Bill as Introduced

HB 1116-FN – AS INTRODUCED

2000 SESSION

00-2002
01/09

HOUSE BILL ***1116-FN***

AN ACT prohibiting partial-birth abortions.

SPONSORS: Rep. Woods, Straf 11; Rep. Wendelboe, Belk 2; Rep. L. Jean, Hills 17; Rep. Wood, Belk 7; Rep. Flora, Hills 15; Sen. Brown, Dist 17; Sen. Krueger, Dist 16; Sen. Roberge, Dist 9; Sen. Johnson, Dist 3; Sen. Francoeur, Dist 14

COMMITTEE: Judiciary

ANALYSIS

This bill prohibits certain abortions.

FILE COPY

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

00-2002
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand

AN ACT prohibiting partial-birth abortions.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Certain Abortions Prohibited. Amend RSA 329 by inserting after section 31 the following new section:

329:32 Certain Abortions Prohibited.

I. In this section:

(a) "Partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

(b) "Physician" means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state, or any individual legally authorized by the state to perform abortions; provided, however, that any individual who is not a physician or not otherwise legally authorized by the state to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.

(c) "Vaginally delivers a living fetus" means deliberately and intentionally delivers into the vagina a living fetus, or a substantial portion thereof, for the purpose of performing a procedure that the physician knows will kill the fetus, and kills the fetus.

II.(a) Any physician who knowingly performs a partial-birth abortion and thereby kills a human fetus or infant shall be guilty of a class B felony. Notwithstanding the provisions of RSA 651:2, a person found guilty under this paragraph may be fined up to $100,000 or be imprisoned for not more than 2 years, or both.

(b) A woman upon whom a partial-birth abortion is performed shall not be prosecuted under this section.

(c) This paragraph shall not apply to a partial-birth abortion that is necessary to save the life of the mother whose life is endangered by a physical disorder, illness, or injury.

III.(a) The woman upon whom the partial-birth abortion was performed in violation of this section, the father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus, may, in a civil action, obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

(b) Such relief shall include:

(1) Money damages for all injuries, psychological and physical, occasioned by the violation of this section; and

(2) Statutory damages equal to 3 times the cost of the partial-birth abortion.

IV.(a) A defendant accused of an offense under this section may seek a hearing before the board of medicine to determine whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, illness, or injury.

(b) The findings on such issue are admissible at the trial of the defendant. Upon motion of the defendant, the court shall delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

V. A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section for conspiracy to violate this section.

2 Effective Date. This act shall take effect January 1, 2001.

LBAO
99-2002
11/2/99

HB 1116-FN - FISCAL NOTE

AN ACT prohibiting partial-birth abortions.

FISCAL IMPACT:

The Judicial Council and Department of Corrections determined that this bill may increase state expenditures by an indeterminable amount in FY 2001 and each year thereafter. There will be no fiscal impact on state, county and local revenue or county and local expenditures.

METHODOLOGY:

The Judicial Council indicated the number of cases which may be brought where the defendant is indigent is unknown. The Public Defender and contract rate of $687.50, or the $60 hourly rate for assigned counsel (maximum $3,000 plus any other costs for services other than counsel) would be charged.

The Department of Corrections stated that the number of individuals who would be incarcerated is unknown, and that the average cost of incarceration in FY 1999 was $19,388 per inmate, per year, plus the $842 average cost of probation/parole.

The Department of Health and Human Services and the Administrative Office of the Courts stated this legislation would have no fiscal impact on their respective offices.

Amendments

Rep. Craig, Hills. 38
Rep. Rowe, Hills. 14
March 14, 2000
2000-3781h
01/09

FILE COPY

Amendment to HB 1116-FN

Amend the bill by replacing all after the enacting clause with the following:

1 New Section; Certain Abortions Prohibited. Amend RSA 329 by inserting after section 31 the following new section:

329:32 Certain Abortions Prohibited.

I. In this section:

(a) "Partial birth abortion" means the medical procedure known as dilation and extraction, or D & X procedure, an abortion in which the person performing the abortion partially vaginally delivers a viable fetus before killing the fetus and completing the delivery.

(b) "Physician" means a doctor of medicine legally authorized to practice medicine and surgery by the state, or any individual legally authorized by the state to perform abortions; provided, however, that any individual who is not a physician or not otherwise legally authorized by the state to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.

(c) "Vaginally delivers a viable fetus" means deliberately and intentionally delivers into the vagina a viable fetus, or a substantial portion thereof, for the purpose of performing a procedure that the physician knows will kill the fetus, and which does kill the fetus.

(d) "Viable" means the point in time in which a physician, licensed under RSA 329, determines that there is a realistic possibility of maintaining and nourishing a life outside the womb.

II.(a) Any physician who knowingly performs a partial-birth abortion and thereby kills a viable human fetus shall be guilty of a class B felony.

(b) A woman upon whom a partial-birth abortion is performed shall not be prosecuted under this section.

(c) This paragraph shall not apply to a partial-birth abortion that is necessary in appropriate medical judgment, for the preservation of the life or physical health of the mother. The term "physical health" shall not include the temporary adverse effects that a pregnancy has upon a woman's health.

III.(a) A defendant accused of an offense under this section may seek a hearing before the board of medicine to determine whether the physician's conduct was necessary for the preservation of the life or physical health of the mother.

(b) The findings on such issue are admissible at the trial of the defendant. Upon motion

of the defendant, the court shall delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

IV. A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section for conspiracy to violate this section.

2 Effective Date. This act shall take effect January 1, 2001.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB-1511 Date Feb. 15, 2000

Committee Judiciary

FILE COPY

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Melinda Volckmann	58 Higgins St Manchester 03102	603-644-4977		X	
Rep. Albert W. Mamel	71 Haverhill Rd Chester, NH 03036	(603) 887-3154	Chester Fremont	X	
State Legislator Mary Lou Rowe	District 4 Epping, Brentwood, Nottingham			X	
Rep. Iris Estabrook			Straff 8		X
Donna M McHatt	PO Box 1149 Laconia NH	524-8335	-	X	
Patrick M Kiefer	19 Folsom St, Laconia	03246 528-2326		X	
Patricia Smith	82 Gossstown	Parker Station Rd	Self		X
Mary Leadbeater	33 High Pond Rd Hopkinton	746-2830	Self		X
Sen. Mary E. Brown	Chichester NH - Dist 17			X	
Mary Lou Kelly	51 Old London Rd. Concord	225-3588	self		X
Amy Landes	14A Preble St. Dover, NH	03820 750-4047	self		X
Stephanie Jacob	43 Blueberry Circle Pelham NH	03076 862-5031	SELF		X
Robert Spagnani	11 WILEY HILL RD	LONDONDERRY 437-6920	self		X
ERIN PEPE	49 LANGDON ST	PLYMOUTH 536-2701	Women's Lobby		X
Lars Christiansen	Dist 23 Rep Hudson			X	
CAROLYN COTTRELL	11 Caresbg LN.,	BEDFORD, NH	self		X
Rebecca Hopper	4 Winter St.	Dover NH	self		X
Terie Norelli	Rock District 31				X
Ellen Ratner Otis	22 Adams Dr	Hudson NH			X
Rep Kathleen M. FLORA	95 Hutchins Rd	Bedford NH Hills Dist 15	603 471-0676	X	
Rep. G Michael Gilman	Grafton 1			X	
Mary Ann O'Leary Cooper	45 Elm St.	Dover		X	
Patti Bamm	10 Celtic St	Concord			X

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To Register Opinion If Not Speaking

FILE COPY

Bill # HB 1116 Date Feb. 15, 2000

Committee Judiciary

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Melinda Volckmann	Manchester, NH 58 Higgins St.	603-644-4977		X	
Rep. George A. LaPorte		627-9252	Hill. 39	X	
Rep. Albert W. Hamel		887-3154	Rock 10	X	
Rep. Iris Estabrook			Strafford		X
Sen. Carl Johnson		279-6492	District 3	X	
[illegible]	60 Box 1149 Laconia	524-5335	Vote to Prohibit PB 1611	X	
Mary Leadbeater	33 High Pond Rd Hopkinton	746-2830	Self		X
Patricia Smith	86 Parker Station Rd Croftstown	497-3497	Self		X
Mary Lou Kelly	510 Old London Rd, Concord	225-3588	Self		X
Andy Landers	14A Preble St. Dover NH 03820	750-4047	Self		X
Stephanie Leach	43 Blueberry Circle Pelham NH 03076		Self		X
Robert Spagiari	11 WILEY HILL RD	437-6920 LONDONDERRY	self		X
ERIN PEPE	49A LANGDON ST.	536-2701 PLYMOUTH, NH	Women's Lobby		X
Jayne W Torrey	401 Main ST	Jaffrey 532-4201 03452	"		X
Rep Robert Boyce	Belk 5			X	
Rep. Lars Christiansen	Hills 25 Hudson			X	
Rebecca Hopper	4 Winter St. Dover, NH 03820				X
Rep G. Michael Gilman	Grafton District 1			X	
Rep Terie Norelli	Rock Dist 31				X
Ellen Rainer Otis	22 Adams Dr Hudson NH				X
Mary Ann O'Leary Cooper	45 Elm St.	Dover NH		X	
Patti Baum	101 Centre St Concord				X

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 1116 Date 2-15 FILE COPY

Committee Judiciary

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Elizabeth J. Larson	18 Old Mill Vernon Rd.	Amherst			✓
Nicole Fouillard	81 Kearsarge Mtn Rd				✓
Rep PAUL MIRSKI	GRAFTON 12			✓	
Rep. James A. McDonald Jr.	Hills 41			✓	
Rep Carol Mone	Mer. 19				✓
Rep Christine Yorgo	Hills 33				✓
Rep. Shaun Norden	Grafton 10				X
Sheila Roberge SA9	271-3080		NH Grade Dist 9	✓	
Betsy Schneider	11 A Ray Rd.		Hennifer CAFTC		✓
Anne Faulkner	PO Box 174	Sullivan NH 03445			X
Rep. Michael Rollo	Straff 10				X
Jay Ward	Pembroke NH	[redacted]			✓
Kate Frey	NHCSW	2660			X
Rep Marion Copenhaver					✓
Gerry LAVOIE	Rep			X	
Rep Rebecca Hutchinson					✓
Rep Robert Batchelder	Cheshire #2				✓
Rep PETER BATULA	#18			X	
Rep Tom Donovan	Sullivan #11			X	

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 1116 FILE COPY Date 2/15/00

Committee Jud.

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Phoenix Mayet	346 A No State St. Concord		Self		X
Yvonne NANASI	41 BRIAR Rd		Self		X
Rep Cayleace W (Bouchard	Concord				X
Rep Doug Scheder				X	
Marni Thibault	77B Packers Falls Rd. Newmarket 03857	659-6852	UNH		X
Jessica Durkis	UNH Women's Studies Program				X
Rep BILL LEBOEUF	ANDOVER		MERR 01	X	
Rep. Martha Fuller Clark			PORTS 36		X
Rep M.E. MARTIN			Hills 34	X	
Daniel C. Itse	Fremont	6429403	Self	X	
Leslie T. Ati	18 Low Ave Concord	224-4394	NH Family Planning Council		X
Jonathan Baird	RR1 Box 163 Danbury		self		X
CAROLYN COTTRELL	11 Colonial Ln Bri	938-5778			X
Rep. Susan B Durham			Hill 22		X

Hearing Minutes

HOUSE COMMITTEE ON JUDICIARY

PUBLIC HEARING ON HB 1116-FN

FILE COPY

BILL TITLE: prohibiting partial-birth abortions

DATE: February 15, 2000

LOB ROOM: 208 LOB **Time Public Hearing Called to Order:** 9:20 am

Time Adjourned: 2:05 pm

(please circle if present)

Committee Members: Reps. Mock, Peterson, Jacobson, Keans, Bergin, Dokmo, L. Jean, Rowe, Ford, Withee, Dudley, Picconi, Soltani, Woods, Wall, DePecol, J. Pratt, Craig, Lasky, Mitchell, Solow and Wood.

Bill Sponsors: Reps. Woods, Jean, Wood and Brown

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. P Woods: Prime
Introduced the bill. Prime motivation is concern not only for babies but also for women. Outlined purpose for legislation. Explained the procedure. Twenty-seven states ban this procedure. Pointed out the untruths in the amount of abortions being performed. "This is a renegade procedure."

Rep. L Jean: Co-sponsor
Has previously always been pro-choice; terrible procedure.

Sen. M Brown: Co-Sponsor
Don't worry about what the Senate did last year – indefinitely proposed – daughter born at 24 weeks.
RRQ: Any definition of living fetus in RSA?
Answer: Can't say.

Rep. J Wood: Co-Sponsor
"Not just another attempt to limit abortion." Even not supported by AMA. Passed by 27 states usually 5-6 moths PHACT DATA PROCEDURE

- Lengthy because 3 days of dilation: not emergency
- Twice as risky as birth
- 1/6000 deaths vs. 1/13,000 births
- Co-sponsors wish to raise dignity of women
- Not in the best interest of women

Dr. Pamela Smith...

***Sen. Katie Wheeler:** Opposed
Just another attempt to prevent abortion. Ask sponsors if they would approve any abortion. Doctor/patient relationship not patient/legislator. Senate will not and can not without suspension of rules because indefinitely postponed. National agenda of anti-abortion. May 1998 "Governing" Emory Univ. Sponsors speak from heart but caught up in national agenda. Breached pregnancy – don't need anyone in room to protect me from my doctor.

Rep. Fran Potter: Opposed
Ordained priest in Episcopalian Diocese. Too broad – intent to outlaw all abortions. Suspect that intent to protect fetus from pain. 99% all abortions before 20th week none in NH after 20th week. Women seeking usually a victim already – no need to continue to ignore and further harm. Until just a few years ago women considered property – control of fertility is important for any society who values life.

Rep. Joe Manning: Support
RRQ: Definition of living fetus?
Answer: Viable
MSQ: Fully formed or fully born?
Answer: Viable
MSQ: Fully born how is that relevant?
Answer: That's my point, sorry I can't explain.

Sen. P Krueger: Co-sponsor
Know you have already made up your mind. Hope to change minds in Senate to be able to debate again. Yes would like to see whole issue of abortion go away. But this procedure is different. Prof. of OB/GYN –
PBQ: Is this same wording as US House?
Answer: Yes.
MSQ: If US Supreme Court has accepted Rove v. Wade as conservative?
Answer: Believe this is an issue we need to keep pursuing.
TSQ: Weren't aware NH had a P/B ban?
Answer: No logic for issue.

Dr. Wayne Goldner: *OB/GYN 19years;* Explain Procedure (resid. 4yrs OB/GYN)
No medical procedure called "P-B Abortion".

- Description is very vague
- No abortion is less risky than
- No 3 days for abortion – 1" only 3cm
- Don't need 10cm to do
- -------- - Never used
- Incompetent cervix always a risk – cancer – infection
- Miscarriage is risky – 50,000/year
- No physician would never use sharp objects
- No one sucks out brains – open brain is 18th century – not modern
- Liken to holocaust is offensive to a Jewish person as I
- Would prohibit procedures for conjoined twins and other procedures for non-survival fetuses
- If goal is to prohibit viable fetus tissue use it is AL
- If goal is to prohibit viable fetus births that should be taken care

- Patient must give informed consent
- Basic medical tenant to give best care to patient

TSQ: definition "partial-birth" abortion is it recommended?
Answer: Description of something does not exist.
BLQ: What is procedure for? 90% fit on a dime; 85% on a quarter. Quadriplegic – done in NY, not in NH.
APQ: If we segregated this procedure – is time frame appropriate?
Answer: Had 27-week fetus, which would not survive very rapidly advancing breast cancer patient? Who was pregnant each case is different. With multiple doctors involved. Leave this in the realm of medicine.
JCQ: The way this bill is described it could fit into any legitimate procedure – any vaginal delivery.

Rep. Rose: Support
Many couples want to adopt, need to let teenagers know.

***Gerald Hamilton, MD:** Opposed Concord *OB/GYN*
Don't know anybody who does partial-birth abortions but situations late in 2nd trimester where fetus is incompatible with life. Technique that would be easier that some of the others I believe. Not made in isolation – with families, medical advisors. Does not approve personally of late 2nd term elective.
TSQ: Is this required/recommended by any medical association in USA?
Answer: Not that I'm aware – never seen any literature.

***Kevin Smith**: Support for *US Senator Smith*
Horrible procedure. Personally was co-sponsor of bill in NH House.

Rob Rabuck: Support
Some common group has finally been found – 70% of Congress

Linda Day: Opposed
Argument people having trouble adopting is because they want a perfect child. NH proud of conservative heritage – in NH it means less government.

Christine Suarez: Support *RN Surgical Including Instructor*
Description: Dr. Haskell does
- ¾ baby is delivered. Inject cranium
- Cannot be medically substantiated
- 30 states have passed a version of this bill, which is written very clear.

Thus compelling state interest. Not aware of any hospital or doctor that would testify here even though believe Dr. Black at Concord Hospital would say that. Neither been present in operating room know actual case.

***Jennifer Frizzel:** *Attorney with Planned Parenthood* 9 Centers in NH
- 1st trimester abortions; but mostly family planning
- concerned about misinformation
- believe opponents don't support any abortions
- law would have chilling affect on medical care available
- Most states enactment have been struck down by appeals court because of sweeping nature of the bills
- Bill does not provide for health of mother but life of mother thus her future fertility would not matter
- Public support is shallow and not based on informed public

- Just look to state of Maine – had a referendum which was overwhelmingly rejected

BLQ: Line 22?
Answer: Conditions of mother not additional conditions for abortion to take place – identical language struck down.
BLQ: Mental/physical disorder?
Answer: Mental required by courts, not in this bill.
DJWQ: Weaken Roe v. Wade?
Answer: Roe v. Wade says constitutional right of privacy to choose without interference up to viability then state may have an interest. No specific # of weeks. This fails (1) does not talk of viability (2) narrow exception.
JCQ: There is a way to define procedure and regorate?
Answer: Would have to see specific language.
RRQ: If living fetus were defined would still opposed?
Answer: No – worry about procedure by procedure banning. Why prohibit if it has legitimate use.
TSQ: Procedure as defined does/not occur.
Answer: Physicians do not recognize term partial-birth abortion. Would say initial/d/c could be described under that terminology. Planned Parenthood only up to 9 weeks. But many believe define. Could refer to 2nd trimester procedures.
DJWQ: Paragraph 2 life of the mother etc. but paragraph 3 lines 21-26 would allow criminal sanctions?
Answer: Doctors would be free of criminal but not civil sanctions.

Mary Stipe: Support
4 Perfect births since Down Syndrome son – would e have been aborted.
MSQ: Would you want others making decision?
Answer: Yes just vehicle for child.

Joe Haas: Support in part RSA:9 ???
After hearing from doctors put in line 16 "health" but after Planned Parenthood, not sure.

***Rep. F Wendleboe**: Co-sponsor
Not motivated by guilt or grief polls show majority not ready to overthrow Roe v. Wade but ready to end partial-birth abortions. 25% illegal 1st trimester, 8% anytime, any reason. Submitting PBS video. Pro-choice extremists "advocate killing during birth". This specific language has been upheld by seven courts. Dr. Goldner did a great disservice with his testimony.
MSQ: Challenge to statistics
Answer: If 50,000 women had died they would have been recorded.

***Claire Ebel:** Opposed *Ex-Director of ALCU*
- 3500-4500 2nd trimester, 500 3rd trimester;
- all that up to 3rd have full legality
- 18 of 30 states have been overturned or enjoined
- AGOG support both D&X and D&E procedures: definition is this bill includes both
- AMA – statement was not a vote but put forth by committee-later reject by vote of members
- Dr. Doug Black should speak for himself not have unsubstantiated opinions entered on the record
- Pregnancy itself could be a threat to life of mother (Casey decision: neither husband nor boyfriend needed). Requires exception for health
- Class B felony – 3 ½ to 7 years; yet this bill is 2years – real point is to discourage any abortions by physicians
- Drowning viable fetus is murder; any nurse or professional present must report
- Incompatibility means "will not live"

PAQ: If we amend by strike replace with Roe v. Wade?
Answer: Need to see language – if confication of Roe v. Wade is done, we need to have a new bill advertised on its own.
TSQ: If delivered then drowned – murder if 4 limbs out legal?
Answer: Prior to viability any infringement is unconstitutional. This definition includes D&E even in 2nd trimester, which in fact could be at 12 weeks. We're not talking about Gerber Babies – but usually hydrocephalic. Will gallons of fluid, which would make vaginal delivery dangerous.

***Dr. Mildred Jefferson:** *General Surgeon,* Mass Medical Society, and President of Right to Life
- D&X is done for only one reason = deliver a dead baby.
- Babies found in wastebaskets & motel rooms are usually the result of a late term abortion.
- Only the legislatures across the land can protect these women & babies
- Pregnancy ends when birth begins

TSQ: Do you understand objective of bill
Answer: Understand the purpose of those who want no relutions to cloud issue.
BLQ: if object to women not being fully informed isn't there other means of ensuring this happens?
Answer: Want abortions to be observed, as any surgeon would be.
JWQ: What is procedure to inform patients?
Answer: Created by US Senate so satisfactory, clear.

Rep. S Vaillancourt: Support
Favorite novel of all times is "Cider House Rules". Voted 3 years ago to repeal 1800's legislation. Opinion has evolved. Most savage killing in society=death penalty. Unborn is most innocent. Can no longer support.

Amos Townsend: Support *Retired Physician*

***Colleen Yout:** Opposed
Last year fetus entwined with a fibroid tumor.

Rev. Msgr. Norman Bolduc: *Manchester Diocese*
TSQ: Is there a theological distinction between child out/in womb?
Answer: No. All life is cherished from moment of conception.

***Jane Terrey:** Opposed
Should legislators interfere with medical decisions because someone....

***Ann Conceison:** Support
Dirty little secrets, RN surgical nurse unfairly questioned. Asking Planned Parenthood for information is like asking fox to guard henhouse. Ghoulish situation to deliver tissue for research Planned Parenthood and NARAL justifying budgets. Opening line of inc. of ill. Supplying body parts.

***Patrick Keefer:** Support *Laconia*

***Frances Witcomb:** Support *Dover* NH Common Sense Conservatives

Diane Borner: *Certified Nurse and MidWife* - Ralph Day OB/GYN
- When is a fetus a baby? (understanding today much more than I ever did)
- Don't believe you should allow 3rd trimester
- 28 week fetus born is easy to take care for
- 22 week difficult – experience: alive, heartbeat, not allowed to care for guess 25-26 week

- would never be done to save life of mother – obstetrician would do a caesarian
- must allow mother to say goodbye – husband takes care of mistakes and things that go wrong
- At Greenland – abort one they immediately go out and get pregnant now in not good condition to then carry next

***Dr. Vincent Rue:** Co-Director of Institute for Pregnancy Loss, Stratham
- 10 year resident of New Hampshire
- greater than any other procedure 5-60% psychological complications
- remarks – focus on trauma of all abortions

MSQ: Is trauma generally accepted in medical field?
Answer: There are no studies done to document.
MSQ: Where do you get data?
Answer: My own experience/research particularly in other countries. Trauma because she is experiencing live birth between her legs.

***Ed Holgate:** *NH Right to Life*
Cannot support or oppose because of the exception for mother's life.

***Brian Fusonie, Esq.:** *VP, NH Right to Life*
Beyond talking about compelling state right to protect. Talking about killing outside the womb. With this first act is to remove from the womb. Then kill – offensive. May NH legally prohibit an act to limit life – yes. Roe v. Wade does not define when life begins so states are free to define. Against abortion, against exceptions. No physician can be forced to do coerced acts, violate of personal beliefs. Death from homicide connected to abortion among women.

Submitting PINK CARDS but not speaking:

*Kendra MacCaillech	Concord Feminist Health Center	Opposed
Sheila Evans	NH Women's Lobby	Opposed
Kris Moody	N.O.W.	Opposed w/testimony
Susan Arnold	Office of the Governor	Opposed
Joel Taar	Self	Opposed w/testimony
*Peg Dobbie	NARAL-NH	Opposed w/testimony

HB 1816

Rep Woods Prime Introduced bill. Prime motivation is concern not only for babies but also for women. Outlined purpose for legislation. Explained the procedure. Twenty seven states ban this procedure. Pointed out the untruths in the amount of ~~cases~~ abortions being performed. "This is a revengeful procedure."

REP. L. JEAN: CO-SPONSOR - HAS PREVIOUSLY ALWAYS ~~BEEN~~ PRO-CHOICE TERRIBLE PROCEDURE

SEN. M. BROWN: CO-SPONSOR: DON'T WORRY ABOUT WHAT SCOTUS DID LAST YEAR — INDEFINITELY POSTPONED — DAUGHTER BORN AT 24 WKS. RRQ? ANY DEFINITION OF LIVING FETUS IN RSA? - ANS. - CAN'T SAY

REP. JANE WOOD: CO-SPONSOR: "NOT JUST ANOTHER ATTEMPT TO LIMIT ABORTION." EVEN NOT SUPPORTED BY AMA. PASSED BY 27 STATES USUALLY 5-6 MONTHS PHACT DATA PROCEDURE

1) LENGTHLY BECAUSE 3 DAYS OF DILATION - ∴ NOT EMERGENCY
2) TWICE AS RISKLY AS BIRTH
3) 1/6000 DEATHS VS 1/13,000 BIRTH.
4) CO-SPONSORS WISH TO RAISE DIGNITY OF WOMEN
5) NOT IN BEST INTERESTS OF WOMEN

DR. PAMELA SMITH - CHICAGO INTERNAL BIRTH PERVERSION. (FOR BREACHED BABIES PERFORATION OF UTERUS HARMS CERVIX, INFERTILITY)

6) RAPTURE OF MOTHER - OFTEN NEED IMMEDIATE HYSTERECTOMY TO SAVE LIFE OF MOTHER.

- NOT GOOD MEDICINE

2.

EX COMM.

1997, AM SOC. GYNECOLOGIST SAID MAY BE BEST METHOD - NOT MEMBERSHIP.

JCQ? WHAT ARE WAYS THAT ARE SAFE? ANS. 1-TRIMESTER BECAUSE NO SKELETON - DISMEMBERMENT

JCQ? LINE 16 - INFANT

JPQ? LINE 21 IF C SAVE LIFE OF MOTHER WHO DECIDES - BURDEN OF PROOF REMAINS W STATE. ANS:

SEN. KATE WHEELER: OPPOSITION JUST ANOTHER ATTEMPT TO PREVENT ABORTION. — ASK SPONSORS IF THEY WOULD APPROVE ANY ABORT. — DOC./PATIENT RELATIONSHIP NOT PATIENT/LEGISLATOR - SENATE WILL NOT AND CAN NOT W OUT SUSPEN. OF RULES BECAUSE INDEFINATELY POSTPONED. NATIONAL AGENDA OF ANTI-ABORTION MAY 1998 — "GOVERNING" - EMORY UNIV. SPONSORS SPEAK FROM HEART BUT CAUGHT UP IN NAT. AGENDA. BREACHED PREGNANCY — DON'T NEED ANYONE IN ROOM TO PROTECT PT FROM ANY DOCTOR

REP. FRAN POTTER: OPPOSITION ORDAINED PRIEST IN EPISCOPALIAN DIOS. TOO BROAD — INTENT TO OUT-LAW ALL ABORTIONS SUSPECT THAT INTENT TO PROTECT FETUS FROM PAIN. 99% ALL ABORT. BEFORE 20TH WK NONE IN NH AFTER 20TH WOMAN SEEKING USUALLY A VICTIM ALREADY - NO NEED TO CONTINUE TO IGNORE AND FURTHER HARM. UNTIL JUST A FEW YEARS AGO WOMEN CONSIDERED PROPERTY - CONTROL OF FERTILITY IS IMPORTANT FOR ANY SOCIETY WHO VALUES LIFE

REP. JOE MANNING: SUPPORT

RBQ? DEFINITION OF LIVING FETUS? ANS. - VIABLE

MSQ? FULLY-FORMED OR FULLY-BORN? ANS. VIABLE

MSQ? FULLY-BORN' HOW IS THAT RELEVENT? ANS. THAT'S MY POINT. SORRY I CAN'T EXPLAIN

SEN P. KRUEGAR CO-SPONSOR: KNOW YOU HAVE ALREADY MADE UP YOUR MIND. HOPE TO CHANGE MINDS IN SENATE TO BE ABLE TO DEBATE AGAIN. YES WOULD LIKE TO SEE WHOLE ISSUE OF ABORTION TO GO AWAY. BUT THIS PROCEDURE IS DIFFERENT PROF. OF OB/GYN —

PBQ? IS THIS SAME WORDING AS US HOUSE? ANS. YES

MSQ? IF US SUPREME COURT HAS ACCEPTED ROE/V WADE AS CONSERVATIVE? ANS. BELIEVE THIS IS AN ISSUE WE NEED TO KEEP PERSUING.

