follow abortions.
- 4) Information gathered thru the maturing process has still not been considered by many young women who are desperately seeking wise counsel.
- 5) Insisting that Montana women be fully informed may result in the reduced rate of abortions and complications, thus helping to make them "rare", as President Clinton has stated in his goal.
- 6) After alternatives are completely known, waiting to think about it for 24 hours is more than reasonable since an abortion decision is unalterable.
- 7) Our society controls or restricts hundreds of activities much less important than abortion, and in spite of the fact that our Supreme Court has ruled in favor of abortion, it is not a mandate to be REQUIRED. We can and must continue to monitor, control, inform and supervise this whole subject of abortion.

During a recent review of the religious preferences of members of the United States 104th Congress, I found that 28 of 100 are Catholics, 13 of 100 are Baptists, 12 of 100 are Methodists, 11 of 100 are Presbyterians, 9 of 100 are Escopalians, 4 of 100 are "Protestants" and 4 of 100 are Lutherans. Without adding in a dozen other Christian categories of 2% or less, the above listed denominations account for 81% of the 104th Congress. Assuming Montana's 54th Legislature is close to the same religious preference breakdown, I would like to speak to at least 80% of you from our common reference book, "The Holy Bible"; for hundereds of years the world's best sold. Would 8 out of 10 of you consider with me what the Bible says about unborn children.

Genesis 16:11 And the angel of the Lord said unto her, Behold, thou art WITH CHILD, and SHALT BEAR a son,...

Psalms 139:13 For thou hast possessed my reins: thou hast covered ME IN MY MOTHER'S WOMB.

Hosea 12:3 He took his brother by the heel IN THE WOMB,...

Matthew 1:18 Now the birth of Jesus Christ was on this wise: When His mother Mary was espoused to Joseph, before they came together, she was found WITH CHILD of the Holy Ghost.

Luke 1:41 And it came to pass, that, when Elizabeth heard the salutation of Mary, the BABE LEAPED IN HER WOMB;...

Luke 2:5 To be taxed with Mary his espoused wife, being great WITH CHILD.

Galations 1:15 But when it pleased God, who seperated ME FROM MY MOTHER'S WOMB,...

I Thes 5:3 For when they shall say, Peace and safety; then sudden destruction cometh upon them, as travail upon a WOMAN WITH CHILD:...

Revelation 12:2 And she being WITH CHILD cried,...

So I ask you Catholics, Baptists, Methodists, Presbyterians, Episcopalians, Lutherans and other Christians, 8 of 10 of us all; can you acknowledge with me that God's Word makes routine mention of unborn children? There are scores more verses similiar to these. Unborn children are real children, Bibically human, but at a younger stage of development than their already born brothers and sisters. This Biblical truth needs to be recognized by 8 out of 10 Christian lawmakers.

Women in Montana need to be told, for certain, all the factual information we can provide to them prior to their irrevokable decision to abort. We can insure that no one will be able to say again in Montana, "I did not know," or "They never told me," or "If I had only known." It is time for Montana to insist women here have accurate information, scientific and practical knowledge, precious hours to consider alternatives, and the reasonable options so abundant in todays modern world.

This "Woman's Right to Know" legislation is supported by a wide cross section of people in the Flathead area as I can show you by this copy of 28 pages of 480 signatures that were gathered on February 17,18 & 19, 1995, in churches, barber shops and restaurants. When asked, people would say, "Of course I agree that women should have a right to know all relative facts before they agree to have an abortion." In fact, I do not recall one single person who refused to sign when it was offered. I strongly urge you, and all these 480 other people strongly urge you, please vote to pass SB 292, The "Woman's Right-to-Know Act". Thank you for your favorable consideration.

Sincerely,


Charles J. Lorentzen



MESSAGE to MONTANA LEGISLATORS

(Please Distribute)

EXHIBIT 9 pg 1 of 27
DATE 3/20/95

Honorable Senators

Baer, Brown, Harp and Mohl SB 292

Honorable Representatives

Boharski, Fisher, Herron, Keenan, Sliter, S. Smith, Somerville and Wagner

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The undersigned strongly urge you to PASS the above bills as they come before you in the weeks ahead:

Name	Residential Address
<u>CHARLES J. LORENTZEN</u>	<u>418 4TH ST. E. KALISPELL, MT 59901</u>
<u>Thomas Perry</u>	<u>1557 Church Drive, Kalispell MT, 59901</u>
<u>Lois Haag</u>	<u>1120 Hwy 209 Bigfork MT 59901</u>
<u>JOHN R. WEAVER</u>	<u>489 Godelin Ridge Rd Kalispell, MT. 59901</u>
<u>Suzanna Ballenger</u>	<u>1655 Lower Valley Rd. Kalispell</u>
<u>Debbie E. Hearty</u>	<u>318 Harrison Blvd. Kalispell</u>
<u>Bonnie A Fox</u>	<u>904 - 5th Ave. W., Kalispell</u>
<u>Barlene Gardner</u>	<u>809 3rd Ave W. Col. Falls</u>
<u>Beverly J. Brandt</u>	<u>635 6th St. West Apt. #11 Kalispell, MT 59901</u>
<u>Brenda Schroek</u>	<u>2325 Whitefish Stage Rd, Kalispell</u>
<u>Tanet McCOOIE</u>	<u>469 2ND AVE E.N. KALISPELL</u>
<u>Anthony Burt</u>	<u>520 Preside Rd. Kalispell, MT 59901</u>
<u>Kathleen Burt</u>	<u>" " " " " "</u>
<u>Wesley Kenne</u>	<u>1125 Sunnyside Dr. Kalispell, 59901</u>
<u>Donald H. Kenne</u>	<u>1125 Sunnyside Dr. Kalispell MT 59901</u>
<u>Fred Striepp</u>	<u>680 - 3rd Ave NW. Kalispell</u>
<u>Janet A. Paliza</u>	<u>310 - 4th Ave E. Troy - Kal. MT</u>
<u>Larry Waller</u>	<u>Box 171 Kula Mt.</u>
<u>C. Walling</u>	<u>310 - 5th Ave. Kalispell Kal 59901</u>



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Pg 2 of 27

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Name

Residential Address

Sherilyn Morris

6258 Hwy 93 S. Whitefish, Mt. 59937

Ryan Burke

565 Country Way Kalispell, MT, 59901

Paul B. Quinn

909 2nd Ave East, Apt. 2 N Kalispell, MT 59901

Paul M. Sibley

4790 Mont. 35 Kalispell 59901

Irene Detroge

590 900 W. Res. #132 Kalispell 59901

Lona Harper

912 6th Ave East Kalispell 59901

Name

Residential Address

June Handberg

1312 1/2 8th Ave E. Kalispell MT 59901

Glyndon S. Haag

1120 Hwy 209 Bigfork MT. 59901

Susan Corbelle

2298 W. Reserve Dr. Kalispell MT 59901

Jimmie Sue Coulter

1695 Hwy 35 #20 Kalispell MT 59901

Dave Williams

75 Foxlake Dr. Kalispell, Mt 59901



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Name	Residential Address
<u>Daniel Viny</u>	<u>135 Clearview Pl.</u>
<u>Shirley Bowdish</u>	<u>300 Bowdish Rd Kalispell, 59901</u>
<u>Linda Jackson</u>	<u>555 Wagner Ln, Kalispell 59901</u>
<u>Diane J Seidel</u>	<u>1164 Lost Creek Dr Kalispell 59901</u>
<u>Bruce Heeger</u>	<u>249 Rosewood Dr Kal 59901</u>
<u>Steve Heeger</u>	<u>249 Rosewood Dr Kalispell 59901</u>
<u>Janet C. King</u>	<u>7380 Trumbull Cr. Rd. Kalispell 59901</u>
<u>J. W. Jellison</u>	<u>100 Hawthorn Dr W Kalispell 59901</u>
<u>Carrie L. Jellison</u>	<u>100 Hawthorn W. Kalispell 59901</u>
<u>Carrie L. Jellison</u>	<u>657 4th Ave W N Kalispell 59901</u>
<u>Elmer R. Jellison</u>	<u>657 4th Ave W N Kalispell 59901</u>
<u>Robney R. Freeman</u>	<u>1501 6TH AVE HAUTE, MT 59501</u>
<u>Carol J. Freeman</u>	<u>1501 6th Ave. Haute, MT 59501</u>
<u>Sheila M. Volkman</u>	<u>585 - 1st Ave. E.N. - Kalispell, MT 59901</u>
<u>Emma Jane Wutke</u>	<u>108 W. Bleegreen Dr. Kalispell</u>
<u>Lulu Lukens</u>	<u>346 W. 7th - Whitefish, MT 59937</u>
<u>Debbie Bae</u>	<u>292 Morning View Dr. Kalispell 59901</u>
<u>Vivian Jackson</u>	<u>555 Wagner Lane, Kalispell</u>
<u>Steve Morgan</u>	<u>652 Shadow Lane, Kalispell, MT 59901</u>



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Name	Residential Address
Barbara Hanson	813 Rhoades Lane Kalispell, Mt.
Konnie Koenig	430 Church Dr. Kalispell mt
Theresa Koenig	321 9th Ave S - Kalispell
Walter Young	124 Maple Dr. Kalispell
Ken Oberdorfer	418 Fir Terrace Kalispell
Carol Oberdorfer	418 Fir Terrace Kalispell
Chis Oberdorfer	329 Blvd Missoula
Robert G. Oberdorfer	Bx 217 Lakeside
Robert Oberdorfer	Kami 211 Lakeside 59726
Lewis Sutton	365 Echo Chalet Dr Bigfork, MT
Doreen Ellis	1445 Southside Rd. Kalispell Mt
Bonnie McGee	1445 Hill Rd Bigfork, MT
Wesley Farnsworth	2810 Farm to Market Rd Kalispell MT
JoAnn Duff	101 White Rd. Kalispell
Larry Be	292 Morning View Dr. Kalispell
Debra Young	966 Birch Lane Kalispell
Glenn Young	966 Birch Lane Kalispell
Marie Louise Poindexter	734 D'Arbo Lane Dr Kalispell



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Name

Residential Address

<u>TERENCE N. CARSTEN</u>	<u>212 N. SOMERS RD. KALISPELL, MT.</u>
<u>Francella C. Jacobsen</u>	<u>946 - 6th Ave. E. Kalispell, MT.</u>
<u>Subbie N. Hunter</u>	<u>460 1st Ave. E. N. Kalispell, MT. 59901</u>
<u>Shirley A. Westley</u>	<u>480 Fifth Ave., NW, Kalispell, MT 59903</u>
<u>Harvey Miller</u>	<u>390 Anderson Lane, Kalispell, MT 59901</u>
<u>Ed Hunter</u>	<u>11-05, Meridian Rd Kal MT 59901</u>
<u>Lena Naumann</u>	<u>200 Garland #4 Kalispell MT 59901</u>
<u>Ralph Naumann</u>	<u>200 Garland St. #4 Kalispell Mt. 59901</u>
<u>Maury Sappington</u>	<u>220 7th Ave. S. Kalispell MT 59901</u>
<u>Jeanie Sappington</u>	<u>344 Harrison Blvd Kalispell, MT 59901</u>
<u>Angus Sappington</u>	<u>344 Harrison Blvd Kalispell, MT 59901</u>
<u>W Gary Shuld</u>	<u>818 5TH AVE N. GREAT FALLS, MT 59401</u>
<u>Rose Ellen Shulch</u>	<u>818 5th Ave. No. Great Falls, MT 59401</u>
<u>Caroline Taylor</u>	<u>1018 4th ave West Kalispell 59901</u>
<u>Greta C. Curt</u>	<u>212 N. Somers Rd Kalispell 59901</u>
<u>Phyllis C. Lenaburg</u>	<u>124 Mission View Dr. Lakeside, Mt 59922</u>
<u>Clarence O. Ekholt</u>	<u>78 5th Ave, W.N. Kalispell mt. 59901</u>
<u>Ernest J. Jacobson</u>	<u>946 6th Ave E Kalispell mt. 59901</u>
<u>Janice A. Kenias</u>	<u>535 Three Mile Dr. Kal. MT 59901</u>



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pg 6 of 27

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Name	Residential Address
<u>Gayle Johnson</u>	<u>P.O. Box 261 Kila, 59920</u>
<u>Barbara J. Hobus</u>	<u>452 3rd Ave WNW Kalispell MT 59901</u>
<u>Melba M. Herron</u>	<u>865 Echo Court Dr. Bigfork MT 59913</u>
<u>Jeanne Schuddebeck</u>	<u>212 Lakewood Dr Kalispell</u>
<u>Allen Schuddebeck</u>	<u>" " "</u>
<u>Kristie B. Adney</u>	<u>115 Ranch Rd Kalispell, MT.</u>
<u>Alice Perry</u>	<u>237 Lakewood Dr. Kalispell, MT.</u>
<u>Edward Naumann</u>	<u>6940 2nd St. Bigfork MT 59913</u>
<u>Rena Handley</u>	<u>Lewistown, Mont.</u>
<u>Joe Sliter</u>	<u>115 Ranch Rd Kalispell</u>
<u>James Fisher</u>	<u>273 Lakewood Dr West-Kalispell</u>
<u>William Becker</u>	<u>" " Kalispell</u>



MESSAGE to MONTANA LEGISLATORS

Pg 7 of 27

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Name

Residential Address

Carol L Hogan 718 Lore Lake Rd. Kalispell, MT 59901

MYRTLE HUTCHENS 6130 FARM TO MKRT WHITEFISH MT 59901

Jillie Kickbusch Box 1089 Phalen New Kalispell 59901

Sharon Robux 135 Sheridan Cir
PO Box 45 Kalispell

Bonnie S. Best 350 Lore Lake Rd, Kalispell, MT

Danga Olson 435 Hwy 2E C. Falls, MT

Bonnie Faynes 1055 N. Meridian #404 Kalispell, MT

Shirley Poe 2880 Farm to MKRT Rd Kalispell

Beryl Garwin 675 Lost Co. Hwy, Kal. 59901

Mary Bacholomus 680 Lore Lake Rd Kalispell MT

Daneth W. Hanson 535 Lodges Rd Whitefish MT 59937

Art Green 160 Haskell Dr. Whitefish, MT 59937

Lillie Green 160 Haskell Dr. Whitefish 59937

Ruth E. Horn 3345 W. Valley Dr Whitefish MT 59937

Kathleen U. Harway 785 Fox Farm Rd. Kal. 59901

Deila Elgin 3282 Whitefish Stage Kalispell 59901

Foyce Stetwell 326 Deer Trail Whitefish, MT 59937

Danga Scholz Box 1514 Whitefish MT 59937

Fayll Stetwell 326 DEER TRAIL, WHITEFISH 59937



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Name	Residential Address
Larry K Keller	Crossroads Cafe
Bill Fisher	23 Tahoe Dr. Kalispell, MT 59901
Judy A. Bailey	Po Box 2736 Kal. / 221 11 th St W
John E Bussey	905 3rd Ave E #2 Kalispell MT
Dawn Alexander	695 7 th NW W. Kalispell MT
Robert Brock	879 Hwy 206 Kal. MT
Carrie Gunderson	111 Dyer Rd. Kalispell MT 59901
Ben Cerise	P.O. Box 804 Columbia Falls, MT 59912
Gus Delay	Columbia Falls MT
Janet Konecky	3200 W Valley Dr. Kal MT
Carl Kinchy	2200 W. Valley DR. Kal. MT 59901
Winston Colley	728 2ND AVE E. KAL MT. 599
Bernice Long	1557 Church St. Kalispell 599
J. Lopez	1110 3rd Ave E. Kalispell MT



MESSAGE to MONTANA LEGISLATORS

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Pg 9 of 27

Honorable Senators

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Name	Residential Address
Audrey Wiser	2596 Hwy 2 W - Kalispell MT
Richard Kiser	2596 - Hwy # 2 W Kalispell Mt.
Patricia Gabriel	110 Carolina Rd Kalispell mt.
Eleanor Stewart	131 Sleepy Hollow Rd., Kalispell, mt.
Gloria Landon	140 W Oregon Kalispell, mt 59901
John R. Wilson	100 Park Lane Dr. Kalispell
Sondra L Hatton	130 Sleepy Hollow Kal
Richard Hatton	130 Sleepy Hollow Kal
Carolyn L. O'Neil	338 Harrison Blvd. Kalispell, mt.
Leisha Chandler	1127 4th Ave W Kalispell MT
Amanda Swenholm	1177 4th Ave W Kalispell, MT
Doris Richards	486 Two Mile Str #1, Kalispell, mt.
Mrs. Annela	1127 4th Ave West
Doug Richardson	Marion MT
James J. Wilson	100 Parklane Dr. Kal.
Sara Landis	130 School Addition Rd. Kal.
Maureen L. Larsh	130 SCHOOL ADDN RD KAL 59901
Angela Lockwood	PO Box 823 Challis, Id. 83226
Ann Clark	234 5th Ave. E. Kalispell, MT



MESSAGE to MONTANA LEGISLATORS

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Pg 10 of 21

Honorable Senators

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Name	Residential Address (please print address)
<u>Gordon C. Dexter</u>	<u>535 12th St. E, Kalispell, MT</u>
<u>Paul M. Bray</u>	<u>318 DEER TRL, WHITEFISH MT</u>
<u>John E. Wilson</u>	<u>165 Wilson Heights, Kalispell, MT</u>
<u>Keith A. Miller</u>	<u>3335 Hwy 2 West, Kalispell, MT</u>
<u>C. Kathleen Sims</u>	<u>1244 5th AVE E. Kalispell, MT</u>
<u>Best J. Pipes</u>	<u>1244 5th AVE E Kalispell, MT.</u>
<u>L. Granite White</u>	<u>68 Sussex Dr. Kalispell, MT.</u>
<u>Jessie M. Kimbrough</u>	<u>1100 E. Oregon #52, Kalispell, MT.</u>
<u>Betty R. Kimbrough</u>	<u>1100 E. Oregon #44 Kalispell, M</u>
<u>Tracy Inabinet</u>	<u>288C Two roads, Kalispell, MT.</u>
<u>Hilda Stedman</u>	<u>1029 5th Ave. E. Kalispell,</u>
<u>Wendy Bicknell</u>	<u>210 Forest Drive Kalispell, MT</u>
<u>Ray Bicknell</u>	<u>210 Forest Drive Kalispell</u>
<u>Ann L. Miller</u>	<u>3335 Hwy. 2 West, Kalispell, MT</u>
<u>Joe C. Smith</u>	<u>831 KIENAS RD Kalispell MT.</u>
<u>Betty J. Nock</u>	<u>342 Hill Top Ave Kalispell MT.</u>
<u>Ray A. Nock</u>	<u>342 Hill Top Ave Kalispell, MT.</u>
<u>Jathyn Schava</u>	<u>651 2nd Ave. W. N., Kalispell,</u>
<u>William Kimbrough</u>	<u>1100 E Oregon #44 Kalispell, MT.</u>



MESSAGE to MONTANA LEGISLATORS

(Please Distribute)

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Honorable Senators

Baer, Brown, Harp and Mohl

Honorable Representatives

Boharski, Fisher, Herron, Keenan, Sliter, S. Smith, Somerville and Wagner

SB 292 "Woman's Right-To-Know Act" Giving women considering abortion complete information on alternatives.