TSQ? WEREN'T AWARE NH HAD A P/B BAN ANS: NO LOGIC FOR ISSUE.

DR. WAYNE GOLDNER OB/GYN 19 YEARS. EXPLAIN PROCEDURE 4YRS OB/GYN RESID.

NO MEDICAL PROCEDURE CALLED "P-B ABORT."

DESCRIPTION VERY VAGUE

NO ABORTION IS LESS RISKY THAN

NO 3 DAYS FOR ABORTION - 1" ONLY 3CM.

DON'T NEED 10CM TO DO.

- NEVER USED

INCOMPETENT CERVIX ALWAYS A RISK - CANCER - INFECTION

MISCARRIAGE IS RISKY — 50,000/YR

NO PHYSICIAN WOULD NEVER USE SHARP OBJ

NO ONE SUCKS OUT BRAINS —

OPEN BRAIN IS 18TH CENTURY - NOT MODERN

LIKEN TO HOLOCAUST IS OFFENSIVE TO A JEWISH PERSON

4

WOULD PROHIBIT ~~ABORT~~ PROCEDURES FOR CONJOINED TWINS
AND OTHER " FOR NON-SURVIVAL FETUSES
IF GOAL IS TO PROHIBIT FETAL TISSUE USE
IT IS AL
IF GOAL IS TO PROHIBIT VIABLE FETUS BIRTHS THAT
SHOULD BE ~~TAKEN~~ CARE.
PATIENT MUST GIVE INFORMED CONSENT
BASIC MEDICAL TENENT TO GIVE BEST CARE TO PATIENT

" "

TSQ? DEFINITION P-B ABORT IS IT RECOMMENDED? ANS.
DESCRIPTION OF SOMETHING THAT DOES NOT EXIST.
BLQ? WHAT IS PROCEDURE FOR
90% FIT ON DIME 95% ON QUART.
QUADRAPLEGIC - DONE IN N.Y. NOT IN NH.
APQ? ASSERED BY SPONSORS MINI-INDUCED ~~IS~~ SHOULD NEVER BE USED?
ANS. NO BLACK/WHITE IN MEDICINE. CDC TAKES TOTAL STATISTICS
DILA/EXTRAC CONSIDERED SAFER THAT ~~MINI~~ INDUCED.
CHOICE DEPENDS ON PATIENT - CARE -
THESE ARE WANTED PREGNANCIES - VERY EMOTIONAL SITUATIONS.
APQ? IF WE SEGREGATED THIS PROCEDURE - IS TIME FRAME
APPROPRIATE - ANS. HAD 27wk FETUS WHICH WOULD NOT SURVIVE
VERY RAPIDLY ADVANCING BREST CANCER PATIENT? ~~WHO~~ WAS PREGNANT
EACH CASE IS DIFFERENT. W MULTIPLE DOCTORS. INVOLVED.
LEAVE THIS IN THE REALM OF MEDICINE.
JCQ? THE WAY THIS BILL IS DESCRIBED IT COULD FIT INTO
AND LEGIT PROCEDURE - ANY VAGINAL DELIVERY.

5/

REP ROSE: SUPPORT: MANY COUPLES WANT TO ADOPT NEED TO LET TEENAGERS KNOW.

GERALD HAMILTON CONCORD MD OB/GYN: OPPOSED — DON'T KNOW ANYBODY WHO DOES P-B ABORT. BUT ARE SITUATIONS LATE IN 2ND TRIMESTER WHERE FETUS IS INCOMPATIBLE W LIFE. TECHNIQUE THAT WOULD BE EASIER THAT SOME OF OTHERS I BELIEVE. NOT MADE IN ISOLATION - WITH FAMILIES, MEDICAL ADVISORS. DOES NOT APPROVE PERSONALLY LATE 2TERM ELECTIVE.

TSQ? IS THIS REQUIRED/RECOMMENDED BY ANY MED. ASSOC IN USA? ANS. NOT THAT I'M AWARE - NEVER SEEN IN ANY MEDICAL LITERATURE

KEVIN SMITH FOR US SEN SMITH - SUPPORT. HORRIBLE PROCEDURE. PERSONALLY WAS CO-SPONSOR OF BILL IN NH HOUSE

ROB ROBECK SUPPORT - SOME COMMON GROUND HAS FINALLY BEEN FOUND - 70% OF CONGRESS.

LINDA DAY OPPOSITION: ARGUEMENT PEOPLE HAVING TROUBLE ADOPTING IS BECAUSE THEY WANT A PERFECT CHILD. NH PROUD OF CONSERVATIVE HERITAGE — IN NH IT MEANS LESS GOVERNMENT.

CHRISTINE SUAREZ - SUPPORT RN - SURGICAL - INCLUDING INSTRUCTOR DESCRIPTION: DR. HASKELL DOES ① S/4 BABY IS DELIVERED. INJECT CRANIUM. ② CAN NOT BE MEDICALLY SUBSTANTIATED. ③ 30 STATES HAVE PASSED A VERSION OF THIS BILL, WHICH IS WRITTEN VERY CLEAR. THUS COMPELLING STATE INTEREST.

NOT AWARE OF ANY HOSPITAL OR DOCTOR THAT WOULD TESTIFY HERE EVEN THO BELIEVE DR. BLOCK AT CONCORD HOSP. WOULD SAY THAT. — NEITHER BEEN PRESENT IN OPERATING ROOM OR KNOW ACTUAL CASE.

6/

JENNIFER FRIZZEL ATTY W PLAN. PARENTHOOD 9 CTRS IN NH.
1ST TRIMESTER ABORT - BUT MOSTLY FAMILY PLANNING
CONCERNED W MISINFORMATION
BELIEVE OPPONENTS DON'T SUPPORT ANY ABORTIONS.
LAW WOULD HAVE CHILLING AFFECT ON MEDICAL CARE AVAILABLE
MOST STATES ENACTMENT HAVE BEEN STRUCK DOWN BY APPEALS COURTS.
BECAUSE OF SWEEPING NATURE OF BILLS.
BILL DOES NOT PROVIDE FOR HEALTH OF MOTHER BUT LIFE OF MOTHER
THUS HER FUTURE FERTILITY WOULD NOT MATTER.
PUBLIC SUPPORT IS SHALLOW & NOT BASED ON INFORMED PUBLIC.
JUST LOOK TO STATE OF MAINE - HAD A REFERENDUM WHICH WAS OVER-WHELMING REJECTED.
BLQ? LINE 22 CONDITIONS OF MOTHER NOT ADDITIONAL CONDITIONS ANS.
FOR ABORTION TO TAKE PLACE. - IDENTICAL LANGUAGE STRUCK DOWN
BLQ? MENTAL/PHYSICAL DISORDER. ANS. MENTAL REQUIRED BY COURTS
NOT IN THIS BILL
DJWQ? WEAKEN ROE V. WADE ANS. RVW SAYS CONSTITUTIONAL
RIGHT OF PRIVACY TO CHOOSE W OUT INTERFERENCE UPTO VIABILITY
THEN STATE MAY HAVE INTEREST. NO SPECIFIC # WEEKS.
THIS FAILS (1) DOES NOT TALK OF VIABILITY (2) NARROW EXCEPTION.
JCQ? THERE IS A WAY TO DEFINE PROCEDURE & REGULATE?
ANS. WOULD HAVE TO SEE SPECIFIC LANGUAGE.
RRQ? - IF LIVING FETUS WAS DEFINED WOULD STILL OPPOSED?
ANS. NO - WORRY ABOUT PROCEDURE BY PROCEDURE BANNING.
WHY PROHIBIT IF IT HAS LEGITIMATE USG.
TSQ? PROCEDURE AS DEFINED DOES NOT OCCUR. ANS.
PHYSICIANS DO NOT RECOGNIZE TERM P-B ABORT -
WOULD SAY INTAL/DIL COULD BE DESCRIBED
UNDER THAT TERMINOLOGY.

7

PLAN PARENTHOOD ONLY UP TO 9 WKS. BUT MANY BELIEVE DEFIN. COULD REFER TO 2ND TRI. PROCEDURES. LINE-21-26
DJW Q? IP2 LIFE OF MOTHER ETC. BUT ~~REPLACE~~ IP3 WOULD ALLOW CRIMINAL SANCTIONS. - DOC COULD BE FREE OF CRIMINAL BUT NOT CIVIL SANCTIONS.

MARY STOE SUPPORT - HIDEOUS PROCEDURE 4-~~MORE~~ PERFECT BIRTHS SINCE
DOWNS SYNDROME SON - WOULD HE HAVE BEEN ABORTED.
MSQ? WOULD YOU WANT OTHERS MAKING DECISION? ANS.
YES JUST VEHICLE FOR CHILD.

JOE HAAS RS11.9 ? SUPPORT IN PART
AFTER HEARING ~~FROM~~ DOCS PUT IN LINE 16 "HEALTHY" BUT AFTER PLAN PARENT. NOT SURE.

REP. FRAN WENDLEBOE CO-SPONSOR: NOT MOTIVATED BY GUILT OR GRIEF
POLLS SHOW MAJORITY NOT READY TO OVERTURN RvW
BUT READY TO END P-B A. 25% ILLEGAL 1ST TRIMESTER
8% ANYTIME ANY REASON. SUBMITTING PBS VIDEO.
PRO-CHOICE - EXTREMISTS "ADVOCATING KILLING DURING BIRTH."
THIS SPECIFIC LANGUAGE HAS BEEN UPHELD BY SEVEN COURTS
DR. GOLDNER DID A GREAT DISERVICE W HIS TESTIMONY

[redacted]

MSQ? CHALLENGE TO STATISTICS. ANS. IF 50,000 WOMEN HAD DIED - THEY WOULD HAVE BEEN RECORDED.

*CLAIRE EBEL OPPOSITION EX-DIR ACLU -
3500 - 4500 2ND TRI 500 3RD TRI
ALL THAT UP TO 3RD HAVE FULL LEGALITY

8

18 OF 30 STATES HAVE BEEN OVERTURNED OR ENJOINED
AGOG SUPPORT BOTH D&X D&E. PROCEDURES
DEFINITION IN THIS BILL ~~EXCLUDES~~ INCLUDES BOTH.
AMA - STATEMENT WAS NOT A VOTE BUT PUT FORTH BY
COMM - LATER REJECT BY VOTE OF MEMBERS.
DR. DOUG BLACK SHOULD SPEAK FOR HIMSELF. NOT HAVE
UNSUBSTANTIATED OPINIONS ENTERED ON THE RECORD
PREGNANCY ITSELF COULD BE A ~~THREAT~~ TREAT TO LIFE OF MOTHER
CASEY - DECISION. REQUIRES EXCEPTION FOR HEALTH.
CLASS B FELONY - ~~SO VAGUE THAT DEF~~ 3½ - 7 YRS.
YET THIS BILL IS 2 YRS. - ~~ADDED~~ REAL POINT IS
TO DISCOURAGE ANY ABORTIONS BY PHYSICIANS
→ NEITHER HUSBAND OR BOYFRIEND NEEDED.
~~TERMINATE~~ DROWNING VIABLE FETUS IS MURDER
ANY NURSE OR OTHER PROFESSIONAL PRESENT MUST REPORT.
INCOMPATIBILITY MEANS "WILL NOT LIVE."

PAQ? IF WE AMEND BY STRIKE REPLACE W R V W. ANS. NEED TO SEE
LANGUAGE — IF CODIFICATION OF R V W IS DONE WE NEED TO
HAVE A NEW BILL ADVERTISED ON ITS OWN.
TSQ? IF DELIVERED THEN DROWNED — MURDER ~~IF~~ LIMBS OUT ~~■~~ LEGAL.
ANS. PRIOR TO VIABILITY ANY INFRINGEMENT IS UNCONSTITUTIONAL
THIS DEFINITION INCLUDES D&E EVEN IN 2ND TRIMESTER WHICH
IN FACT COULD BE AT 12 WKS. WERE NOT TALKING ABOUT
GERBER BABIES - BUT USUALLY HYDROCEPHALIC ~~NOT~~ WILL GALLONS
OF FLUID WHICH WOULD MAKE VAGINAL DELIVERY DANGEROUS.

9

MILDRED

DR. JEFFERSON SUPPORT: GEN. SURGEON, MASS MED. SOCIETY, PRES. OF RIGHT TO LIFE COMM.

D&X IS DONE FOR ONLY ONE REASON = TO DELIVER A DEAD BABY. BABIES FOUND IN WASTE BASKETS & MOTEL ROOMS IS USUALLY THE RESULT OF A LATE TERM ABORTION.

ONLY THE LEGISLATURES ACROSS THE LAND CAN PROTECT THESE WOMEN & BABIES ~~BE~~ - PREGNANCY ENDS WHEN BIRTH BEGINS.

TSQ? DO YOU UNDERSTAND OBJECTIVE OF BILL ANS. UNDERSTAND THE PURPOSE OF THOSE WHO WANT NO RELATIONS TO CLOUD ISSUE.

BLQ? IF OBJECT TO WOMEN NOT BEING FULLY INFORMED ISN'T THERE OTHER MEANS OF ENSURING THIS HAPPENS ANS. WANT ABORTIONISTS TO BE OBSERVED AS ANY GEN. SURGEON WOULD BE.

JWQ? WHAT IS PROCEDURE TO INFORM PATIENTS ANS. WHY, NEED CONSEQUENCES, HOW AND DESCRIPTION.

JCQ? SATISFIED W DEFINITION P-B ABORT ANS. CREATED BY US SENATE. SO SATISFACTORY, CLEAR,

REP S. VAILLANCOURT SUPPORT FAVORITE NOVEL OF ALL TIMES IS "CIDER HOUSE RULES" VOTED 3 YRS AGO TO REPEAL 1800's LOGS. OPINION HAS EVOLVED. MOST SAVAGE KILLING IN SOCIETY = DEATH PENALTY UNBORN IS MOST INNOCENT. CAN NO LONGER SUPPORT.

AMOS TOWNSEND - SUPPORT. RETIRED PHYSICIAN

* COLLEEN YOUT OPPOSE LAST YEAR FETUS ENTWINED WITH A FIBROID TUMOR.

* REV. MSGR NORMAN BOLDUC - MANCH. DIOCESE

TSQ? IS THERE A THEOLOGICAL DISTINCTION BETWEEN CHILD OUT / IN WOMB.?

10

ANS. — NO - ALL LIFE IS CHERISHED FROM MOMENT OF CONCEPTION.

* JANE TERRY — OPPOSED — SHOULD LEGISLATORS INTERFER WITH MEDICAL DECISIONS. BECAUSE SOMEONE E

* ANN CONCEISON SUPPORT DIRTY LITTLE SECRETS, RN SURGICAL NURSE UNFAIRLY QUESTIONED. ASKING PLAN PARENTHOOD FOR INFORMATION IS LIKE ASKING FOX TO GUARD HEN HOUSE. GHOULISH SITUATION TO DELIVER TISSUE FOR RESEARCH P.P. & NARAL JUSTIFYING BUDGETS. OPENING LINE INC OF ILL. SUPPLYING BODY PARTS.

* PATRICK KEEFER - LACONIA SUPPORT -

* FRANCES WITCOMB DOVER - SUPPORT "NH COMMON SENSE CONSERVATIVES" ???

DIANE ~~WARNER~~ BORNER ROCHESTER CERT. NURSE/MIDWIFE WIFE OF RALPH DAY OB/GYN WHEN IS A FETUS A BABY? (UNDERSTANDING TODAY MUCH MORE THAN I EVER DID) DON'T BELIEVE SHOULD ALLOW 3RD TRIMESTER. 28WK FETUS BORN IS EASY TO CARE FOR 22WKS DIFFICULT — EXPERIENCE: ALIVE, HEART BEAT, NOT ALLOWED TO CARE FOR GUESS 25-26 WKS. WOULD NEVER BE DONE TO SAVE LIFE OF MOTHER — OBSTETRICIAN WOULD DO A CAESARIAN. MUST ~~BE~~ ALLOW MOTHER TO SAY GOODBYE — HUSBAND TAKES CARE OF MISTAKES & THINGS THAT GO WRONG. AT GREENLAND. ABORT ONE THEY IMMEDIATELY GO OUT & GET PREGNANT NOW IN ~~THE~~ NOT GOOD CONDITION TO THEN CARRY NEXT

* DR. VINCENT RUE CO-DIRECTOR OF INST. ~~FOR~~ STRATTHAM — REPRODUCTIVE LOSS FOR RESIDENTS OF NH. GREATER THAN ANY OTHER PROCED. 5-60% PSYCHOLOGICAL COMPLICATIONS. REMARKS - FOCUS ON TRAUMA OF ALL ABORTIONS MSQ? IS ~~IT~~ TRAUMA GENERALLY ACCEPTED IN MEDICAL FIELD. ANS.

-21-

THERE ARE NO STUDIES DONE TO DOCUMENT.
MSQ? WHERE DO YOU GET DATA? ANS. MY OWN EXPERIENCE/RESEARCH
PARTICULARLY IN OTHER COUNTRIES. TRAUMA BECAUSE SHE
IS EXPERIENCING LIVE BIRTH BETWEEN HER LEGS.

* ED HOLDGATE NH RIGHT TO LIFE CAN NOT SUPPORT OR
OPPOSE BECAUSE OF THE EXCEPTION FOR MOTHERS' LIFE.

* BRIAN FUSONIE, ESQ SUPPORT IN-PART V.P NH RIGHT TO LIFE
BEYOND TALKING ABOUT COMPELLING STATE RIGHT TO PROTECT.
TALKING ABOUT KILLING OUTSIDE WOMB. W THIS
1ST ACT IS TO REMOVE FROM WOMB. THEN KILL - OFFENSIVE
[redacted] MAY NH LEGALLY PROHIBIT AN ACT TO LIMIT LIFE ANS. YES,
ROE V. WADE DOES NOT DEFINE WHEN LIFE BEGINS SO ~~THOSE~~
STATES ARE FREE TO DEFINE.
AGAINST ABORTION - AGAINST EXCEPTIONS - [redacted]
NO PHYSICIAN CAN BE FORCED (COERCED) TO DO ~~WHAT~~ ACTS VIOLATIVE OF PERSONAL
BELIEVES. DEATH FROM HOMICIDE CONNECTED TO ABORT.
AMONG WOMEN.

205

HOUSE COMMITTEE ON JUDICIARY

PUBLIC HEARING ON HB 1116-FN

BILL TITLE: prohibiting partial-birth abortions.

DATE: 2/15/00

LOB ROOM: 208 **Time Public Hearing Called to Order:** 9:20 AM

Time Adjourned: 2:05

(please circle if present)

Committee Members: Reps. Mock, Peterson, Jacobson, Keans, Bergin, Dokmo, L. Jean, Rowe, Ford, Wither, Dudley, Piccon?, Soltani, Woods, Wall, DePecol, J. Pratt, Craig, Lasky, Mitchell, Solow and Wood.

Bill Sponsors: {Type SPONSORS' NAMES}

WOODS BROWN
JEAN
WOOD

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

* SEN. WHEELER
* HAMILTON, MD
* SEN. BOB SMITH
* PFIZZER
* WONDERBOOF - VIDEO PBS
* EBEL
* DR. JEFFERSON RIGHT TO LIFE MASS
* PEG DORBIE NARAL NON SPEAK
X KENDRA MACCAILLECH CONCORD FEMINIST HEALTH CTN NON-SPEAK
* COLLEEN YOUT FOR SHERY SHIRLEY PHD PLYM. ST. COLL.
* JANE TERREY
* ANN CONCELSON
* PAT KIEFER
* FRAN WHITCOMB
* VINCENT RUE PHD.
* ED HOLDGATE NH-RIGHT TO LIFE
* BRIAN

JUDICIARY COMMITTEE - HB 1116: prohibiting partial-birth abortions.

Public Hearing – February 15, 2000

FILE COPY

Those Giving Testimony:

Ed Holdgate, 63 Royal Range, Sandown, NH 03873, 603-887-3731
Representing: NH Right to Life

Brian Fusonie, Esq., 617 Rimmon St., Manchester, NH, 624-2085, Support of Bill in part. *Written Testimony - Representing: Self

Sen. Mary Brown, Chichester, NH – Co-Sponsor – 271-2736, Support

Gerald L. Hamilton, MD, 35 West St., Concord, NH 03301 603-224-0000, Opposed
Representing: Women's Rights

Rep. Jane Wood, Laconia Belk. 7, Support

Sen. Katie Wheeler, District 21, Opposed

Rep. Frances Potter, 38 Little Pond Rd., Concord, NH 03301 – 225-3999, Opposed - *Written Testimony – Representing Self

Rep. Joseph P. Manning, Ches #9, Support

Linda Day, 48 Raymond Rd., Deerfield, NH 603-463-5507, Opposed
Representing Self

Dr. Wayne Goldner, 4 Boxwood Dr., Bedford, NH 03110, Opposed

Christine Suarez, 158 School St., Concord, NH 03301 – 223-9772, Support
Representing Myself – as a medical surgical clinical nurse specialist.

Kevin Smith, 634-5000, Support, *Written Testimony
Representing US Senator Bob Smith

Rob Rabuck, 163 School St., Concord, NH 03301 – 226-3737, Support
Representing Self

Rep. Bill Frose, District #13, Richmond, NH 239-8690, Support

Kudra McGilluh, 38 So. Main, Concord, NH 225-2739, Opposed, *Written Testimony. Representing Concord Feminist Health Center

Claire Ebel, 18 Low Ave., Concord, NH 225-3080, Opposed – Representing NHCLU

Mary Stipe, 1 Cota Rd., Merrimack, NH 424-9329, Opposed – Representing Self & Family

Jennifer Frizzell, 18 Low Ave., Concord, NH 03301, 225-2925, Opposed, Representing Planned Parenthood

Peg Dobbie, 18 Low Ave., Concord, NH 03301, 228-1224, Opposed, *Written Testimony – Representing NARAL-NH

Rep. Phyllis Woods, 1 Barry St., Dover, NH 038240, 749-2177, Support, Representing Self

Joe Haas, P.O. Box 218, Ashland, NH 03217, E-Mail: JosephHaas53@HotMail.com, Opposed (1 page) *Written Testimony of RSA Ch. 92:2 corruption ref. HB #999 (Ch. 338 Laws of 1999) and RSA Ch. 9:8-b. Time needed to ~~speak:~~ Act (as long as it takes to see attached removed!)

Kris Moody, 7 Colby Crt, Bedford, NH 03110, 603-749-8900, Opposed *Written Testimony, Representing NOW. Do Not Need To Speak

Sheila Evans, Concord, NH, Opposed. Representing NH Women's Lobby. (Left, Did Not Speak)

Ed Holdgate, 63 Royal Range, Sandown, NH, Representing New Hampshire Right to Life

Rev. Msgr. Norman Bolduc, 153 Ash Street, Manchester, NH 03105, 603-66-3100, Support, Representing Diocese of Manchester

Colleen Yout, 6 Lonoview Dr., Bow, NH 03304, 225-5771, Opposed, Representing Sheryl Shirley

Dr. Mildred F. Jefferson, MD, P. O. Box 935, Boston, MA 02117-0935, 617-342-7280, Support, Representing Citizens Select Committee on Public Health Oversight

Rep. Steve Vaillancourt, 161 Faith Ave., Manchester, NH, 622-9047, Support, Representing Hills. 47

Amos R. Townsend, MD, 8 Northside Rd., Lee, NH 03821, 659-6050, Support, Representing Self

Patrick M. Kiefer, 19 Folsom St., Laconia, NH 03246, 528-2326, Support, *Written Testimony

Frances Witcomb, 6 Northway Cir. #17, Dover, NH 03820, 603-742-7730, Support, *Written Testimony, Representing NH Common Sense Conservatives

Dr. Vincent Rue PHD, Institute for Pregnancy Loss, P.O. Box 279, Stratham, NH 03885, 603-778-1450, Support, Representing Self

Ann Conceison, 1 Old Milford Rd., Amherst, Support, Representing Self & Babies

Jane W. Torrey, 401 Main St., Jaffrey, NH 03482, 532-4701, Opposed, Representing Self & Women's Lobby

Testimony

For more information, contact New Hampshire Right to Life, 626-7950

FILE COPY

COMMENTS TO THE HOUSE JUDICIARY COMMITTEE FROM NEW HAMPSHIRE RIGHT TO LIFE REGARDING HB-1116

The New Hampshire Right to Life Committee is pleased that New Hampshire lawmakers are having today's hearing, affording an opportunity for an open discussion of partial-birth abortion (PBA) and the public interest to be served in regulating the abortion industry to a degree. We thank the sponsors of the bill for their intentions, and we agree with them that there is no reason for New Hampshire to permit the practice of PBA.

The bill currently before you has a serious flaw which prevents us from endorsing the bill as written. HB 1116 contains a clause commonly known as a "life of the mother" (LOM) exception. That exception is worrisome on two counts.

First, it assumes that under some circumstances, a partial-birth abortion can be therapeutic to the mother. In other words, a direct attack on the child, including imposition of skull trauma and brain damage for the purpose of completing the abortion, is presumed to be medically indicated in some cases. We dispute that any procedure covered under HB 1116 is of therapeutic value. Any attempt to treat the mother that has the unintended effect of injuring the child would be another matter entirely. PBA, however, is a procedure designed to have only one direct effect: the killing of a child.

The life of the mother exception is also of grave concern in view of the U.S. Supreme Court's treatment of such an exception in the Texas statutes reviewed by the Court in Roe v. Wade (1973). Writing for the Court, Justice

Blackmun acknowledged the impossibility of reconciling the personhood of the unborn child with the life of the mother exception contained in Texas law. The Court's "solution," with which we take issue and will continue to challenge, was to deny legal personhood to the unborn child. The Court has not yet overturned that holding. The existence of any LOM exception in New Hampshire law would create avoidable difficulties for any future New Hampshire legislature trying to create a community where both mother and child are valued.

Yet we acknowledge that this is not a forum for challenging Roe. HB 1116 makes no attempt to overturn any constitutional right. It is an attempt – and we believe an admirable one – to regulate one procedure used by the abortion industry. Removal of the LOM exception would render the bill stronger.

At this time, NHRTL neither endorses nor opposes the bill. We ask that the sponsors and committee take a look at amending the bill to remove the LOM exception. We believe that the spirit of the legislation could only be strengthened by such a move.

FILE COPY

Dear New Hampshire Representative,

I'm writing to urge you to vote against HB 1116-FN, the so-called "partial-birth" abortion bill. "Partial-birth" is not a medical but a political term used by its opponents to elicit an emotional response. While people are naturally repelled by the thought of infanticide, this is not an anti-infanticide bill. The proposed legislation is extremely vague and would deny the rights of women by prohibiting a procedure that is sometimes warranted. Women should be allowed to decide, with the advice of their physicians, whether or not to undergo dilate and extract abortion procedures.
Dilate and extract (D&X) procedures may be warranted under the following circumstances:

1) when the fetus is dead
2) when the fetus is alive, but continued pregnancy would represent a risk to the health of the mother
3) when the fetus is seriously malformed

My feelings on this subject are based largely on my own personal experience.
Last year during my fourth month of pregnancy, doctors determined that a large fibroid tumor was interfering with the normal development of the fetus. Through sonograms, we could see that the fetus was pinned beneath the tumor and that the fetus was unable to extract itself. My Ob advised me that this situation could have resulted in deformities and my husband and I were concerned about whether to proceed with the pregnancy. Shortly thereafter, another sonogram revealed fetal demise. My Ob sent me to Dartmouth-Hitchcock where I underwent induced labor. Following the delivery, the placenta was retained and bleeding continued, so they carried out a D&X procedure and gave me a blood transfusion.

I strongly feel that any woman should be able to choose whether or not to proceed with a pregnancy if it is determined that the child will be severely disabled. Moreover, I believe that D&X procedures are at times necessary to protect the health of the woman. Though HB 1116-FN would appear to allow doctors to make exceptions in cases where the women's health is threatened, I am doubtful that doctors will feel free to do so. Whose burden will it be to demonstrate that there was a threat to the woman's health? Will the doctor's decision whether to proceed with a D&X be influenced by the burden of proving that the threat to the woman's health was sufficiently severe? HB 1116-FN is so vague that it may, in effect, deny women both their right to appropriate medical care and their right to terminate a pregnancy. I hope that you will vote against this legislation and urge your colleagues to do likewise.

Sincerely,

Sheryl Shirley, Ph.D.

Sheryl Shirley, Ph. D.
Assistant Professor
Plymouth State College
Plymouth, NH 03264

TESTIMONY IN SUPPORT OF H. B. 1116 TO BAN PARTIAL BIRTH ABORTION
IN HEARING BEFORE THE NEW HAMPSHIRE HOUSE JUDICIARY COMMITTEE

MILDRED F. JEFFERSON, M. D.
President, Right To Life Crusade, Inc.
Past President, National Right To Life Committee, Inc.
Formerly, Assistant Clinical Professor of Surgery,
Boston University School of Medicine

FILE COPY

15 February 2000

HONORABLE MEMBERS OF THE COMMITTEE:

Thank you for considering the following points:

I. IDENTIFICATION

Technical Name: DILATATION AND EXTRACTION, INTACT (D&E, INTACT or D&X). Known by opponents of the procedure as " D&X, DILATATION AND EXTERMINATION".