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The undersigned strongly urge you to PASS the above bills as they come before you in the weeks ahead:

Name

Residential Address

Pastor James E. Hoff	29 Meadowlark Dr. Kalispell
James J. Angle	1020 Helena Flats Rd, Kalispell
Walt Dupes	8585 Hwy - 35, Bigfork
Linda Hailman	3440 Hwy 2 N, Kalispell
Ruby Howard	730 3rd Ave W, Kalispell
Shirley Riche	PO Box 265 Kila, MT 59920
Marjorie Taylor	1128 Kenway E-7-
DAN GOODWIN	4174 Hwy 93 S, KALISPELL, MT
Al Cole	179 Sylvia Dr, Bigfork, MT
Shari Handal	1019 2nd Ave E, Kalispell, MT 59901
DeLise Ryan	614 2nd Ave E, Kalispell, MT 59901
Lisa Angle	1020 Helena Flats Rd, Kalispell, MT 59901
Jeffrey Handal	1019 2nd Ave E, Kalispell, MT 59901
J.P. B.	614 2nd Ave East Kalispell, MT 59901
W.S. B.	PO Box 1258, Browning, MT. 59417
Uva Walters	PO Box 62, Kalispell, MT 59903
Dana Hills	364th Ave West Kalispell, MT
Alice Wiedman	Brendan House 350 Conway Dr, Kalispell, MT 59901
Dorothy C. Hoff	29 Meadowlark Dr, Kalispell, MT 59901



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Name	Residential Address
Leresa Verber	473 Vanderheide Ln. Kalispell, MT 59901
Connie Oley	270 Kauffman Ln, Kal. Mt. 59901
John Verber	473 Vanderheide Ln Kalispell, MT 59901
Margdalena Shoemaker	210 Glenwood Dr Kalispell mt 59901
Arthur Tenfeld	221 - 3rd St W, Kalispell Mt. 59901
Mrs Beverly J Dyck	545 Army Road Whitefish, MT 59937
Mary Wape	528 3rd Ave. W. #1 - 59901
David R. Burt	820 Riverside Road. Kalispell 59901
Kanlyll Masters	1479 Rhodes Drive Kalispell 59901
Dolores Fuebrytz	469 2nd Ave EN Kalispell mt
Mary Ballinger	179 Arbor Dr. Kalispell
Patti Gruba	Box 352 Kalispell
John Logan	641 Shadow Lane Kalispell MT 59901
Theresa Logan	641 Shadow Lane Kalispell MT 59901
Don Samant	1321 - 5th Ave. E. Kalispell mt 59901
Ryan Femen	59 Sunrise Drive
Beppi Benson	215 Van Sant Rd Kal
Rachel Miller	44 Harbin Hill Kal.
Mark Halland	632 Granite View Dr. Kal.



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Name	Residential Address
<i>Alfred M. Kesa</i>	<i>2859 WHITEFISH STOK KAL. MT</i>
<i>Alice [unclear]</i>	<i>1105 Lake Avenue West - Kalispell, MT</i>
<i>Ashley Jo [unclear]</i>	<i>157 W. Kidding Rd Kal MT</i>
<i>Amanda L. Hoober</i>	<i>Box 9062 Kal MT</i>
<i>Danna Raymond</i>	<i>2358 Foothill^{Kal} MT</i>
<i>Diane Stee</i>	<i>735 Addison Sq. Kalispell</i>
<i>Jeanne Roberts</i>	<i>136 Trail Ridge Rd. Kalispell</i>
<i>John Bishop</i>	<i>954 Echo Lake Rd. - Bigfork, MT 599</i>
<i>Danica M. Markey</i>	<i>310 STEEL BRIDGES RD. KALISPELL</i>
<i>Robert M. Maloney</i>	<i>147 Ashov Dr. Kalispell, MT 599</i>
<i>Arden L. Neallung</i>	<i>87- 5th Ave W.N. Kalispell MT 5990</i>
<i>Jane L. Thompson</i>	<i>450 KettleBach Lane Kalispell MT 59901</i>
<i>Harold Wachsmeider</i>	<i>578 EASTMAN DR Bigfork, mt 59961</i>
<i>Rud [unclear]</i>	<i>1555 HAVEN DR Kalispell MT 59901</i>
<i>Samuel T. Soto</i>	<i>3659 Highway 40 W. Columbia Falls MT 59</i>
<i>Geraldine J. Teane</i>	<i>611 3rd Ave West, Kalispell, MT 5</i>
<i>Teresa L. Purse</i>	<i>3151 Parkwood Lane Bigfork, mt 5</i>
<i>L. G. Mohr</i>	<i>428 Kings Way - Kal. mt. 59901</i>
<i>Renal Lind</i>	



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Name	Residential Address
<i>[Signature]</i>	2798 Mt 206 Col. Falls MT
Deanne Pringer	" " "
<i>[Signature]</i>	364 N. Fogs Lake Dr. Kalispell
<i>[Signature]</i>	P.O. BOX 3006 LAKESIDE, MT
Rebecca J. Hefly	P.O. Box 3000 Lakeside MT
<i>[Signature]</i>	101 W. Bluegrass Rd. Kalispell
Miko Dwyer	310 W 2nd St. Wph.
Marilyn Kuthe	22 Glacier St. Kalispell
Stephan Swinstead	98 Northern Lts Kalispell
Donna Harden	101 W. Bluegrass Kalispell
Ellen Herset	43 Silver Leaf Drive Kalispell
<i>[Signature]</i>	109 Shelter View Kalispell
Joanne Herset	43 Silver Leaf Dr. Kalispell
<i>[Signature]</i>	412 4 th St E Kalispell
<i>[Signature]</i>	9 Panoramic Drive Kalispell
Janet E. Ferguson	835 West 7 th St. Whitefish
Vernon M. Ferguson	835 West 7 th St. Whitefish mt.
<i>[Signature]</i>	118 Dorset Lane Xli Kalispell, MT
<i>[Signature]</i>	179 Arbor Dr. Kalispell, MT 59901



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Name

Residential Address

<u>Lilly Swan</u>	<u>Columbia Falls, MT</u>
<u>Donna Hui</u>	<u>208 Lake Shore Dr, Kalispell, MT</u>
<u>Donna Falser</u>	<u>162 Christ Lodge, Kalispell, MT</u>
<u>Yvonne H. H. H.</u>	<u>431 Judith Rd #2 Kalispell, MT</u>
<u>Bob H.</u>	<u>250 LAKE BLANDING RD KALISPELL, MT</u>
<u>Ruth M. Nash</u>	<u>340 4th Ave E A-1 Kalispell MT</u>
<u>Dave Leighty</u>	<u>536 Mennonite Ch. Rd Kalispell, MT</u>
<u>John McChesney</u>	<u>1965 Mission Way Swan Kalispell</u>
<u>Robert E. McChesney</u>	<u>1965 Mission Way So Kal.</u>
<u>Robert S. Blehe</u>	<u>380 5TH AVE. E.N.</u>
<u>Coralyn Raymond</u>	<u>288 Wishart Rd Col. Falls, MT.</u>
<u>Jessica Wood</u>	<u>370 Wishart Rd Col. Falls MT.</u>
<u>Craig R. Ambrose</u>	<u>160 Looking Eagle Dr. Somers MT 59932</u>
<u>David R. Thoun</u>	<u>990 Swan River Rd. Bigfork MT 5</u>
<u>Becky Bahr</u>	<u>PO BOX 1232 Columbia Falls MT 59</u>
<u>Caleb Bahr</u>	<u>Po Box 1232 Columbia Falls Mt 599</u>
<u>Michael Bahr</u>	<u>PO Box 1232 Columbia Falls MT 59</u>
<u>Birdie Faris</u>	<u>570 5th. Ave. W.N., Kalispell, MT 59</u>
<u>Edwaine Schmittz</u>	<u>354 hore hake rd itd</u>



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Name	Residential Address
John W. Kersted	140 Reservoir Road - Whitefish, MT
Bob West	1416 W. Lakeshore Dr. Whitefish, MT
Bill Sigmon	1135 W. Whitefish Stage Kalispell Mont.
Cynthia Williamson	805 13 th St W C.F. MT.
Roger Hjelm	524 C. F. STg. Rd. KAL MT.
Lizette Stanton	105 Windward way Act 10LA Kalispell, MT 59901
Sue Myers	East Star Rt. Bigfork MT 59914
Jayne Bohof	930 7 th Ave W. Kalispell
Ed Johnson	451 7 th Ave E. Kalispell
Marla Lewis	Box 651 Col. Falls, MT 59912
Carolyn M. Johnson	368 E. Reserve Dr. Kalispell, MT 59901
William J. Foster	704 COUNTRY WAY, KALISPELL, MT 59901
Babak S. Schult	250 Lake Elaine Dr. Kalispell MT 59901
Steve C. Shoemaker	210 Glenwood Dr. Kalispell, Mt. 59901.
Kathleen D. Walker	213 Lakeshore Dr. Kalispell 59901
William Walker	213 Lakeshore Dr. Kalispell 59901
Stephanie Raymond	288 Wishart Rd. Col. Falls MT 59912
Kathy Anderson	132 N. Haven Dr. Kalispell 59901



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Name	Residential Address
Douglas M. Lewis	211 Sherry Lane Kalispell MT
Gulmn Lewis	211 Sherry Ln Kal, MT
Roland Demault	324 Kings way Kal. MT.
Sylvia Demault	324, Kings Way Kalispell
Vernon Demault	324-Kings Way Kalispell
Curtis Haag	1340 Willow Glen Dr #16 Kal
Gloria Johnson	928 2nd Ave. W. Kalispell
Helen Green	920-2nd Ave. W. Kalispell
Jill Lenoa	109 GARLAND ST KALISPELL
ECHO B. HEFTY	119 NORTHERN LIGHTS BLVD, Kal
Marilyn Steg	527 Crestview Rd.
Randall Fox	169 Shelter View Dr Kal.
Cheryl Fox	27 Double Lake, Cth Kal.
Oscew Olson	527 Crestview Rd
Miriam Olson	109 Shelter View Kal.
Kristi Maltby	27 Double Lake Ct Kalispell
James J. Espar	159 Garland St. Kalispell
Angie Bristead	98 N Lights Blvd Kalispell
Delia P. Brix	920 2nd Ave. West, Kalispell



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Name	Residential Address
<u>John Edwards</u>	<u>1842 Ashley Sp. Rd. Kalispell</u>
<u>J.R. MYERS</u>	<u>1100 MTN. RDW. RD., KALISPELL</u>
<u>Bob Niedenz</u>	<u>220 E HarmonyRD Kal. Mt.</u>
<u>Ed Prestegaard</u>	<u>2100 S. Woodland Dr., Kalispell, MT. 59901</u>
<u>Pat Prestegaard</u>	<u>2100 S. Woodland Dr. Kal.</u>
<u>Doreen Canfield</u>	<u>2367 Whitefish Stage Rd., Kalispell, MT 59901</u>
<u>Ken Canfield</u>	<u>" " " " " "</u>
<u>Debra Taylor</u>	<u>1023 7th Ave W. - Kalispell</u>
<u>Barbara Woodhouse</u>	<u>431 Judith Rd #2 Kalispell, MT 59901</u>
<u>Bette J. Dyck</u>	<u>1042 Outlook^{tr.} P.O. Box 703 Whitefish, MT 59907</u>
<u>Cheryl P. Kamps</u>	<u>234 Fairview Dr. #4 Kalispell, MT 59901</u>
<u>Honda Mott</u>	<u>676 Shadow Ln Kalispell MT 59901</u>
<u>Michelle Christensen</u>	<u>6 Yellowstone St. Kalispell MT 59901</u>
<u>Janet Pine</u>	<u>208 Lake Shore Dr Kalispell, MT. 59901</u>
<u>Sheryl Coats</u>	<u>1045 Concord Dr Kalispell</u>
<u>Pat Brown</u>	<u>140 River Butte Dr. Columbia Falls, MT</u>
<u>Carl R. Sharp</u>	<u>Box 325, Columbia Falls, Mont. 59912</u>
<u>John J. Harold</u>	<u>12 Terry Rd. Kalispell, MT 59901</u>
<u>Cheryl Krichner</u>	<u>471 VonDerNeide Kalispell 59901</u>



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Name	Residential Address
<i>Sharon Guelch</i>	<i>427 4th Ave E. Kalispell, Mt 59</i>
<i>Joyce Norton</i>	<i>1901 Darlington Kalispell, Mt. 59901</i>
<i>Bess Newbold</i>	<i>931 - 3rd St. W. Kalispell mt. 59901</i>
<i>Allyson Keidin</i>	<i>302 Two-mile Rd Kal</i>
<i>John NR</i>	<i>549 ARMORY RD. whitefish</i>
<i>Ingelborg Wallitt</i>	<i>1721 Woodlark Dr. #4 Kalispell, mt 59901</i>
<i>Robert J Poll</i>	<i>1490 Memory Lane, Kalispell, mt 59901</i>
<i>SUSAN K. SHARP</i>	<i>2857 WHITEFISH STAGE, KALISPELL, MT 59901</i>
<i>Deon C. Goff</i>	<i>2071 MISSION WAY S. BOX 1553 KAL 59903</i>
<i>Lester Adkins</i>	<i>15 Ridgewood Dr. Kalispell, Mt</i>
<i>Anson A. Manugh</i>	<i>434 6th Ave W. Kalispell, mt</i>
<i>Tim Roberts</i>	<i>735 Addison Sq KAL. M.T.</i>
<i>ELLENJOY HOEWER</i>	<i>1651 MONTE VISTA DR COL. FALLS MTS</i>
<i>Donna L. Hoover</i>	<i>1651 monte vista dr Col Fall, mt</i>
<i>Philip L. Marken</i>	<i>954 Eden Lake Road Bigfork 59911</i>
<i>Marilyn L. Nash</i>	<i>1303 7th Ave W. Kalispell Mt. 59901</i>
<i>Glynda Lee Spelman</i>	<i>1253 Berne Rd. Col Falls 59912</i>
<i>Carol Cook</i>	<i>1930 Camelot Kalispell Mt. 59901</i>



MESSAGE to MONTANA LEGISLATORS

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Name	Residential Address
<u>Linda S. Wegener</u>	<u>1400 Col Drive, Col Falls, Mt. 59912</u>
<u>Stacy Dyer</u>	<u>835 ANDERSON LN KATH.</u>
<u>Winnie Solomonson</u>	<u>330-32nd Ave N. #109 Kalispell Mt. 59901</u>
<u>Cynthia M...</u>	<u>Box 13 Bigfork</u>
<u>Mary Powell</u>	<u>P.O. Box 2188, C.F., MT. 59912</u>
<u>M.L. Warner</u>	<u>2872 Hwy 93 N. Kalispell MT 59901</u>
<u>Joseph W. Zwick</u>	<u>Box 13 Bigfork MT. 59911</u>
<u>Connie Ambrose</u>	<u>160 Looking East Drive, Jones Mt. 59932</u>
<u>Sharon Kestner</u>	<u>368 S. MARY STS W. Kal 59901</u>
<u>LeRoy Schmitz</u>	<u>354 LORE Lake Rd Kal 59901</u>
<u>Yvonne Fanger</u>	<u>11 Harvest Lane Kal. 59901</u>
<u>Paul Andron</u>	<u>3655 Hwy 40 W, Col Falls, MT 59912</u>
<u>Robert R. Anderson</u>	<u>3655 Hwy. Col. Falls Mt. 59912</u>
<u>Carolyn Bishop</u>	<u>36 Trail Ridge Rd. Kalispell, MT. 59901</u>
<u>Lebet Kild</u>	<u>471 Von Der Heide Ln. Kalispell, mt. 59901</u>
<u>Deanne Bennett</u>	<u>902 Creston Hatching Rd Kalispell MT 59901</u>
<u>Gladys A. Peltz</u>	<u>825 Helena Plaza Rd. Kalispell, MT 59901</u>
<u>Susan Guthrie</u>	<u>P.O. 935 LAKESIDE MT 59912</u>



MESSAGE to MONTANA LEGISLATORS

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Name	Residential Address
Peggy Christensen	PO Box 1248 Condon, MT 59826
Glenda Brown	330 Goodrich Rd Kalispell MT 59901
Judy Foster	234 Lake Blaine Dr. Kal. MT 5990
Mary Williams	1156 Thompson Ln Kal. MT. 59901
Jay Hedman	" " " " " "
Jessie Mc Carthy	
Maie Phillips	140 Ponderosa Ln, Kalispell
Barbara	140 Ponderosa Ln Kal.
Don Nelson	Box 717 Kalispell, MT.
Howard E. Tash	1303 Tore West Kalispell
Red Fanger	11 Harvest Lane Kalispell, MT. 59901
Susan Douglas	835 Anderson Lane, Kalispell, MT
John Foreman	418 4th St. E. Kalispell MT 59901
R. W. Brown	401 West Valley Dr Kalispell
Harold St. John	9 Panoramic Dr Kalispell MT
Wanda Paul	5457 r mary Rd Whitefish, MT. 59901
Albert P. Pisch	825 Helena Heights Rd Kalispell
Terry Kompt	20 Appleway Dr Kalispell 59901
Bob Lyford	3005 Hwy 2 East Kal.



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Name	Residential Address
Gerald J. Spurns	300 Leaven Lane, Kalispell
Donald E. Kach	P.O. Box 7445 Kalispell, MT,
Edward W. Peterson	330-3rd Ave N #115 Kalispell Mt. 59901
Naomi Bahr	P.O. Box 1232 656 8th Ave. E. N. Col. Falls
Rudy Z. Koestner	302 So. Many Lakes Dr. Kalispell, MT
Mark J. Stumburg	115 Drumlin Way
Frank Spornung	115 Drumlin Way Kal, MT 59901
Cal Omb	PO Box 783 Whitefish MT
Caroline Sharp	Columbia Falls, MT Box 385
M. Helen Jones	1320 2nd Ave E. Kal. Mt.
John R. Sullivan	191 ARBOUR DRIVE Kalispell, MT
Barbara E. Hadley	215 Fox Hill Dr. Kal.
Paul M.	PO Box 10752 Kal 59904
Ceffie P. Jones	152 Trailridge Rd., Kalispell, MT 59901
Coir Dick	549 Armory Rd Whitefish
Roll Matt	676 SHADOW LAKE, KALISPELL 59901
Tim Nutter	1819 Foothill Rd. Kalispell, MT 59901
Paul Glock	Box 183 Somers mt 59932
Paul Christensen	PO Box 1248 Colman - MT 59823



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Name	Residential Address
<u>Andy Klasing</u>	<u>613 ... Kalispell</u>
<u>Debra Foch</u>	<u>1972 4th Ave NW, #111, Kal</u>
<u>Christine Hoegland</u>	<u>4790 Whitefoot Stage Rd Whitefoot</u>
<u>Kimberly Ansell</u>	<u>635 6th St. West #4 Kalispell, MT 59901</u>
<u>Nathan Ellis</u>	<u>501 McCaffery Rd Bigfork 59911</u>
<u>Nancy Burgess</u>	<u>900 W Reserve #207 Kalispell</u>
<u>Christine ...</u>	<u>111 Laurel Hills Kalispell</u>
<u>Brandi Winegarner</u>	<u>416 Kingsway, Kalispell, MT. 59901</u>
<u>Debbie ...</u>	<u>900 Carter, Hatcher, Id. 83401</u>
<u>Robert ...</u>	<u>16 Silverleaf Dr. Kalispell, MT 59901</u>
<u>Timothy ...</u>	<u>902 1st Ave E Kalispell MT 59901</u>
<u>Tammy A. K ...</u>	<u>13510th Ave. Kalispell, MT. 59901</u>
<u>Michael Wehrman</u>	<u>2720 Hwy 93 S Kalispell MT</u>
<u>...</u>	<u>...</u>
<u>Lillian ...</u>	<u>235 Laurel Hills Kalispell 59901</u>
<u>Eric ...</u>	<u>1221 W. Plain Rd. Kalispell MT 59901</u>
<u>Neil Broad</u>	<u>1229 4th Ave West Kal MT 59901</u>
<u>Paul ...</u>	<u>2694 115th 22nd St 35th St, Kal. MT</u>
<u>Linda Chandler</u>	<u>1127 1/2th Ave W Kalispell MT 59901</u>



MESSAGE to MONTANA LEGISLATORS

(Please Distribute)

Honorable Senators

Baer, Brown, Harp and Mohl

Honorable Representatives

Boharski, Fisher, Herron, Keenan, Sliter, S. Smith, Somerville and Wagner

SB 292 "Woman's Right-To-Know Act" Giving women considering abortion complete information on alternatives.

HB 442 Physicians Only Clarifying that only physicians are allowed to perform abortions in Montana.

HB 482 Parental Notification Requiring parents be told before a minor be given an abortion in Montana.

The undersigned strongly urge you to PASS the above bills as they come before you in the weeks ahead:

Name

Residential Address

- The Drommhart 259 W. Reservoir Kalispell
- Ed F. Gardner 1045 FOY'S LAKE RD, KALISPELL
- A. Roelwood 160 Condit Dr. Kalispell MT
- Lewis 734 KM Round Rd Whitefish mt 59937
- P. Sanders " " " " " "
- Stewart 321 Cougar Trail Whitefish, MT 59937
- Shaw 338 Harrison Blvd, Kalispell, MT 59901
- Gardner 1045 Foy's Lake Rd, Kalispell, MT 59904
- D. Pomeroy 9, 4th Ave. E. Kalispell MT 59901
- Hays 912 6th ave E Kal mt 59901
- Kapell 902-6th Ave East Kalispell, MT, 59901
- Kapell 912 6th Ave E, Kalispell, mt 59901



MESSAGE to MONTANA LEGISLATORS

(Please Distribute)

pg 26

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Name	Residential Address
Mark D. Lampman	1606 Ave East N Columbia Falls MT 5
Mere Shewalter	420 3rd ave West C. Falls 892-4726
Larry and Patsy Dayford	2475 Hwy 206 Col. Falls MT 59916
Patrick Gray	673 Scenic Dr. Kalispell Mt.
Jan Korpela	2090 Jarm. to-Market Kal
Black & Loren	602 Sunnyside Dr. Kalispell MT
Laura A. Lowen	602 Sunnyside Dr. Kalispell, MT 59901
Quincy Graham	Box 352 Kalispell, MT 59901
Gladys Graham	95 Grandview Dr. Kalispell, MT 59901
Bill Singer	1135 W Whitefish Slough Kalispell MT
Lee A. Snowbird FRANK	3530 Hwy 206 Col Falls, MT. 59912
Bye Heffernan	1028 - 2nd Ave W. Kalispell, MT 59901
Mida Heffernan	1028 - 2nd Ave W Kalispell, MT 59901
Karla K. Russell	101 W. 2nd Ave "2 Whitefish
Denise Polu	P.O. Box 4192 Whitefish MT 59937
Scott Krutz	615 1st Cr Rd Kalispell MT 59901
Robert J. Brown	233 MARY LAKE DR, KALISPELL, 59901
Helen A. Brown	233 Mary Lake Dr. Kalispell. 59901
Ed Skelton	P.O. Box 902 Kalispell, Mont. 59902



MESSAGE to MONTANA LEGISLATORS

(Please Distribute)

Honorable Senators

Baer, Brown, Harp and Mohl

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Name

Residential Address

B. H. Harris 2550 HAYWICK KALISPELL MT

John Skipp " " " "

John Skipp " " " "

David Meier P.O. Box 752 LAKESIDE MT

Anda Lynn P.O. Box 178 Somers, mt

Glen Lyman " " " "

Robert Seymour 1336 MOUNTAIN MEADOWS RD. KALISPELL MT.

Mark Romine 1154 3RD St W, N. Columbia Falls MT.

Ray Seymour 1336 MOUNTAIN MEADOWS RD. KALISPELL, MT.

Robert Canupp PO Box 308 Somers, MT.

Sheila A. Dringer MT. Box 2655 - Somers MT 59932

Ronald L. Wiering P.O. Box 265 Somers MT 59932



MESSAGE to MONTANA LEGISLATORS

1128

(Please Distribute)

Honorable Senators

Baer, Brown, Harp and Mohl

Honorable Representatives

Boharski, Fisher, Herron, Keenan, Sliter, S. Smith, Somerville and Wagner

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Name	Residential Address
<u>April Adams</u>	<u>155 Eastland Crossroads, Col. Falls, MT, 59912</u>
<u>Daniel Adams</u>	<u>155 Eastland Crossroads Col. Falls, MT, 59912</u>
<u>Lorena Adams</u>	<u>15.5 Eastland C.R. Columbia Falls 59912</u>
<u>Nora Bergstrom</u>	<u>P.O. Box 4232 WF, MT 59937</u>
<u>Meissa Weststone</u>	<u>P.O. Box 1361 Whitefish, MT</u>
<u>Karen Wright</u>	<u>P.O. Box 2584 Columbia Falls</u>
<u>Kristin Creamer</u>	<u>101 Larch Ln. Kalispell, MT 59901</u>
<u>Sheila Nestell</u>	<u>P.O. Box 1441 Whitefish, MT 59937</u>
<u>Lynn Huelin</u>	<u>257 Grandale Ave Kalispell, Mt. 59901</u>
<u>Don Snyton</u>	<u>Box 4232 WF</u>
<u>Chris Nestell</u>	<u>P.O. Box 1441 Whitefish MT 59937</u>
<u>Samuel Wright Jr.</u>	<u>P.O. Box 2584 Cd. Fls. MT, 59912</u>
<u>Thomas B. Keller</u>	<u>257 Grandale Ave., Kalispell, Mt. 59901</u>
<u>Kirk Holth</u>	<u>170 Demersville Wagon Rd Lakeside, MT 59922</u>
<u>Heidi Keller</u>	<u>170 Demersville Wagon Rd Lakeside MT 59922</u>
<u>Ardis Sweet</u>	<u>315 Lake Blaine Rd., Kalispell, MT</u>
<u> </u>	<u> </u>
<u> </u>	<u> </u>
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EXHIBIT 10
DATE 3/20/95
SB 292

Mr. Chairman and members of the committee,
My name is Andy Klein from the Flathead valley representing
myself.

Regarding ^{Senate} ~~House~~ Bill 292:

I believe it is imperative that a person receive all the information
possible concerning procedures of abortion, options and
alternatives before making this very important decision.

It seems to me If we have the womans best interest in mind
as the opponents of this bill will tell you, she should have all the
information before any procedures take place.

If she has all the information possible, and still decides that
it is the best thing to do, she may be less likely to have emotional
problems later because of this decision.

Therefore, I strongly urge you to vote for ^{Senate} ~~House~~ Bill 292

Thank you

Andy Klein

EXHIBIT 11
DATE 3/20/95
SB 292

The Honorable Senator Bob Brown
Mt State Senate
Capitol Station
Helena MT 59620

RE: Senate Bill 292

I am a woman who has had 2 abortions - One as a girl of 17 when my parents took me to Washington (it was not legal in Montana then)- The other a couple of years later when I lived in California. I will not go into all the details and circumstances, except that neither time was I made aware of what was really happening. Not the first time with my parents (and neither were they) nor the second time when I was alone and on my own.

Since that time, I have learned the reality of what abortion is. The ABOSOLUTE truth. The horror of what happens to the unborn child, and the consequences to the woman of physical and emotinal trauma. None of wich they tell you.

Sir - If I had known before, I would not have chosen to destroy those lives. I don't believe my parents would have either.

There are thousands of girls and women walking into abortion clinics our of fear, with doubts and questions as I did. I was not told what was really goint to happen - "only a minor procedure", "a little cramping, like having a heavey period" I was told, "nothing to it".

Why has it been allowed that a woman can and indeed is encouraged to get an abortion without benefit of educating them on what it really means and then given time to think about it. To make that decision based on truth and not fear, lies and pressure. You would not go into any other surgical procedure without being thoroughy informed, but abortion is done that way all the time.

Why is it then, that we who value life - that of the child AND that of the woman - are forbidden to educate the girl on what really happens and let her make a decision based on all the facts.

I've been one of the lucky ones. I've since had two children and I suffered no permanent physical trauma. But there are many women who are not so lucky and would have chosen otherwise if informed.

By the grace of God, I've also healed emotionally. But there are scores who who have not.

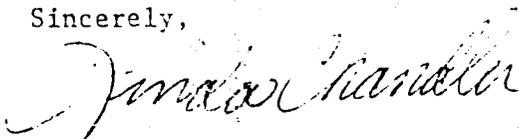
I will never forget the 2 babies, children, individuals that never got to enjoy life, to contribute, they were as precious as any.

I wish with all my heart that someone would have told me, shown me, educated me, and made me take time to think. I would not have chosen the way I did.

I urge you Sir, to vote for education and a waiting period, that these girls/women will make a truly "free" choice. For the good of all people.

May God guide you as you serve.

Sincerely,



Linda Chandler
1127 - 4th Ave W
Kalispell, MT 59901

EXHIBIT 12
DATE 3/20/95
SB 292

TO WHOM IT MAY CONCERN:

My name is Cindy DeLay. I'm a 34 yr. old mother of two. 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 spontaneously 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 hypocritical 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 THAT A WOMAN SHOULD BE TOLD THE WHOLE TRUTH REGARDING ANY & ALL SURGERIES PERFORMED ON HER BODY

Thank You,
Cindy D. DeLay 862-4380
Box 2032 COLFLSMT 39912

February 7, 1995
SB 292
A Woman's Right to Know

Dear Mr. Armstrong,

Fifteen years ago I had an abortion performed by you in Kalispell. I was seventeen years old when I discovered I was pregnant. I was excited about this baby and wanted it very much. Our plans were to continue with the little extra addition to come later....until my fiancé walked out on me.

I thought about having an abortion, not really understanding what it was all about. I called your office. You were leaving on vacation in a couple of days for two weeks. I was three months along and by the time that you would return I thought it would be too late....I didn't know that abortions were allowed after three months. I panicked and asked if there was any way to get in to see you and I was scheduled for a 5:00 P.M. appointment.

The counseling that I received from you consisted of you telling me why you favored abortion. That was basically it. You said you wanted to make sure that was what I wanted. I totally broke down and became hysterical. I remember saying, "I don't know what else to do. I just want to get it over with." Does this sound like someone who really knew what she wanted to do?

I was a pregnant teen, scared and alone. I didn't know there were any other alternatives. I desperately needed counseling....what was I doing to myself and to my baby?

Do you know that until April 1988 I did not know that I had given you my consent to kill my baby? Through the years my attitude had slowly changed, but the reality of what I'd done still hadn't really registered. For years I never thought a baby was actually a "baby" until after the third month....I had thought it was just a mass of tissue. It had to be or why else would abortion be legal? Certainly no one could legally kill a living child.

I saw "The Diary of an Unborn Child" in April 1988 and I realized for the first time what I had done. The first half of the presentation was magnificent. I was four months pregnant at the time and it was amazing to see what my beautiful baby looked like inside of me. The second half of the presentation was horrifying. There were photographs of "real babies"--not tissue--that had been aborted for money just as you had done to me.

Since then I have read everything that I could get my hands on. I listened to your radio debate of April '85. You named things that must be "legally" explained before the procedure is performed. Mr. Armstrong, none of these things were explained to me. Had you been honest and explained what would happen to me and my unborn baby, I would have gotten up and left. I could not have gone through with it.

Mr. Armstrong, you were wrong in your decision of what you thought the best "choice" for me was, as you also have been wrong in the lives of many, many others. You're not helping women, protecting women, protecting children. You're hurting all of them, all of us.

The pain and the loss of a child from abortion is real, Mr. Armstrong.

Claudia Matthews
328 Cougar Drive
Whitefish, Montana
862-8339

2-7-95

Honorable Bob Brown,

I am writing in regard to SB 292 -
A Woman's Right to Know.

Let me introduce myself, my name is Anita Lynn. When I was 16 I was gang raped, I have lived with child sexual abuse at home since the age of 4. After I told my parents I was pregnant my father attempted to rape me; I was beat on with a hammer and shot at.

All during my pregnancy I was ignored. I was given no information or options. I had no pre-natal care and the pregnancy was never spoken of.

When my daughter was born I was then given an option, bring the baby home and both of us be killed by my father or give her up for adoption. I chose to protect my child and gave her up for adoption, she was never mentioned again to me, it was as if she were dead. Like a postpartum abortion.

It took me $\approx 9\frac{1}{2}$ years to find my daughter and was also blessed with \approx beautiful grandchildren.

Because I have not known the facts I have made tragic decisions in my adult life. Decisions that tore my family apart.

A woman should have the right to know all the facts and information concerning the physical, emotional and mental process and or development of herself and her baby.