II. INDICATION

ONE ONLY: TO GUARANTEE THAT THE PREGNANCY ENDS WITH A DEAD BABY.

III. MISREPRESENTATIONS

A. Procedure done to protect the life, health and/or future fertility of the mother.

FACT: Obstettrical complications and emergencies that endanger the mother's life generally require speed to save that mother's life. This procedure takes place over 3-5 days, converts a normal delivery to a breech, then footling delivery thus jeopardizing the mother's life.

B. Pregnant women understand the procedure.

FACT: Women undergoing the procedure are not likely to be fully informed about what the operator will do to her or the baby. Few are fully informed of the risks of repeat local anesthesia or the added risk of antibiotics in the days prior to evacuating the uterus.Few are told about the possibility of calamitous or precipitous end to the delivery without time to reach medical supervision.

Who bothers about how the women feel if ever they learn that they have allowed a baby large enough for them to hold to be killed in the birth canal--- just inches away from escape?

****

P. O. BOX 935, BACK BAY ANNEX BOSTON, MA 02117-0935
(617) 342-7280

OB-GYN UNLIMITED
Professional Association
35 West Street
Concord, New Hampshire 03301-3596
Telephone (603) 224-0000

Gerald L. Hamilton, M.D.
Bobbie Terrill, A.R.N.P., RN-C
Christine F. Kuhlman, C.N.M.

FILE COPY

February 15, 2000

To: The NH House Judiciary Committee

From: Gerald L. Hamilton, MD, FACOG
OB-GYN Unlimited, P.A.
35 West Street
Concord, NH 03301-3596

Re: HB-1116-FN "Partial Birth Abortion"

I am a Board Certified OB-GYN who has practiced in Concord for the past 25 years. I Strongly oppose this bill and strongly recommend that it not be passed nor approved. My views are based upon the following.

1. I personally am opposed to ELECTIVE late 2nd trimester or even 3rd trimester pregnancy terminations. However, there are circumstances where a pregnant woman is diagnosed late in pregnancy by ultrasound or genetic studies that indicates a markedly abnormal pregnancy. Such pregnancies may be incompatible with life or so deformed or potentially so mentally deficient or challenged that they would be a burden to the family or society. I believe that a woman carrying such a pregnancy should not be forced to carry said pregnancy to term when a termination by dilatation and extraction and/or evacuation could shorten the mother's emotional suffering, anxiety and fear and allow her to recover sooner so she may again attempt a normal pregnancy.
2. I, as an obstetrician and gynecologist, feel strongly that the decision to terminate a defective pregnancy is not a legislative issue but it is an issue to be decided among the mother, her partner, and the referring and/or treating physician.
3. At the present time, I know of no one in the State of New Hampshire who performs such procedures in the first place. The potential need for justifiable, medically indicated, late pregnancy terminations should remain an option for the citizens of this "Live free or Die" State.
4. I have brought some sections from the 4th edition of Smith's Recognizable Pattern of Human Malformation edited by Kenneth L. Jones, MD, a Pediatric Professor of the California School of Medicine, San Diego, California to illustrate some of the potential malformation and genetic problems that fetuses can develop that might warrant serious consideration for pregnancy termination. These problems obviously are not common but they can occur and have occurred here in this State.

Respectfully Submitted,

Gerald L. Hamilton, MD, FACOG

BOB SMITH
NEW HAMPSHIRE

opinion@smith.senate.gov
http://www.senate.gov/~smith/

CHAIRMAN,
ENVIRONMENT AND PUBLIC WORKS

COMMITTEE ON ARMED SERVICES

COMMITTEE ON THE JUDICIARY

SELECT COMMITTEE ON ETHICS

United States Senate

WASHINGTON, DC 20510-2903

February 15, 2000

FILE COPY

Mrs. Phyllis Woods
717 Shore Drive
Laconia, NH 03246

Dear Phyllis and members of the Judiciary Committee:

I am writing today in support of H.B. 1116, a bill to ban the late term abortion procedure known as partial-birth abortion. I deeply regret that I could not personally attend this hearing, but this letter will serve as my passionate endorsement of this legislation.

The partial-birth abortion method is a horrible procedure where babies are mostly delivered, except for the head, and killed just inches from being born.

As many of you know, I have led the fight to ban this procedure in the United States Senate. I was the original sponsor of the partial birth abortion ban several years ago. Sadly, this legislation still has not been signed into law. However, I will keep fighting until this gruesome, cruel procedure is abolished. To be sure, all abortions are reprehensible to me and I am wholeheartedly against any medical procedure that deliberately takes the life of a helpless unborn child.

The already-flimsy case for partial-birth abortions was devastated by the admission by Dr. Ron Fitzsimmons, a leading spokesman for the abortion industry, that he "lied through [his] teeth" when he joined with other partial-birth abortion advocates to claim that the procedure is employed only rarely and only in cases of grave risk to the mother. The truth is, this procedure is performed thousands of times each year on perfectly healthy mothers carrying perfectly healthy babies. In fact, no one has pointed to a circumstance in which this procedure is needed to protect a woman's life, health or future fertility. Nevertheless, too many in Congress and in the media had bought into what Dr. Fitzsimmons candidly described as the abortion industry's "party line."

In addition, I have strong reason to be believe that there could be a link between the partial birth abortion technique and the sale of baby body parts for research. When you consider the other methods of abortion and how little salvageable tissue they leave for research, you could possibly conclude that the partial birth abortion method produces a mostly intact fetal cadaver suitable for fetal tissue research.

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I believe that more Americans are becoming increasingly convinced that the partial birth abortion procedure is wrong, regardless of their traditional stance on the abortion issue. In fact, thirty states have already passed legislation banning the partial birth abortion procedure. It is my hope and prayer that New Hampshire will become number thirty-one.

For these reasons and many more, I urge the members of this great body of leaders to pass H.B. 1116. This abortion procedure is an affront to thousands upon thousands of New Hampshire citizens, as well as millions of Americans nationwide.

Sincerely,



Bob Smith, U.S.S.

THE SELLING OF BABY BODY PARTS
A SUMMARY

FILE COPY

HOW BABY BODY PARTS MARKETING WORKS:

- **Baby body parts marketing occurs when the woman comes to a clinic for her abortion and may or may not sign a consent form to donate her dead baby to research. After her abortion, a wholesaler's middleman (or technician) dissects the baby (limbs, organs, etc) and then ships the parts (or transports them, if the end user is nearby) across the country to researchers, universities, and government agencies. A "site fee" is paid to the clinic by the wholesaler, and a "retrieval fee" is paid by the researcher to the wholesaler. Profits are being realized on the sale of dead baby body parts.**

ILLEGAL OR IMMORAL ASPECTS OF THE SALE OF BABY PARTS:

- **There are several illegal and immoral aspects of baby body parts marketing. Below is a brief description of these practices, with more explanation to follow.**

- **The first is that current law prohibits making a profit from the sale of aborted children for research purposes, and this is what is taking place. Secondly, live births are occurring at these clinics. It is the law of every state to make every medical effort to save the life of a baby that is born alive during an abortion, and there are witnesses who will attest to the fact that they have seen live births occur at some abortion clinics, with the baby then killed outright (drowning, stabbing, beating, etc.). Thirdly, our tax payer dollars are being used to fund Planned Parenthood and other government agencies involved with this practice. Fourthly, the baby body parts industry is not being honest about their business because women are not always given their consent form and the wholesalers are not forthright about how they ship the tissue, among other things. Finally, abortion procedures are sometimes being altered to obtain better tissue.**

- **PROFIT: It is legal to use fetal body parts derived from abortions for therapeutic research purposes. But it's against the law to profit from the sale. But that's exactly what is happening. Abortion clinics and wholesalers are using a loophole which says that the definition of valuable consideration does not include "reasonable payments associated with the transportation, implantation, processing, preservation, quality control, or storage of human fetal tissue."**

- **As long as the tissue is "donated" it's legal. But large amounts of cash is changing hands, which is prohibited by federal law.**

- LIVE BIRTHS: Live births are sometimes occurring at these clinics, and then these babies are killed and then immediately taken to the back room for dissection.

- Many of these order forms suggest that the baby be put on ice within ten minutes of exiting the womb. This is a situation in which a live birth is very likely.

- TAX-PAYER MONEY: Planned Parenthood, one of the abortion providers involved in this industry, receives federal tax-payer money. In 1996, Planned Parenthood received $158 million from the federal government.

- In addition, NIH- one of the end users of baby body parts- also receives taxpayer money.

- In addition, universities receive federal funding. In fact, there are some universities that receive federal funding specifically for fetal tissue research.

- NO CONSENT: Fourthly, women are sometimes not given their consent forms to donate their baby to research. One former abortion clinic director has stated that the women in his clinic were not always given a consent form. What is worse, women were scheduled to come in sometimes a few weeks later to have their abortions, in order to get more developed tissue.

- ALTERING PROCEDURE: Finally, abortion doctors are altering medical procedures so they can get the desired "specimen." The abortion industry is putting American women at risk by altering abortion procedures in order to maximize profit.

- There are several other disturbing aspects of this industry, including some women who are forced to abort after they have changed their minds in order to get their fetus for research, and mysterious "midnight abortions" performed on late term babies.

HEARINGS and LEGISLATION:

- On October 21st of last year, Senator Bob Smith introduced an amendment to the partial birth abortion bill which would have provided for disclosure and limitations with respect to the transference of human fetal tissue. This amendment provides a reasonable regulation to require the disclosure of any individual or company involved in the transfer of fetal tissue for research. The amendment failed 46-51 with two prolife voters absent (Mack and Gregg). The actual vote would have been 48-51.

- The amendment said that any entity that receives "human fetal tissue obtained as a

result of an induced abortion...shall file with the Secretary (HHS) a disclosure statement."

- The amendment also requires disclosure to shippers for any package "containing human fetal tissue" shipped.
- Also, contained is language to limit the payment of a site fee from the transferee entity to the abortionist to be "reasonable in terms of reimbursement for the actual real estate or facilities used by such entity."
- The amendment also disclosed several other aspects of the industry.
- We are planning a hearing on this practice in the very near future. Legislation addressing this disgraceful practice will be introduced following the hearing.

TO VIEW THE SENATOR'S SPEECH ON THIS TOPIC, CLICK ON OUR WEBSITE AND THEN TO FLOOR STATEMENTS

www.Senate.gov/~smith

Amendment

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the Landrieu amendment, add the following:

SEC. ___. TRANSFERENCE OF HUMAN FETAL TISSUE.

Section 498N of the Public Health Service Act (42 U.S.C. 289g-2) is amended—

(1) by redesignating subsections (c) and (d), as subsections (e) and (f), respectively; and

(2) by inserting after subsection (b) the following:

"(c) DISCLOSURE ON TRANSPLANTATION OF FETAL TISSUE.—

"(1) REQUIREMENT.—With respect to human fetal tissue that is obtained pursuant to an induced abortion, any entity that is to receive such fetal tissue for any purpose shall file with the Secretary a disclosure statement that meets the requirements of paragraph (2).

"(2) CONTENTS.—A disclosure statement meets the requirements of this paragraph if the statement contains—

"(A) a list (including the names, addresses, and telephone numbers) of each entity that has obtained possession of the human fetal tissue involved prior to its possession by the filing entity, including any entity used solely to transport the fetal tissue and the tracking number used to identify the packaging of such tissue;

"(B) a description of the use that is to be made of the fetal tissue involved by the filing entity and the end user (if known);

"(C) a description of the medical procedure that was used to terminate the fetus from which the fetal tissue involved was derived; and the gestational age of the fetus at the time of death.

"(D) a description of the medical procedure that was used to obtain the fetal tissue involved;

"(E) a description of the type of fetal tissue involved;

"(F) a description of the quantity of fetal tissue involved;

"(G) a description of the amount of money, or any other object of value, that is transferred as a result of the transference of the fetal tissue involved, including any fees received to transport such fetal tissue to the end user;

"(H) a description of any site fee that was paid by the filing entity to the facility at which the induced abortion with respect to the fetal tissue involved was performed, including the amount of such fee; and

"(I) any other information determined appropriate by the Secretary.

"(3) DISCLOSURE TO SHIPPERS.—Any entity that enters into a contract for the shipment of a package containing human fetal tissue described in paragraph (1) shall—

"(A) notify the shipping entity that the package to be shipped contains human fetal tissue;

"(B) prominently label the outer packaging so as to indicate that the package contains human fetal tissue;

"(C) ensure that the shipment is done in a manner that is acceptable for the transfer of biomedical material; and

"(D) ensure that a tracking number is provided for the package and disclosed as required under paragraph (2).

"(4) DEFINITION.—In this subsection, the term 'filing entity' means the entity that is filing the disclosure statement required under this subsection.

"(5) Nothing in this subsection shall permit the disclosure of—

"(A) the identity of any physician, health care professional, or individual involved in the provision of abortion services;

"(B) the identity of any woman who obtained an abortion; and

"(C) any information that could reasonably be used to determine the identity of individuals or entities mentioned in paragraphs (A) and (B).

"(6) Violation of this section shall be punishable by the fines of more more than $5,000 per incident.

"(d) LIMITATION ON SITE FEES.—A facility at which induced abortions are performed may not require the payment of any site fee by any entity to which human fetal tissue that is derived from such abortions is transferred unless the amount of such site fee is reasonable in terms of reimbursement for the actual real estate or facilities used by such entity.".

Mr. SMITH of New Hampshire. Mr. President, I yield the floor.

Mr. FITZGERALD addressed the Chair.

The PRESIDING OFFICER (Mr. SMITH of Oregon). The Senator from Illinois.

Mr. FITZGERALD. Mr. President, thank you for this opportunity to be heard.

Mr. President, listening to my distinguished colleague from California, Senator BOXER, I thought back to earlier this year. We had an issue on which we agreed; in fact, we have had a few this year. This isn't one of them, however.

But earlier this year, Senator BOXER was very concerned about the inhumane treatment of dolphins who are getting caught in tuna fishing nets. In fact, she spoke so eloquently on the cruel and inhumane treatment of dolphins that I distinctly remember during that debate, I called home to see how my family was doing, and my 7-year-old boy answered the phone, and he said to me: Daddy, I hope you're going to vote tonight to protect the dolphins. And boy, when I heard that, I really took a careful look at Senator BOXER's bill. I was inclined to support her already, but when I heard that from my son, and I started to focus on that debate, and the eloquence with which she spoke, I wound up voting with her to support and protect those dolphins.

Mrs. BOXER. Would my friend yield for a question so I have a chance to thank him for that support, and thank his son, and tell his son that I am going to fight just as hard to protect the life and health of his mother and all the moms of this country and to make sure we protect the children as well. Thank you.

Mr. FITZGERALD. I would like to encourage the Senator from California, and others in the Senate, to maybe think about the humanity issue here as we focus on the debate on partial-birth abortion.

Mr. President, I rise today as an original cosponsor of this bill, the Partial-Birth Abortion Ban Act of 1999. I would like to thank Senator SANTORUM for sponsoring it again and for his forceful and eloquent arguments on behalf of the innocent unborn.

description of amendment + vote

PART III of fax

This is a serious problem. Clearly, it is a big industry.

This amendment requires disclosure of certain information prior to the transfer of any of this fetal body tissue or parts in induced abortions. That is what it does. It is against the law to sell fetal tissue for research. It is against Federal law.

This amendment allows HHS to track these transfers to enforce current law. You can donate tissue, but you can't sell it. It is being sold. We need the sun to shine in on this industry to find out what is happening.

It protects the privacy of all women undergoing abortions and the doctors providing them.

But this is something that is occurring within the industry. It is a very elaborate network of abortion providers getting those body parts to a wholesaler who then in turn is selling those body parts to universities and other research institutions. It simply let's the light in. That is all it does.

The PRESIDING OFFICER. All time has expired. The question is on agreeing to amendment No. 2324. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative assistant called the roll.

Mr. NICKLES. I announce that the Senator from Rhode Island (Mr. CHAFEE), the Senator from Florida (Mr. MACK), and the Senator from New Hampshire (Mr. GREGG) are necessary absent.

The result was announced—yeas 46, nays 51, as follows:

[Rollcall Vote No. 338 Leg.]

VOTE

YEAS—46

Abraham	Enzi	McCain
Allard	Fitzgerald	McConnell
Ashcroft	Frist	Murkowski
Bennett	Gorton	Nickles
Bond	Gramm	Roberts
Breaux	Grams	Santorum
Brownback	Grassley	Sessions
Bunning	Hagel	Shelby
Burns	Hatch	Smith (NH)
Campbell	Helms	Smith (OR)
Cochran	Hutchinson	Thomas
Coverdell	Hutchison	Thompson
Craig	Inhofe	Thurmond
Crapo	Kyl	Voinovich
DeWine	Lott	
Domenici	Lugar	

NAYS—51

Akaka	Feinstein	Mikulski
Baucus	Graham	Moynihan
Bayh	Harkin	Murray
Biden	Hollings	Reed
Bingaman	Inouye	Reid
Boxer	Jeffords	Robb
Bryan	Johnson	Rockefeller
Byrd	Kennedy	Roth
Cleland	Kerrey	Sarbanes
Collins	Kerry	Schumer
Conrad	Kohl	Snowe
Daschle	Landrieu	Specter
Dodd	Lautenberg	Stevens
Dorgan	Leahy	Torricelli
Durbin	Levin	Warner
Edwards	Lieberman	Wellstone
Feingold	Lincoln	Wyden

NOT VOTING—3

Chafee	Gregg	Mack

The amendment (No. 2324) was rejected.

Mr. LOTT. Mr. President, I move to reconsider the vote.

Mrs. BOXER. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. LOTT. Mr. President, I ask unanimous consent that the remaining votes in this series be limited in length to 10 minutes each.

The PRESIDING OFFICER (Mr. BENNETT). Without objection, it is so ordered.

AMENDMENT NO. 2323, AS MODIFIED

The PRESIDING OFFICER. There are 3 minutes equally divided. Who yields time?

Mrs. BOXER. Mr. President, as I understand the unanimous consent agreement, Senator LANDRIEU will have 1½ minutes and the other side will have 1½ minutes on her amendment, which I strongly support.

The PRESIDING OFFICER. That is correct.

Mrs. BOXER. Senator LANDRIEU has 1½ minutes.

The PRESIDING OFFICER. The Senator from Louisiana.

Ms. LANDRIEU. I thank the Chair. Mr. President, we have been debating a very contentious and emotional issue for many, many hours now. This debate will perhaps go on for some years to come as we try to resolve our many differences. It is a very tough issue for many families and for policymakers all over our Nation.

This amendment is an attempt to help because whether you are for or against, pro-life or pro-choice, or somewhere in the middle, we can say today it is the sense of this Congress that we want to help all families who have children with birth defects or special needs, regardless of their circumstances.

It is a very tough situation when families, even with a wanted pregnancy, have to sometimes make a very tough decision that could result in their financial ruin. We should step up to the plate, and that is what this amendment does.

It simply says it is the sense of the Senate that many families struggle with very tough decisions and that we should fully cover all expenses related to educational, medical, and respite care requirements of families with special-needs children.

I commend this to my colleagues and ask for their support.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I support the amendment, and I yield back the remainder of my time.

The PRESIDING OFFICER. All time has been yielded back. The question is on agreeing to amendment No. 2323, as modified. The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from Florida (Mr. MACK), the Senator from Rhode Island (Mr. CHAFEE), and the Senator from New Hampshire (Mr. GREGG) are necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 46, nays 51, as follows:

[Rollcall Vote No. 339 Leg.]

YEAS—46

Abraham	Harkin	Murkowski
Akaka	Hatch	Murray
Baucus	Hollings	Reed
Biden	Hutchinson	Reid
Boxer	Jeffords	Santorum
Breaux	Kennedy	Sarbanes
Bryan	Kohl	Schumer
Cleland	Landrieu	Smith (OR)
Conrad	Lautenberg	Snowe
Daschle	Leahy	Specter
DeWine	Levin	Torricelli
Dodd	Lieberman	Voinovich
Dorgan	Lincoln	Wellstone
Durbin	Lugar	Wyden
Feingold	Mikulski	
Feinstein	Moynihan	

NAYS—51

Allard	Edwards	Kyl
Ashcroft	Enzi	Lott
Bayh	Fitzgerald	McCain
Bennett	Frist	McConnell
Bingaman	Gorton	Nickles
Bond	Graham	Robb
Brownback	Gramm	Roberts
Bunning	Grams	Rockefeller
Burns	Grassley	Roth
Byrd	Hagel	Sessions
Campbell	Helms	Shelby
Cochran	Hutchinson	Smith (NH)
Collins	Inhofe	Stevens
Coverdell	Inouye	Thomas
Craig	Johnson	Thompson
Crapo	Kerrey	Thurmond
Domenici	Kerry	Warner

NOT VOTING—3

Chafee	Gregg	Mack

The amendment (No. 2323), as modified, was rejected.

The PRESIDING OFFICER. The question is on the engrossment and the third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

The PRESIDING OFFICER. Under the previous order, there are 3 minutes equally divided.

The Senator from California.

Mr. KYL. Mr. President, the arguments against the Partial-Birth Abortion Act keep changing. During previous consideration, for example, we heard from proponents of the procedure that it was used in only rare and tragic cases, so it would be wrong to ban it. Here is how the Planned Parenthood Federation of America characterized partial-birth abortion in a November 1, 1995 news release: "The procedure, dilation and extraction (D&X), is extremely rare and done only in cases when the woman's life is in danger or in cases of extreme fetal abnormality." Planned Parenthood was not the only group to make such sweeping statements at the time.

But it did not take long for the story to unravel. On February 26, 1997, the New York Times reported that Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, admitted he "lied in earlier statements when he said [partial-birth abortion] is rare and performed primarily to save the lives or fertility of women bearing severely malformed babies." According to the Times, "He

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Pancreas(> 8 weeks)		$75
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Thymus(> 8 weeks)		$75
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Mesentary(≤ 8weeks)		$125
Mesentary(> 8 weeks)		$100
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Kidney-with/without adrenal(> 8 weeks)		$100
Limbs(at least 2)		$150
Brain(≤ 8weeks)	*30% discount if significantly fragmented*	$999
Brain(> 8 weeks)	*30% discount if significantly fragmented*	$150
Pitutary Gland(> 8 weeks)		$300
Bone Marrow(≤ 8weeks)		$350
Bone Marrow(> 8 weeks)		$250
Ears(≤ 8weeks)		$75
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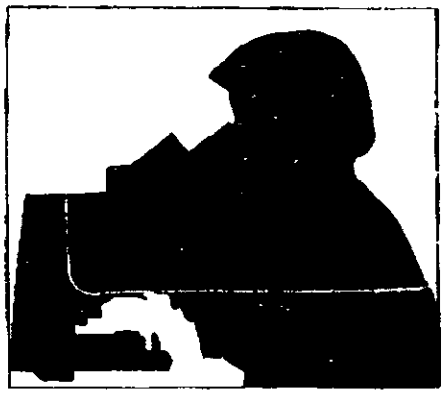
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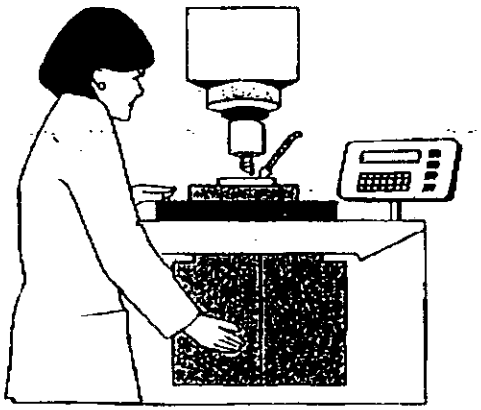


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FAX: 301 496-8396 301-496-5093 → secretary, leave msg 1/95
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Principal Investigator: Neal Young, M.D., Hematology Branch Chief

Contact Person: Daniel E. Dunn [home phone (e.g. Saturday morning): 301 215-9298]

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Request expires: indefinite

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Tissue desired:

1. fetal tibia and/or femur; spleen or thymus or liver
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   quantity: 2-4 bones & either spleen (preferably) or thymus or liver (sub-optimal)
   receipt within 24 hours post-mortem (i.e. cells need to remain viable)
   preparation: standard (i.e. in DMEM or RPMI with antibiotics on wet ice); obtained aseptically

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   gestational week 16-24
   quantity: 1
   receipt within 24 hours post-mortem
   preparation: standard; obtained aseptically

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4-92

HIV 2

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attn: Marjorie Sullivan

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Addt'l. Contacts: (301) 496-1124 or x 0310
Fax: (301) 402-0070

Constraints: 18-24 weeks gestation: No history of Aids, ARC, hepatitis, prostitution, I.V. drug abuse, hemophilia in father, no sepsis or jaundice.

Procedure: Dissect fetal liver and thymus and occasional lymph node from fetal cadaver within 10 min WTT and ship within 12 hrs. of preparation. Perform screen for HIV, Hep B, and Hep C. Need at least 3/4 of thymus and 1 lobe of liver. Place fresh in media:RPMI with 10% FCS, 1% pen-strep, 1% L-glutamine, 1% Hepes, 1% superoxide.

Shipping: 5) **Ship on wet ice.**
6) **Ship next day. Federal Express**

3/93 → No Abnormal Donors

4/93 → All from Same donor

Confidential
Protocol

Weinberg
(lung)

Dr. Weinberg, Adriana

Mailing Address:
Dr. Adriana Weinberg
Diagnostic Virology
4200 E. 9th Ave. C-227
Denver CO 80220

Shipping Address:
Dr. Adriana Weinberg
Diagnostic Virology, UCHSC
4200 E. 9th Ave. Rm MS 1632
Denver CO 80220

Phone: Dr. Adriana Weinberg **DAY: (303)-270-8312**
Night: 303-890-6818

Add'l Contact Dr. Helen Masters

Fax#(303)-270-6955

Tissue: **Fetal lung, 1 or both from same donor 12-16 weeks.**

Preservation: **Fresh, media**

Gestation: **12-16**

Shipping: **Fresh, media / Wet ICE.**

via: Fed ex, acct# 1904-506305.

Constraints:
No known abnormalities

Procedure: 1) Obtain tissue under "sterile" or "clean" conditions.

Frequency: 1) **Prefers weekly shipments, Tuesday.**

Tissue Use: Diagnostic Virology, human pathogens, specializing in Pediatric Infectious diseases.

PLEASE SEND LIST OF CURRENT FROZEN TISSUES.

Confidential

Tissue Request week of 11/17/97 500 Series

TRI. Tissue	Pres	Researcher	Instructions
1-2nc Liver, ABNL	FZN	Mahoney	5-24(+)whl/Frg
1-2nc BLOOD	FZN	Mahoney	FZ use foil or 50cc tubes, 5-24(+) concentrate 10-17
1-2nd Blood can be visceral/CORD/cardiac, please document which & can be "sopped" w/filt			NO FILTER PAPER/only foil if neccessary, prefer tube
1-2nc liver, FRESH	FRES	Mahoney	#1 FRESH 10-15 AMAPweeks Mon thru Thurs Proc.
1-2nc liver, FRESH	FRES	Mahoney	2/wk #1 FRESH 18-19 weeks Mon thru Thurs Proc. Mahoney: don't fill tube w/media above 45ml line
1-2nc liver, FZN	FZ	Mahoney	#2 FZN 10-13 /FRIDAYS / SATURDAYS
1-2nc ChorVilli	FRE	Mahoney	551 only: FRESH 10-20 wks Mon-Thurs

Please cut Mahoney lg livers into 3-4 sections! Use 50cc conicals. Thanks

2nd Miscellaneous

~~2nd pancreas~~	~~fresh Howell~~		~~ANY GESTATIONAL AGE~~
1s2n Trachea	FIX	Carson	13,14,15 only wks only fix on provided soln
1s2n eyes	~~Fresh~~	~~Spee~~	20+ weeks eyes (must be 20(+) — will talk to
1s2n BRAIN	fres	~~Sheen~~	WEDS 1 donor brain 16(+) wks, intact hemishere
1s2n kidfeney	fresh	Wilson	13-16 wk kidneys 2-6 kidneys: 1 ship per week
1s2n LUNG	~~Pres~~	~~Barker~~	1 lung 20(+) NO YOUNGER
1s2n lung	fresh	Ballard	6-11 wks only lung, 1 donors within that range
1s2n lung	~~Fres~~	~~Holland~~	1 lungs:18-24 (prefer 1 to be 23-24)

2nd Liver, Thymus, Limb combos.