EXHIBIT 15
DATE 3/20/95
SB 292

February 3, 1995

My name is Kim Jones. Twenty one years ago this summer, when I was nineteen I found myself pregnant and unmarried. I was told by Dr. Armstrong that my baby was nothing more than a mass of tissue. I had an abortion.

Promiscuous? Yes I was. Many factors in my upbringing influenced why I wasn't very good at making choices for myself. So, when I found out I was pregnant, my life crumbled before me. I literally did not know what to do. This was my freshman college summer away from home.

After sharing the news with the baby's father, he TOLD me he would find out the name of the doctor that performed abortions in Kallispell where I lived. At that time in my life abortion was a new term to me. He told me to go and I went. I was given no choice by the father. I was in shock over the whole situation.

As I said before, Dr. Armstrong told me my baby was nothing more than a mass of tissue. When in fact, at six weeks development, my baby had a beating heart, functioning liver, fingers, toes and eyes. Dr. Armstrong lied to me!!! I was given no counsel on the possible risks and complications. I was given no counsel on the psychological effects. I was given no counsel on options, such as adoption. I WAS told what kind of procedure would be used. That was no concern SINCE my baby was only a mass of tissue. When in fact my baby's arms, legs and head were literally torn off his body with the SUCTION CURETTAGE. Oh, the pain my baby went through. Oh, the pain I have gone through these last 21 years, and the guilt caused me to put my family through much pain too.

My abortion was never spoken of again. I told no one. I began to drink heavily. The weight of my shame and guilt combined with my drinking took a toll on my academics. My sophomore year of college was a failure. I did not return the next term. Year after year I buried my pain, deeper and deeper. My pain turned into anger, bitterness, depression. The list goes on and on. I was in and out of counseling. The expense kept me from

bothering me. I didn't know. I believe my pregnancy illness was an outward symptom of my guilt and shame.

Then like so many others, with the birth of my first baby, I was faced for the first time with what I had done. A beautiful baby girl.....with fingers and toes and ears and a nose. Instead of rejoicing I sat in my hospital bed crying. Eight weeks after her birth she stopped breathing. I was struck with terror. Diagnosed "Near Miss SIDS" (Sudden Infant Death Syndrome or Crib Death). Well of course I thought I was being punished. There were other episodes. My daughter is a walking miracle. Strangely enough the birth of my second baby, a son, also presented me with a Near Miss SIDS situation. He is another walking miracle. I was spared SIDS with my third baby. We have no family history what so ever of SIDS. I wonder if there is any correlation to SIDS and abortion.

In closing I would like to share with you that in all my pain I even left my husband. I took my children and moved to another state. I was just so empty inside. It wasn't until I received Jesus Christ as my Lord and Saviour did I begin down the very long road of recovery. You see He forgave me for the death of my baby. I am happy to say because of Jesus forgiveness I was able to return to my husband a year later. Unfinished business was still at hand though. Now another eight years later, thanks to a Post Abortion Recovery class, I have been able not only to forgive myself but all those involved as well. So now at this time in my life not only do I have the pain of my baby's death but also the reminder of my academic failures. But most importantly I have received forgiveness and I have forgiven. It is my greatest desire to do all I can to prevent any more baby's from dying and to prevent any more unnecessary suffering of women. Please, I urge you to support the "Womens Right to Know" bill. It is so very important for the health and well being of our nation. Women are the backbone of this nation. I would like to close with a question. Passing this bill for women only protects them, and I ask you what harm does it do to a physician? This bill would only make physicians accountable. This bill would

My name is Constance Wagner. I am thirty-three. In 1976 I found out I was pregnant. I was nineteen. I found out I was pregnant over the phone from a counselor at a free clinic run by Planned Parenthood. They reminded me of my right to a legal abortion and gave me the number of a Planned Parenthood abortion center in Minneapolis. No other options were presented. They assumed I would want an abortion. Within days I found myself at my sisters in Minneapolis. It was there that I convinced myself abortion was the most loving thing to do. I thought abortion would get rid of my problem and then I could go on with my life.

Early the next morning we made the drive to a large abortion center run by Planned Parenthood. I was confused and panic-stricken. I was not sure if I really wanted an abortion. I wasn't even sure what an abortion was. I was merely sold on the idea that woman needed to have the right to have one. The counselor was brief, but friendly. I was told that what was inside of me was nothing but tissue - without form - without life. I was told the procedure was painless: that it was safe, simple, and the right thing to do. I was not informed on the abortion procedure, nor was I given any facts of possible complications. Ironically, I was asked to sign a waiver that said I had been adequately counseled on the procedures and informed of the risks. By signing, I was consenting to all procedures the doctor felt would be necessary and that I would not hold him or the clinic liable for any problems stemming from the operative procedure. I signed it quietly, feeling my questions would appear stupid.

When my name was called I said goodbye to my sister and followed a woman into an operating room. That is where the first promise the counselor gave me was broken. The abortion would not be painless. I was given a local anesthesia to numb my cervix, but the doctor didn't wait long enough for it to take effect. I had severe cramping as he worked to dilate my cervix. I begged him to stop. The nurses held me down. When he shut off the machine I lay on the table sobbing. He told the nurses to quiet me down - "after all" he said "the walls are thin". I was helped into a room and told to get a hold of myself. I was bleeding rather heavily - but they dismissed it as normal post operative flow. After 45 minutes I limped out to my sister who helped me to the car. I was exhausted. They said I could return to work tomorrow. But when tomorrow came, I was bleeding very heavily and had passed part of a body mass left in the uterus. The doctor had perforated my uterus and a severe case of Pelvic Inflammatory disease set in. I was also diagnosed with endometriosis and peritonitis. Over the next three years I had three major surgeries resulting from the abortion. The second one was a total hysterectomy. I was twenty two. For all of this, the doctor was not held liable.

Three months before my hysterectomy, I went in for treatment and I found out I was pregnant. The father of the child was a professor who had three children. He told me I needed to get an abortion. I refused. I would not go through that again. The next day his best friend - my doctor - told me I had an ectopic pregnancy and that I would need to go to Minneapolis for an abortion. He told me it was a medical emergency, and that if I did not go the child and I would die. I did not find out until last year - 11 years later - that you can not have a suction abortion on an ectopic pregnancy. If I had indeed had a fallopian tube pregnancy I would have had to have surgery to remove the tube and the child. They had lied to me to ensure that the pregnancy was terminated. That was April of 1979. I had just turned 22. Three months later I had the hysterectomy.

I was unable to process the emotions I felt following the abortions. I was overwhelmed with anger and sadness. In order to protect myself from the profound sense of loss I felt, I rationalized that

EXHIBIT 17
DATE 3/20/95
SB 292

January 31, 1995

My name is Roni Corpron. When I was 19 years old, I had an abortion. At 11 years my parents were divorced. I was thankful when they parted, in a way, because all I ever remember about my parents was them fighting all the time. They would party all night, come home and fight and argue for hours. I would cry myself to sleep. When I woke for school, I never knew what I would get up to, and feared the worst.

I was raised on marijuana from about 7 or 8 years of age. My aunt and uncle (who were then in High School) thought it was funny to get us high. So by the time I got to High School I was a pretty messed up teenager.

Starving for love, acceptance and attention, I became sexually promiscuous. By adding alcohol to marijuana it wasn't too hard. I just numbed all the pain with drugs and alcohol. I never used birth control or protection. I thank God that I didn't end up with anything worse than an unwanted pregnancy. That was bad enough.

So here I am, 19 and pregnant. No job, no husband, no one to turn to. My father had a new family and he was a truck driver so we didn't see him much anyway. My mom was in another abusive marriage so I couldn't make her life any worse than it already was. I felt abortion was my only choice.

So on June 12 1985 I aborted my first child. I killed my own baby.

No one at the clinic told me, at 12 weeks pregnant, that my baby was completely formed, with fingers, toes, a heart and a brain. In fact, they lied to me and told me it was a "blob of tissue" the size of a pinhead. They didn't inform me of the possible risks and complications or psychological effects it might have. They just gave me a pill for cramping and sent me on my way.

I put the whole thing in the back of my mind and locked it behind a door bolted with shame, guilt and regret.

Exactly a year later I was pregnant again. You see I had to numb even more pain now so I couldn't possibly allow myself to think about anything. So if I wasn't stoned or drunk or having sex I was sleeping. I didn't change any of my habits.

Two months later I had a miscarriage. I married the father anyway. I didn't feel I would ever amount to much anyway so I better marry somebody that wants me now. Whether we loved each other then or not, I don't know. Maybe we were just convenient for each other, but I'm glad to say we are married still and love each other very much.

We wanted to have children right away, or I did anyway. So 2 months after the wedding I was pregnant for the third time. Two months later I miscarried again. I was completely devastated. I know the miscarriages were a result of abortion and I thought God was punishing me. I was terrified I would not be able to have children. So I became obsessed about having children.

A month after my second miscarriage I became pregnant a fourth time. I am happy to say I gave birth to a beautiful baby girl but not without complications. You see abortions

After my abortion, I felt compelled to reach out to other women who had been through an abortion.

I now help women deal with the emotional and psychological wounds resulting from their abortions.

In the women that I have talked with, the most common physical complications I have seen are miscarriages, scar tissue in uterus resulting in long, difficult labor. There are other more serious affects but not as common. One woman had severe hemorrhage, cervical lacerations, shock, and intense pain following her abortion. The ultimate complications are infertility and even death from infection.

Although there are definite physical wounds, there are many, many more psychological ones. The most common of these are Denial, guilt, shame, anger, rage, drug & alcohol abuse, sexual problems, and obsession to get pregnant again. In almost all cases the woman is pregnant again within a year. The woman has often times a subconscious desire to have an "atoneement" baby to replace the one she lost. She will have a preoccupation with her aborted baby and the dates of her abortion and the due date of the baby.

Because a woman's maternal instincts

March 20

Nancy Vigel
SB 292

When 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.

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The Myth of the Abortion Trauma Syndrome

EXHIBIT 19
 DATE 3/20/95
 SB 292

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 abortion⁴ 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

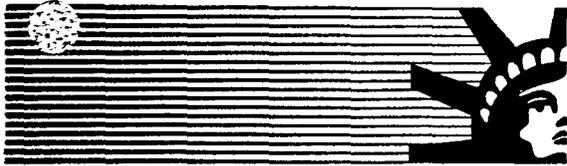
An uninterrupted pregnancy eventuates in labor and delivery. Therefore, any physical and psychological sequelae of legal abortion can only be meaningfully understood in contrast with those of illegal abortion or unwanted childbirth. After undesired childbirth, a woman must face either the stresses of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



**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.

- 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.

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 abor-

tion 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

Members of the Council on Scientific Affairs at the time of the report included the following: Yank D. Coble, Jr, MD (Vice-Chairman), Jacksonville, Fla; E. Harvey Estes, Jr, MD (Chairman), Durham, NC; C. Alvin Head, MD (Resident Representative), Tucker, Ga; Mitchell S. Karlan, MD, Beverly Hills, Calif; William R. Kennedy, MD, Minneapolis, Minn; Patricia Joy Numann, MD, Syracuse, NY; William C. Scott, MD, Tucson, Ariz; W. Douglas Skelton, MD, Macon, Ga; Richard M. Steinhilber, MD, Cleveland, Ohio; Jack P. Strong, MD, New Orleans, La; Christine C. Toews (Medical Student Representative), Greenville, NC; Henry N. Wagner, Jr, MD, Baltimore, Md; Jerod M. Loeb, PhD (Secretary), Chicago, Ill; Robert C. Rinaldi, PhD (Assistant Secretary), Chicago, Ill; and Janet E. Gans, PhD (staff author), Chicago, Ill.

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.

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Psychological Factors in Abortion

A Review

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Psychological research is increasingly involved in debates regarding abortion. While recognizing the diversity of ethical and moral issues intertwined with abortion, the American Psychological Association (APA) has focused its involvement on psychological factors, most recently by appointing an expert panel to review the literature on psychological effects. This article notes the history of APA involvement and reports on the panel's conclusions. It presents evidence that abortion is not likely to be followed by severe psychological responses and that psychological aspects can best be understood within a framework of normal stress and coping rather than a model of psychopathology. Correlates of more negative responses following abortion are also discussed.

The American Psychological Association (APA) has had a long history of involvement in relation to psychological factors associated with abortion. Public policy and other debates have increasingly included psychological issues, and findings from psychological research have been conveyed to policymakers. When APA, in 1989, appointed a panel of experts to examine relevant psychological considerations, it was recognized that differing moral, ethical, and religious perspectives impinge on how abortion is perceived. Our mission, however, was not to assess values but to consider the best available scientific evidence on psychological responses to abortion. In this article we summarize APA's involvement with abortion issues, examine the status of abortion in the United States, and report our conclusions about psychological responses of women after abortion.

APA Involvement in Abortion Issues

In 1969, the APA Council of Representatives adopted a resolution that identified termination of unwanted pregnancies as a mental health and child welfare issue, resolving that termination of pregnancy be considered a civil right of the pregnant woman, to be handled as other medical and surgical procedures in consultation with her physician. In the 23 years since that initial resolution, APA and some of its divisions and members have conducted and disseminated research on abortion issues to

fellow psychologists, policymakers, and the public. APA staff have prepared reports and met with government officials (Wilmoth, 1989) and arranged testimony by experts before Congress on abortion issues (e.g., Adler, 1989; David, 1989; Russo, 1983). Other activities have included sponsorship of a pamphlet on unwanted children by APA's Board of Social and Ethical Responsibility (Russo & David, 1983), an Interdivisional Committee on Adolescent Abortion (Melton et al., 1987), and a Psychology in the Public Forum of the *American Psychologist* on adolescent abortion and public policy (Melton & Russo, 1987).

In addition, APA has submitted amici curiae in eight court cases on abortion issues: *City of Akron v. Akron Center for Reproductive Health* (1983), *Thornburgh v. American College of Obstetricians and Gynecologists* (1986), *Hartigan v. Zbaraz* (1987), *Hodgson v. Minnesota* (1987), *Webster v. Reproductive Health Services* (1988), *State of Ohio v. Akron Center for Reproductive Health* (1983), *Janet Hodgson MD v. State of Minnesota* (1990), and *Planned Parenthood v. Casey* (1992). These cases involved a range of public policy issues, including pre-abortion counseling, parental notification, and waiting periods.

In 1980, in response to governmental attempts to suppress research on abortion, APA Council of Representatives passed a resolution supporting the right to conduct scientific research on abortion and reproductive health, stating that APA "affirms the right of qualified researchers to conduct appropriate research in all areas of fertility regulation (Abeles, 1981, p. 581).

In 1987, public debate began to focus on postabortion psychological responses. On July 30, 1987, President Ronald Reagan directed his surgeon general, C. Everett Koop, to develop a comprehensive report on the psychological and medical impact of abortion on women. Over the next 15 months, Koop and his staff met with a variety of groups and experts, including psychologists. On De-

ary R. VandenBos served as action editor for this article.

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ember 2, 1987, APA representatives presented oral testimony to the surgeon general's office on methodological issues in research on the psychological sequelae of abortion. APA Public Interest Directorate staff Brian Wilcox, Gwendolyn Puryear Keita, Greg Wilmoth, and Daniel Adelstein Bussell prepared a written report on those issues and delivered the testimony (Wilmoth, 1989).

In January, 1989, Koop and Otis Bowen, Secretary of Health and Human Services, met and decided that Koop would not issue a report. Instead, the surgeon general sent a letter to President Reagan stating that "despite a diligent review . . . the scientific studies do not provide conclusive data on the health effects of abortion on women." The APA staff report was prominently included in the wave of publicity that followed.

In February, 1989, APA, wishing to improve the accuracy of the debate, convened a panel of experts to review the best scientific studies of abortion outcome.¹ The work of the group was timely. On March 16, 1989, the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations of the U.S. House of Representatives held hearings to investigate possible discrepancies between the surgeon general's draft report and information made public (see Staff, 1990, for summary of the discrepancies). In those hearings, Nancy E. Adler testified in behalf of APA, and another panel member, Henry P. David, testified on behalf of the American Public Health Association.

In August 1989 the APA Council of Representatives, concerned about the distortions of the research findings in the press, passed its third abortion resolution. This resolution, which cited the work of the panel, initiated a public awareness effort to correct the record on the scientific findings of abortion research. Materials are available from APA's Public Information Office as resources to inform psychologists, the public, and policymakers on abortion issues and research findings. In addition, the current article supplements our initial summary (Adler et al., 1990) and is designed to improve understanding in the psychological community about theoretical, methodological, and substantive findings on psychological responses following abortion.

History and Status of Abortion in the United States

Since the 1973 Supreme Court decision in *Roe v. Wade* (1973), abortion has been a legal, albeit controversial, surgical procedure in all states of the United States. That landmark ruling set out the circumstances under which an abortion may be legally regulated.

In essence, in *Roe v. Wade* (1973), the Court ruled that the abortion decision was protected by the right of privacy but that the state has legitimate interests in protecting both the pregnant woman's health and potential human life—interests that grow and reach a compelling point at later stages of gestation. In the first trimester, when abortion is safer than normal childbirth, the abortion decision is protected by the right of privacy and rests with a woman and her physician. Later in pregnancy,

however, the state "may regulate the abortion procedure in ways that are reasonably related to the preservation and protection of maternal health" (*Roe v. Wade*, p. 732). In the third trimester, the viability of the fetus permits the state to exercise its interest in protecting potential life, and regulation and prohibition of abortion is thus permitted except where abortion is necessary to preserve the life or health of the woman.

In weighing the health risks of unwanted pregnancy and its alternatives, the Supreme Court identified mental health and child welfare issues as important to its consideration, creating a critical role for psychological research in challenges to the court's opinion.

After the 1973 decision, organized opposition to abortion became a national movement (Packwood, 1986). Some supporters of this movement have asserted that the abortion experience produces widespread and severe negative mental health effects among women who have undergone the procedure (Speckhard, 1987). This review also considers the scientific merit of that assertion.

Abortion Practices Before 1973

Determining numbers of abortions in the United States before 1973 is difficult because the vast majority were clandestine procedures. Estimates range from a low of 200,000 to a high of 1,200,000 per year (Tietze & Henshaw, 1986). The consequences of illegal abortions were clear in relation to maternal mortality, however. In 1965, an estimated 20% of all deaths related to pregnancy and childbirth were attributable to illegal abortion (Alan Guttmacher Institute, 1982).

Under some state laws existing before the 1973 *Roe v. Wade* decision, psychological issues provided a basis for access to legal abortion. As described by Schwartz (1986), physicians, under increasing pressure from upper and middle class patients to perform safe abortions, turned to psychiatrists to certify the need for the procedure. Hospitals established rules that permitted abortion if a woman could provide a letter from one or two psychiatrists certifying that it was needed to prevent suicide. Abortions for psychiatric reasons increased from 10% of procedures in 1943 to 80% in 1963: about 8,000 such "therapeutic abortions" were performed each year from 1963 to 1965 (Schwartz, 1986). In 1970 more than 98% of the legal therapeutic abortions performed in the state of California were for mental health reasons (Niswander & Porto, 1986).

Abortion Practices After 1973

After 1973 the number of clandestine abortions in the United States dropped sharply, and the number of legal abortions rose steadily, from nearly 800,000 in 1973 to more than 1.5 million in 1980. Between 1.5 and 1.6 mil-

¹ We wish to express our appreciation to the APA staff who organized and supported the working of the group, particularly James Jones, Brian Wilcox, Jacqueline Gentry, and Gwendolyn Keita. We also thank Anthony Schlage! for his contribution to the preparation of this article.

lion abortions have been performed annually for the past decade—about 3 out of 10 pregnancies. The number of abortions reflects the actual abortion rate and the number of women of reproductive age, both of which have increased since 1973. In 1987 the U.S. abortion rate was 27 per 1,000 women aged 15–44 years (Henshaw, Koonin, & Smith, 1991). An estimated 21% of American women of childbearing age have experienced this procedure (Henshaw, 1987; Tietze, Forrest, & Henshaw, 1988).

After *Roe v. Wade*, several aspects of the abortion context changed. The proportion of legal abortions performed in hospitals dropped from 52% in 1973 to 13% in 1985 (four fifths of them outpatient procedures). The proportion of abortions performed in nonhospital clinics rose from 46% to 83%, while the proportion in doctor's offices stayed low—2% compared with 4% (Henshaw, Forrest, & Van Vort, 1987). The geographic locale of abortions also changed. The proportion of women obtaining abortions outside their city of residence decreased markedly from about 40% in 1972 to about 6% in 1982 (Tietze et al., 1988). Finally, the time of gestation at which abortion was typically performed has dropped; since 1973 the proportion of legal abortions performed at eight weeks or less has increased from 38% to nearly 50%.

Demographic Characteristics of U.S. Abortion Patients

Data on the characteristics of abortion patients are derived mainly from national surveys of providers conducted by the Alan Guttmacher Institute (AGI), and reports to the Centers for Disease Control Abortion Surveillance Unit.² These reports all attest to the diversity of the characteristics of women undergoing abortion.

The summary below is based on 1987 data from the AGI surveys (Henshaw et al., 1991; Henshaw & Silverman, 1988), unless otherwise noted, and presents proportions and relative rates of abortion for women varying on key demographic characteristics. Although we discuss each variable separately, these should be read with an understanding that demographic variables are intercorrelated, making it difficult to attribute differences in abortion rates to any given variable. For example, compared with older women, younger women are more likely to be unmarried and nulliparous. Similarly, ethnicity is confounded with socioeconomic and marital status.

Age. The majority of women seeking abortion are young. The modal age of abortion patients is 20–24 years, and almost 60% are less than 25 years old; 12% are minors, aged 17 years or less. Abortion rates are highest among women 18–19 years of age and begin to drop after age 19, reaching a low among women 40 and over.

Race and ethnicity. Statistics on abortion are grouped by race (White vs. non-White) or ethnicity (Hispanic vs. non-Hispanic). Based on total numbers, nearly 69% of women obtaining abortions in 1987 were White (and of these 13% were Hispanic), and 31% were non-White. Abortion rates, which are based on the number of abortions within each population, show that rates are higher for non-Whites than for Whites and for Hispanics compared with non-Hispanics.

Marital status. Most abortion patients (82%) are not married; 63% have never been married. Estimates of age-adjusted abortion rates among women who are separated, divorced, or widowed are approximately four to five times the rate of women married and living with their husbands. Women cohabiting with men had abortion rates estimated to be five times greater than the overall abortion rate and nine times greater than that of married women (Henshaw, 1987).

Parity. Abortion is used both to postpone births and to limit them. Over half of women having abortions (52%) have had no previous births. Nearly 70% of women having abortions say they intend to bear children in the future.

Abortion procedure and gestational age. The safest procedures for abortion are "instrumental evacuation" (e.g., vacuum curettage, surgical curettage, and dilation and evacuation); the vast majority of procedures done (97%) are of this type. Approximately 3% of procedures are medical induction of labor to expel the fetus, and about 0.1% are uterine surgery—hysterotomy and hysterectomy (Tietze & Henshaw, 1986). The procedure used is largely a function of the length of gestation, with instrumental evacuation being the method of choice up to 16 weeks of pregnancy (Tietze & Henshaw, 1986). The median gestation period for all women having abortions is 9.2 weeks (Kochanek, 1990); more than 90 percent of all abortions are performed at less than 13 weeks gestation (Tietze & Henshaw, 1986).

A number of factors can contribute to delay in obtaining an abortion. Failure to suspect pregnancy and difficulty in making arrangements to have an abortion are most frequently cited as reasons for delay (Torres & Forrest, 1988). The health care system and the woman's financial state have been implicated in delay in other studies (Bracken & Swigar, 1972; Henshaw & Wallisch, 1984). Finally, approximately 1,500–3,750 second-trimester abortions are performed each year as a result of a detected defect in the fetus from diagnostic testing (Grimes, 1984).

Bracken and Kasl (1975) found that, compared with women having first-trimester abortions, those delaying until the second trimester generally are younger and more likely to be unmarried, Black, nulliparous, in a relatively unstable relationship, Protestant rather than Catholic, and to have a lower level of education and socioeconomic status.

Postabortion Emotional Responses: The Research Literature

Theoretical Frameworks

Much of the research on abortion has been descriptive rather than theory-based, but two broad types of theoretical perspectives underlie the research. One perspective, deriving from clinical experience and theories, focuses on

² A summary of the sources and limitations of U.S. abortion data can be found in Henshaw, Forrest, and Van Vort (1987).

psychopathological responses following abortion. This perspective, drawing heavily from psychoanalytic theory, characterized earlier work on abortion. The second perspective, characterizing more recent work, is that of stress and coping. From this perspective, unwanted pregnancy, and abortion are seen as potentially stressful life events, events that pose challenges and difficulties to the individual but do not necessarily lead to psychopathological outcomes. Rather, a range of possible responses, including growth and maturation as well as negative affect and psychopathology, can occur.

Differences in these perspectives have affected the kinds of questions asked and methodologies used to study women who have had abortions. Clinical case studies drawn from the experience of clinicians or those studying women who are self-selected because they have reported experiencing psychological distress following an abortion (e.g., Speckhard, 1987) have looked almost exclusively at indicators of psychological distress. Broader descriptive studies and research conducted from a stress and coping perspective have generally used more representative samples of women undergoing abortion, strengthening the generalizability of findings. In addition, a few studies have included both positive and negative outcomes, providing a fuller picture of the experiences of women undergoing induced abortion (Major & Cozzarelli, in press).

From the stress and coping perspective, an unwanted pregnancy is seen as an event that can be challenging or stressful. Stress has been defined as emerging from an interaction of the individual and the environment in situations that the person appraises as "taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p. 19). The circumstances surrounding conception (e.g., whether it was planned, whether the woman has adequate resources to care for a child, whether the male partner is supportive, whether there is an indication of genetic abnormality) in conjunction with a woman's psychological and social resources provide the context that will affect a woman's response to her pregnancy.

Termination of an unwanted pregnancy may reduce the stress engendered by the occurrence of the pregnancy and the associated events. At the same time, the abortion itself may be experienced as stressful. As with pregnancy, the circumstances surrounding abortion (e.g., the woman's feelings about the morality of abortion, support for abortion by the partner and others who are close to the woman, and the actual experience she has in obtaining the abortion) are likely to influence later responses.

Research on the impact of stressful life events has pointed to the importance of several variables that mediate or moderate the impact of such events on the individual. Among the key variables that have been identified are social support, attributions for the cause of the event, the meaning attached to the event, and the coping strategies used for dealing with the event. As will be seen below, all of these factors have been shown to play an important role in responses of women following induced abortion.

Methodological Critique

Before reviewing the literature on abortion, methodological shortcomings must be noted. Several authors (Adler, 1979; Dagg, 1991; David, 1973; Illsley & Hall, 1976; Simon & Senturia, 1966) have identified biases in the abortion literature. Some biases arise from ideological viewpoints or assumptions inherent in particular theories and approaches. For example, Fingerer (1973) demonstrated the operation of such bias in traditional psychoanalytic theory. She asked postdoctoral psychology students in psychoanalytic training programs to predict responses of women following abortion. They predicted severe sequelae, significantly greater than those predicted by women before undergoing an abortion or by men and women who accompanied women to an abortion clinic. The responses predicted by the postdoctoral psychologists were significantly more negative than those actually reported by 324 women following their abortions. The bias toward expecting severe negative responses inherent in a number of studies has been exacerbated by the inappropriate generalization of conclusions from clinical or case studies that are of limited scientific merit and tell little about the experience of the vast majority of abortion patients.

Limited operationalization of postabortion responses has been problematic in many studies. A narrow set of research questions has been emphasized, focusing almost exclusively on pathological or negative outcomes (Illsley & Hall, 1976). In addition, outcome measures have often been of questionable reliability and validity. Some researchers have used interviews to assess the mental health of abortion patients. It often is not possible to judge the results in terms of accuracy, interrater reliability, or convergent and discriminant validity. In other studies questionnaires have been used but have not been evaluated for their psychometric characteristics. For example, a single item rating postdecisional regret is not a valid measure of a psychological disorder. In yet other instances standardized instruments have been used, and results have been discussed in terms of statistical significance; however, what constitutes *clinically* meaningful differences in scores is not considered in the discussion.

The interpretation of research on postabortion experiences must consider the entire context of the abortion (see Adler, in press). This should include the reasons for the occurrence of the pregnancy (e.g., whether pregnancy was intended or not, whether it was the result of rape, the hardship the pregnancy would pose), the circumstances under which a decision to terminate was made (e.g., as a result of diagnostic testing, whether it was made with the support of others), and the experience of the procedure itself (e.g., type of procedure, treatment by provider, experience with protesters). Given the variety of experiences associated with abortion, it is inappropriate to generalize from one abortion circumstance (e.g., a late abortion using saline induction) to another without adequate evidence that similar responses are found in different contexts. In part because of the complexity of the

abortion experience, abortion researchers since 1973 have concentrated largely on testing conditional hypotheses about variables that may influence postabortion psychological responses within identified samples of women.

The varied quality of studies examining psychological responses of women following abortion makes it difficult to draw conclusions from the entire body of existing research literature. Many reports are clinical observations of small numbers of women (e.g., Friedman, Greenspan, & Mittleman, 1974; Hatcher, 1976; Senay, 1970; Talan & Kimball, 1972; Wallerstein, Kurtz, & Bar-Din, 1972); some provide no data, or data are inappropriately or inadequately analyzed (e.g., Freeman, 1978; Perez-Reyes & Falk, 1973; Smith, 1973). Some studies report responses of women having illegal or therapeutic abortions rather than legal, elective procedures. Some studies, particularly those that are retrospective, may have a mix of women who had illegal, therapeutic, and elective abortions that are not analyzed separately (e.g., Speckhard, 1987). Such case studies are useful for developing hypotheses about why abortion may be followed by psychological dysfunction or pathology, for example in cases of coerced or late abortion. However, they do not have adequate samples for determining common or normative responses following abortion, nor are they able to sort out the causal dynamics that result in a given outcome, particularly if retrospective reporting is used and preabortion emotional state is not assessed.

Reviews of the early studies have appeared elsewhere (e.g., Adler, 1979; Olson, 1980; Osofsky, Osofsky, & Rajan, 1973; Shusterman, 1976; Simon & Senturia, 1966). Here we examine findings from only the best scientific studies that reflect current legal abortion practices in the United States and provide quantitative measures of psychological responses following abortion. We did not use meta-analysis in reviewing those studies because the number of appropriate studies that would be used for any given analysis is so small. Posavac and Miller (1990) conducted a meta-analysis of two types of effect sizes (pre-post comparisons and comparison group differences). However, only two studies of elective abortion in the United States were available for pre-post comparison and only three studies using a comparison group. Until a larger literature is available, meta-analysis is unlikely to prove useful.

Selection Criteria for This Review

Conclusions presented in this article regarding psychological responses following abortion are based on review of studies that met three minimum criteria:

First, the study had to be empirical (involving collection of data subjected to statistical analysis) and use a definable sample. This ruled out reviews of the literature, statements of opinion, or case reports. This criterion assured inclusion only of those studies with the potential for replication and for which estimates of generalizability could be made.

Second, because the experience of illegal abortion or of having to qualify for legal abortion under restrictive

conditions is likely to be more stressful than that of a legal abortion, samples of women studied had to have had their abortions under legal, nonrestrictive conditions.

Third, the sample had to be of women in the United States. Although it is likely that the experience of abortion is similar in other Western industrialized cultures, it seemed most useful to summarize the U.S. experience. Particularly relevant findings from a unique study in Denmark are presented later in the article, however.

The studies reviewed have used samples drawn from a variety of settings: private abortion clinics (both for profit and nonprofit), university and other hospital-based clinics, and counseling and referral centers. Most of the samples are of mixed ethnicity, although some do not report on the ethnic characteristics of the sample. Where samples are almost exclusively of one ethnic group, this is noted. Most samples are not restricted by age and generally reflect the national figures on distribution of abortion rates by age; a few have specifically targeted adolescents.

Normative Responses to Abortion

As we noted in the abbreviated report of our review (Adler et al., 1990), the weight of the evidence is that legal abortion as a resolution to an unwanted pregnancy, particularly in the first trimester, does not create psychological hazards for most women undergoing the procedure. Studies that have used measures with clinically relevant norms have found means obtained by abortion patients following the procedure to be well within normal (i.e., nonpathological) bounds (e.g., Athanasiou, Oppel, Michaelson, Unger, & Yager, 1973; Major, Mueller, & Hildebrandt, 1985). The incidence of severe negative responses has been low. Even in studies using ratings of distress rather than measures of severe psychological disorder, positive feelings have been reported to be felt relatively more strongly than are negative emotions.

A woman's responses to abortion are complex, and she may feel a mixture of positive and negative emotions. When women are asked to indicate which emotions they experience following first-trimester abortion, the most frequent response is to report feelings of relief and happiness (Adler, 1975; Lazarus, 1985; Osofsky & Osofsky, 1972). For example, in a sample of 292 patients studied two weeks post abortion by Lazarus (1985), 228 (76%) reported feeling happiness. The most frequently cited negative emotion, guilt, was reported by only 49 women, 17% of the sample.

Adler (1975) identified three separate factors accounting for variations in emotions experienced by a sample of 70 women over a two- to three-month period following a first-trimester abortion. One factor consisted of positive emotions, relief and happiness. This factor showed the strongest response over the three-month period; women indicated a mean intensity of 3.96 on a scale ranging from 1 (*not at all*) to 5 (*extremely*). The negative emotions fell into two separate factors. One, consisting of shame, guilt, and fear of disapproval, was termed *socially based* and seemed to reflect responses to having

taken an action that could generate social disapproval. The second negative emotion factor consisted of regret, anxiety, depression, doubt, and anger. These emotions were termed *internally based* and seemed to relate to the loss of the pregnancy and the meaning it had for the woman. The mean intensity ratings on these two factors were 1.81 and 2.26, respectively.

Some researchers have obtained measures of psychological responses and functioning both before and after the abortion or at two points following abortion. Psychological distress has generally been found to drop from before the procedure to immediately afterward and from preabortion or immediately postabortion to several weeks afterward. For example, Cohen and Roth (1984) found significant decreases from before to several hours after the procedure in measures of depression and anxiety and on scores on the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979), an indicator of stress. In two longer follow-up studies, Major et al., (1985) and Mueller and Major (1989) found significant improvement in adjustment, including lower scores on the Beck Depression Inventory (Beck & Beck, 1972), among women three weeks following the abortion compared with their immediate postabortion scores.