2nd t Lim,Liv,or Thy	Fres	Systemix	20+ (call) 'been taking more than 1 donor
2nd legs	fresh	Shih	19-24 wks legs 1 pair NO DIGOXIN DONORS
~~2nd THYMUS~~	~~fresh~~	~~Shih~~	~~18-24 wks thymus~~
~~2nd liver~~	~~fresh~~	~~Shih~~	~~18-24 wks liver~~
2nd	fresh	Kerr	Thursdays 1 Thymus 17+, 1 Liver 17-22 same donor
~~2nd legs~~	~~fresh~~	~~Soles~~	~~19(+) intact arm/legs 1-4 donor NOT need paired~~
2nd legs	fresh	DODGE	2-4 legs intact 19+, intact as poss. prefer no dig
2nd Thym	fresh	SU	1-2 thymus 20 wk(+) (19(+)ok
2nd Thym	fresh	Scadden	1-2 thymus 18(+): need foot pad measurement
2nd Thym/Liver	fresh	Aldrovandi	1 thymus/liver sets prefer 1 each day
~~2nd Spleen~~	~~fresh~~	~~Zanjani~~	~~1 THURSDAY PREFER 18(+) male or fem.~~
~~2nd Liver/Thymus~~	~~fresh~~	~~Zanjani~~	~~1 THURSDAY liver/thymus set 18(+) male or female~~

National Institutes of Health Revitalization Act of 1993 part 1 of 4. (Enrolled Bill (Sent to the President))

PART II--RESEARCH ON TRANSPLANTATION OF FETAL TISSUE

SEC. 111. ESTABLISHMENT OF AUTHORITIES.

Part G of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by inserting after section 498 the following section:

`RESEARCH ON TRANSPLANTATION OF FETAL TISSUE

`Sec. 498A. (a) **Establishment of Program**:

`(1) **In general**: The Secretary may conduct or support research on the transplantation of human **fetal** tissue for therapeutic purposes.

`(2) **Source of tissue**: Human **fetal** tissue may be used in research carried out under paragraph (1) regardless of whether the tissue is obtained pursuant to a spontaneous or induced abortion or pursuant to a stillbirth.

`(b) **Informed Consent of Donor**:

`(1) **In general**: In research carried out under subsection (a), human **fetal** tissue may be used only if the woman providing the tissue makes a statement, made in writing and signed by the woman, declaring that--

`(A) the woman donates the **fetal** tissue for use in research described in subsection (a);

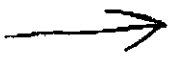
`(B) the donation is made without any restriction regarding the identity of individuals who may be the recipients of transplantations of the tissue; and

`(C) the woman has not been informed of the identity of any such individuals.

`(2) **Additional statement**: In research carried out under subsection (a), human **fetal** tissue may be used only if the attending physician with respect to obtaining the tissue from the woman involved makes a statement, made in writing and signed by the physician, declaring that--

`(A) in the case of tissue obtained pursuant to an induced abortion--`

`(i) the consent of the woman for the abortion was obtained prior to requesting or obtaining consent for a donation of the tissue for use in such research;



`(ii) no alteration of the timing, method, or procedures used to terminate the pregnancy was made solely for the purposes of obtaining the tissue; and

`(iii) the abortion was performed in accordance with applicable State law;

`(B) the tissue has been donated by the woman in accordance with paragraph (1); and

`(C) full disclosure has been provided to the woman with regard to--

`(i) such physician's interest, if any, in the research to be conducted with the tissue; and

`(ii) any known medical risks to the woman or risks to her privacy that might be associated with the donation of the tissue and that are in addition to risks of such type that are associated with the woman's medical care.

`(c) **Informed Consent of Researcher and Donee**: In research carried out under subsection (a), human **fetal** tissue may be used only if the individual with the principal responsibility for conducting the research involved makes a statement, made in writing and signed by the individual, declaring that the individual--

`(1) is aware that--

`(A) the tissue is human **fetal** tissue;

`(B) the tissue may have been obtained pursuant to a spontaneous or induced abortion or pursuant to a stillbirth; and

`(C) the tissue was donated for research purposes;

`(2) has provided such information to other individuals with responsibilities regarding the research;

`(3) will require, prior to obtaining the consent of an individual to be a recipient of a transplantation of the tissue, written acknowledgment of receipt of such information by such recipient; and


Forward to part II of IV


Back to the Stop Fetal Tissue Research Main Index.

National Institutes of Health Revitalization Act of 1993 part 2 of 4. Enrolled Bill (Sent to the President)

`(4) has had no part in any decisions as to the timing, method, or procedures used to terminate the pregnancy made solely for the purposes of the research.

`(d) **Availability of Statements for Audit**:

`(1) **In general**: In research carried out under subsection (a), human **fetal** tissue may be used only if the head of the agency or other entity conducting the research involved certifies to the Secretary that the statements required under subsections (b)(2) and (c) will be available for audit by the Secretary.

`(2) **Confidentiality of audit**: Any audit conducted by the Secretary pursuant to paragraph (1) shall be conducted in a confidential manner to protect the privacy rights of the individuals and entities involved in such research, including such individuals and entities involved in the donation, transfer, receipt, or transplantation of human **fetal** tissue. With respect to any material or information obtained pursuant to such audit, the Secretary shall--

`(A) use such material or information only for the purposes of verifying compliance with the requirements of this section;

`(B) not disclose or publish such material or information, except where required by Federal law, in which case such material or information shall be coded in a manner such that the identities of such individuals and entities are protected; and

`(C) not maintain such material or information after completion of such audit, except where necessary for the purposes of such audit.

`(e) **Applicability of State and Local Law**:

`(1) **Research conducted by recipients of assistance**: The Secretary may not provide support for research under subsection (a) unless the applicant for the financial assistance involved agrees to conduct the research in accordance with applicable State law.

`(2) **Research conducted by secretary**: The Secretary may conduct research under subsection (a) only in accordance with applicable State and local law.

`(f) **Report:** The Secretary shall annually submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing the activities carried out under this section during the preceding fiscal year, including a description of whether and to what extent research under subsection (a) has been conducted in accordance with this section.

`(g) **Definition**: For purposes of this section, the term `human **fetal** tissue' means tissue or cells obtained from a dead human embryo or fetus after a spontaneous or induced abortion, or after a stillbirth.'.

SEC. 112. PURCHASE OF HUMAN FETAL TISSUE; SOLICITATION OR ACCEPTANCE OF TISSUE AS DIRECTED DONATION FOR USE IN TRANSPLANTATION.

Part G of title IV of the Public Health Service Act, as amended by section 111 of this Act, is amended by inserting after section 498A the following section:

`PROHIBITIONS REGARDING HUMAN FETAL TISSUE

`Sec. 498B. (a) **Purchase of Tissue**: It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human **fetal** tissue for valuable consideration if the transfer affects interstate commerce.

`(b) **Solicitation or Acceptance of Tissue as Directed Donation for Use in Transplantation**: It shall be unlawful for any person to solicit or knowingly acquire, receive, or accept a donation of human **fetal** tissue for the purpose of transplantation of such tissue into another person if the donation affects interstate commerce, the tissue will be or is obtained pursuant to an induced abortion, and--

`(1) the donation will be or is made pursuant to a promise to the donating individual that the donated tissue will be transplanted into a recipient specified by such individual;

 Forward to part III of IV.

 Back to part I of IV.

Click here to see the petition to stop this horror.

 Back to the Stop Fetal Tissue Research Main Index.

Nurse backed into corner by questioning

Other procedures don't provide ~~[illegible]~~ tissue that can be utilized

Saline
dissection ~~[illegible]~~

~~AMA~~

~~Coop~~
~~Novella~~

Some things are not acceptable in NH
Claim not tods in NH.

Cong. record
Smith + Santorum

1, 2 I dispute Dr. Goldners info.
AMA, Surgeon Gen., 50 K. illegal abortions pre Roe.

Comp. w/life
Fetus = child

Dr Fitzsimmons

Testimony in opposition to H.B. 1116 February 15, 2000

I am addressing the question of whether legislators should interfere with medical decisions. I ask you to imagine a situation where you or your husband is told by his doctor that he should have, let us say, a transurethrab resection, that you really need this procedure but that unfortunately it is illegal. The legislature has decided on the basis of very questionable evidence and biassed ethical reasoning that the procedure is immoral and that therefore you will have to do without it.

I am simply asking you to think how you would feel about being denied your choice.

Jane W Torrey
401 Main ST
Jaffrey 03452
532-4201

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6 Northway Circle #17
Dover, NH 03820-2441
(603) 742-7730

February 15, 2000

Mr. Chairman, Judiciary Committee Members, ladies & gentlemen:

My name is Frances Witcomb, from Dover, with evidence supporting HB 1116-FN and a compelling state interest in establishing a ban on partial-birth abortions (hereafter referred to as PBA's).

PBA's physically harm women, with deliberate breech-deliveries. Babies exhibit extreme pain, when surgical scissors puncture the base of their skulls, widen the wound, and then a powerful aspirator sucks out their brains. Would anyone treat a pet like that?

Dr. Martin Haskell personally admitted performing over 1,000 PBA's "routinely" for non-medical reasons, 80% of which were "purely elective." He wrote a paper in 1992, saying he uses only nitrous oxide (a general anesthetic too weak to neutralize the pain of a skin incision and too weak to anesthetize the baby if given to the mother at levels safe for her.)

Even when the mother is given general anesthesia, the baby receives only a harmless "very small percentage," of the mother's dose, according to Dr. Norig Ellison, president of the American Society of Anesthesiologists, in testimony before the U.S. Senate Judiciary Committee, on Nov. 17, 1995.

London research Professor Nicholas Fisk measured the amount of stress hormones released into the bloodstreams of fetuses between 19 and 34 weeks' gestational age, when necessary blood samples were drawn by needle puncture. (Centre for Fetal Care, Queen Charlotte and Chelsea Hospital)1.

As a control, the punctures were made in the umbilical vein, which has no sensory nerve endings, and through the abdominal wall. The same stress hormones released by adults who feel pain: **serumcortisol**, in the fetuses rose **183% above baseline**, and **beta-endorphin rose 590% above base-line.** "These levels are from **two to seven times** as high as those measured from premature infants, who undergo surgery under light anesthesia. In the control group, there was no hormonal surge in the fetus, "when the puncture was made at the painless umbilical vein site." 2 (Ibid)

Congressman Tom Coburn, an obstetrician who has delivered more than 3,000 babies, says "there is no medical need ever to do a PBA." Rep. Coburn describes the technique as "a method of cruelly killing an infant only for the convenience of the abortionist, so he can do it quicker, so he can do more." And since 1993, so he could make huge profits trafficking in baby body parts .

Please do the right thing; vote FOR HB 1116-FN. Thank you!

FAMILY NEWS FROM DR. JAMES DOBSON

May 1997

They Lied Through Their Teeth

It is now known that a massive campaign of deceit and distortion was launched last fall when Congress was attempting to ban the horrible procedure known as "partial-birth abortion" (PBA). People in high places, including the President of the United States, blatantly lied to the American people about this method of killing late term babies. Their claims were immoral and outrageous, including the assertions (1) that partial-birth abortion occurs very rarely, perhaps just a few times per year . . . (Congressman Tom Coburn, a physician who has delivered more than 3,000 babies, said that there may be 40,000 to 50,000 PBAs per year, but who knows. They don't have to be reported!)[1] (2) that the babies are anesthetized before their brains are sucked out; (3) that the babies are actually dead before PBA is performed; (4) that it is only done on tragically deformed or fatally ill "fetuses"; (5) that the procedure is only used when the woman's fertility is threatened; and (6) that it is only used to save the life of the mother, etc. Most people in the media, the medical community and the radical feminists knew very well that every one of these claims was untrue, but they proclaimed them so often that they began to sound valid. Frustrated pro-life leaders and physicians knew it too, but they were powerless to get out the truth.

Then, a remarkable thing happened. One of the abortion movement's own lobbyists, Ron Fitzsimmons, courageously reported having pangs of conscience. He admitted that the justifications for partial-birth abortion were untrue—and that he had "lied through [his] teeth" to Ted Koppel and the Nightline television crew. "It is a form of killing. You're ending a life." he said.[2] There was an audible gasp from newspeople, the abortionists and the liberal politicians as they realized their cover was blown. They were caught defending outright infanticide, which is tough to explain. Since then, most of them have grown understandably quiet about the procedure. Mr. Clinton, however, never missed a beat. He promptly held a news conference and reiterated his phony story[3]—which is like O.J. Simpson denying he wore Bruno Magli shoes.

This exercise in distortion is nothing new for the pro-abortion people, as we know. The movement has been characterized by deceit from the beginning. Sandra Cano was coerced by abortion advocates into the role of "Mary Doe" in the 1973 Supreme Court case of Doe v. Bolton. That case threw open the doors to abortion on demand. Now Mrs. Cano says, "I'm just now learning a lot of the details [of how they manipulated me], and I'm really

FROM: CENTER FOR BIO-ETHICAL RESEARCH, 1995

FastFacts: D&X Abortions

D&X ABORTIONS

1. Most of the babies killed by D&X abortion procedures are alive at the time of their partial birth (see also *National Right to Life News*, Nov. 30, 1995). In a 1993 interview with American Medical News, Dr. Martin Haskell admitted that approximately two-thirds of the babies are alive when he begins the "extraction" procedure.

2. The babies who are killed by these procedures are unaffected by the regional anesthesia given the mother and even when the mother is given general anesthesia the baby receives only a harmless, "very small percentage," of the mother's dose, according to Dr. Norig Ellison, president of the American Society of Anesthesiologists, in testimony given before the Senate Judiciary Committee on November, 17, 1995. These facts are important to rebut the false argument that anesthesia given the mother anesthetizes or even kills the baby before the start of this procedure which subjects the baby to extreme pain. Dr. Martin Haskell, a leading practitioner of this procedure, acknowledged in a 1992 clinical paper that he uses only nitrous oxide (a general anesthetic too weak to neutralize the pain of a skin incision when used alone and too weak to anesthetize the baby if given to the mother at levels safe for her) and a local anesthetic (which will not reach the baby in anything like a therapeutic dose). Stronger forms of general anesthesia which could anesthetize the fetus are seldom used for late-term abortions (see *Abortion Practice*, p. 303, Warren Hern, MD) and when given pregnant women for non-abortion related surgery, Dr. Ellison says they are harmless to the fetus.

3. The late Dr. James McMahon of Los Angeles, CA, a leading partial-birth abortionist, conceded that these procedures frequently are performed for reasons unrelated to the health of the mother or baby. He himself acknowledged that of 175 cases he associated with "maternal health indications," 22% were for maternal depression (a usually transient, generally treatable condition) and 16% were for conditions consistent with the birth of a normal child (e.g., sickle cell trait, prolapsed uterus, narrow pelvis, etc.).

4. The bill banning partial-birth abortions doesn't interfere with attempts to treat genuine diagnoses of conditions threatening to the mothers' life because it permits the use of the procedure if a doctor "reasonably believed" that a mother's life was in jeopardy and that no other form of medical intervention would suffice.

Further evidence that fetal pain exists emerged from a research study conducted last year at the Centre for Fetal Care at the renowned Queen Charlotte and Chelsea Hospital in London. Professor Nicholas Fisk and co-workers measured the amount of "stress hormones" released into the bloodstream when necessary blood specimens were drawn (by needle puncture) from fetuses between 19 and 34 weeks' gestational age (late second and early third trimester).

As a control, the punctures were made at two sites: either in the umbilical vein, which has no sensory nerve endings (and would be expected to be painless), or in a vein draining the liver, requiring a puncture through the abdominal wall, which is richly innervated with sensory nerves (and would be expected to be painful).

The release of stress hormones following the abdominal punctures was massive. The hormone beta-endorphin went up 590% above baseline. Serum cortisol, a stress hormone released by the adrenal gland, went up 183% above baseline. These levels are from two to seven times as high as those measured from premature infants who undergo surgery under light anaesthesia. These are the same stress hormones released by adults who feel pain.

By contrast, when the puncture was made at the painless umbilical vein site, there was no such hormonal surge.

The inference is clear. By every measure available, the fetus of 20 weeks of age and up can detect what scientists delicately call "nociceptive" sensation, i.e., pain.

ROBERTS-SC PHOCOMELIA SYNDROME

(Pseudothalidomide Syndrome, Hypomelia-Hypotrichosis-Facial Hemangioma Syndrome)

Hypomelia, Midfacial Defect, Severe Growth Deficiency

FILE COPY

This disorder was initially described by Roberts in 1919 and more recently by Appelt et al. Freeman et al. reported five cases and reviewed the features in the 17 previously recognized patients. The cases reported by Herrmann et al. as "pseudothalidomide or SC syndrome" and the case reported by Hall and Greenberg as "hypomelia-hypotrichosis-facial hemangioma syndrome" may be examples of this disorder, although this question is not fully resolved.

ABNORMALITIES

Performance. Microbrachycephaly. Severe mental defect in some and borderline to mild mental deficiency in others.

Growth. Profound growth deficiency of prenatal onset. Birth weight 1.5 to 2.2 kg and birth length frequently less than 40 cm.

Facial. Cleft lip with or without cleft palate and prominent premaxilla, hypertelorism, midfacial capillary hemangioma, thin nares, shallow orbits and prominent eyes with bluish sclerae, micrognathia. Malformed ears with hypoplastic lobules.

Hair. Sparse, may be silvery-blond in some survivors.

Limbs. Hypomelia, more severe in upper limbs, varying from phocomelia to lesser degrees of limb reduction, often including hypoplasia or absence of radii, first metacarpals and thumbs, fibulae, ulnae, carpals, and tibiae; syndactyly, fifth finger clinodactyly, and talipes deformity. Incomplete development of dermal ridges.

Genitalia. Cryptorchidism. Phallus may *appear* relatively large in relation to body size.

OCCASIONAL ABNORMALITIES. Frontal encephalocele, hydrocephalus, microphthalmia, corneal clouding, cataract, lid coloboma, cranial nerve paralysis, short neck, cardiac anomaly (atrial septal defect), renal anomaly (polycystic and/or horseshoe kidney). Bicornuate uterus. Polyhydramnios. Thrombocytopenia. Hypospadius.

NATURAL HISTORY. Most individuals born at term with birth length less than 37 cm and severe defects in midfacial and limb development have been stillborn or have died in early infancy. The survivors have had marked growth deficiency, and some have had severe mental deficiency as well. Birth length greater than 37 cm, less severe limb defects, absence of cleft palate, and presence of thin nares have been associated with a better prognosis.

ETIOLOGY. Autosomal recessive.

COMMENT. Approximately 50 per cent of tested individuals have had premature separation of centromeric heterochromatin of many chromosomes. Included have been a number of patients exhibiting phenotypic overlap between the Roberts syndrome and the SC phocomelia syndrome, suggesting that the two are either allelic or represent variable severity of the same genetic condition.





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Freeman, M. V. R., et al.: Roberts syndrome. Clin. Genet., *5*:1, 1974.

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A

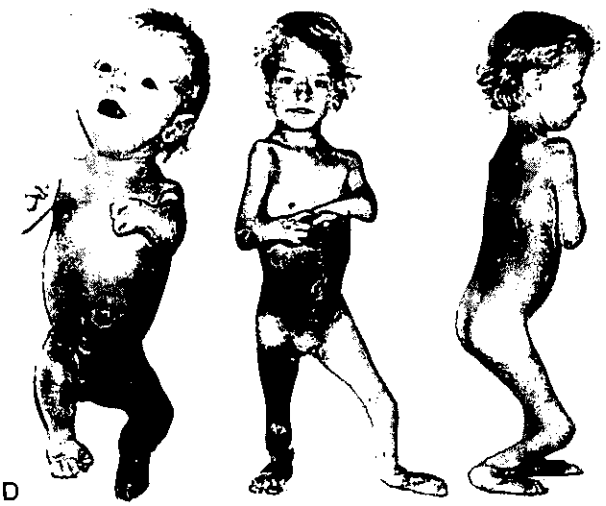


B

Roberts-SC phocomelia syndrome. *A*, Severely affected infant female at autopsy and, *B*, her severely growth deficient and mentally deficient ten year old brother. (From Freeman, M. V., et al.: Clin. Genet., *5*:1, 1974.)



C, Eight year old severely mentally deficient boy with silvery-blond hair and a height age of three and one-half years. (From S. Jurenka, St. Amant Wards, Winnipeg, Canada.) *D*, Same patient, as an infant and at eight years of age. Note capillary hemangioma on forehead in infancy and sparse scalp hair as a child. (From Hall, B. D., and Greenberg, M. H.: Am. J. Dis. Child., *123*:602, 1972.)



D

OLIGOHYDRAMNIOS SEQUENCE

(Potter Syndrome)

Primary Defect—Development of Oligohydramnios

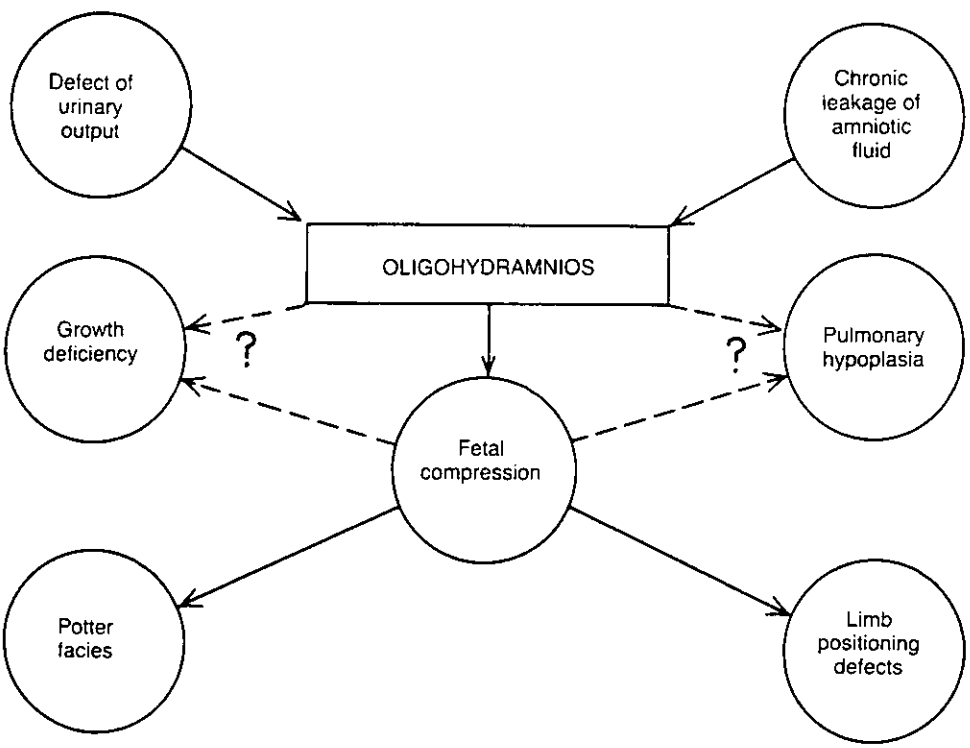
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Renal agenesis, which must occur prior to 31 days of fetal development, will secondarily limit the amount of amniotic fluid and thereby result in further anomalies during prenatal life. The renal agenesis may be the only primary defect, or it may be one feature of a more extensive caudal axis anomaly. Other types of urinary tract defects such as polycystic kidneys or obstruction may also be responsible for oligohydramnios and its consequences. Another cause is chronic leakage of amniotic fluid from the time of midgestation. Regardless of the cause, the secondary effects of oligohydramnios are the same and would appear to be the result of compression of the fetus, as depicted below. The cause of death is respiratory insufficiency, with a lack of the late development of alveolar sacs. A similar lag in late development of the lung is observed with diaphragmatic hernia or asphyxiating thoracic dystropy. In both of these latter situations, there is external compression of the developing lung; this is considered the most likely cause in oligohydramnios, as shown in the figure.

When the oligohydramnios is secondary to agenesis or dysgenesis of both kidneys or agenesis of one kidney and dysgenesis of the other, renal ultrasonagraphic evaluation of both parents and siblings of affected infants should be performed, since 9 per cent of first degree relatives had asymptomatic renal malformations in a study by Roodhooft et al.

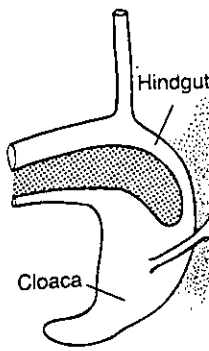
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Depiction of the origin and effects of oligohydramnios. The oligohydramnios sequence is implied to be secondary to fetal compression.

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Med. J., *1*:841, 1960.
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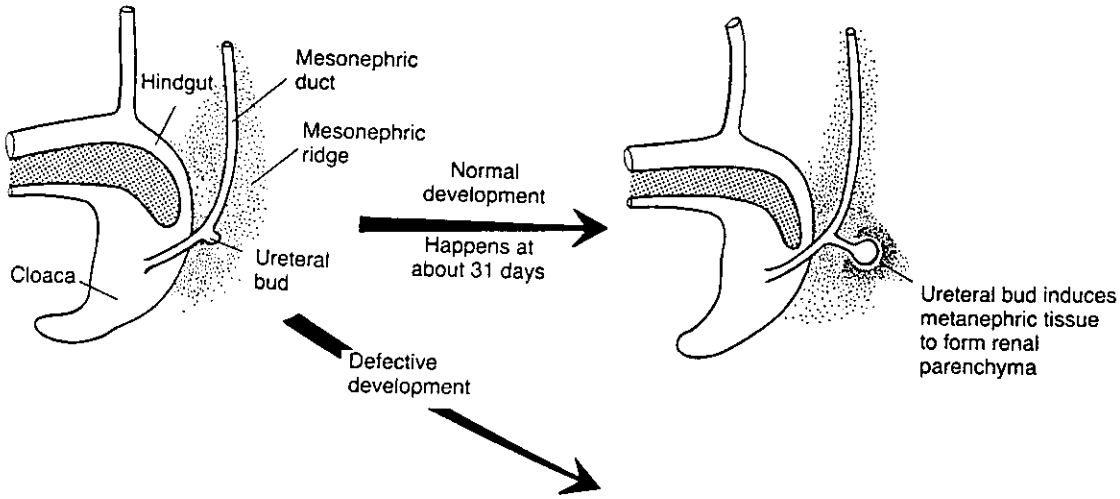




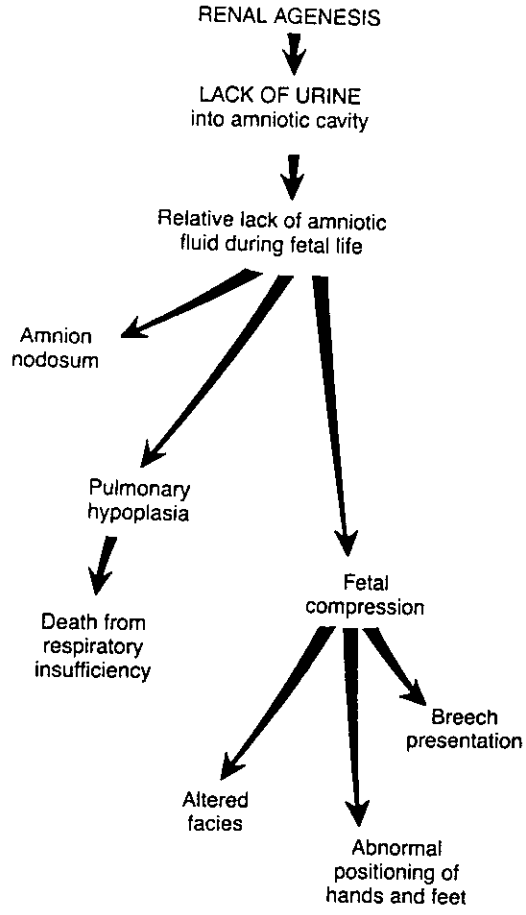
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The consequences of renal agenesis.

MENINGOMYELOCELE, ANENCEPHALY, INIENCEPHALY SEQUENCES

FILE COPY

Primary Defect—In Neural Tube Closure

The initiating malformation appears to be a defect in closure of the neural groove to form an intact neural tube, which is normally completely fused by 28 days. Anencephaly represents a defect in closure at the anterior portion of the neural groove. The secondary consequences are as follows: (1) the unfused forebrain develops partially and then tends to degenerate; (2) the calvarium is incompletely developed; and (3) the facial features and auricular development are secondarily altered to a variable degree, including cleft palate, frequent abnormality of the cervical vertebrae, and occasional incomplete development of the anterior pituitary.

Defects of closure at the mid- or caudal neural groove can give rise to meningomyelocele and other secondary defects, as depicted. The early form of one such lesion is illustrated below.

Defects of closure in the cervical and upper thoracic region can culminate in the iniencephaly sequence, in which secondary features may include retroflexion of the upper spine with short neck and trunk, cervical and upper thoracic vertebral anomalies, defects of thoracic cage, anterior spina bifida, diaphragmatic defects with or without hernia, and hypoplasia of lung and/or heart.