Zabin, Hirsch, and Emerson (1989) obtained ratings of self-esteem, locus of control, and state and trait anxiety for a group of 360 Black adolescents at the time they sought a pregnancy test and again one and two years later. They compared those who had a negative pregnancy test, those who had a positive test and subsequently carried to term, and those who had a positive test and subsequently terminated the pregnancy. Given the circumstances under which the measurements were made (awaiting the results of a pregnancy test), it is not surprising that the state measure of anxiety was far higher than the trait measure. Over the two-year period, both state and trait anxiety fell among all three groups, with a more dramatic change in state than trait anxiety. In the abortion group, a mean percentile of 74.6 on state anxiety and 56.8 on trait anxiety was obtained at the time of the pregnancy test, falling to 45.6 and 48.3, respectively, at the one-year follow-up and 43.6 and 45.7 at the two-year follow-up.

This study is one of only three studies that compare responses following abortion and term birth. On the critical psychological variables (state and trait anxiety, self-esteem, and locus of control), few differences were shown at baseline, although the abortion group showed somewhat lower scores on trait anxiety. Comparisons across groups at the one- and two-year follow-ups showed no adverse effects of the abortion experience. In fact, the abortion group scored significantly lower on trait anxiety than did either the negative pregnancy or the childbearing group at the two-year follow-up (although, as noted above, at baseline they were already somewhat, although not significantly, lower). In addition, despite the absence of significant differences at baseline among the three groups, the abortion group showed more positive responses on the Rosenberg Self-Esteem Scale (Rosenberg, 1965) than

did the negative pregnancy group at the two-year follow-up and showed a more internal orientation than did the childbearing group at both the one- and two-year follow-ups. No other significant differences emerged.

Athanasiou et al. (1973) compared responses of women after first- and second-trimester abortion and term birth. First-trimester patients had undergone suction abortions whereas second-trimester patients had undergone saline abortions. Thirty-eight patients in each of the three groups were matched out of a sample of 373 to obtain groups comparable on ethnicity, age, parity, and marital and socioeconomic status. Women completed the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1951) and the Symptom Checklist (SCL; Derogatis, Lipman, Covi, & Rickels, 1972) before the abortion or delivery and again 13 to 16 months afterward. At follow-up, women who had experienced term birth had higher scores on the Paranoia subscale of the MMPI than did women in either abortion group. Women who had experienced a first-trimester suction abortion reported fewer somatic complaints on the SCL than did either the second trimester saline abortion or delivery patients. On all other comparisons, no significant differences emerged, leading the authors to remark that the three groups were "startlingly similar." Despite its small size, the careful matching of groups on demographic characteristics and the relatively longer term follow-up makes this study noteworthy. Congruent with findings of Zabin and her colleagues (Zabin et al., 1989), few differences emerged, but those that did favored the abortion group.

Similar findings regarding benign effects of abortion versus childbirth emerged in a recent study by Russo and Zierk (1992). These researchers examined the relationship of abortion and childbearing to self-esteem in a national sample of 5,295 U.S. women interviewed annually from 1979 to 1987 in the National Longitudinal Study of Youth (Center For Human Resources Research, 1988). In 1987 those women who had previously had an abortion had slightly (and statistically significantly) higher global self-esteem compared with women who had never had an abortion. This difference was greater when comparing women having had an abortion with women having had unwanted births. Women who had experienced repeat abortions did not differ in self-esteem from women who had never had an abortion. Multivariate analyses were done on a subsample of 4,502 women who had not had an abortion before 1980. Controlling for preexisting self-esteem, employment, income, and education, neither having one abortion nor having repeat abortions in the period from 1980 to 1987 was related to self-esteem. In addition, in an analysis of those women who had undergone an abortion, the time elapsed since the abortion was not related to self-esteem. This study demonstrates that up to eight years following an abortion, no negative associations occur with self-esteem.

Who Has Negative Responses After Abortion?

The discussion above documents a relatively benign course for women following termination of a pregnancy.

Yet some women experience distress and negative responses following abortion. What factors account for such responses? And to what extent are these factors similar to those that influence responses following other potentially stressful life events?

Below we summarize the factors that have been found in the key studies to relate to a higher likelihood of negative response (see also Major & Cozzarelli, in press). With one exception (Mueller & Major, 1989), the evidence is correlational, relating characteristics of the woman or her situation to a variety of measures following abortion. On scales for which standardized norms are available, mean responses fall well within a normal range, and correlations capture variation along the whole range of responses. Another strategy, not used in any study to date, would be to identify the women who have the most extreme negative response (i.e., exceeding a threshold indicating psychopathology) and determine the characteristics that differentiate them from those not showing extreme responses. Because relatively few women would show such a response, a large sample would be needed.

Demographic and social factors. Younger and unmarried women without children are relatively more likely than those who are older and who have already given birth to experience negative responses. So, too, are women whose culture or religion prohibits abortions and those who attend church more frequently (Adler, 1975; Osofsky & Osofsky, 1972).

Length of gestation and medical procedure. Procedures done in the first trimester of pregnancy carry lower risks of physical morbidity and psychological difficulties than do second-trimester procedures (Kaltreider, Goldsmith, & Margolis, 1979; Rooks & Cates, 1977). The increased likelihood of more negative psychological response may have to do in part with the characteristics of the small percentage of women who delay until the second trimester. They are younger and more likely to be Black, nulliparous, and in unstable relationships (Bracken & Kasl, 1975)—characteristics that are associated with a higher likelihood of negative responses following first-trimester abortion (Adler, 1975; David, 1973; Osofsky & Osofsky, 1972). Women who delay into the second trimester may also be more conflicted about the pregnancy, have less social support for the abortion decision, or have fewer resources for dealing with the unwanted pregnancy and abortion (for an expanded discussion, see Major and Cozzarelli, in press).

The medical procedures used for second trimester abortions are themselves more likely to be experienced as stressful than are those used in the first trimester. In the second trimester, saline or prostaglandin induction are used; these involve a more prolonged and painful experience than the dilation and evacuation or dilation and curettage procedure used in early pregnancy. In two studies in which comparisons were made between second-trimester patients undergoing a saline procedure versus those who had dilation and evacuation, more favorable responses were shown by the latter (Kaltreider et al., 1979; Osofsky, Osofsky, Rajan, & Spitz, 1975).

The decision process. A number of studies have examined the relationship between aspects of the woman's decision process regarding abortion and her emotional responses afterward. Most women do not have difficulty with the abortion decision (Bracken, 1978; Osofsky et al., 1973). For example, Osofsky et al. (1973) found that 12% of 100 first-trimester patients stated the decision to have an abortion was difficult, and 7% reported initial indecision regarding continuation or termination of the pregnancy. However, among 200 second-trimester patients in the study, 51% reported difficulty in deciding, and 36% reported initial indecision. Other correlates of difficult decisions or of ambivalent feelings are being married (Bracken, 1978) and being Catholic (Osofsky & Osofsky, 1972). Finally, satisfaction beforehand with the decision to abort has been related to perceived support from significant others, a favorable opinion of the abortion option, generally favorable attitudes toward abortion, and more years of education (Bracken, Klerman, & Bracken, 1978; Eisen & Zellman, 1984; Shusterman, 1979).

Studies examining the relation between aspects of satisfaction with the abortion decision and postabortion emotional response consistently find that women who are satisfied with their choice or who report little difficulty in making the decision to abort, show more positive postabortion responses. Greater difficulty in making the decision has been associated with higher negative postabortion reactions (Shusterman, 1979), including feelings of guilt (Osofsky & Osofsky, 1972), anxiety (Bracken, 1978), and internally based negative emotions (e.g., regret, depression) but not positive or socially based negative emotions (Adler, 1975).

Women who initially want to be pregnant may react more negatively to abortion. Shusterman (1979) found an association between a woman's immediate affective response to learning that she was pregnant and her response to abortion. Major et al. (1985) examined the relation between meaningfulness and intentionality of the pregnancy and postabortion responses. Among 247 women undergoing first-trimester abortions, 89.3% reported their pregnancy to be completely unintended. Women who reported the pregnancy as "highly meaningful" to them reported more physical complaints immediately after and anticipated more negative consequences from the abortion than did women who reported their pregnancy to be less meaningful. A subset ($n = 99$) of women were followed up three weeks following the abortion. In this group the women who had indicated that they had no intention of becoming pregnant exhibited significantly fewer subclinical symptoms of depression than women who had indicated that they had some intention to conceive.

In summary, women who are satisfied with their choice or who report little difficulty in making their decision show more positive responses postabortion. Greater meaningfulness and intentionality of the pregnancy, in contrast, are associated with poorer postabortion adjustment. Women who report greater difficulty in deciding to abort are more likely to be married or Catholic, to

have negative attitudes toward abortion, and to perceive little social support for their decision.

Perceived social support. Research within the general stress and coping literature has demonstrated links between social support and general well-being. Both perceived and actual social support can act to buffer some adverse psychological effects of exposure to stressful life events (Cohen & Wills, 1985; Kessler & McLeod, 1985). Studies examining the relationship of perceived support from significant others with women's postabortion response suggest that postabortion responses will be more positive among women with greater support for the decision to terminate.

Bracken, Hachamovitch, and Grossman (1974) studied 489 women before a suction abortion and again one hour after the procedure. The questionnaire given beforehand assessed knowledge of the abortion by partner and parents and perceived support for the decision from them. Whether or not the partner and parents actually knew about the abortion was unrelated to postabortion responses. However, higher levels of perceived or anticipated support were associated with more favorable reactions to the abortion.

The role of the partner has similarly been found to be a significant predictor of psychological responses (Moseley, Follingstad, Harley, & Heckel, 1981; Robbins & DeLamater, 1985; Shusterman, 1979), as has the role of parents (Moseley et al., 1981).

Robbins (1984) examined the role of the woman's relationship with her partner *after* the abortion among primarily Black single women who had abortions or delivered at the same hospital. Reporting a strong relationship with the partner six weeks following the abortion was related to negative change on the MMPI and to greater regret over the abortion among women who had aborted. For women who delivered, negative change on the MMPI was related to having a weak relationship with the partner. At one year postresolution, a strong relationship with the male partner was associated with feelings of regret among aborters but was unrelated to regret among deliverers.

Perceived social support may or may not accurately reflect actual support. Major et al. (1985) recorded whether women were or were not accompanied by a male partner on the day of their procedure. Out of 247 women, 83 (33.6%) were accompanied. These women were significantly more depressed and reported more physical complaints immediately after the abortion than were women who were unaccompanied by a partner. Further analyses revealed that women who were accompanied were younger and expected to cope less well with the abortion. Controlling for these differences eliminated the difference in physical complaints, but the difference in depression remained significant (which did not persist at the three-week follow-up of a subset of these women, however). This study demonstrates the complexity of social support. It may be that women who were more distressed about the abortion expressed a greater need for their partners to accompany them to the clinic. No mea-

asures of perceived support were obtained in this study, so one cannot determine the relationship between (the indicator of support) accompanying the woman to the clinic and the woman's perception of support.

In summary, perceived support generally appears to contribute to more positive postabortion adjustment. However, the relationship of social support to postabortion responses may be mediated and moderated by other variables.

Attributions for pregnancy. Attributions for negative life events have been found to relate to subsequent psychological adjustment (see Michela & Wood, 1986; Petersen & Seligman, 1984; Silver & Wortman, 1980; and Sweeney, Anderson, & Bailey, 1986, for reviews). In relation to abortion, adjustment may be affected by the woman's attributions for why the pregnancy occurred. Major et al. (1985) asked women before abortion the extent to which their pregnancy was due to aspects of their own character, their own behavior, chance, the situation they were in at the time, or someone else. Women who blamed their pregnancy on their own character were significantly more depressed, anticipated more severe negative consequences from the abortion, and tended to have more negative moods immediately postabortion than did women who were not self-blamers. In addition, women who blamed their pregnancy on someone else anticipated more negative consequences from the abortion than did those who did not. These differences as a function of blame did not persist at a three-week follow-up of a reduced sample, however. Mueller and Major (1989) replicated all these findings on a new sample of 283 abortion patients (see Major & Cozzarelli, in press).

Coping expectancies. Earlier research on coping has shown that both generalized positive outcome expectancies (Scheier & Carver, 1987) and coping expectancies regarding specific situations (Bandura, 1977) relate to better health-relevant outcomes and successful treatment of psychological disorders. Coping expectancies also appear to play a role in responses following abortion. Major et al. (1985) used a single item on which women indicated, before their abortion, how well they expected to cope with the abortion. Women who expected beforehand to cope well were less depressed, had more positive moods, anticipated fewer negative consequences, and reported fewer physical complaints both immediately following the abortion and at a three-week follow-up compared with women who expected to cope less well. These findings were later replicated using a 10-item scale to assess coping self-efficacy (Mueller & Major, 1989).

Belief in one's ability to cope has been found to be *causally* linked to postabortion emotional responses. An experimental study of counseling interventions documented that enhancing self-efficacy for coping, combined with a regular counseling session, was effective at lowering women's risk for depressive symptoms after abortion compared with standard abortion counseling alone (Mueller & Major, 1989).

Other factors related to postabortion responses. Several other factors have also been found to relate to

postabortion responses. Studying 120 women, Alter (1984) examined the relation between sex-role orientation and psychological response two weeks after a first-trimester abortion. Regression analyses controlling for demographic and support variables revealed that women whose self-descriptions were congruent with their descriptions of how a career woman would complete the scale exhibited more positive responses than did women whose self and career woman descriptions were incongruent.

Cohen and Roth (1984) examined the relation between coping style and anxiety and depression in a sample of 55 women undergoing suction abortion. Active approach (e.g., thinking about, talking about) versus avoidant/denial coping styles, anxiety, and depression were assessed both before and immediately after the abortion. Results revealed that both anxiety and depression significantly decreased from pre- to postabortion, that coping style was consistent across assessments, and that high deniers were significantly more depressed than low deniers at both time points. In addition, the use of approach strategies was associated with a greater decrease in anxiety from pre- to postabortion.

Athanasίου et al. (1973) examined variables that predicted responses of women 13–16 months after suction or saline abortion, conducting multiple regressions on the responses in the combined groups. These analyses revealed that women who delayed seeking abortion, who had low contraceptive knowledge, who were low in self-esteem, and who were high in alienation exhibited more negative responses on the MMPI and reported more negative body symptoms at follow-up. Unfortunately, they did not analyze whether these factors would predict responses among the matched group of term-delivery patients.

A Unique Study From Denmark

Although this review was limited to U.S. studies, results from a study in Denmark are important because they provide data not possible to obtain in the United States (David, Rasmussen, & Holst, 1981). Denmark has a uniform national population registration system that provides access to national abortion, birth, and admission to psychiatric hospital registers. Linkage among these registers makes it possible to compare the risks of psychiatric hospital admission following abortion and childbirth. However, it should be noted that because there may be a bias against hospitalizing a new mother, particularly if she is nursing, the relative psychological risk of abortion compared with childbirth may be exaggerated by using hospital admission to operationalize psychiatric illness.

Psychiatric hospital admissions were tracked three months postabortion and postpartum for all women under age 50 residing in Denmark. Women who had been admitted to a psychiatric hospital within 15 months before abortion or delivery were excluded. Data were obtained on 27,234 women terminating pregnancy, 71,378 women carrying to term, and the entire population of 1,169,819 women 15–49 years old.

Among women who were never married and women who were currently married (who represented the majority of women), the postpregnancy risk of admission to a psychiatric hospital was approximately the same for abortions or deliveries: approximately 12 per 10,000 versus 7 per 10,000 for all women of reproductive age. However, among the smaller group of separated, divorced, or widowed women, those who had terminated pregnancies showed a substantially higher psychiatric admission rate (64 per 10,000) than did separated, divorced, or widowed women carrying to term (17 per 10,000). Women who are divorced, separated, or widowed may be relatively more likely to be terminating pregnancies that were originally intended, placing them at higher risk for negative psychological reactions. In the aggregate, there appears to be little risk to psychological well-being after either abortion or delivery in Denmark.

Conclusions

As we concluded in the brief summary of our review (Adler et al., 1990), the best available studies on psychological responses following legal, nonrestrictive abortion in the United States suggest that severe negative reactions are infrequent. Some individual women may experience severe distress or psychopathology following abortion, but it is not clear whether these are causally linked to the abortion (Dagg, 1991). As former Surgeon General C. Everett Koop (1989) testified before Congress regarding his review of research on psychological effects of abortion, emotional responses may be overwhelming to a given individual, but the problem of the development of significant psychological problems related to abortion is "minuscule from a public health perspective" (p. 211). Studies that have included comparison groups of women who carry to term (Athanasίου et al., 1973; Zabin et al., 1989) suggest that the choice made by women regarding their pregnancy is the one that is most likely to be best for them. Women at higher risk for relatively more negative responses include those who are terminating pregnancies that are wanted and meaningful, who perceive a lack of support from their partner or parents for the abortion, who are more conflicted and less sure of their decision and coping abilities beforehand, who blame themselves for the pregnancy, and who delay until the second trimester.

For the vast majority of women, an abortion will be followed by a mixture of emotions, with a predominance of positive feelings. This holds immediately after abortion and for some time afterward. We do not know about very-long-term effects. However, the positive picture shown up to eight years after abortion makes it unlikely that more negative responses will emerge later. Studies of other stressful life events show that those who experience the most distress in the immediate aftermath of the event are most likely to experience longer term difficulties and that those who show little distress in this period are unlikely to develop problems later (Wortman & Silver, 1989).