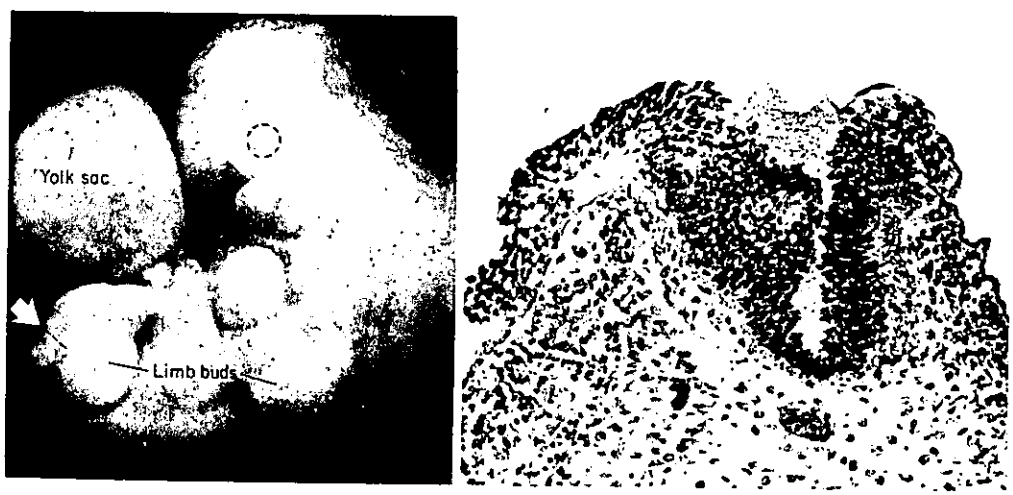
There appear to be multiple etiologies for defects of neural tube closure, including early amnion rupture and possibly hyperthermia. Most commonly no mode of etiology is appreciated, and the recurrence risk is about 4 per cent for parents who have had one affected child. Liberation of alpha fetoprotein into the amniotic fluid from the anencephaly or meningomyelocele that is not skin-covered allows for early amniocentesis detection, which may be augmented by sonography and/or radiography.

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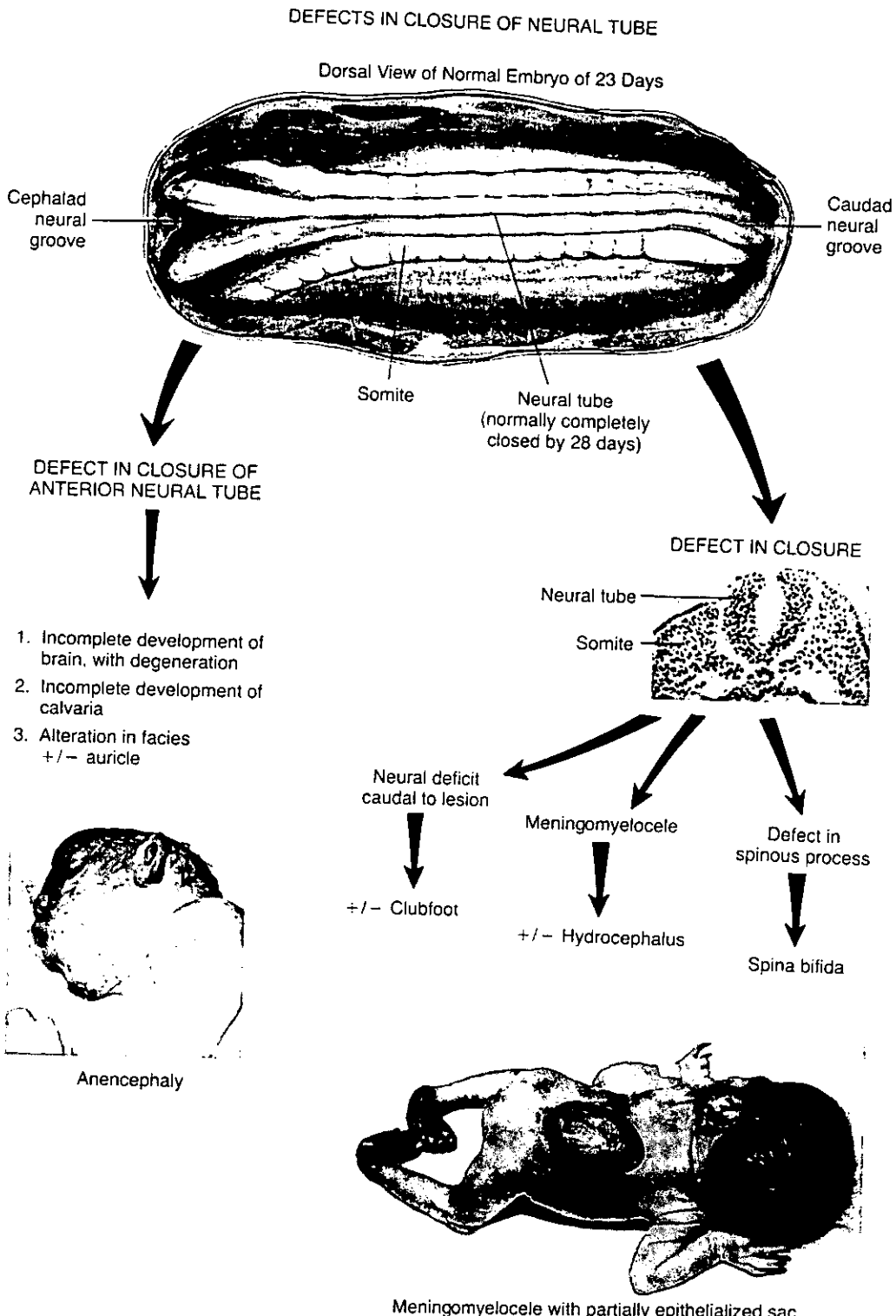
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Meningomyelocele, anencephaly, iniencephaly sequences. Otherwise normal 28 day embryo with incomplete closure of the posterior neural groove (arrow), which shows aberrant growth of cells to the side in a transverse section (right). Had this embryo survived, it would presumably have developed a meningomyelocele. (From Lemire, R.: Anat. Rec., *152*:9, 1965.)



Developmental pathogenesis of anencephaly and meningomyelocele.

OSTEOGENESIS IMPERFECTA SYNDROME, TYPE II

(Osteogenesis Imperfecta Congenita, Vrolik Disease)

FILE COPY

Short Broad Long Bones, Multiple Fractures, Blue Sclerae

A perinatally lethal variety of osteogenesis imperfecta, this disorder is characterized by short limbs, short, broad long bones, radiologic evidence of severe osseous fragility and defective ossification. Based on subtle differences in radiographic features, Sillence et al. recently have subdivided this disorder into three groups. Group A is characterized by short, broad crumpled femora and continuously beaded ribs; group B by short, broad crumpled femora but normal ribs or ribs with incomplete beading; and group C by long, thin, inadequately modeled, rectangular long bones with multiple fractures and thin beaded ribs.

ABNORMALITIES

Growth. Prenatal short-limbed growth deficiency.

Craniofacial. Poorly mineralized, soft calvarium with large fontanels and multiple wormian bones. Deep blue sclerae, shallow orbits, small nose, low nasal bridge.

Limbs. Short, thick, ribbon-like, poorly mineralized long bones with multiple fractures and callus formation, especially in lower limbs.

Other. Flattened vertebrae, hypotonia, inguinal hernias, variable hydrocephalus. Hydrops.

NATURAL HISTORY. These patients usually are stillborn or die in early infancy of respiratory failure.

ETIOLOGY. Recent biochemical studies by Dr. Peter Byers at the University of Washington have now documented synthesis of both normal and abnormal type I collagen molecules in approximately 90 per cent of affected infants studied. This suggests that the majority of cases of type II osteogenesis imperfecta are the result of sporadic mutation of an autosomal dominant gene as opposed to autosomal recessive inheritance as had previously been suggested. For these cases, a recurrence risk of about 6 per cent has been observed and is felt to be the result of a parental germ cell mutation. However, biochemical evidence of autosomal recessive inheritance has been documented in a small number of affected infants. In those few cases, recurrence risk is 25 per cent.

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Osteogenesis im
Young infant of
Baird, University
ver.)







Osteogenesis imperfecta syndrome, type II. Young infant of normal parents. (Courtesy of P. Baird, University of British Columbia, Vancouver.)

LEROY I-CELL SYNDROME

(Mucolipidosis II)

FILE COPY

Early Alveolar Ridge Hypertrophy, Joint Limitation, Thick Tight Skin in Early Infancy

This disorder was recognized by Leroy and DeMars when they noted unusual cytoplasmic inclusions in the cultured fibroblasts of a girl who had been considered to have the Hurler syndrome despite the fact that she did not have cloudy corneas or excessive acid mucopolysaccharide in the urine.

ABNORMALITIES

Growth. Birth weight less than 5½ pounds. Marked growth deficiency with lack of linear growth after infancy.

Performance. Slow progress from early infancy, reaching a plateau at approximately 18 months with no apparent deterioration subsequently.

Craniofacial. High, narrow forehead. Thin eyebrows, puffy eyelids, inner epicanthal folds, clear or faintly hazy corneas. Low nasal bridge, anteverted nostrils. Long philtrum.

Mouth. Progressive hypertrophy of alveolar ridges.

Skeletal and Joints. Moderate joint limitation in flexion, especially of hips. Dorsolumbar kyphosis. Broadening of wrists and fingers. Roentgenographic findings in the later phases similar to those seen in children with the Hurler syndrome. In early infancy, periosteal new bone formation leading to a "cloaking" of the long tubular bones is best seen in femora and humeri.

Skin. Thick, relatively tight skin during early infancy that becomes less tight as the patients become older. Cavernous hemangiomata.

Other. Minimal hepatomegaly. Diastasis recti. Inguinal hernia (one case). Systolic murmurs after one year of age.

Note. No metachromatic granules noted in leukocytes. Urinary mucopolysaccharides normal to mildly increased.

NATURAL HISTORY. By 18 months of age, most patients can sit with support, and some stand with support. However, severe progressive retardation of growth and development occur. Recurrent bouts of bronchitis, pneumonia, and otitis media have been frequent during early childhood. Death, which usually occurs by five years of age, is often associated with congestive heart failure.

ETIOLOGY. Autosomal recessive. The consistent finding is a deficiency of lysosomal enzymes within cultured skin fibroblasts and an increase in lysosomal enzymes in plasma, cerebrospinal fluid, and urine. Cultured fibroblasts contain an abundance of mucopolysaccharide and glycolipid material within lysosomal structures. It is currently believed that in I-cell disease the lysosomal enzymes are missing a common recognition marker that directs them into lysosomes. This recognition marker is believed to be 6-phosphomannose. A marked increase in serum activity of beta-hexosaminidase, iduronate sulfatase, and arylsulfatase A is seen in this disorder as well as in mucolipidosis III (pseudo-Hurler polydystrophy).

Heterozygotes cannot be detected. Prenatal diagnosis can be established on the basis of cultured amniotic fluid cells.

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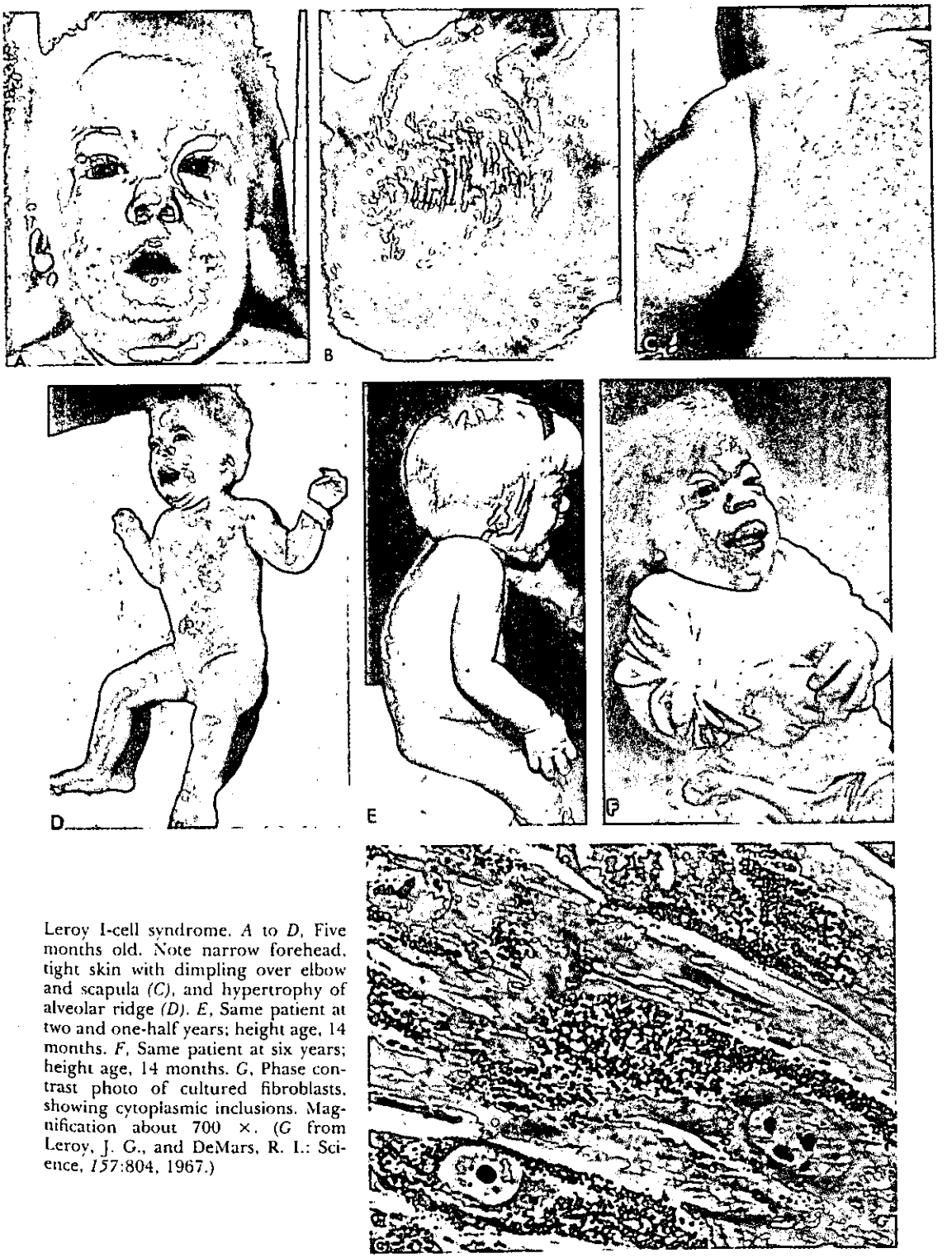
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Leroy I-cell syndrome. *A* to *D*, Five months old. Note narrow forehead, tight skin with dimpling over elbow and scapula *(C)*, and hypertrophy of alveolar ridge *(D)*. *E*, Same patient at two and one-half years; height age, 14 months. *F*, Same patient at six years; height age, 14 months. *G*, Phase contrast photo of cultured fibroblasts, showing cytoplasmic inclusions. Magnification about 700 ×. (*G* from Leroy, J. G., and DeMars, R. I.: Science, *157*:804, 1967.)

ANTLEY-BIXLER SYNDROME

(Multisynostotic Osteodysgenesis, Trapezoidcephaly/Multiple Synostosis)

Craniosynostosis, Choanal Atresia, Radiohumeral Synostosis

FILE COPY

First described by Antley and Bixler in 1975, subsequent cases have been reported by DeLozier et al. and Robinson et al. Schinzel et al. documented the first instance of affected siblings.

ABNORMALITIES

Craniofacial. Brachycephaly. Frontal bossing. Large anterior fontanel. Craniosynostosis. Midfacial hypoplasia. Depressed nasal bridge. Proptosis. Choanal stenosis and/or atresia. Dysplastic ears.

Limbs. Radiohumeral synostosis. Joint contractures, including inability to extend fingers and decreased range of motion at wrists, hips, knees, and ankles. Arachnodactyly associated with enlarged interphalangeal joints, increased numbers of flexion creases, and distal tapering with narrow nails. Femoral bowing. Femoral fractures.

OCCASIONAL ABNORMALITIES. Hydrocephalus. Preauricular tags. Vaginal atresia. Atrial septal defects. Renal defect. Multiple hemangiomata.

NATURAL HISTORY. Respiratory compromise secondary to upper airway obstruction has varied from severe nasal congestion to multiple apneic episodes leading to death. Although gross and fine motor function have been difficult to assess because of joint contractures, psychosocial development has been normal in two patients greater than 1 year of age. Joint contractures have improved with age and passive range of motion exercises. Resection of the radiohumeral synostosis was attempted in one child at six months of age. However, recurrence of the bony fusion recurred within three months. There has been no propensity to fracture postnatally.

ETIOLOGY. Probable autosomal recessive inheritance based on one example of affected sisters born to unaffected parents.



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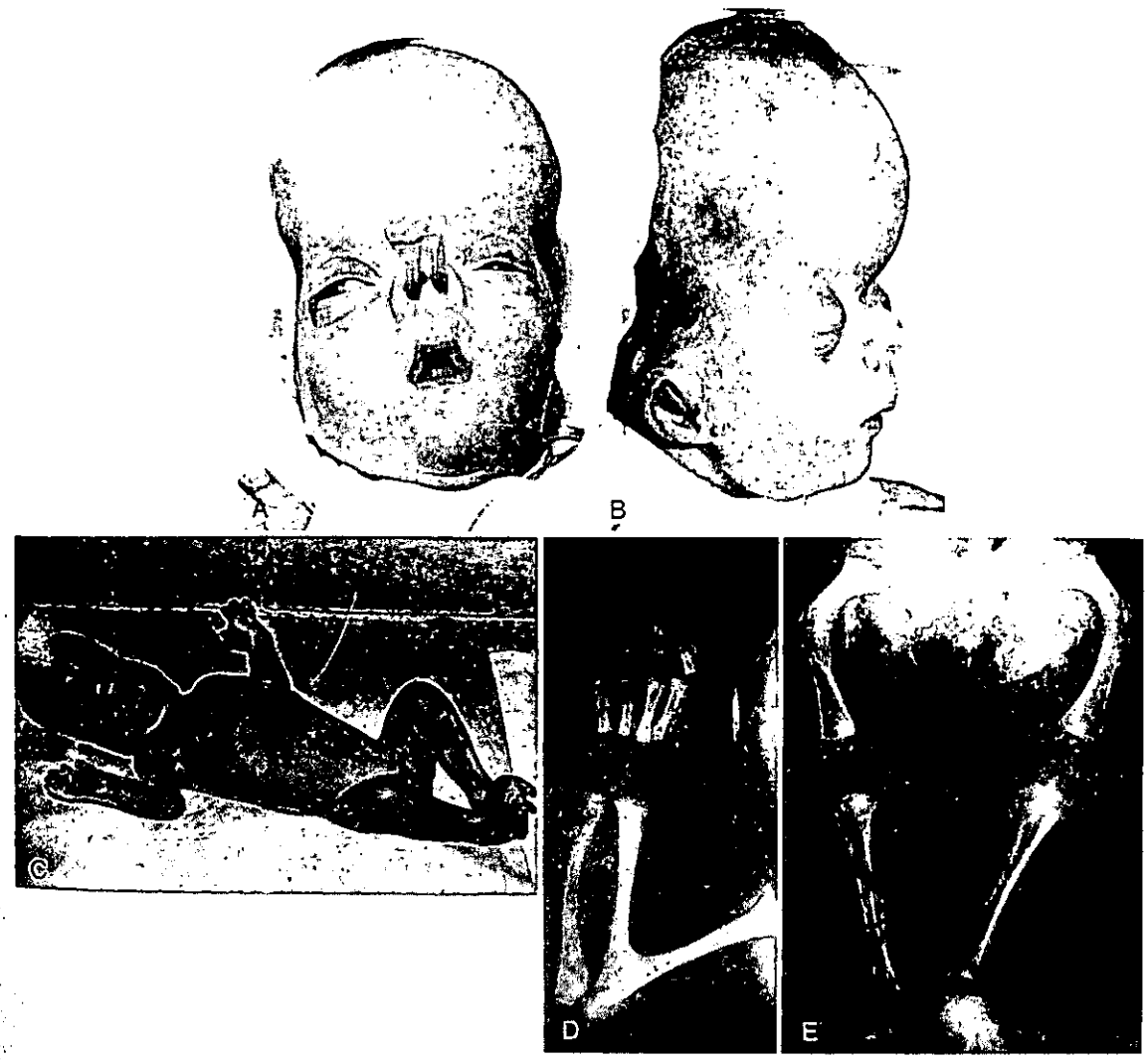
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Antley-Bixler syndrome. *A* to *E*, Newborn female infant with severe maxillary hypoplasia, depressed nasal bridge, proptosis, and dysplastic ears. Note the multiple joint contractures, radiohumeral synostosis, and femoral bowing. (From Robinson, L. K., et al.: J. Pediatr., *101*:201, 1982.)

HYPOPHOSPHATASIA

Poorly Mineralized Cranium, Short Ribs, Hypoplastic Fragile Bones

FILE COPY

Rathbun recognized this disease in 1948, and numerous cases of this autosomal recessive, invariably lethal condition have been documented subsequently.

ABNORMALITIES

Growth. Small stature.

Cranium. Poorly mineralized globular cranium.

Other Skeletal. Hypoplastic fragile bone of varying density with irregular lack of metaphyseal mineralization, bowed lower extremities with overlying cutaneous dimpling, and short ribs with rachitic rosary and small thoracic cage.

NATURAL HISTORY. Death secondary to respiratory insufficiency during early infancy is usual. Of those who survive, early failure to thrive, hypotonia, irritability and occasionally seizures, anemia and/or hypercalcemia, and nephrocalcinosis are common. The hypercalcemia may be responsive to hydrocortisone analogue therapy.

ETIOLOGY. Autosomal recessive. The homozygote has a severe deficiency of tissue and serum alkaline phosphatase and an excessive urinary excretion of phosphoethanolamine. The heterozygote may have a low value for serum alkaline phosphatase and mildly elevated phosphoethanolamine excretion. Prenatal diagnosis has been accomplished successfully with mid-trimester ultrasonography and recently by alkaline phosphatase assay on chorionic villus sample taken in the first trimester.

COMMENT. A much milder autosomal dominant form of hypophosphatasia, characterized by decreased serum alkaline phosphatase, elevated urinary phosphoethanolamine, premature deciduous tooth loss, and later onset, has been described. Affected individuals have late closure of wide fontanels and irregular, rachitic-appearing, incomplete metaphyseal mineralization, with bowing of the lower extremities and awkward gait. Bone pain, dental problems, and occasionally fractures occur, but the osseous abnormalities tend to improve with time.



Hypophosphatasia. *A* alkaline phosphatase v

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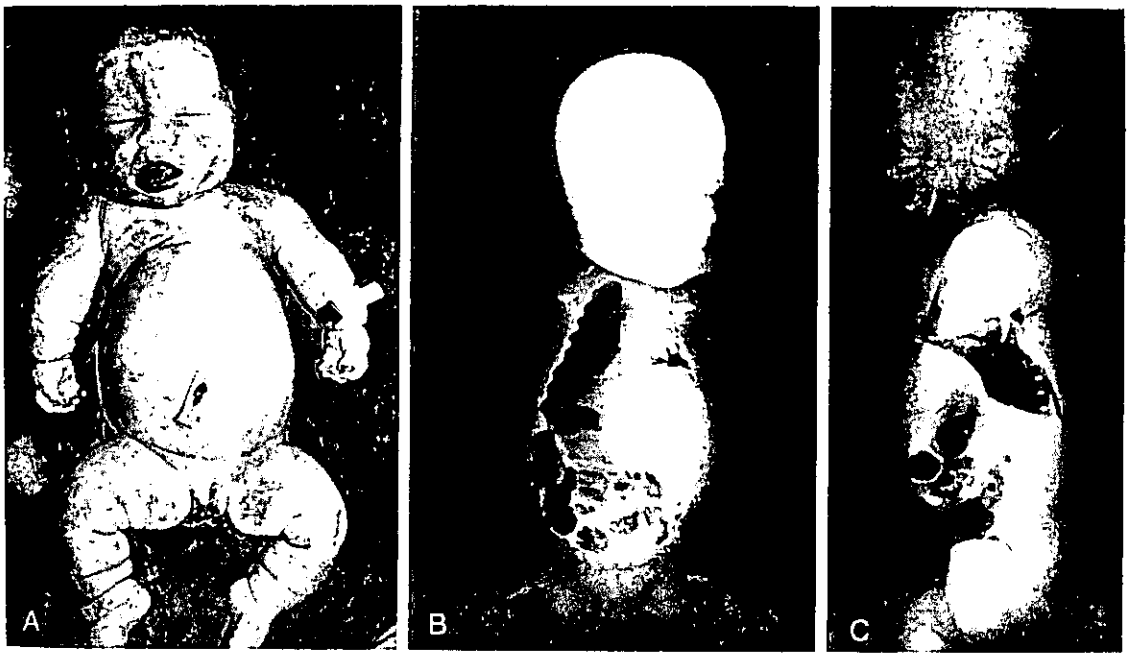
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Hypophosphatasia. *A* to *C*, Stillborn infant with almost complete lack of mineralization of bony skeleton. Serum alkaline phosphatase was low, and there was an increased urinary phosphoethanolamine.

CAMPTOMELIC DYSPLASIA

Bowed Tibiae, Hypoplastic Scapulae, Flat Facies

FILE COPY

Though reports of this condition appeared in the 1950s by Bound et al. and Bain and Barrett, it was not until the 1970s that the syndrome became more broadly recognized by Spranger et al. and Maroteaux et al., who utilized the term "camptomelique," meaning bent limb, to epitomize the disorder. Three recent reports provide excellent summaries of large numbers of patients.

ABNORMALITIES

Growth. Prenatal onset growth deficiency with retarded osseous maturation and large head. Birth length, 35 to 49 cm. Average occipitofrontal circumference is 37 cm.

CNS. Tendency toward having large brain with gross cellular disorganization, most evident in cerebral cortex, thalamus, and caudate nucleus. Absence or hypoplasia of olfactory tract or bulbs. Hydrocephalus.

Facies. Flat-appearing small face with high forehead, anterior frontal upsweep, large anterior fontanel, low nasal bridge, micrognathia, cleft palate, short palpebral fissures, and malformed and/or low-set ears.

Limbs. Anterior bowing of tibiae with skin dimpling over convex area, short fibulae, mild bowing of femurs, and talipes equinovarus.

Radiographic. Short and somewhat flat vertebrae, particularly cervical. Hypoplastic scapulae, small thoracic cage with slender and/or decreased number of ribs, kyphoscoliosis, small iliac wings with relatively wide pelvic outlet. Absent mineralization of sternum. Lack of ossification of proximal tibial and distal femoral epiphysis and talus.

Tracheobronchial. Incomplete cartilaginous development with tracheobronchiomalacia.

Genitalia. Some of the affected XY individuals fail to develop masculine characteristics and have XY gonadal dysgenesis with ovarian, müllerian duct, and vaginal development.

OCCASIONAL ABNORMALITIES. Cardiac defects. Hydronephrosis. Polyhydramnios.

NATURAL HISTORY. The great majority of patients die in the neonatal period from respiratory insufficiency, and those surviving into early infancy have feeding problems, failure to thrive, and evidence of serious central nervous system deficiency, including apneic spells. The oldest survivors include a seven month old, a 19 month old, and a 17 year old boy with an I.Q. of 45.

ETIOLOGY. Autosomal recessive.-Prenatal diagnosis utilizing ultrasonography has been accomplished successfully at 18 weeks' gestation.

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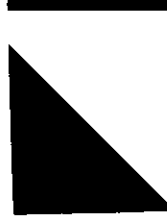
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Camptomelic dy
positioning, and
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Camptomelic dysplasia. Two newborn babies, showing low nasal bridge, micrognathia, small thorax, aberrant hand positioning, and bowed tibiae with dimples at the maximal point of bowing. Roentgenogram shows the slim, poorly developed bones and osseous immaturity (knee and foot). (From D. Hoefnagel, et al.: Lancet, *1*:1068, 1972.)

JEUNE THORACIC DYSTROPHY

(Asphyxiating Thoracic Dystrophy)

Small Thorax, Short Limbs, Hypoplastic Iliac Wings

FILE COPY

First described by Jeune et al. in 1955, over 100 cases have now been reported.

ABNORMALITIES

Growth. Short stature.

Skeletal. Infancy: Short ribs with irregular costochondral junctions and small thoracic cage. Hypoplastic iliac wings. Horizontal acetabular roofs with spur-like projections at lower margins of sciatic notches. Early ossification of capital femoral epiphysis. Childhood: Irregular epiphyses and metaphyses with relatively short limbs, especially the hands. Ulnae and fibulae relatively short. Cone-shaped epiphyses and early fusion between epiphyses and metaphyses of distal and middle phalanges.

Respiratory. Lung hypoplasia, presumably secondary to the small thoracic cage, is the major cause of death in early infancy.

Renal. Cystic tubular dysplasia and/or glomerular sclerosis.