The best studies available on psychological responses to unwanted pregnancy terminated by abortion in the

United States suggest that severe negative reactions are rare, and they parallel those following other normal life stresses. The time of greatest distress is likely to be before the abortion. Despite methodological shortcomings of individual studies, the fact that studies using diverse samples, different measures of postabortion response, and different times of assessment come to very similar conclusions is persuasive evidence that abortion is usually psychologically benign.

After completing its review, the panel again recognized that abortion is intertwined with diverse moral, religious, and ethical perspectives that will impinge on how a given woman will react to her choice of pregnancy resolution. Although making the decision to terminate an unwanted pregnancy is difficult, available psychological evidence suggests that, in the aggregate, women tend to cope successfully and go on with their lives.

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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 abortion⁴ 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 al¹⁵ 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.¹⁵

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.^{4,7,9} 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.^{4,7,9} 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 al²¹ 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 roles, 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 an abortion 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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**Planned Parenthood
of Missoula**

EXHIBIT 20
DATE 3/20/95
SB 292

Thank you very much, Mr. Chairman and members of the committee. I am here today to speak in opposition to SB 292. 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 on page two which states: "that some abortion facilities or providers offer only limited or impersonal counseling opportunities; and some 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 confident 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. I recognize that this particular language in the bill has been softened, yet despite what the proponents of this bill may claim, impersonal and unprofessional counseling and hard-sell technics simply do not happen in Montana.

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 this session, 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 this is an issue about women's health and safety, as the proponents claim, and not merely a means to erect more barriers to abortion for women to surmount, how come there is no one speaking in its behalf from any reputable medical association or group? The American

Medical Association itself is opposed to waiting periods. The only groups here, supporting this bill, are anti-abortion groups. When they allege that their only concern is for women's health, don't believe it. This bill is simply a smoke screen for limiting women's access to abortion, especially the most vulnerable women in our society: the young and the poor.

February 10, 1995

EXHIBIT 21
DATE 3/20/95
SB 292

The Honorable Members of the
Senate Judiciary Committee
The 54th Montana Legislature
The Capitol
Helena, Montana 59620

Dear Ladies and Gentlemen of the Committee:

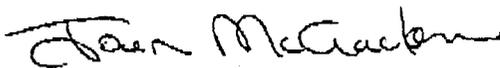
I am the Executive Director of InterMountain Planned Parenthood. I am responsible for seven clinics in Montana, two of which are clinics that provide abortion. Less than 5% of all the medical visits to these seven clinics involve abortion services. However, each time the legislature meets, bills are 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 findings 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 clinics, 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

The Effects of Mandatory Delay Laws On Abortion Patients and Providers

By Frances A. Althaus and Stanley K. Henshaw

Since the Supreme Court ruled in 1973 in *Roe v. Wade* that a woman has the right, based on her constitutional right to privacy, to have an abortion, activists and legislators opposed to abortion have sought other means of restricting access to abortion. One common strategy has been the introduction of legislation requiring a woman to delay her abortion for a certain number of hours or days after receiving certain state-mandated information and being offered information on fetal development and lists of agencies that provide prenatal care or other services for women who decide to carry their pregnancies to term. Those who sponsor such legislation say it is intended to assure that women seeking an abortion are adequately informed and have time to consider their decision. Those who oppose the legislation contend that it is designed to create barriers to abortion and to persuade women to continue their pregnancies, pointing out that portions of the mandated information are already provided as a matter of course.

As of August 1994, such legislation had been passed and signed into law in 15 states, although it was being enforced in only seven—Kansas, Mississippi, Nebraska, North Dakota, Ohio, Pennsylvania and Utah. In three states—Kentucky, Massachusetts and South Dakota*—enforcement of a mandatory delay requirement has been stayed or enjoined by a federal court, and in two states—Michigan and Tennessee—such a requirement has been enjoined by a state court. In Delaware, Idaho and Indiana, mandatory delay legislation is on the books but is not currently being enforced.

Frances A. Althaus is senior editor of *Family Planning Perspectives* and Stanley K. Henshaw is deputy director of research, The Alan Guttmacher Institute (AGI). The authors thank Joan Coombs of Planned Parenthood of South-eastern Pennsylvania, Terry Sollom of AGI and Dara Klassesel of Planned Parenthood Federation of America, as well as the sources cited in this report, for their assistance.

In addition to the legislation in these 15 states, a provision for a one-hour delay with mandatory counseling was passed in mid July in South Carolina. At the time this report was written, it had not yet been signed by the governor.

In states in which mandatory delays are being enforced, the waiting period required is generally 24 hours; Kansas, the exception, requires an eight-hour delay. The information that must be given to a woman seeking an abortion, who may provide the information and how it may be provided vary from state to state. Most states require that a woman be told the probable gestational age of the fetus and the medical risks of abortion and childbirth. In almost all states, she must also be informed that the father is liable for child support and that medical assistance benefits may be available for prenatal care, childbirth and neonatal care. In some cases, this information must be provided by a physician. In Mississippi, the law has been interpreted as requiring the woman to make two visits to the clinic, once for state-mandated "counseling" and once for the abortion. In the other states, however, only one visit may be needed because the laws specify or have been interpreted to mean that the mandated information may be provided by mail, by telephone or, in some cases, by other electronic means.†

In addition, most states require abortion providers to furnish or make available to their patients (and, in some cases, to pay for) government-produced material on fetal development and lists of agencies that arrange adoptions or provide prenatal care or other services for women who decide to carry their pregnancy to term. The material on fetal development often depicts a fetus at two-week gestational intervals; it may also, according to the particular state law, give information on fetal viability and describe the "probable anatomical and physiological character-

istics of the unborn child," such as brain and heart function and "the presence of external members and internal organs during the applicable stages of development." Some states require that women be told of "possible detrimental psychological effects of abortion" and "the risks of infection, hemorrhage, danger to subsequent pregnancies and infertility." Although two states (Michigan and Ohio) require that women receive this information, no state requires that she actually review it. Many, however, require her to certify that she was informed of its existence and her right to review it, and that it was provided if requested.

Although these laws are commonly promoted as efforts to protect women by giving them the time and information needed to make an informed decision, they can create difficulties for women and the clinics that serve them. This report examines how the laws have affected providers and women seeking abortions in three states. In Ohio and Pennsylvania, enforcement of mandatory delay laws did not begin until March 1994, so it is too early to determine the impact of these laws on women's access to abortion. However, information provided by administrators of two clinics shows the ways in which the laws have affected providers. In Mississippi, evidence of the effect of the mandatory delay law on women's access to abortion is available because the law has been enforced since August 1992. This report presents results of an analysis of abortion trends in Mississippi before and after enforcement of the law began.

*On August 22, a federal court ruled that the waiting period and information requirements were constitutional, but enjoined the civil and criminal penalties that made up the law's statutory enforcement mechanism.

†Whether two trips are necessary is often unclear from the statutory language and depends on interpretation by courts, state officials and clinics' legal advisers. Even within states, clinics' interpretations may vary.

Ohio

Provisions of the Law

The Ohio mandatory delay bill was signed into law in August 1991, but was enjoined in April 1992 before it could take effect; a month later, a state judge ruled that the law violated the federal and state constitution. In 1993, the district appeals court reversed this decision and the Ohio Supreme Court declined to review the reversal. The law went into effect on March 14, 1994.

The law includes several major provisions. At least 24 hours before a woman has an abortion, a physician must inform her of the nature of the abortion procedure to be used and the medical risks associated with that procedure, the probable gestational age of the fetus, and the medical risks associated with carrying the pregnancy to term. This information must be given verbally or by some other nonwritten means. The woman must have an opportunity to ask the physician questions about the abortion.

In addition, at least 24 hours before the procedure, the physician or someone acting for the physician must inform the woman of the name of the doctor who will perform the abortion and give the woman state-mandated information on fetal development and a list of agencies that offer alternatives to abortion. The woman is not required to read the information; the person providing the material may or may not comment on it. This information may be provided in person or by telephone, certified mail (with a return receipt) or regular mail (with a certificate of mailing). Finally, the woman must sign a form consenting to the abortion and certifying that she has received the state-mandated information, has had her questions answered and is not under the influence of drugs or alcohol.

Dayton Women's Health Center

The Dayton Women's Health Center, Inc., which opened in September 1973, was the second abortion facility in Ohio. (The state now has a total of 22 such facilities in seven cities.) The clinic, which has a staff of 12, provides pregnancy tests, annual exams, Pap smears, birth control, and options counseling for pregnant women by a state-licensed counselor, as well as termination of pregnancies of less than 20 weeks of gestation. (A contract physician comes to the clinic every two weeks to perform second-trimester abortions.) The clinic schedules abortions three days a week and performs 40–50 abortions weekly.

The clinic has had to make major changes in its procedures to meet the requirements of the law. Previously, patients

could simply call for an appointment and have an abortion within a day or two. Now, the process is lengthier and more complex, with an average wait of 3–4 days. If a patient lives reasonably near the clinic, the staff make two appointments for her. During the first appointment, she fills out a medical history, views a video prepared by one of the clinic's physicians in accordance with state requirements, talks with the physician by telephone if she has questions, has an ultrasound and receives a packet of state-prepared information.

If a woman cannot make two trips to the clinic, the staff play an audio tape over the telephone; the tape, prepared by one of the clinic's physicians, covers the same information provided by the video. The woman may then speak to the physician if she has questions, and the clinic staff mail the state-mandated information packet to her if her personal circumstances allow it. When the patient comes in for her abortion, she must bring the information packet to confirm that she received it.

According to clinic executive director Anita Wilson, compliance with the law has created a "scheduling nightmare."

The addition of preprocedure appointments for the majority of abortion patients jams the waiting room at times and stresses the staff. Because limiting the hours for these initial appointments did not prove feasible, the sessions are scheduled throughout the week, resulting in higher costs because of longer hours for the ultrasound technician. Wilson points out that complying with the mandatory information requirement alone takes at least half an hour per patient—or a minimum of 20–25 additional hours of staff time per week.

The clinic has not yet raised its abortion fees, preferring to wait until it has had six months of experience in coping with the new requirements. Wilson notes, however, that a cost analysis conducted by the executive director of another Ohio clinic shows that printing the extra consent form, purchasing the state-prepared brochures, mailing the brochures to patients and paying for extra staff time has raised costs by 10%.

On the other hand, Wilson says, fewer patients fail to keep their abortion appointments, perhaps because they have already invested time in an initial visit. From March through July, she says, only 6% of the patients who attended the 24-hour information session failed to keep their abor-

tion appointment. She comments that few of the clinic's patients have changed their mind after receiving the state-mandated materials, and that, in fact, most women refuse to take them.

Pennsylvania

Provisions of the Law

Pennsylvania's mandatory delay law was passed by the state legislature in 1989 but legal challenges postponed its enforcement until March 21, 1994. The law requires that, 24 hours before performing an abortion, a physician orally inform the woman of the nature of the procedure, the risks involved in abortion and childbirth, and the "probable gestational age of the unborn child."

The physician or a qualified nonphysician acting for the physician must inform the woman of the availability of state-pro-

"Previously, patients could simply call for an appointment and have an abortion within a day or two. Now, the process is lengthier and more complex, with an average wait of 3–4 days."

duced printed materials describing the fetus and providing information about medical assistance for carrying her pregnancy to term, information about the father's liability for child support, and a list of agencies that provide adoption and other services as alternatives to abortion. The woman must sign a statement that she was informed of the availability of these printed materials and that, if she requested them, she was provided with them. The law also requires that clinics report to the state the name of the referring physician, the name of the physician who performed the abortion and the name of the facility where the abortion was performed. This information is entered on an individual form that must be kept confidential.

Philadelphia Area Clinic

Planned Parenthood of Southeastern Pennsylvania operates a surgical services clinic and 10 contraceptive clinics in the greater Philadelphia area. The surgical clinic, which has been in operation and offering abortions since 1973, also provides vasectomies. It has a regular staff of 13, plus several volunteers and on-call people. Three contract physicians provide abortions four days a week at the center.

In Pennsylvania as in Ohio, the mandatory delay law has made obtaining and providing abortion services longer and more difficult processes. Staff at the surgical services clinic inform each patient who calls of the law's requirements. Because of the extra time needed to provide this information, the clinic has had to assign an extra person to its appointment phone lines so that callers will not be kept on hold for too long.

To provide the required information, the clinic schedules one 15-minute session each weekday. These group sessions are conducted by physicians who receive \$50 per session, except for a few who volunteer their time. In addition, the clinic has found it necessary to have an extra staff person available at the sessions to review preabortion instructions with the patients, explain the 24-hour delay requirement and answer questions about scheduling and payment. Often, there is not enough space in the waiting room to accommodate patients who are attending an information session as well as those who have come in for a procedure.

For women seeking an abortion, the necessity of making two trips means extra time and expense, especially if they live far from the clinic. Moreover, it is no longer possible for a woman to have an abortion within a day of calling for an appointment. Because the clinic can hold only one information session each day, with the time dictated by physician availability, patients sometimes have to wait two or three days for a convenient session. The agency's associate executive director, Dayle Steinberg, estimates that the average waiting time between calling for an appointment and obtaining an abortion at the surgical clinic has risen by at least a day; in general, women can obtain an abortion within a week.

Steinberg notes that the number of abortions performed at the clinic rose by 10% immediately after the implementation of the law. However, five weeks later, the number of women seeking abortions dropped and has now stabilized at about 10-15% below the preimplementation level. Some of these women may be obtaining abortions elsewhere: The number of Pennsylvania residents obtaining abortions at the New Jersey provider closest to the clinic has more than doubled since the implementation of the law.¹

Thus far, the state-mandated information seems to have had little effect on women's decisions. According to Steinberg, only about 1% of patients ask for the booklet on fetal development. She notes

that, just as in the past, a small percentage of patients change their mind at some point in the preabortion process, but she adds that that percentage has not changed since implementation of the law. Clinic staff know of only two women who cancelled their appointment immediately after the information session adjourned.

Patients react to the new regulations in various ways. Steinberg says that many women initially accept the law's requirements as "just something they need to do to have the abortion performed." She notes, however, that these same women often react in anger after coming in for the "counseling." "They wonder why they had to [make an extra visit] to hear information that a counselor could have provided to them on the day of their procedure," Steinberg says. "Many of them feel insulted by the prenatal and adoption referrals offered to them. Most of them (99%) have no interest at all in seeing pictures of fetal development."

The clinic has not raised its abortion fees, in part because the cost of complying with the law is not yet clear. Steinberg estimates that complying with the law takes about 10-15 additional hours of staff time per week. She is looking into the possibility of substituting an audio tape played over the telephone for the preprocedure information session. This method of providing the required information would make the abortion process less onerous and costly for patients because they would need to make only one visit to the clinic. For the clinic, the initial expense of a new phone system would be offset by lower personnel costs.

Mississippi

Provisions of the Law

Mississippi passed mandatory delay legislation in 1991 over the veto of the governor, but a district court ruled the law unconstitutional. A year later, however, after the U.S. Supreme Court upheld a similar law in Pennsylvania, an appeals court removed the injunction. The law took effect on August 8, 1992.

According to the law, a woman must be given the following information at least 24 hours before her abortion: the name of the physician who will perform the abortion; the medical risks associated with the particular procedure, including "the risks of infection, hemorrhage, danger to subsequent pregnancies and infertility"; the probable gestational age of the fetus and the medical risks of carrying the pregnancy to term. This information must be provided by either the referring physician or the physician who

will perform the abortion. The law has been interpreted as requiring that this information be given to women in person, thus necessitating two visits to the clinic.

In addition, the physician or the physician's agent must inform the woman, at least 24 hours before her abortion, that medical assistance benefits may be available for prenatal care, childbirth and neonatal care; that the father is liable for child support; and that pregnancy prevention services are available. The woman must also be told that she has the right to review state-produced materials including lists of agencies that provide services to assist a woman through pregnancy and childbirth and while the child is dependent, and brochures that describe the "unborn child" at two-week gestational increments and give "any relevant information on the possibility of the unborn child's survival."

The woman must certify in writing before the abortion that she has been given the required information and that she has been informed of her right to review the material on fetal development and the list of agencies providing alternatives to abortion. The law also requires that, before performing the abortion, the physician receive a copy of this certification.

Abortion Trends

After the 24-hour delay law took effect in Mississippi, reports from local abortion clinics suggested that the number of women having abortions there dropped sharply, after increases in 1990 and 1991. To assess whether the law was having an effect on the number of Mississippi residents having abortions, we requested special tabulations of the 1992 abortion data collected by the Mississippi State Department of Health, Division of Public Health Statistics. Mississippi's abortion reporting is among the best in the country; the number of abortions reported to the state was slightly greater than the number counted by The Alan Guttmacher Institute (AGI) in its surveys of all known abortion providers in 1987, 1988, 1991 and 1992. The tabulations show the number of Mississippi residents and nonresidents who had abortions each month in 1992 and, for residents, breakdowns by age, race, educational level, county of residence and gestation of the pregnancy.

To allow for the possibility that increasing numbers of women were going to neighboring states for abortion services, we obtained similar tabulations, with the exception of county of residence, for Mississippi residents who had abortions in Al-

abama and Tennessee. The tabulations were provided by the Alabama Department of Public Health, Center for Health Statistics, and the Tennessee Department of Health, Division of Information Resources. Like Mississippi, these states have good abortion reporting. We were unable to obtain data from Louisiana, the only other state that borders on Mississippi, but we judged that the lack of these data would have only a small effect, given that in 1988, the latest year for which the information is available, fewer Mississippi residents had abortions in Louisiana than in Alabama and Tennessee (339 versus 532 and 1,138, respectively, according to AGI data).