Hepatic. Variable proliferation of small duct radicals.

OCCASIONAL ABNORMALITIES. Polydactyly, usually of hands and feet, notching of distal end of metacarpal and metatarsal bones; lacunar skull; pancreatic cysts; retinal degeneration with predominantly cone-type cells remaining.

NATURAL HISTORY. Early death, usually the consequence of asphyxia with or without pneumonia, occurs in the majority of patients. Those who survive usually have progressive improvement in the relative growth of the thoracic cage and may have only slight to moderate shortness of stature. Chronic nephritis leading to renal failure is a serious potential feature of this disorder. Renal insufficiency may be evident by two years of age. However, survival to the fourth decade has occurred.

Autopsy has revealed disordered growth at the costochondral juncture with hyperplastic proliferating cartilage and poor progression of endochondral mineralization.

ETIOLOGY. Autosomal recessive. Prenatal diagnosis utilizing ultrasonography has been accomplished successfully at 18 weeks' gestation.

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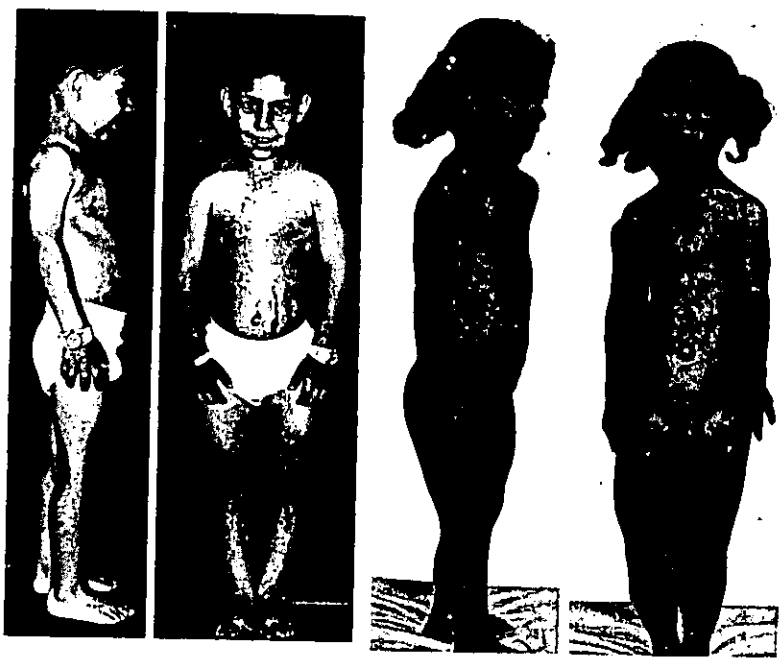
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Affected children w
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Affected children with Jeune thoracic dystrophy. Note the small thoracic cage, short hands, and mild bowing of legs. (Courtesy of Dr. Jaime Frias, University of Nebraska Medical School, Omaha.)

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J. OSTEOCHONDRODYSPLASIAS

ACHONDROGENESIS, TYPES IA AND IB

Low Nasal Bridge, Very Short Limbs, Incomplete Ossification of Lower Spine

This early lethal disorder was described in 1925 by Donath and Vogl and termed achondrogenesis by Fraccaro in 1952. More than 15 cases have been reported. Recent studies by Borochowitz et al. indicate that achondrogenesis type I (previously referred to as Parenti-Fraccaro type) represents two radiographically and histopathologically distinct disorders referred to as types IA and IB. In the classification set forth by Whitley and Gorlin, type I is synonymous with type IA and type II with type IB.

ABNORMALITIES

Growth. Extreme small stature, 22 to 30 cm.

Craniofacies. Cranium large for gestational age. Low nasal bridge, micrognathia.

Limbs. Severe micromelia.

Radiographs. In both types, the skull, vertebral bodies, fibula, talus, and calcaneus are poorly ossified, the ilia are crenated, the long bones are stellate, and the ribs are extremely short. In type IA, multiple rib fractures are present, and the proximal femurs have metaphyseal spikes. Conversely, in type IB, rib fractures do not occur, and the distal femurs have metaphyseal irregularities.

NATURAL HISTORY AND COMMENT. The defect in the development of cartilage and bone is severe. In type IA, normal-appearing but hypervascular cartilage matrix is present with increased cellular density. Large lacuna surround the chondrocytes, which contain round cytoplasmic inclusion bodies. In type IB, sparse interterritorial cartilaginous matrix is present, with a marked deficiency of collagen fibers. The chondrocytes are large, have a central round nucleus, and are surrounded by a dense collagenous ring.

Developmental pathology beyond the skeletal system is implied by the frequent findings of polyhydramnios, hydrops, and early lethality. Most infants are stillborn or die shortly after birth.

ETIOLOGY. Autosomal recessive.

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TYPE	ACHO
Skull	Poorly
Ribs	Short
Spine	Com
Ilium	Arch
Ischium	*Oss
Femur	Wea met
Tibia	Sho
Fibula	met
	*Un

A. Stillborn infant type IA from type and Dr. D. Rimoi



TYPE	ACHONDROGENESIS IA	ACHONDROGENESIS IB
Skull	Poorly ossified	Poorly ossified
Ribs	Short & fractured	Short, no fractures, cupped ends
Spine	Completely unossified	Posterior pedicles only
Ilium	Arched	Crenated
Ischium	*Ossified-hypoplastic	Unossified
Femur	Wedged with metaph. spike	Trapezoid
Tibia	Short with metaph. flare	Crenated
Fibula		Unossified

*Unossified 30 weeks' gestation

B

A, Stillborn infant at 30 weeks' gestation with achrondrogenesis, type IA. *B*, Radiographic features that differentiate type IA from type IB are delineated on the drawings. (Courtesy of Dr. R. Lachman, Harbor–UCLA Medical Center, and Dr. D. Rimoin, Cedars-Sinai Medical Center, Los Angeles.)

ACHONDROGENESIS, TYPE II

(Langer-Saldino Achondrogenesis; Hypochondrogenesis)

Initially described by Langer et al. and Saldino, this early lethal disorder has recently been more completely delineated by Chen et al. and Borochowitz et al.

ABNORMALITIES

Growth. Extremely short stature (27 to 36 cm).

Craniofacies. Large calvarium with large anterior and posterior fontanels, flat nasal bridge, small anteverted nostrils, micrognathia.

Limbs. Short.

Radiographs. Normal cranial ossification. Short ribs without fractures. Short, broad long bones with disproportionately long fibula and metaphyseal irregularity of distal ulna. Variable degrees of failure of ossification of lumbar spine, cervical spine, sacrum, ischial and pubic bones, and calcaneus and talus.

Other. Polyhydramnios.

OCCASIONAL ABNORMALITIES. Cleft soft palate.

NATURAL HISTORY AND COMMENT. Although one child survived to 3 months, the majority are stillborn or die in the first few hours of life. Chondro-osseous histology has revealed hypervascularity and hypercellularity of cartilage, with multiple small, round dilated cysternae of rough endoplasmic reticulum.

ETIOLOGY. Autosomal recessive.

COMMENT. Recent data indicate that hypochondrogenesis previously thought to be a distinct disorder, and achondrogenesis type II represent a spectrum of the same disorder, with marked phenotypic variability.

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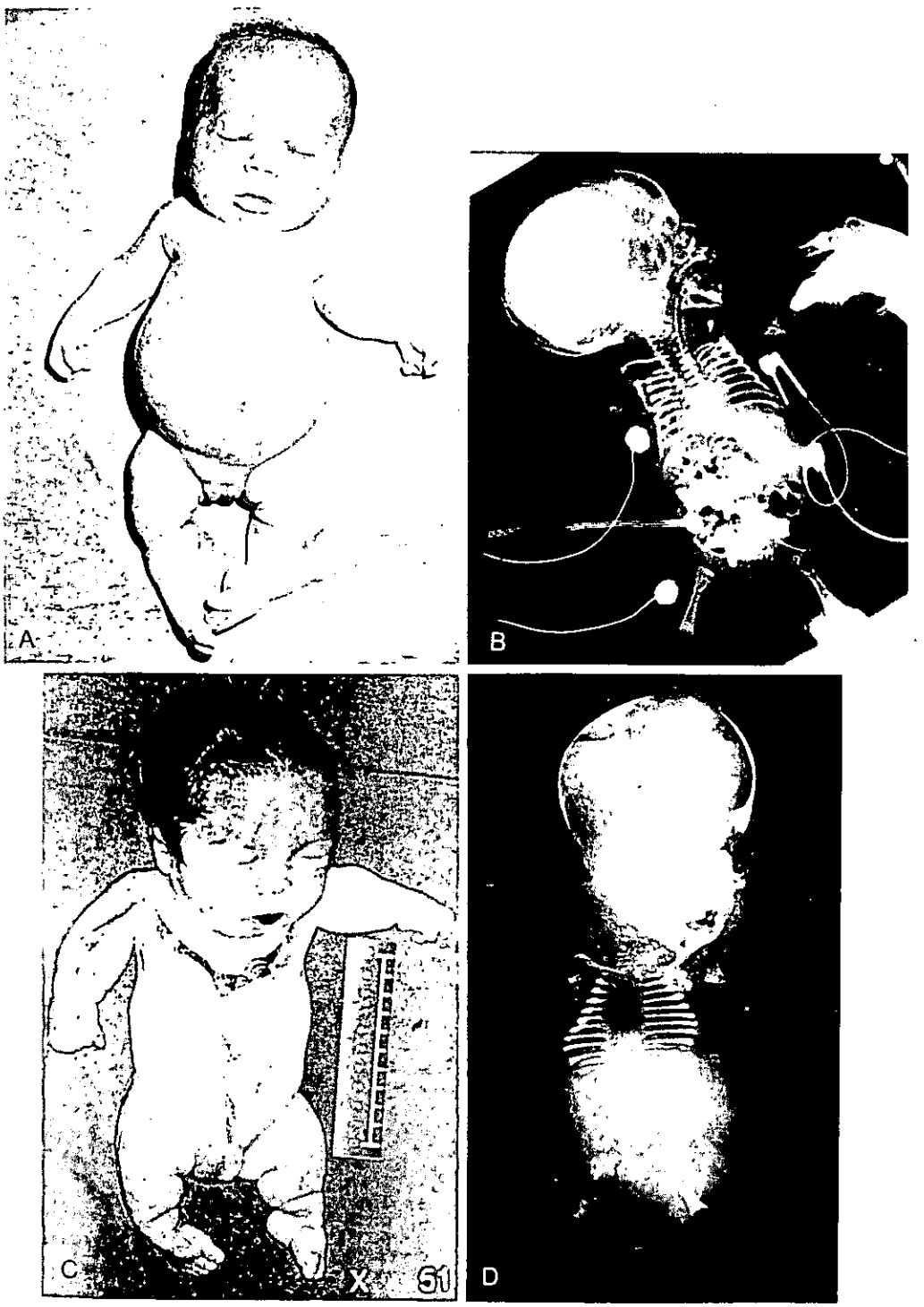
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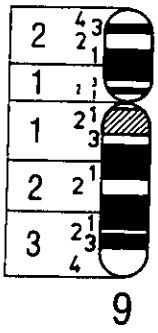




A to *D*. Two stillborn
the relatively normal
cervical spines, sacrun
and Dr. D. Rimoin, C



A to *D*, Two stillborn infants with achondrogenesis, type II, showing the variation in severity of the disorder. Note the relatively normal cranial ossification, short ribs, and variable degrees of failure of ossification of lumbar and cervical spines, sacrum, and ischial and pubic bones. (Courtesy of Dr. R. Lachman, Harbor–UCLA Medical Center, and Dr. D. Rimoin, Cedars-Sinai Medical Center, Los Angeles.)



TRISOMY 9 MOSAIC SYNDROME

Joint Contractures, Congenital Heart Defects, Low-set Malformed Ears

FILE COPY

In 1973, Haslam et al. reported the first case of trisomy 9 mosaicism. In the same year, Feingold et al. reported the first example of a child with full trisomy 9 utilizing blood lymphocytes.

ABNORMALITIES

Growth. Prenatal onset growth deficiency.

Performance. Severe mental deficiency.

Craniofacial. Sloping forehead with narrow bifrontal diameter; upslanting, short palpebral fissures, deeply set eyes; prominent nasal bridge with short root, small fleshy tip, and slit-like nostrils; prominent upper lip covering receding lower lip; micrognathia, low-set, posteriorly rotated, and misshapen ears.

Skeletal. Joint anomalies including abnormal position and/or function of hips, knees, feet, elbows, and digits; kyphoscoliosis; narrow chest; hypoplasia of sacrum, iliac wings, and pubic arch; hypoplastic phalanges of toes.

Other. Congenital heart defects in about two thirds of cases, micropenis, cryptorchidism, renal malformations, cystic dilatation of fourth ventricle with lack of midline fusion of cerebellum.

OCCASIONAL ABNORMALITIES. Subarachnoid cyst, microphthalmia, preauricular tags, cleft lip and/or palate, bile duct proliferation in absence of a demonstrable stenosis or atresia, punctate mineralization in developing cartilage. Diaphragmatic hernia. Meningocele. Lack of gyration of cerebral hemispheres. Absence of optic tracts. Corneal opacities.

NATURAL HISTORY. The majority of patients die during the early postnatal period. In those that survive, failure to thrive and severe motor and mental deficiency are the rule. Some patients remain bedridden throughout their lives, whereas others achieve the ability to walk and minimal speech.

ETIOLOGY. Trisomy for chromosome 9. The incidence and severity of malformations and mental deficiency correlate with the percentage of trisomic cells in the different tissues.

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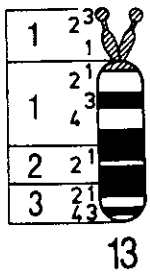
Trisomy 9 mo
Long and narr
goloid position
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Trisomy 9 mosaic syndrome. Two month old boy. Long and narrow face with narrow eyelids in mongoloid position, broad and bulbous nose with a broad and prominent bridge, short upper lip covering the receding lower lip, small mandible, left preauricular pit, cutis marmorata, inability to lie on the back because of congenital thoracic kyphosis, and flexion position of hands and fingers. (From Schinzel, A., et al.: Humangenetik, 25:171, 1974.)



TRISOMY 13 SYNDROME

(D, Trisomy Syndrome)

FILE COPY

Defects of Eye, Nose, Lip, and Forebrain of Holoprosencephaly Type; Polydactyly; Narrow Hyperconvex Fingernails; Skin Defects of Posterior Scalp

Apparently described by Bartholin in 1657, this syndrome was not generally recognized until its trisomic etiology was discovered by Patau et al. in 1960. The incidence is about 1 per 5000 births.

ABNORMALITIES FOUND IN 50 PER CENT OR MORE OF PATIENTS

Central Nervous System. Holoprosencephaly type defect with varying degrees of incomplete development of forebrain and olfactory and optic nerves. Minor motor seizures, often with hypsarrhythmic electroencephalogram pattern. Apneic spells in early infancy. Severe mental defect.

Hearing. Apparent deafness (defects of organ of Corti in the two cases studied).

Cranium. Moderate microcephaly with sloping forehead. Wide sagittal suture and fontanels.

Eyes. Microphthalmia, colobomata of iris, or both. Retinal dysplasia, often including islands of cartilage.

Mouth. Cleft lip (60 to 80 per cent), cleft palate, or both.

Auricles. Abnormal helices with or without low-set ears.

Skin. Capillary hemangiomata, especially forehead. Localized scalp defects in parieto-occipital area. Loose skin, posterior neck.

Hands and Feet. Distal palmar axial triradii. Simian crease. Hyperconvex narrow fingernails. Flexion of fingers with or without overlapping and camptodactyly. Polydactyly of hands and sometimes feet. Posterior prominence of heel.

Other Skeletal. Thin posterior ribs with or without missing rib. Hypoplasia of pelvis with shallow acetabular angle.

Cardiac. Abnormality in 80 per cent with ventricular septal defect, patent ductus arteriosus, auricular septal defect, and dextroposition, in decreasing order of frequency.

Genitalia. Male: cryptorchidism, abnormal scrotum. Female: bicornuate uterus.

Hematologic. Increased frequency of nuclear projections in neutrophils. Unusual persistence of embryonic and/or fetal type hemoglobin.

Other. Single umbilical artery. Inguinal or umbilical hernia.

ABNORMALITIES FOUND IN LESS THAN 50 PER CENT OF PATIENTS

Growth. Congenital hypoplasia; mean birth weight, 2480 g.

Central Nervous System. Hypertonia, hypotonia, agenesis of corpus callosum, hydrocephalus, fusion of basal ganglia, cerebellar hypoplasia, meningomyelocele.

Eyes. Shallow supraorbital ridges, slanting palpebral fissures, absent eyebrows, hypotelorism, hypertelorism, anophthalmos, cyclopia.

Nose, Mouth, and Mandible. Absent philtrum, narrow palate, cleft tongue, micrognathia.

Hands and Feet. Retroflexible thumb, ulnar deviation at wrist, low arch digital dermal ridge pattern, fibular S-shaped hallucal dermal ridge pattern, syndactyly, cleft between first and second toes, hypoplastic toenails, equinovarus, radial aplasia.

Cardiac. Anomalous venous return, overriding aorta, pulmonary stenosis, hypoplastic aorta, atretic mitral and/or aortic valves, bicuspid aortic valve.

Abdominal. Omphalocele, heterotopic pancreatic or splenic tissue, incomplete rotation of colon, Meckel's diverticulum.

Renal. Polycystic kidney (31 per cent), hydronephrosis, horseshoe kidney, duplicated ureters.

Genitalia. Male: hypospadias. Female: duplication and/or anomalous insertion of fallopian tubes, uterine cysts, hypoplastic ovaries.

Other. Thrombocytopenia, situs inversus of lungs, cysts of thymus, calcified pulmonary arterioles, large gallbladder, radial aplasia, flexion deformity of large joints, diaphragmatic defect.

NATURAL HISTORY. Forty-four per cent of these babies die within the first month and 69 per cent by six months; only 18 per cent survive the first year. Survivors have severe mental defects, often seizures, and fail to thrive. Only one adult, 33 years of age, has been detected. Because of the high infant mortality, surgical or orthopedic corrective procedures should be withheld in early infancy to await the outcome of the first few months. Furthermore, because of the severe brain

defect, it is the opinion of the author that no medical means should be utilized to prolong the life of individuals with this syndrome, as should be self-evident from the accompanying illustrations.

ETIOLOGY. Trisomy for all or a large part of a specific D group (13–15) chromosome that is tentatively referred to as number 13. Older maternal age has been a factor in the occurrence of this aneuploidy syndrome, the mean maternal age being 30.9 years. Although no accurate empiric recurrence risk data are presently available, it is presumed that the likelihood for recurrence is of very low magnitude for the full 13 trisomy cases. As with Down syndrome, chromosomal studies are indicated on 13 trisomy syndrome babies born of young mothers, in order to detect the rare translocation patient having a balanced translocation parent for whom the risk of recurrence would be of major concern.

Cases with *trisomy 13 mosaicism* most often show a less severe clinical phenotype with every degree of variation, from the full pattern of malformation seen in Trisomy 13 to a near-normal phenotype. Survival is usually longer. The degree of mental deficiency is variable.

Partial trisomy for the proximal segment (13pter→q14) is characterized by a nonspecific pattern, including a large nose, short upper lip, receding mandible, fifth finger clinodactyly, and usually severe mental deficiency. The overall picture shows little similarity to that of full trisomy 13, and survival is not significantly reduced. *Partial trisomy for the distal segment (13q14→qter)* has a characteristic phenotype associated with severe mental deficiency. The facies is marked by frontal capillary hemangiomata, a short nose with upturned tip, and elongated philtrum, synophrys, bushy eyebrows and long, incurved lashes, and a prominent antihelix. Trigonocephaly and arhinencephaly have occasionally been seen. About one fourth of the patients die during early postnatal life.

COMMENT. The defects of midface, eye, and forebrain, which occur in variable degree as a feature of this syndrome, appear to be the consequence of a single defect in the early (three weeks) development of the prechordal mesoderm, which is not only necessary for morphogenesis of the midface but also exerts an inductive role on the subsequent development of the prosencephalon, the forepart of the brain. This type of defect has been referred to as holoprosencephaly or arhinencephaly and varies in severity from cyclopia to cebocephaly to less severe forms.

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Trisomy 13 syndrome. *A*, Note sloping forehead, variable defect in facial development. (From Smith, D. W., et al: J. Pediatr., *62*:326, 1963.) *B*, Narrow hyperconvex fingernails, anomalous scrotum, prominent heel, and posterior scalp lesions. (From Smith, D. W.: Am. J. Obstet. Gynecol., *90*:1055, 1964.)







Partial 13 trisomy, proximal segment Q. *Above*, Six month old patient. High forehead; left esotropia; large, broad-based nose; receding mandible. (From Schinzel, A., et al: Humangenetik, *22*:287, 1974.) *Below*, Same patient at 11 years of age. Hypertelorism; prominent and broad-based nose; no strabismus; normal size of the mandible. (From Schinzel, A., Arch. Genet., *52*:180, 1979.)



Partial 13 trison
half year old. No
small nose, incre
and prominent a
52:178, 1979.) *B*
Schinzel, A., et a









Partial 13 trisomy, distal segment Q. *Above*, One and one-half year old. Note bushy eyebrows, long and curled lashes, small nose, increased distance between nose and upper lip, and prominent antihelix. (From Schinzel, A., Arch. Genet., 52:178, 1979.) *Below*, Same patient at 12 years of age. (From Schinzel, A., et al.: Humangenetik, 22:287, 1974.)

ıt Q. *Above*, Six month
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(Greenwich District Hospital), B Vallance (Hairmyres Hospital, East Kilbride), K Hine (Cuckfield Hospital), J Powell-Jackson (Royal Hampshire Hospital, Winchester), M Varma (Erne Hospital, Enniskillen, Northern Ireland), S Joseph (Mayday Hospital, Croydon), T Greenwood (West Middlesex Hospital), A Harley (Broadgreen Hospital, Liverpool), and A J Handley (Colchester General Hospital): Switzerland—C Cottier (Kantonspital, Liestal), O Berrel (Triemlispital, Zurich); Luxembourg—C Delagardelle (Centre Hospitalier); Belgium—R Ranquin (AZ Middelheim, Antwerpen), P Timmermans (Virga Jesse Ziekenhuis, Hasselt), M Laurent (Centre Hospitalier De Tivoli, La Louvière), D El Allaf (Centre Hospitalier De Huy), M Hermans (Sint-Josefskliniek, Bornem), Y Bekaert (Sint-Josef Kliniek, Turnhout), M Quinones (Centre Hospitalier Du Bois De L'Abbaye, Sersing), R Bernard (Hopital Saint-Pierre, Bruxelles), L Boxaert (UZA, Edegem), C Vandermeersch (Kliniek Maria's Voorzienigheid, Kortrijk), J Baluwe (Stuivenberg Algemeen Ziekenhuis, Antwerpen), J Prihodi (Ste Barbara, Lanaken); Canada—M Turabian (Brandon General Hospital), W Klinke (Royal Alexandra Hospital, Edmonton), J Lopez (University (Hospital De Cruces, Baracaldo), M Fiol (Hospital San Doreta, Palma De Mallorca).

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Conflict of interest: None.

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Suicides after pregnancy in Finland, 1987-94: register linkage study

Mika Gissler, Elina Hemminki, Jouko Lönnqvist

Abstract

Objective—To determine rates of suicide associated with pregnancy by the type of pregnancy.

Design—Register linkage study. Information on suicides in women of reproductive age was linked with the Finnish birth, abortion, and hospital discharge registers to find out how many women who committed suicide had had a completed pregnancy during her last year of life.

Setting—Nationwide data from Finland.

Subjects—Women who committed suicide in 1987–94.

Results—There were 73 suicides associated with pregnancy, representing 5.4% of all suicides in women in this age group. The mean annual suicide rate was 11.3 per 100 000. The suicide rate associated with birth was significantly lower (5.9) and the rates associated with miscarriage (18.1) and induced abortion (34.7) were significantly higher than in the population. The risk associated with birth was higher among teenagers and that associated with abortion was increased in all age groups. Women who had committed a suicide tended to come from lower social classes and were more likely to be unmarried than other women who had had a completed pregnancy.

Conclusions—The increased risk of suicide after an induced abortion indicates either common risk factors for both or harmful effects of induced abortion on mental health.

Introduction

Childbirth has an impact on the mental health of women. Short term postnatal "blues" are experienced by 45-70% of women.[1,2] An increased risk of non-psychotic depression after a delivery has been reported.[3,4] The incidence of puerperal psychosis is 1.7 per 1000 live births.[5] The initial stress effect of having a child, however, is transitional, and overall having a child has positive effects on women's mental health.[6]

Reports of mental complications after an induced abortion are controversial. Puerperal psychosis is rare (0.3 per 1000 abortions), but depression is more common (13-41%).[7] Long term follow up studies, however, have documented more positive reactions and fewer undesirable feelings than short term studies.[7]

Less is known about the effects of miscarriage on mental health. A normal grief period is said to be from 6 to 12 months, but in some cases delayed, unresolved, and pathological grief may remain for years.[8]

There are only a few studies on suicides associated with pregnancy.[9] The main reason may be the difficulty of getting reliable information on pregnancy before death[10] and the relative rarity of suicides compared with other mental problems. The most reliable way to collect information on deaths related to pregnancy seems to be register linkage.[11]

We determined the incidence of suicides up to one year after the end of a pregnancy by using national health registers. We analysed suicide rates by the type of pregnancy (birth, induced abortion, or miscarriage) and by background characteristics of the mothers.

Subjects and methods

Information on all deaths (n=9192) of women of childbearing age (15-49 years) in Finland in 1987-94 was extracted from the register of death certificates. Of these, 1347 had suicide as the main cause of death. No death had suicide as a contributing cause. The suicides were linked to the medical birth register (519 139 births in 1987-94), to the abortion register (117 139 abortions in 1986-94), and to the hospital discharge register (9 881 254 discharges in 1986-94) by using the mother's unique identification number to find evidence of termination of a pregnancy in the year before her death. The follow up period of one year was chosen according to the current definition of late maternal death.[12] We found 73 suicides associated with pregnancy. Ten violent and 16 non-violent deaths with unclear cause and 55 accidents associated with pregnancy were not included in the analysis.

The death certificate register, collected by Statistics Finland, is based on death certificates written by physicians. All the death certificates are checked by forensic specialists and by medical experts at Statistics Finland. Information on age, cause of death, residence, and occupation (in 1987) was gathered from the death certificates.

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Table 1—*Basic statistics of Finnish women with ended pregnancies, 1987-94*. Figures are numbers (percentages) of women unless stated otherwise*

Detail	Births	Abortions	Miscarriages
No of women	518 139	99 807	63 726
Mean (SD) age (years):	29.2 (5.2)	27.8 (6.0)	33.8 (7.2)
<20	14 353 (2.8)	15 266 (15.3)	2878 (4.5)
>35	70 256 (13.7)	21 038 (22.4)	22 693 (27.0)
Marital status:			
Married	379 627 (72.0)	25 932 (27.7)	NA
Cohabiting	86 346 (16.4)	58 079 (61.9)	NA
Single	28 587 (5.5)		NA
Widowed or divorced	5974 (1.1)	9753 (10.4)	NA
Social class†:			
I	11 028 (16.9)	1321 (1.4)	NA
II	41 862 (63.4)	62 124 (65.5)	NA
III	12 603 (19.6)	36 057 (40.6)	NA
First pregnancy	155 277 (29.9)	35 527 (37.9)	NA

NA = Information not available.
Missing data not shown.
*Data from medical birth register, abortion register, and hospital discharge register.
†Social class in abortion register is based on its own classification and in medical birth register on mothers' education (in 1991 only); they are not comparable with each other.

Data on births since 1987 were obtained from the medical birth register. Information on the mother's marital status, occupation (since October 1990), education (in 1991), and on the newborn's perinatal health was derived from this source. The register is complete, and its quality of data is high.[13] Data on abortions and on women's marital status and social class on the basis of the women's own occupations were gathered from the register on abortions. More than 99% of abortions are registered, and the quality of data is high for the variables used in this study.[14]

The Finnish Hospital Discharge Register gave information on all miscarriages (*International Classification of Diseases*, ninth revision, codes 630-632, 634, and 637) and extrauterine pregnancies (code 633) treated in hospitals.[15] In 1986, data on 5% of all admissions to hospital were missing, but 99% of admissions for mental disorders and all admissions related to pregnancy, childbirth, or puerperium were reported correctly.[16] Information on hospital admissions and diagnoses was collected from this register. Because the number of extrauterine pregnancies was low they were combined with miscarriages. If a woman had been pregnant when she committed suicide the case could have been found in our data only if she was admitted to hospital at some time during pregnancy or if the pregnancy was mentioned in the death certificate. As no such cases were found, suicides during pregnancy were not included in our analysis.

Suicides occurring within a given year were calculated per 100 000 births, abortions, and miscarriages by age groups. The annual suicide rate per 100 000 women in the age group 15-49 years and in each age group was used as a reference.[17] The risks of suicide by the outcome of pregnancy were compared with odds ratios. Differences in timing of the suicide and socioeconomical differences were tested with χ^2 test. Table 1 gives details of Finnish women who were pregnant during the study period.

Table 2—*Distribution of suicides by amount of time since birth, abortion, or miscarriage in Finland, 1987-94**

Detail	Months						
	1-2	3-4	5-6	7-8	9-10	11-12	Total
Birth	7	4	7	5	3	4	30
Abortion	9	5	1	5	7	4	29
Miscarriage	4	1	1	4	2	2	14
Total	20	8	9	14	12	10	73

*Differences between age groups 35-39 and 20-34, 15-19 and 20-34, and 15-19 and 30-34 are significant ($P<0.05$).

Table 3—*Proportion of all suicides in women that were related to pregnancy and risk per pregnancy by age in Finland, 1987-94*

Detail	Age group						
	15-19	20-24	25-29	30-34	35-39	40-49	Total
All suicides in women	60	120	147	167	248	585	1347
No (%) of suicides related to pregnancy*	6 (10.0)	10 (8.3)	21 (14.3)	12 (7.0)	19 (7.7)	4 (0.6)	73 (5.4)
No of ended pregnancies*	30 198	125 918	229 440	171 146	81 001	27 868	667 572
Suicides per 100 000 ended pregnancies*	19.9	7.9	9.2	7.5	23.5	14.4	10.9

*Births, abortions, and miscarriages.

Results

Among the women of childbearing age 1347 suicides represented 15% of all deaths. In the 73 suicides associated with pregnancy in our data information on outcome of pregnancy was mentioned in only 11% of the death certificates. Two suicides were connected with infanticide, and one suicide was connected with a preterm birth resulting in a neonatal death. In total, 30 suicides were committed after women gave birth (42%), 29 after an abortion (40%), and 14 after a miscarriage (19%), of which two were after an extrauterine pregnancy. The risk of suicide was at its highest during the two first months after the end of pregnancy (table 2). The difference between the two first months and two following months was significant ($P<0.05$). Of all suicides in women aged 15-49 every 19th was related to an ended pregnancy (table 3). For each pregnancy the risk of a suicide was 11 per 100 000 ended pregnancies. This risk was highest in the age group 35-39 and lowest in age group 30-34.

Among younger women, who overall had a lower risk of suicide but higher rates of pregnancy, suicides associated with pregnancy were proportionally more common. The suicide rate associated with birth was 5.9 per 100 000 births and for associated abortions was 34.7 per 100 000 abortions, giving an odds ratio of 5.9 compared with births (95% confidence interval 3.6 to 9.9). The suicide rate associated with miscarriages was 18.1 (3.3; 1.8 to 6.3).

Among women aged less than 20 years, the suicide rates both after a birth and after an abortion were higher than in the same age group in the general population (table 4, figure 1). In the age group 20-34 the rate of suicide associated with birth was lower than the total suicide rate and the rate associated with abortions and miscarriage. After the age 35, the suicide rate increased for abortions. The same was true for miscarriages in the age group 40-49.

In 63% (46) of all suicides associated with pregnancy women were living in urban areas. This equals the proportion of all women giving birth, but it is smaller than the proportion who have abortions (74%; $P=0.09$). The stated reasons for the abortion in suicide cases did not differ from those for all abortions; over 80% were performed because of social reasons. In our data on suicide no abortion was performed for fetal abnormality.

Six per cent of women who gave birth were single and 1% divorced, but among women who committed suicide 19% were single ($P=0.001$) and 7% divorced ($P<0.001$). For suicides after an abortion the proportion of unmarried (that is, single or cohabiting) women was 41% compared with 62% of all women who had had an abortion ($P=0.011$). The proportion of divorced women, however, was reversed: 24% compared with 10% ($P=0.004$).

Table 4—*Od by age group*

Detail
Birth
Abortion
Miscarriage

*No suicides.

Table 4—*Odds ratios (95% confidence intervals) for suicide after birth, abortion or miscarriage compared with general population by age group in Finland, 1987-94*

Detail	Age group						Total
	15-19	20-24	25-29	30-34	35-39	≥40	
Birth	2.87 (1.02 to 8.04)	0.11 (0.01 to 0.82)	0.62 (0.18 to 1.48)	0.34 (0.11 to 1.03)	1.03 (0.51 to 2.09)	0.76 (0.38 to 1.48)	0.52 (0.19 to 1.41)
Abortion	4.51 (1.69 to 12.03)	3.38 (1.55 to 6.97)	4.76 (2.41 to 9.38)	1.87 (0.94 to 3.73)	4.94 (2.78 to 8.41)	*	3.08 (1.57 to 6.03)
Miscarriage	*	2.33 (1.00 to 4.97)	2.25 (1.07 to 4.72)	1.97 (0.99 to 3.90)	1.21 (0.61 to 2.38)	2.01 (1.17 to 3.44)	1.61 (0.70 to 3.38)

*No suicides.

Complete information on social class was available only for suicides associated with abortion: 51% of these women belonged to the lowest of three social groups, while 41% of all women who had had an abortion belonged to this group (P=0.06)

Discussion

In this study information from death certificates was linked with national health registers to find out the recent reproductive history of women of childbearing age who had committed suicide. In only 11% of suicides was an ended pregnancy mentioned in the death certificate. This shows that the data linkage was necessary to get complete information.

Our data may underestimate the number of suicides associated with pregnancy. We used the official cause of death to define a suicide. Apart from the 73 pregnancy associated suicides, there were also 26 pregnancy associated deaths with an unclear cause and 55 accidents. Some of these cases might have been suicides, but it would be difficult to re-examine the actual cause of death after the event. Other studies suggest that the official rate of suicide is underestimated by up to 10%.[17]

In total, 15% of all deaths in women were suicides. This equals the proportions in Sweden and in Norway (15-16% of all deaths among women aged 15-44) but is higher than in some other countries in northern Europe, Australia, and the United States (6-12%) and in southern Europe (1-4%).[18]

Our data showed that the suicide rate associated with birth was half of the general suicide rate in women aged 15-49. This suggests that childbearing prevents suicide or that women capable of giving birth are not at high risk for suicide. The only exception might be teenage mothers, whose suicide rate associated with birth was three times the general rate in this age group. This is, however, a tentative finding because of small numbers.

The suicide rate after an abortion was three times the general suicide rate and six times that associated with birth. Similarly, the rate of psychiatric admissions within three months after the end of pregnancy was 53% higher in women who delivered than in women who had had an induced abortion in a Danish register study.[19]

We were not able to assess an exact suicide rate after miscarriage because only those women who were admitted to hospital for miscarriage are registered. Our estimate is unbiased if we assume that the site of care is not correlated to the risk of suicide. The suicide rate was found to be slightly higher than the general suicide rate and higher than the rate after a birth. Our data suggest that miscarriage is not as important a risk factor as abortion but clearly more important than birth.

A literature review for years 1963-80 showed that 1.8% of women who committed suicide and were of childbearing age were pregnant.[1] If this figure were true now in Finland, the number of women committing suicide while pregnant would be 24, and a quarter of cases would be missing from our data, which included only completed pregnancies.

Low social class and poor social support have been connected with risk factors for suicide after birth. The risk for postnatal depression is greater for women with low income or with occupational instability,[20 21] and puerperal psychoses are more common among young mothers and women with poor social support.[5] Social class has also been found to be associated with all mental disorders after an abortion.[19 22] Data from the abortion register showed that women in the lowest social class were highly over-represented among women who committed suicide. We did not, however, have complete information on social class in our data. No control group for social class after birth and miscarriage and for the general population was available. In addition, the social class was based only on the mother's occupation.

The proportion of divorced women who commit suicide was more than double after an abortion and eightfold after a birth, which suggests that low social support is associated with suicide. Similarly, in a Danish study, a fivefold rate in admissions to psychiatric hospitals after abortion was found for separated, divorced, or widowed women compared with that of other women.[19]

The relation between suicide, mental disorders, life events, social class, and social support is a complex one.[23] Abortion might mean a selection of women at higher risk for suicide because of reasons like

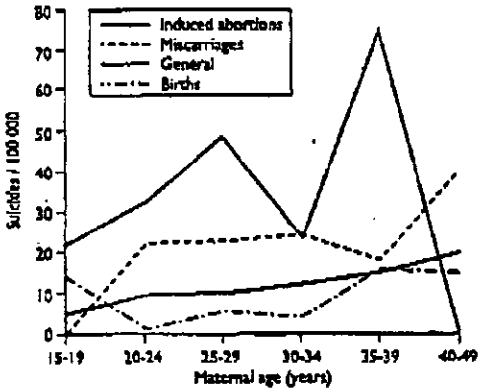


Fig 1—*Suicides for different age groups per 100 000 births, abortions, and miscarriages compared with annual general suicide rate per 100 000 women, Finland 1987-94*

Key messages

- About 5% of suicides in women of childbearing age are associated with an ended pregnancy
- The risk of suicide after birth is half of that among women of reproductive age in general
- Suicides are more common after a miscarriage and especially after an induced abortion than in the general population
- Increased risk for suicide after an abortion indicates either common risk factors for both or harmful effects of induced abortion on mental health

depression. Another explanation for the higher suicide rate after an abortion could be low social class, low social support, and previous life events or that abortion is chosen by women who are at higher risk for suicide because of other reasons. Increased risk for a suicide after an induced abortion can, besides indicating common risk factors for both, result from a negative effect of induced abortion on mental wellbeing. With our data, however, it was not possible to study the causality more carefully. Our data clearly show, however, that women who have experienced an abortion have an increased risk of suicide, which should be taken into account in the prevention of such deaths.

Funding: National Research and Development Centre for Welfare and Health (Stakes).
Conflict of interest: None.

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(Accepted 2 October 1996)

Association of cardiovascular disease risk factors with socioeconomic position during childhood and during adulthood

D Blane, C L Hart, G Davey Smith, C R Gillis, D J Hole, V M Hawthorne

Abstract

Objective—To investigate strength of associations between risk factors for cardiovascular disease and socioeconomic position during childhood and adulthood.

Design—Cross sectional analysis of status of cardiovascular risk factors and past and present social circumstances.

Subjects—5645 male participants in the west of Scotland collaborative study, a workplace screening study.

Main outcome measures—Strength of association between each risk factor for cardiovascular disease (diastolic blood pressure, serum cholesterol concentration, level of recreational physical exercise, cigarette smoking, body mass index, and FEV_1 score (forced expiratory volume in one second as percentage of expected value) and social class during childhood (based on father's main occupation) and adulthood (based on own occupation at time of screening).

Results—All the measured risk factors were significantly associated with both father's and own social class ($P<0.05$), apart from exercise and smoking (not significantly associated with father's social class) and body mass index (not significantly associated with own social class). For all risk factors except body mass index, the regression coefficient of own social class was larger than the regression coefficient of father's social class. The difference between the coefficients was significant for serum cholesterol concentration, cigarette smoking, body mass index, and FEV_1 score (all $P<0.001$).

Conclusions—Subjects' status for behavioural risk factors (exercise and smoking) was associated primarily with current socioeconomic circumstances, while status for physiological risk factors (serum cholesterol, blood pressure, body mass index, and FEV_1) was associated to varying extents with both past and present socioeconomic circumstances.

Introduction

The current debate about the origins of cardiovascular disease in early life has important implications for health promotion and preventing cardiovascular disease. If risk of disease in adulthood is substantially influenced by either biological programming in utero[1,2] or circumstances in early life[3–6] then what remains for attempts to encourage healthy lifestyles in adults? Should such attempts be abandoned or amended in line with more recent information?

Previous studies of the relation between childhood social circumstances and adult cardiovascular disease provide uncertain guidance because each study, from this point of view, is limited in some respect: the number of risk factors for cardiovascular disease included in the analyses is restricted,[4,6] social circumstances during adulthood are excluded,[7,8] or social circumstances during childhood are so different from those in most industrialised countries that generalisation is difficult.[9,10]

We addressed these issues in an industrial population and compared the influence of childhood and adult social circumstances on six widely accepted risk factors for cardiovascular disease. Our intention was to estimate the strength of the associations between these risk factors and adult socioeconomic circumstances, after childhood circumstances had been taken into account (and vice versa), in order to determine where

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Dr Blane.

BMJ 1996;313:1434–8

VOTING TO PROHIBIT A PARTICULARLY GRUESOME AND INHUMAN ACT

"A particular problem of conscience can arise in cases where a legislative vote would be decisive for the passage of a more restrictive law, aimed at limiting the number of authorized abortions, in place of a more permissive law already passed or ready to be voted on. Such cases are not infrequent. ... In a case like the one just mentioned, when it is not possible to overturn or completely abrogate a pro-abortion law, an elected official, whose absolute personal opposition to procured abortion was well known, could licitly support proposals aimed at limiting the harm done by such a law and at lessening its negative consequences at the level of general opinion and public morality. This does not in fact represent an illicit cooperation with an unjust law, but rather a legitimate and proper attempt to limit its evil aspects."

-- John Paul II, *Evangelium Vitae* ("The Gospel Of Life"), n. 73

A Hypothetical: The State of New Concord has a death penalty which permits a criminal to be put to death by cutting a hole in the back of the criminal's head and suctioning his or her brains out and then crushing the convict's head, or by public flogging and then hanging. The legislature is asked to vote on a bill that prohibits each of these "cruel and inhuman methods of carrying out a death sentence." Instead it wants to restrict death sentences to only lethal injections of a pain killer. Many within the State Legislature object to the death penalty altogether as a matter of their own "personally-held moral principles" and "religious convictions." But they know if they do not vote to pass the bill, then death will continue to be imposed upon convicts in the State by hangings or by suctioning out their brains and crushing their skulls. They want to stop these particularly gruesome and inhuman means of terminating a human person's life.

In such a situation, the legislator can licitly vote to prohibit those methods in a bill that does not altogether prohibit the death penalty. They can object to the death penalty and still be morally compelled and accountable to vote to prohibit that which is particularly gruesome and offensive.

March 7, 2000

Dear Legislator

Concerning HB 1116, (partial birth abortion) I am totally against it. It is a barbaric procedure.

Who knows what this baby might have grown up to be, what good it may have done to society, another Marie Curie or Thomas Edison?

Why should a young girl, who just delivered a baby by herself be prosecuted if the baby dies? Have you any idea how it feels to give birth? And after? Those who should be prosecuted are the doctors who do such procedures + are supposed to work for health and not for death.

Sincerely

Mrs. Ernest Chabot
146 Cartier St.
Manchester N.H.
03102

FILE COPY

HB 1116: A Ban on Partial Birth Abortion

Patrick M. Kiefer
19 Folsom St.
Laconia, NH 03246

603-528-2326

FILE COPY

In support of HB 1116

Partial Birth Abortion! What is a partial birth? Until this procedure was introduced and made known this phrase would have seemed an oxymoron. How can someone be partially born?

We are either born or we are unborn. There is no in-between. This is the problem with this method of abortion. The infant is forced to begin the process of birth. In the middle of this process the birth is stopped. This is the most important step. If the birth isn't stopped before it is completed then the end result isn't an abortion. If the baby is allowed to complete the birth the ending of its life is murder. Simply keeping one or two inches of the baby's head within its mother is the difference between an abortion and a murder. A little slip of that baby's head and the abortion cannot legally be performed.

What a difference an inch or two makes. An inch or two of the baby's head inside its mother and that tissue is considered a fetus, with no legal rights. Allow the baby's whole head outside its mother's body and the law declares that it is a human being, with all the rights of any other human. Among those rights are life and liberty.

Throw out all the legalities and think like a rational human. What is the real difference in the circumstances of those two inches? There is no difference. The baby is human in both cases. One is wanted by its mother, the other isn't.

If a mother's health is truly in question what difference will those two inches make? Doesn't it make sense to bring the baby out those two inches and save both mother and child?

In an article in the January 31 issue of The New Republic, titled "Abortion and Brainwaves," author Gregg Easterbrook argues that scientists can now record brain activity in the third trimester that is virtually the same as that of a newborn. This means that the child in the womb feels pain and is aware of its surroundings. Easterbrook is not pro-life. He justifies the majority of abortions because they occur when science is unable to document brain activity.

In fetal surgery, doctors are able to remove the uterus, operate upon the unborn child for such diseases as spina bifida and then place the uterus back into the mother so that she can carry the child to term. For most common sense Americans, it is not hard to understand that if a fetus can be a patient, then it most certainly is a human being, not a "choice."

Please vote in favor of HB 1116 and end this illogical procedure. Thank you.

February 20, 2000

Representative Henry Mock
East Branch Rd
Jackson NH 03846

Dear Representative Mock:

Please include me in any affirmative voting on the abolition of the partial-birth abortion, HB 1116. I misplaced the article on the updates about such bills and I see I missed the Feb. 15th Hearing. If I can still be counted as being against it please count me in loud and clear.

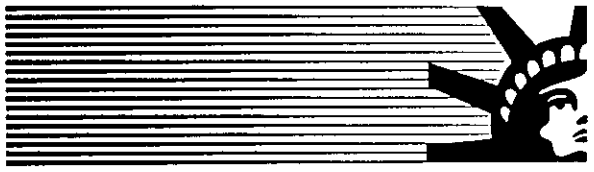
Please keep me updated on the status of this bill. Thank you very much.

Sincerely,
Susan Cook

Susan Cook
317 Mast Road
Goffstown, NH 03045

FILE COPY

Promoting Reproductive Choices **NARAL**



New Hampshire

FILE COPY

TO: House Judiciary Committee
FROM: Peg Dobbie, NARAL-NH
RE: HB 1116-FN, prohibiting partial birth abortions
DATE: February 15, 2000

Mr. Chairman and Members of the Committee:

My name is Peg Dobbie, and I am the Executive Director of the National Abortion and Reproductive Rights Action League of New Hampshire (NARAL-NH). I am here today on behalf of our 2,500 members statewide to express our opposition to HB 1116-FN.

Opponents of choice have been using inflammatory rhetoric about "infanticide" and "partial birth" abortion in a nationwide strategy to further their goal of eroding women's reproductive options. These legislators say they are trying to ban only one abortion procedure, but the vague and broadly worded legislation indicates another motive: they want a political tool to use against women and politicians to undermine support for reproductive choice.

NARAL-NH opposes HB 1116-FN for the following reasons:

1) Private medical decisions should be made by women and their families, not politicians.

Medical decisions are often difficult and complex and depend on a variety of individual factors. Politicians are not trained to make medical decisions and should not regulate medicine in a way that undermines the safety of patients. Bans on so-called "partial birth" abortion would take medical decisions out of the hands of women and their families and give it to politicians.

The American College of Obstetricians and Gynecologists (ACOG), an organization dedicated to women's health, opposes this criminal ban because "[t]he intervention of legislative bodies into medical decision making is inappropriate, ill advised and dangerous."

2) Women's health would be endangered by bans on abortion procedures.

HB 1116-FN does not provide an exception to protect women's health. The Supreme Court has concluded in several cases that a woman's health must remain the physician's primary concern and that a physician must be given the discretion to determine the best course of treatment to protect women's lives and health.

(over)

3) HB 1116-FN violates the core principles of *Roe v. Wade*.

In court challenges across the country, judges have found similar bans on abortion procedures unconstitutional. These courts have concluded that:

- The definition of what methods of abortion would be banned is vague and overbroad. "Partial birth" abortion is a political term, not a medical term. Courts have found that it would ban a variety of safe and common abortion procedures, not just one procedure.

- By banning a variety of safe abortion procedures, the bans impose an undue burden on women seeking access to abortions by forcing them to rely upon less safe medical options.

- The bans, as typically introduced, apply throughout pregnancy. The Supreme Court said that the government cannot restrict a woman's decision prior to fetal viability.

- The bans are unconstitutional because they do not allow women to obtain a banned procedure when it would preserve their health.

On behalf of NARAL-NH's 2,500 members, I urge you to find HB 1116-FN Inexpedient to Legislate. Thank you for your consideration.

New Hampshire NOW
7 Colby Court
Unit 4-252
Bedford, NH 03110-6427
phone: (603) 749-8900
email: nh-now@nh.ultranet.com
web: http://www.nh/.ultranet.com/~nh-now

FILE COPY

11 February 2000

Dear Judiciary Committee Members,

I address you in the name of the New Hampshire chapter of the National Organization for Women and its approximately 1300 members in New Hampshire, to ask you to oppose House Bill 1116, a bill entitled "prohibiting partial-birth abortions."

House Bill 1116 should not become law in New Hampshire for many reasons. It is vague. It is unnecessary. It is a popular strategy to overturn laws that recognize that the right to privacy extends to the decision of a woman, in consultation with her physician, to terminate her pregnancy. The term "partial-birth" abortion is not even a medical term. Anti-abortion strategists use this language to mislead the public as well as state and federal lawmakers, in their continued effort to ban many procedures all at once.

House Bill 1116 is vague. In other states when laws similar to this one have been brought before the state courts, they have been struck down because they are unconstitutionally vague. Even if narrowly interpreted, these bans would prohibit late-term procedures which a woman's physician may recommend as the safest method of termination and vital to the protection of her physical, reproductive and/or emotional health. Procedures bans place unqualified legislators in the position of making medical decisions. As one Illinois judge said of the ban considered in his state, "...the statute, as written, has the potential effect of banning the most common and safest abortion procedures."

House Bill 1116 is not necessary. Late-term abortions are not undertaken lightly, and are very rare. Most involve wanted pregnancies that go tragically wrong when the woman's life or health is endangered or the fetus develops abnormalities incompatible with life. Roe v. Wade addressed legal restrictions to abortion related to trimester and viability. We already have laws that ban later-term abortions except to protect the health or life of the woman. New Hampshire should not create new laws for which there is no need.

House Bill 1116 ranks among the worst tactics known to achieve a hidden political agenda. This bill takes a seriously personal and heart-wrenching situation and uses simplistic images to emotionally influence lawmakers and the public at large. While anti-abortion forces claim to be targeting a specific late-term procedure, this proposed law purposely contains broad language, no clear definition of the procedure and no reference to trimester. This bill, with its vague wording and threats of fines and imprisonment, is designed to scare doctors away from performing any abortion.

The National Organization for Women supports every woman's right to safe, legal abortion. We believe that the "partial-birth abortion" ban is an extreme and dangerous measure. This proposed ban's vague language and criminal penalty could affect a doctor's medical decision and seriously compromise a woman's health. This bill addresses a recognized medical procedure, not a crime. New Hampshire does not need this superfluous, vague and unnecessary law.

Please oppose House Bill 1116.

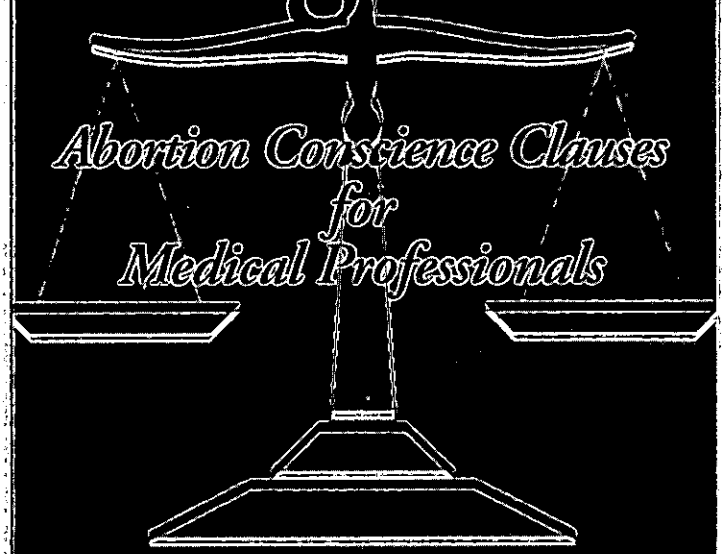
Thank you,

Kris Moody
President, New Hampshire National Organization for Women (NH NOW)

43 STATES. LISTED.

N.33

Knowing Your Rights:



Abortion Conscience Clauses for Medical Professionals

THE HIPPOCRATIC OATH is clear as to the responsibility of the physician not to procure or participate in an abortion:

> *I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion.*

While some "doctors" have violated this medical ethic of antiquity, many stand firm.

Some 43 states have laws on the books to protect the consciences of those who refuse to abandon the Hippocratic Oath, who understand that life is to be served, not destroyed. Below is a list of these states and their conscience laws.

ALASKA – "Nothing in this section requires a hospital or person to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion." (*Alaska Stat.* 18.16.010)

ARIZONA – "A physician, or any other person who is a member of or associated with the staff of a hospital, or any employee of a hospital, doctor, clinic or other medical or surgical facility ... shall not be required to participate in the abortion." (*Ariz. Rev. Stat.* 36-2151)

ARKANSAS – "No person shall be required to perform or participate in medical procedures which will result in the termination of pregnancy." (*Ark. Stat. Ann.* 20-16-601)

CALIFORNIA – "No such employee of person with staff privileges in a hospital, facility, or clinic shall be subject to any penalty or discipline by reason of his or her refusal to participate in an abortion." (*Cal. Govt. Code* 123420)

COLORADO – "The refusal of any such person to participate [in an abortion] does not form the basis for any disciplinary or other recriminatory action against the person." (*Colo. Rev. Stat.* 18-6-104)

DELAWARE – "No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy." (*Del. Code Ann.* 1791)

FLORIDA – "Nothing in this section shall require any hospital or any person to participate in the termination of a pregnancy, nor shall any hospital or any person be liable for such refusal." (*Fla. Stat. Ann.* 390.001)

GEORGIA – "Any person who states in writing an objection to any abortion...shall not be required to participate in procedures which will result in such abortion; and the refusal of the person to participate therein shall not form the basis of any claim for damages or for any disciplinary or recriminatory action against the person." (*Ga. Code. Ann.* 16-12-142)

HAWAII – "Nothing in this section shall require any hospital or any person to participate in such abortion nor shall any hospital or person be liable for such refusal." (*Hawaii Rev. Stat.* 453-17)

IDAHO – "Neither shall any physician be required to perform or assist in any abortion, nor shall any nurse, technician or other employee of any physician or hospital be required by law to assist or participate in the performance or provision of any abortion." (*Idaho Code* 18-612)

ILLINOIS – "No physician, hospital, ambulatory surgical center, nor employee thereof, shall be required...to perform, permit, or participate in any abortion." (*720 ILCS* 510/13)

INDIANA – "No physician or employee or member of the staff of a hospital or other facility in which an abortion may be performed shall be required to perform an abortion." (*Ind. Code Ann.* 16-34-1-4)

IOWA – "A person shall not discriminate against any individual in any way... because of the individual's participation in or refusal to participate in recommending, performing, or assisting in an abortion procedure." (*Iowa Code* 146.1)

KANSAS – "No person shall be required to perform or participate in medical procedures which result in the termination of a pregnancy." (*Kas. Stat. Ann.* 65-443)

KENTUCKY – "No physician, nurse staff member, or employee of a public or private hospital or employee of a public or private health care facility... shall be required to, or be held liable for refusal to, perform, participate, or cooperate in such abortion." (*KRS* 311.800)

LOUISIANA – "No physician, nurse, student, or other person shall be ... in any way prejudiced or damaged because of his refusal for any reason to recommend, counsel, perform, assist with, or accommodate an abortion." (*La. Rev. Stat. Ann.* 40:1299.31)

MAINE – "No physician, nurse, or other person, who refuses to perform or assist in the performance of an abortion, shall, because of that refusal, be dismissed, suspended, demoted, or otherwise prejudiced or damaged." (*Me. Rev. Stat. Ann. tit.* 22, 1591)

MARYLAND – "A person may not be required to perform or participate in any medical procedure that results in termination of pregnancy." (*Md. Health-Gen. Code Ann.* 20-214)

MASSACHUSETTS – "A physician or any other person who is a member of or associated with the medical staff of a hospital or other health facility shall not be required to participate in the medical procedures which result in such abortion." (*Mass. Gen. Laws Ann. ch.* 112.121)

MICHIGAN – "A physician, member, or associate of the staff, or other person connected therewith, may refuse to perform, participate in, or allow to be performed on its premises an abortion." (*Mich. Comp. Laws* 333.20181)

MINNESOTA – "No person and no hospital or institution shall be coerced, held liable, or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion." (*Minn. Stat.* 145.414)

MISSOURI – "It shall be unlawful for any employer to discriminate against any individual ... because of such individual's refusal to participate in abortion." (*Mo. Ann. Stat.* 188.105)

MONTANA – "All persons shall have the right to refuse to advise concerning, perform, assist, or participate in abortion." (*Mont. Code Ann.* 50-20-111)

NEBRASKA – "No person shall be required to perform or participate in any abortion." (*Neb. Rev. Stat.* 28-338)