Our initial calculations found that the average number of abortions per month performed in Mississippi in 1992 fell from 717 during the period preceding enforcement of the law (January through July) to 507 during the period after the law went into effect (August through December), a drop of 30%. These calculations, however, ignore fluctuations in abortion incidence, which is normally higher in some months than in others. To control for seasonality, we calculated the number of abortions that would be expected in August through December 1992 from the actual number in January through July and the seasonal pattern in Mississippi in 1990, 1991 and 1993.*

The top row of Table 1 shows that 2,537 abortions were performed in Mississippi from August through December 1992, that 3,537 would have been expected based on the experience of other years, and that the actual number was 22% below the expected number. Similarly, Mississippi providers performed 25% fewer abortions from January through July 1993 than during the same months in 1992 (not shown).

Part of the drop occurred because 17% more Mississippi residents had abortions in Alabama and Tennessee and because the number of residents of other states who had abortions in Mississippi fell by 30% after the law went into effect. When Mississippi residents alone are considered, taking into account the increase in the number who had abortions in Alabama and Tennessee, the data show that 13% fewer had abortions in August through December than would have been expected on the basis of the number who had abortions in January through July.

If the number of Mississippi women who had abortions in Louisiana increased to the same extent as it did in Alabama and Tennessee, the decline in abortion incidence among Mississippi residents would have been 11% rather than the 13% shown in the table. A χ^2 test indicated that this decline is highly statistically significant

($p < .001$); a decline as small as 6% would be statistically significant at the .05 level. This significance test, however, assumes that no global factors other than the change in the law and seasonality affected the number of abortions.

If the delay law had caused women to continue pregnancies that would otherwise have ended in abortion, one might expect the number of births to increase correspondingly beginning around February and March 1993. If abortions to residents decreased by 11%, or about 850 abortions, the number of births would increase by 90% of this amount (to allow for the pregnancies that would end in miscarriage or stillbirth), or about 770 births on an annual basis. Thus, one would expect an additional 640 births between March 1993 and the end of the year because of the law. This would represent an increase of 1.5% in the number of births. In fact, the number of births decreased by 1.3% between 1992 and 1993, continuing the trend of the previous two years. The expected small effect of the delay law on the number of births may have been masked by other effects on births such as changing economic conditions and the changing age distribution among women of reproductive age.

If the 24-hour delay law is an impediment to women seeking abortions, which women have been affected the most? The decline in the number of abortions among women younger than age 18 did not differ statistically significantly from the decline among those aged 18 or older; similarly, the decreases among whites and nonwhites were not significantly different (not shown). Whether a woman lived within a county with an abortion provider, within 50 miles of such a county, or more than 50 miles from such a county had no effect on the percentage decline in abortion. However, a decline of 28% occurred among women without a high school degree, compared with a decrease of 10% among those with 12 or more years of education.

After the delay law went into effect, the gestational age at which pregnancies were aborted changed substantially. The number of abortions performed at eight weeks or less fell by 25%, while the number performed at more than 12 weeks changed little. During the seven months before the

Table 1. Expected and actual number of abortions performed, by selected characteristics, Mississippi, August–December 1992

Characteristic	Actual number	Expected number*	Percent difference
Abortions performed in Mississippi	2,537	3,263	-22%
Mississippi residents having abortions in Alabama and Tennessee	673	576	17%
Out-of-state residents having abortions in Mississippi	550	787	-30%
Mississippi residents having abortions in Mississippi, Alabama and Tennessee	2,660	3,052	-13%
Mississippi residents with <12 yrs. of education	286	400	-28%
Mississippi residents with ≥12 yrs. of education	2,374	2,652	-10%
Mississippi residents <9 wks. of gestation	1,224	1,624	-25%
Mississippi residents >12 wks. of gestation	319	310	3%

*The number of abortions performed in January through July 1992 multiplied by .650 (the ratio of abortions performed in Mississippi in August through December to those performed in January through July in 1990, 1991 and 1993).

law went into effect, 10.3% of abortions were performed at more than 12 weeks of gestation, compared with 12.1% in the last five months of the year. Thus, among Mississippi residents having abortions, the proportion obtaining an abortion at more than 12 weeks of gestation increased by 17% between the two periods.

Effects of Mandatory Delays

At the time this report was written, the mandatory delay requirements in Ohio and Pennsylvania had been in effect for about four months, too short a time for a final evaluation of their consequences. It is clear, however, that these restrictions have lengthened the time needed to obtain an abortion, especially for women who do not live near a provider and those who must make more than one trip. In Pennsylvania, Steinberg says, 90% of all abortions are performed by providers (including hospitals and private physicians) in eight of the state's 67 counties. In 1992, the state had 81 providers in 20 counties; 47 counties had no provider.² In Mississippi, where women must make two visits, providers are even scarcer and the distance to be traveled is likely to be much greater: In 1992, the state had only eight abortion providers in four counties, and 78 counties had no provider.³ In such circumstances, a 24-hour delay can easily become

(continued on page 233)

*In those years, the number of abortions in Mississippi in August through December was .65029 the number in January through July. The expected number in August through December 1992 is therefore .65029 times the actual number in January through July 1992. The ratio of .65029 corresponds closely to the ratios calculated from special tabulations of data tapes compiled by the National Center for Health Statistics of 303,700 abortions in 14 states in 1988 (the ratio is .65220) and of 310,182 abortions in 13 states in 1986 (ratio .65456). The ratio would be .71429 if abortions were equally distributed among the months.

Mandatory Delay Laws...

(continued from page 231)

nuch longer. Moreover, women who must make two visits may have substantial expenses for transportation, accommodations or child care, as well as time lost from work, school or other responsibilities.

Although it is impossible to be sure that other factors did not affect the use of abortion by Mississippi women during the last part of 1992 and 1993, the most likely explanation of the results is that the 24-hour delay law in Mississippi prevented approximately 11-13% of the women who would have had abortions from doing so. These women do not appear to have been dissuaded by the mandated information: Clinic directors in Mississippi have found that few women change their minds after receiving it and almost all women who make the initial visit to the clinic return for the abortion procedure.⁴ The effect of the law must therefore result from the creation of barriers that some women are unable to overcome. Some women may mistakenly believe that abortion services are no longer available or are more difficult to obtain than is in fact the case. This would explain the disproportionate effect on women without a high school education.

The lack of disproportionate effects on minors, nonwhite women and women who live long distances from a provider is counterintuitive. Even before the law went into effect, women in these subgroups who had abortions probably had to overcome substantial barriers and were therefore already above average in motivation, personal competence and resources. Thus, the additional burden of making a second trip may be about the same as for more advantaged women.

It is not surprising that since the law went into effect, women have been having abortions later in pregnancy. In many cases, the 24-hour requirement may necessitate a delay considerably longer than 24 hours. The days on which women can come to a clinic may be limited by lack of transportation, lack of flexibility in their personal schedules, and the days the clin-

ic is open. One Mississippi clinic, for example, sees patients for preabortion visits on Fridays and performs abortions on Saturdays. A woman who cannot come to the clinic on both Friday and Saturday would be delayed for at least a week.

In the case of second-trimester abortions, a mandatory waiting period can greatly increase the time needed to obtain an abortion. According to Anita Wilson, one woman who came to the Dayton Women's Health Center at 17 weeks of gestation could not obtain an abortion until she was 19 weeks pregnant. The physician who performs second-trimester abortions for the clinic was there the day the woman came, but could not perform her abortion at that time because of the 24-hour waiting period. She had to wait until his next regularly scheduled visit two weeks later. Because the risk of major complications from abortion rises sharply with length of gestation after the first trimester, such delays can increase risks to a woman's health.⁵

Mandatory delay laws also add unnecessary costs to clinic operations by increasing the staff needed to answer calls, provide information and process paperwork. In some states, clinics must also pay physicians to provide information that could be given to patients by another health care provider at lower cost. The Ohio and Pennsylvania clinics profiled in this report have not yet raised their fees to patients, but may eventually have to do so. By scheduling frequent information sessions, expanding staffing on telephone appointment lines, carefully explaining the requirements of the law, and offering alternative ways of meeting those requirements, they have tried to minimize the burden on women seeking abortions. Despite their efforts, however, mandatory delay laws impose considerable burdens both on women and on the clinic staff who serve them.

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EXHIBIT 23
DATE 3/20/95
SB 292

March 20, 1995

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 of this bill 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 make the decision to have an abortion as one of two extremes:

- either we are victims of evil doctors and an "abortion industry" that seeks to coerce us, 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 financial, physical, and emotional implications as well as my religious and spiritual beliefs. I was well aware that there were other options available to me.

Please note that 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 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 fathers and mothers had full access to legal abortion.

- In fact, abortion was not banned nationwide until the 1880's.
- Also, the Catholic Church did not ban abortion until 1869.

If this bill were truly designed and intended to assist women during a difficult time, I would endorse it wholeheartedly. Instead, it is a poorly disguised attempt to make it more difficult for women who are in the midst of making a serious decision.

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, derogatory and misleading language, or you can choose to protect what is constitutionally guaranteed.

Respectfully Submitted,


Christine A. Phillips

553 Spencer, Helena, MT 59601

MONTANA WOMEN'S LOBBY

P. O. BOX 1099 HELENA, MT 59624 406-449-7917

Kate Cholewa

EXHIBIT 24

DATE 3/20/85

SB 292

RE: Opposition to SB 292

Please let us put to rest the hypocrisy that the intent of this bill is to somehow look out for the well-being of women. Placing obstacles between women and their medical decisions, lobbying them when they are making life and health care decisions, and deeming them as lacking the sense to think about important life decisions without legislative instruction to do so demonstrates a great disrespect for women and a great disregard for their lives.

The hypocrisy in the intent of this bill would be mirrored by its passing in this legislative body. This bill violates the preeminent missions of this legislature which are to cut state spending, cut the size of government, and get government out of our lives.

This bill creates more government in Helena at the Department of Health; more government in your doctor's office, lobbying you as you make medical decisions; and government smack in the middle of women's private and personal decisions.

This bill increases state spending. It's ironic that a legislative body opposed to abortions would invest general fund dollars in this program, but not accept \$50,000 in federal money for family planning, money that helps make the issue of abortion irrelevant. It forces the question: What do anti-abortion forces want? To prevent unwanted pregnancies, the underlying reason for abortions? Or, as this bill indicates, do they just want to harass women who choose to have them and the doctors that perform them?

We agree with this bill that no one should be coerced into having an abortion, but we also believe no one should be coerced into giving birth. Perhaps we need to define this coercion as stringently as we have for abortion. Otherwise, you legitimize and, indeed, institutionalize obstacles to a woman's exercising of her constitutional rights.

We ask you to oppose this bill.

EXHIBIT 25
DATE 3/20/95
SB 292

The Billing Clinic
P.O. Box 35100
Billings, MT 59107-5100

March 3, 1995

Representative Joan Hurdle
Capitol Station
Helena, MT 59620

Dear Representative Hurdle:

I am writing to you to express my opposition to **Senate Bill 292-- An Act Creating The "Woman's Right-To-Know Act"** which has been transmitted to the House. As a practicing obstetrician/gynecologist who does not routinely provide abortions services, I am concerned about the many implications this bill has for the traditional physician-patient relationship. Furthermore, I believe it will seriously diminish the quality of care provided to the women of Montana. Please allow me to enumerate my concerns.

Section 3 part 4 of the bill mandates that the State publish a brochure to be issued to the patient 24 hours prior to the abortion procedure. This totally undermines the physicians responsibility to provide informed consent. Will the State soon be providing brochures for patients undergoing bypass surgery? How is this really different?

Implicit in providing informed consent to a patient is the duty to explain not only the procedure and the risks of the procedure, but also the alternatives and the risks of the alternatives. It is well documented that the risk of maternal mortality with a first trimester abortion is less than one seventh that of the risk of childbirth. Will the state publish the fact that the risk of dying from childbirth is seven times greater than the alternative? As you can see the process of providing true informed consent is complex, personal, and, I believe, best left up to the physician who is caring for the patient.

Section 6 of the bill calls for complex reporting requirements by physicians. This is an affront to the physician-patient relationship whose intent is nothing but sinister. I understand that this year the legislature has turned away Federal money to bolster our state's Tumor Registry. The registry provides valuable information about the prevalence and treatment of cancer in our state. I am horrified that we would opt not to bolster a valuable tool in the improvement of healthcare for Montanans, but on the other hand establish a registry whose sole purpose is the encumbrance and persecution of those who provide abortion information to women in need.

Section 8 allows for civil or criminal persecution of abortion information providers in the absence of written consent by the woman upon who the abortion has been performed.

This may be done by a person not even related to the case under a pseudonym. Furthermore it makes a patients anonymity the exception rather than the rule. I don't think that I need to explain my several objections to this section which goes against the grain of everthing I ever learned in civics.

Section 11 mandates a twenty-four hour waiting period prior to the abortion. In general, I am not opposed to this except for one caveat. Remember, that in Montana, women often come from great distances to receive their health care. Women seeking abortion are often of little means. They may not be able to afford to stay an extra night in Great Falls, Bozeman, Billings, or Missoula. They often do not have phones or a way to contact them sufficiently in advance of the procedure. This barrier may create a delay in the procedure. Although abortions are safe, the risks of the procedure double with every two weeks of delay.

Thank you for reading and considering my comments carefully. As a provider of health care to women I am strongly opposed to this bill as a whole and the above sections in particular. I would encourage legislation in the future that would make abortions safe, available but rare through the support of sex education, contraceptive availability, and improved social and economic support of those who wish to continue their pregnancy or adopt after delivery.

I would be more than happy to discuss this matter with you personally. I can be reached at my office at 238-2268 or after hours at 248-1744.

Sincerely,



C. H. "Tersh" McCracken III, MD
The Billing Clinic
P.O. Box 35100
Billings, MT 59107-5100

John -
Thanks for discussing this to me this week on the phone. I hope that you will do all in your power to defeat this heinous piece of legislation

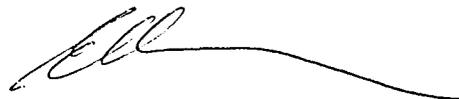


EXHIBIT 26
DATE 3/20/95
SB 292

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 is 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,



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,



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.~~

Concerns for our personal safety prevent us from testifying in person, due to the violence surround this issue.

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 *issues for* herself and the fetus. For the legislature to interfere in the doctor-patient relationship in ~~absolute~~ 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 *"get government out of our lives"* 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,

Guido Richard M.D.

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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In closing, we ask you to vote against this bill, **it is bad law and bad medicine.**

Sincerely yours,

Thomas A. Baumgartner, M.D.

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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In closing, we ask you to vote against this bill, **it is bad law and bad medicine.**

Sincerely yours,

A handwritten signature in cursive script, appearing to read "George Simelunas MD". The signature is written in dark ink and is positioned below the typed name "George Simelunas 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:

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.

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Sincerely yours,

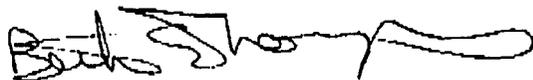




EXHIBIT 27
DATE 3/20/95
SB 292

BOX 3012 • BILLINGS, MONTANA 59103 • (406) 248-1086 • FAX (406) 248-7763

March 21, 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 hurdles and hinderances aimed at discouraging and deterring 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.

EXHIBIT 28
DATE 3/20/95
SB 292

Abortion Making A Decision

Commonwealth of Pennsylvania

Robert P. Casey
Governor

Allan S. Noonan, M.D., M.P.H.
Secretary of Health

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

JUDICIARY

COMMITTEE

DATE

3/20/95

BILL NO. SB292

SPONSOR(S) Sen. Braun

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Robert M. St. John, MD	Self	X	
Angey Klein	self	X	
Charles J. Lorentzen	SELF	X	
David Jachida	SELF	X	
Laurie Katnik	Christian Coalition of MT	✓	
Arlette Randash	EAGLE Forum	✓	
SHARON HOFF	MT CATHOLIC CONF	✓	
Darci Heck		✓	
Syd Grosfield	self	✓	
Thijs Frazer	MT NAKAL		✓
Kate Chelmer	MT Women's lobby		✓
Deborah Frandsen	Planned Parenthood		✓
Linda Rykowski	MTRL	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HR:1993

wp:visbcom.man

CS-14

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

JUDICIARY

COMMITTEE

DATE 3/20/95

BILL NO. SB292 SPONSOR(S) Sen Brown

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Christine Phillips	self		<input checked="" type="checkbox"/>
Smart Holmes	MT NARAL		<input checked="" type="checkbox"/>
Sandra Hale	self		<input checked="" type="checkbox"/>
Ann Bratsky	self		<input checked="" type="checkbox"/>
Brenda Nordlund	self		<input checked="" type="checkbox"/>
Melanie Reynolds	self		<input checked="" type="checkbox"/>
Devon Hartman	Planned Parenthood of Helena		<input checked="" type="checkbox"/>
Betty J. Bebeck	Eagle Forum	<input checked="" type="checkbox"/>	
Peggy Blumhagen	self	<input checked="" type="checkbox"/>	
Tim Whalen	MRTL	<input checked="" type="checkbox"/>	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HR:1993

wp:visbcom.man

CS-14