NEVADA – "An employer shall not require a nurse or any other person employed to participate di-

rectly in the induction or performance of an abortion." (*Nev. Rev. Stat. Ann.* 632.475)

NEW JERSEY – "No person shall be required to perform or assist in the performance of an abortion." (*N.J.S.A.* 2A:65A-1)

NEW YORK – "Any person may refuse to perform or assist in such abortion." (*NY CIV RTS s* 79-I)

NORTH CAROLINA – "Nothing in this section shall require a physician or nurse ... to perform or participate in medical procedures which result in an abortion." (*N.C. Gen. Stat.* 14-45.1)

NORTH DAKOTA – "Nor may such hospital or person in any circumstances be required to participate in the performance of an abortion." (*N.D. Cert. Code* 23-16-14)

OHIO – "No person is required to perform or participate in medical procedures which result in abortion." (*Ohio Rev. Code Ann.* 4731.91)

OKLAHOMA – "No person may be required to perform, induce, or participate in medical procedures which result in an abortion." (*Okla. Stat. Ann. tit.* 63-1-741)

OREGON – "No hospital employee or member of the hospital medical staff is required to participate in any termination of a pregnancy." (*Or. Rev. Stat.* 435.485)

PENNSYLVANIA – "No medical personnel or medical facility, nor any employee, agent or student thereof shall be required to aid, abet, or facilitate performance of an abortion or dispensing of an abortifacient." (18 *Pa. Stat. Ann.* 3213)

RHODE ISLAND – "A physician or any other person ... shall not be required to participate in the medical procedures which result in abortion." (*R.I. Gen. Laws* 23-17-11)

SOUTH CAROLINA – "No physician, nurse, technician, or other employee of a hospital, clinic, or physician, shall be required to recommend, perform, or assist in the performance of an abortion." (*S.C. Code Ann.* 44-41-50)

SOUTH DAKOTA – "No physician, nurse, or other person who refuses to perform or assist in the performance of an abortion shall be liable to any person." (*S.D. Comp. Laws Ann.* 34-23A-12)

TENNESSEE – "No physician shall be required to perform an abortion and no person shall be required to participate in the performance of an abortion." (*Tenn. Code Ann.* 39-15-204)

TEXAS – "A physician, nurse, staff member, or employee of a hospital or other health care facility may not be required to perform or participate, directly or indirectly, in an abortion procedure." (*Tex. Rev. Civ. Stat. Ann. art.* 4512.7)

UTAH – "A physician or any other person ... shall not be required to participate in the medical procedures which will result in abortion." (*Utah Code Ann.* 76-7-306)

VIRGINIA – "Any person who shall state in writing an objection to any abortion ... shall not be required to participate in procedures which will result in such abortion." (*Va. Code Ann.* 18-2-75)

WASHINGTON – "No hospital, physician, nurse, hospital employee, nor any other person shall be under any duty, to participate in a termination of pregnancy." (*Wash. Rev. Code Ann.* 9.02.080)

WISCONSIN – "No hospital, school, or employer may discriminate against any person on the ground that the person refuses to recommend, aid, or perform procedures for the removal of a human embryo or fetus." (*Wis. Stat. Ann.* 253.09)

WYOMING – "No person shall, in any way, be required to perform or participate in any abortion." (*Wyo. Stat.* 35-6-106)

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SERVING MAINE, NEW HAMPSHIRE AND VERMONT

NH PUBLIC AFFAIRS OFFICE
18 Low Avenue
Concord, NH
03301
Phone 603.225.2925
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Testimony in Opposition to House Bill 1116
February 15, 2000

Good Morning. My name is Jennifer Frizzell. I am an attorney and the Public Affairs Director for Planned Parenthood of Northern New England in the state of New Hampshire. Planned Parenthood operates nine women's health centers throughout New Hampshire where we offer a wide variety of preventive health, education and family planning services, including first trimester abortion in some sites. The health professionals at Planned Parenthood work on a daily basis to help people plan and control their reproductive lives with regard to their individual values and with full respect for their individual decisions. We trust that NH women and their partners are moral decision-makers and we believe that NH doctors must be free to make the most appropriate medical judgments when caring for pregnant women. We are deeply concerned by the amount of misinformation that has circulated on abortion, abortion techniques, and about the potential devastating consequences HB 1116 would have on medical care for women in New Hampshire. We are also disturbed that the medical community is being abstractly vilified and targeted by individuals who do not support access to safe, legal abortion at any stage of pregnancy. **HB 1116 is bad public health policy and bad law.**

The proposed legislation seeks to make a troubling policy statement.... that the potential of fetal life is more valuable than women's health. HB 1116 would substitute a "one size fits all" political prescription for "case-by-case" medical judgment. It would have a chilling effect on the willingness of physicians to undertake medical procedures or to treat abnormal pregnancies. The legislation erects barriers which prevent physicians from considering the most medically appropriate options for their patients. And in the end, it would allow legislators to dictate medical care and interfere with the physician / patient relationship.

I hope that you will be able to see through the emotional, graphic testimony presented by proponents of this bill and recognize the true intentions of this legislation – to further the political agenda of individuals who do not support a women's right to choose abortion under any circumstances. This legislation, if successful, will simply be the first step in a "procedure by procedure" attempt to make the constitutional right to choose meaningless for NH women. In states around the country where identical statutes have been enacted, more than 20 U.S. federal courts have recognized that these laws are in direct conflict with the legal principles enunciated in Roe vs. Wade [1] and in doing so have struck the laws as unconstitutional for several compelling reasons. 1) First, the bill's language is extraordinarily vague and broad enough to encompass almost all methods of abortion at nearly every stage of pregnancy. "Because of the sweeping breadth of this language, it would operate to eliminate some of the safest abortion procedures...needlessly leaving women with only far riskier alternatives."[2] 2) Second, by banning the most commonly performed abortion procedure used in the second trimester of pregnancy, the language restricts access to abortion even before a fetus has reached viability – thus infringing upon well established constitutional rights to be free of government interference. 3) Finally, the bill does not provide any exception for the protection and preservation of the health of the mother.

In conclusion, I would like to ensure you that the public support for these initiatives is shallow and based on sheer ignorance of the medical realities of abnormal pregnancies and abortion techniques. You only need to look to our neighboring state of Maine who recently put the issue of banning so-called "partial-birth" abortion out to referendum, to affirm that when educated about the ban's true intentions and consequences, citizens overwhelmingly reject the idea of leading government down the path of interfering with these very private decisions and eroding the basic principles enunciated in Roe vs. Wade. **Along the same rationale, we hope that you will reject HB 1116 and steer NH clear of imposing restrictions on abortion that will jeopardize a woman's life or health. Please vote HB 1116 "Inexpedient to Legislate".** Thank you for your time and consideration.

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[1] 410 US 113, (1973)

[2] Evans v. Kelly, No. 97-CV-71246, 1997 WL 471906 (E.D. Mich July 31, 1997)

FILE COPY

Dear Representative,

I am writing today to ask you to do everything possible to end partial birth abortion in the State of New Hampshire. This procedure has been acknowledge to be dangerous to women, and is virtually never necessary as a medical procedure. There are no medical professional groups who recommend this procedure as a good medical procedure.

It is also a bad moral precedent to allow a medical practice which destroys a possibly viable human life while it is in the process of being born. If life can be destroyed at this moment, why not two minutes after birth, or even later. The protection of any citizen's' Right to Life' is generally under attack if such a procedure is given legal protection.

As a Christian I also believe that God is creator of life and that it is a gravely immoral act to kill a human being at this early stage of development when it still vulnerable and helpless. Indeed, not to put into place protection for these babies who are being killed as they are being born, is to be guilty of these very acts of infanticide out of indifference and passivity, something which people of prior times in history have learned to regret with great sorrow. I recall those persons in Germany who stood idly by and turned a blind eye to the evils of genocide taking place in the holocaust. I therefore, plead for these babies who are unable to plead for themselves.

Sincerely,

Carolyn Momenee
Dave Momenee
23 North St., Milford, NH 03055

Please act on HB 1116 to ban partial birth abortion.

February 15, 2000
The House Judiciary Committee
Testimony In Opposition To HB 1116,
A Ban Of A Specific Abortion Procedure

FILE COPY

By Sen. Katie Wheeler

This bill is another insidious attempt to ban all abortions. If you oppose abortion, the method of abortion is not an issue. If you don't trust women to make their own decisions, you don't support any form of abortion. Once again, we find ourselves in the untenable position of legislators being asked to make decisions which we have no right to make. We license doctors to make medical decisions. Legislators have no business discussing which medical procedure a doctor should use. Nor do we have any business interfering with the doctor-patient relationship.

As the committee and the sponsors must know, this bill was defeated in the Senate last year, and then, indefinitely postponed. As all legislators know, this means that the Senate will not and can not take up this bill this year. As there is absolutely no hope that this bill could be signed into law this year, the only reason for bringing it forth must be political--the desire to get people on record with their votes in an election year. This is pretty cynical behavior for people who purport to have only the welfare of the unborn in mind. In fact, this bill and all the other bills you will hear this year regarding abortions have the same goal, to so weaken the provisions of Roe V. Wade, that abortions will be unavailable if not illegal. This bill and the others like it are part of a national agenda that changed a few years ago when opponents of Roe v. Wade finally realized that their efforts to overthrow the entire court decision protecting a woman's right to reproductive privacy would not succeed. This bill and all the others are part of a chipping away process, a process which is clearly delineated in the May 1988 issue of *Governing,* where Emory University law professor David Garrow is quoted as saying: "The great step forward the pro-life movement has made is in no longer going for the whole enchilada".

I have heard the sponsors of this bill speak many times on these issues. I know that they speak from the heart, and I know they don't like being called part of a national agenda, but whether they like it or not, they are. When questioned, they agree that they don't accept any form of abortion, which means that all the fuss about this procedure is really just a smoke screen to cover the path to a total ban on all abortions, or, if not a ban, then an inability to get an abortion because it will be unavailable.

In previous years, I have listened to testimony on this bill which trivialized a woman's decision to have an abortion by saying that she would have it for "convenience". It is extremely insulting to women to think that we have no moral compass of our own, that we need some bunch of legislators telling us what is right for us, what is morally correct. I don't presume to make these judgments for any of you, and I don't want you making them for me. The best you can do with this bad situation is to recommend that this bill should be inexpedient to legislate. It should never have been introduced.



C O N C O R D
FEMINIST HEALTH
C E N T E R

February 15, 2000
Testimony re: HB 1116-FN
Relative to prohibiting "certain abortions" [IDE]
House Judiciary Committee

FILE COPY

Members and Chair of the Committee:

My name is Kudra MacCaillech and I represent Concord Feminist Health Center and Portsmouth Feminist Health Center in Greenland. Our non-profit facilities provide community education, well-woman gynecological care and reproductive health services including first-trimester abortion. We oppose HB 1116-FN as we find it an unacceptable legislative invasion of private medical decisions and an attempt to limit women's access to the constitutionally protected right to obtain an abortion. We stand in agreement with professional health organizations such as American College of Obstetricians and Gynecologists and Physicians for Reproductive Choice and Health in that any legislation which criminalizes a safe, legitimate medical procedure is unjustified.

OB-GYN providers have spent the last 27 years developing methods of surgical and medical abortion, largely without the benefit of medical schools, teaching institutions or government agencies. And still, they have made abortion the **safest surgical procedure** performed in this country today.

It it our hope that they continue to develop safe methods so to provide the best medical care to women. Abortion surgery has been an evolution of physician-developed techniques. Each is a step in advancing the health and safety of patients. The intact D&E and D&X were developed for precisely that reason..it is a continuum of good care.

38 South Main Street • Concord, New Hampshire 03301 • phone: 603 . 225 . 2739 • fax: 603 . 228 . 6255

In the US, only 1% of all abortions are done after 20 weeks. Some doctors perform the intact D&E method before 24 weeks because they feel it is in the best interest of the patient. And, for those rare but necessary D&X procedures performed after 24 weeks, doctors **must** be able to use this method because of a serious health threat posed to the patient or because of a severe fetal anomaly.

The Health Center provides referrals for women seeking abortion services in the second trimester. We know that women seek later term abortions for a myriad of reasons; reasons always unique to her specific life/health circumstances and often complex. These are women who perhaps have no source of transportation, making it difficult to get to a provider; women who have had great ambivalence about their decision to terminate the pregnancy; women who for a variety of reasons including extreme emotional distress, are in denial of the fact that they are pregnant; women who have little or no financial resources in which to pay for the costs associated with the procedure and/or travel expenses; women who find that relationship changes have changed the feasibility of carrying the pregnancy to term; women who have health problems and pregnancy complications that deem the procedure the best medical option.

The truth about abortion is that women, who before 24 weeks of pregnancy, and for whatever personal reasons are unable to have a baby at a particular time in their life, seek out our medical and referral services. They've made an extremely difficult decision and know that if they do not act, they will have a child. They don't engage in the debate; they come to us because they want safety, confidentiality and compassion. In turn, it is our responsibility to provide them with the best possible medical care and advice, in an atmosphere of dignity and respect.

We continue to focus on a particular method and avoid the reasons why women need abortions. Why, in this age of contraception, public education and awareness, are there still so many unwanted pregnancies? All of us share the responsibility for the problem of unwanted, unplanned pregnancies. The focus should not be on abortion or those who provide the services, but rather what can we as a country do to solve this problem.

It is hard to think that lawmakers would wish to take the responsibility of tying the hands of physicians, who with great skill and expert medical judgment, need to be free to manage the complicated health conditions that their female patients present with. These sensitive decisions are for the woman and her physician to make within the privacy of the doctor's office, not for the legislators within the courtrooms. Laws that restrict therapeutic options undermine our system of delivery of quality medical care and could potentially lead to unnecessary injury and harm. For these reasons, I urge you to vote in opposition to this bill.

Thank you for your consideration.

I am,

Kudra MacCaillech

FILE COPY

Testimony

of

Vincent M. Rue, Ph.D.
Co-Director
Institute for Pregnancy Loss
Stratham, NH

Before the House Judiciary Committee

State of New Hamphsire

2000 Session

Regarding

Partial-Birth Abortion Ban -

House Bill 1116-FN

Concord, NH

15 February 2000

Testimony of Vincent M. Rue, Ph.D.

1 **In General, Elective Abortion Carries Certain and Significant Psychological Health Risks for Some Women:**

1.1 From the research available, women who have elected to terminate their pregnancies can experience the following reactions: relief, mild transient anxiety and depression, stress, trauma, dissociation, major depression, posttraumatic stress disorder, psychosis and suicide. Depending upon the study, the incidence of these reactions range from 5% to 60%.

1.2 Some women who made their abortion decision in certainty and experienced only positive outcomes following the procedure are surprised and overwhelmed by the intensity and duration of their negative emotional responses months or years later.

1.3 Symptoms of intrusiveness and reexperience followed by avoidance and denial are hallmarks of posttraumatic stress disorder in general, and postabortion trauma in particular.

1.4 Certain pregnant women are more likely to experience postabortion emotional injury than others:

1.4.1 *adolescents*
1.4.2 *repeat abortions*
1.4.3 *mid or late trimester abortions*
1.4.4 *coerced or pressured abortions*
1.4.5 *when abortion violates personal beliefs, morals and values*
1.4.6 *abortion undertaken for medical/genetic reasons*
1.4.7 *no or limited partner/parental support*
1.4.8 *when the abortion choice is not duly considered, counseled or informed*
1.4.9 *preabortion emotional maladjustment*
1.4.10 *when a woman's perceived postabortion coping expectancy is negative*
1.4.11 *when a woman perceives her uterine contents as "human" and a "child"*
1.4.12 *when the abortion event is perceived by the woman as violent and death producing*
1.4.13 *conflicted abortion decision, including considerable ambivalence*
1.4.14 a secret abortion

2 **Women Who Obtain Mid or Late Trimester Abortions Are Generally a Vulnerable Population with Special Needs**

2.1 These women are likely to be under 21 years of age.

2.2 These women are likely to have lower educational attainment.

2.3 Some of these women have wanted or desired pregnancies and consider abortion only for medical/genetic reasons.

2.4 These women are likely to have more disturbed relationships with mates and/or parents.

2.5 These women are likely to function with considerable denial, ambivalence and decision-making conflict.

2.6 These women are more likely to experience their abortion as emotionally stressful and problematic than women obtaining first trimester abortions.

3 **Special Conflicts Affecting Women Who Terminate Their Pregnancies in Mid to Late Trimester**

3.1 These women are more likely to have experienced fetal movements.

3.2 These women are more likely to identify their pregnancy as a "baby" or "child."

3.3 These women are more likely to have formed attachment/bonding to this child.

3.4 These women must exert more emotional management of conflicted feelings and employ more rationalizations in order to deny the person/human nature of the fetus.

3.5 This restricted range of affect and avoidance effort results in more role conflict, i.e., thwarting of maternal instinct and relatedness, anticipatory grief and complicated mourning, as well as traumatic loss, i.e., disruption of the woman's sense of safety and control which causes the loss of a sense of identity and purpose.

4 **The Nature and Risks of Mid or Late Trimester Abortions Include:**

4.1 an emotionally wrenching experience for patient, physician and attending staff

4.2 greater risks of morbidity and mortality than first trimester procedures

4.3 greater emotional stress than first trimester procedures

4.4 at 20 wks >, risks of mortality and morbidity equal or exceed risks of childbirth

4.5 little social support and considerable stigma, particularly when undertaken for personal/social reasons

4.6 increased significant risks of subsequent spontaneous abortion, premature delivery, and low birth weight

4.7 increased risks of future negative reproductive outcomes increase the risks of attendant psychological problems that can result from these physical outcomes

4.8 at 21 wks. > the risk of mortality from elective abortion is three times greater than that from childbirth, using the corrected computation of Koonin et al.

4.9 a mid or late trimester abortion is in itself a risk factor for negative postabortion emotional aftermath

5 **When Wanted Pregnancies Are Terminated for Medical/Genetic Reasons (The Minority of Partial Birth Abortions), There are Increased Emotional Risks Associated With This Decision and They are More Likely to:**

5.1 experience intense guilt and grief

5.2 experience unresolved grief

5.3 become pregnant again prematurely

5.4 experience durational emotional problems

5.5 be at risk for a subsequent abortion and its attendant psychological sequelae

6 **The Human Context of Partial-Birth Abortions**

6.2 Fetal development at 24 wks. LMP is undeniably human: 9 inches in length; 1 lb. in weight; is completely formed and has the appearance of a child; noticeably moves, sucks and grips; has toenails, fingernails, eyebrows, and ears; gender is apparent; is responsive to external stimuli; and is capable of surviving outside of the uterus.

6.3 While research suggests that women who do not perceive the fetus as human have less conflict associated with an abortion, in partial birth abortion the rationalization necessary to disguise fetal humanity is extensive generating considerable cognitive dissonance.

6.4 Hence, for a woman to consent to partial birth abortion, even if she is afforded complete and accurate information regarding fetal development and the procedure itself (which is unlikely), she must deny maternal instincts, deny fetal humanity, compromise her objectivity, and mobilize her decision-making around rationalization and denial. This kind of decision-making is likely to result in serious and lasting adverse postabortion emotional adjustment.

7 Stress & Trauma Associated with Partial Birth Abortion

7.1 Women who are likely to obtain a partial birth abortion are at increased risk of serious emotional injury due to:

7.1.1 *the length of pregnancy and/or degree of attachment/bonding*

7.1.2 *the special vulnerability of this population*

7.1.3 *the lack of full disclosure of relevant information regarding fetal development, the procedure itself and its attendant risks so as to result in misinformed consent*

7.1.4 *the intentional design and participation in their child's death because of fetal anomalies*

7.1.5 *the intentional design and participation in their child's death because of social or non-medical reasons*

7.1.6 *the experimental, shocking, and brutally violent nature of the procedure itself*

7.2 Women who are likely to obtain a partial birth abortion are at increased risk of suffering a range of mental disorders, including depression, posttraumatic stress related symptoms and suicidal ideation due to:

7.2.1 *personally experiencing the violent death of one's child*

7.2.2 *personally experiencing intense fear and threat to one's physical integrity from an unproven and experimental surgical procedure*

7.2.3 *personally experiencing intense fear and threat to one's physical integrity from the insertion of multiple dilators over several days, most likely left alone, and being in an unattended non-hospital setting during this pre-extraction period*

7.2.4 *voluntarily designing and personally approving the gruesome death of one's child and the resulting traumatic symptom picture is likely to be especially severe or long lasting*

7.2.5 *voluntarily allowing, and personally experiencing and/or witnessing the unwilling extraction of one's living child by its foot*

7.2.6 *voluntarily allowing, and personally experiencing and/or witnessing the unwilling*

partial vaginal delivery of one's living child so as to cause its death

7.2.7 voluntarily allowing, and personally experiencing and/or witnessing the mortal penetration of the head of one's child and the suction of its cranial contents

7.3 Women who obtain partial birth abortions are likely to experience significant and lasting symptoms of postabortion trauma due to the traumagenic nature of this procedure, the social stigma attached to late abortion and this particularly inhumane procedure, the corresponding lack of social support necessary for recovery, and the isolation she is likely to experience.

8 **Maternal Health Risk Conclusions**

8.1 Existing research indicates that traditional methods of induced abortion beyond 20 wks. carry equal or greater risks of morbidity and mortality than childbirth.

8.2 Few if any pregnant women seeking a partial birth abortion are informed that this is an experimental procedure, and that the risks of morbidity and mortality are unknown.

8.3 When health risks of a particular abortion procedure are unknown, the public interest is best served by restricting the legality and availability of that procedure until such time that the degree of safety can be quantified, excluding identifiably experimental protocols.

8.4 Partial birth abortion requires a "high degree of surgical skill." On its face, Dr. Haskell's 1992 assertion would suggest that this procedure can be dangerous if undertaken without a "high degree" of surgical skill and training. He further added and "[it] may not be appropriate for a few patients," (previous C-section over 22 wks.; obese patients; twin pregnancy over 21 wks.; and patients 26 wks. and over). However, there is no reliable evidence to support this assertion. In fact, partial birth abortion may be contraindicated for an even larger number of patients.

8.5 If partial birth abortion remains available and legal, despite its traumagenic nature, and its largely unknown health risks, the safety and health of pregnant women are unnecessarily endangered. This procedure is more infanticidal than abortive, carries unjustified physical & psychological health risks, and is both unsupported in public opinion and unethical in practice. A ban should be enacted for the well-being of women, unborn children, and society.

The opinions described herein were formulated as a result of: (a) my clinical experience of 25 years of working with bereaved and traumatized women who have terminated their pregnancies; (b) the research I have conducted; and (c) the psychological literature descriptive of complicated grief, trauma, and induced abortion.

The Institute for Pregnancy Loss *is located in Stratham, NH. It is a not- for- profit research, education & treatment center founded in 1990 by Drs. Vincent Rue & Susan Stanford-Rue to assist women and men in their recovery from volitional (abortion & adoption) and involitional (miscarriage & stillbirth) pregnancy losses. Telephone: (603) 778-1450 & Email: rue@nh.ultranet.com.*

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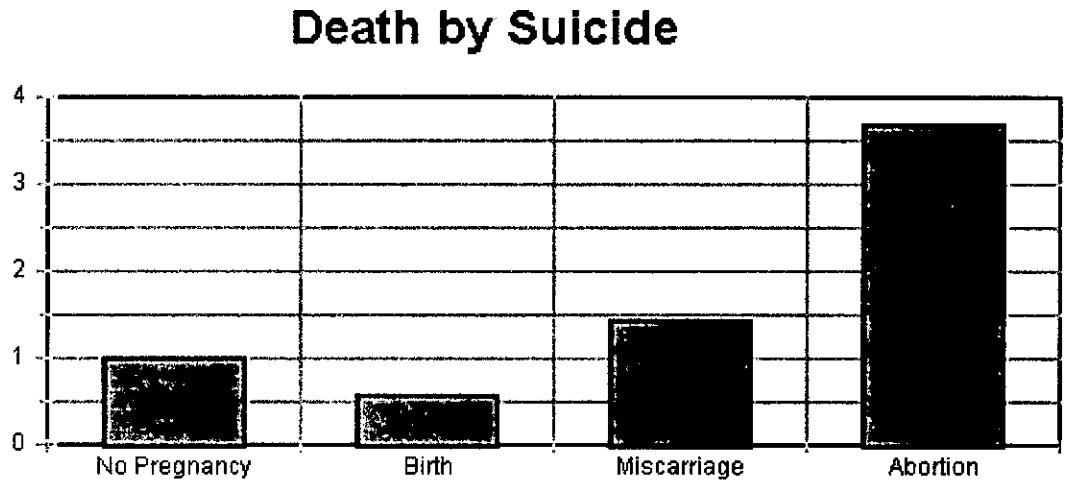
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FILE COPY

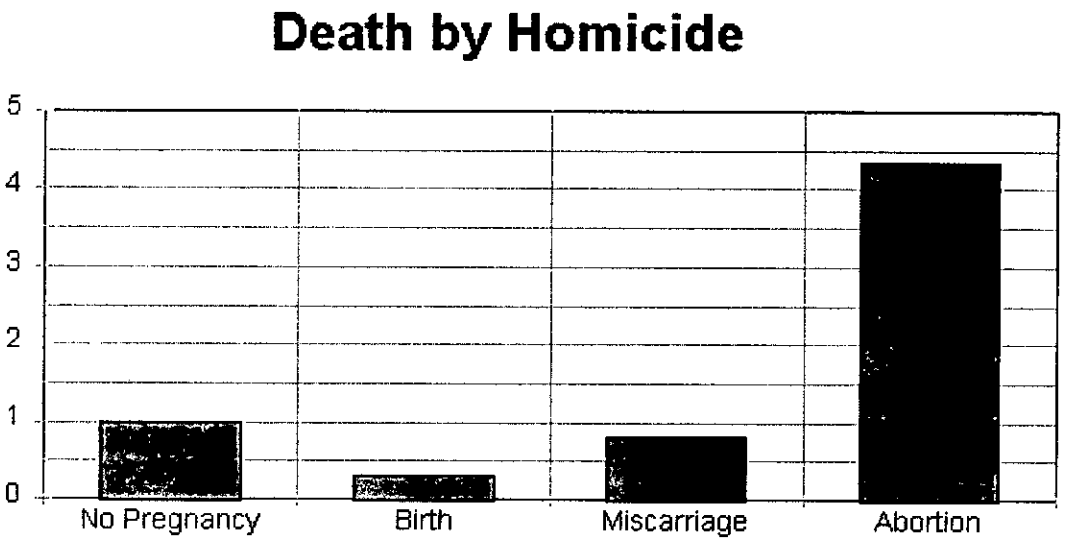
The tables below show the age adjusted odds ratio, 1 being equal to the "normal" death rate for women who were not pregnant in the year prior to their deaths. All data from Gissler, M., et. al., "Pregnancy-associated deaths in Finland 1987-1994 -- definition problems and benefits of record linkage," *Acta Obsetricia et Gynecolgica Scandinavica* 76:651-657(1997).

BRIAN FUSONIE

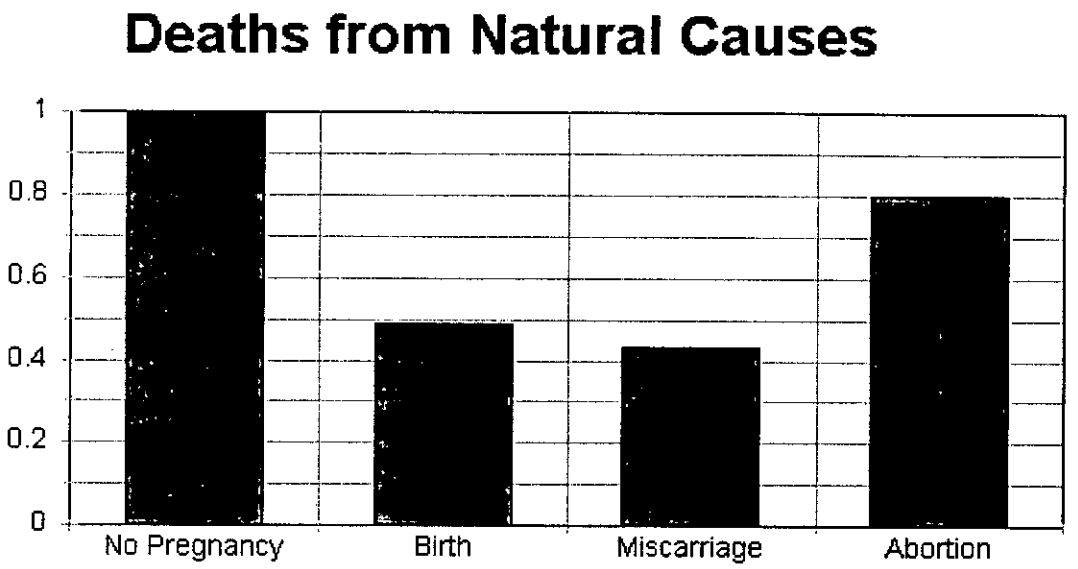
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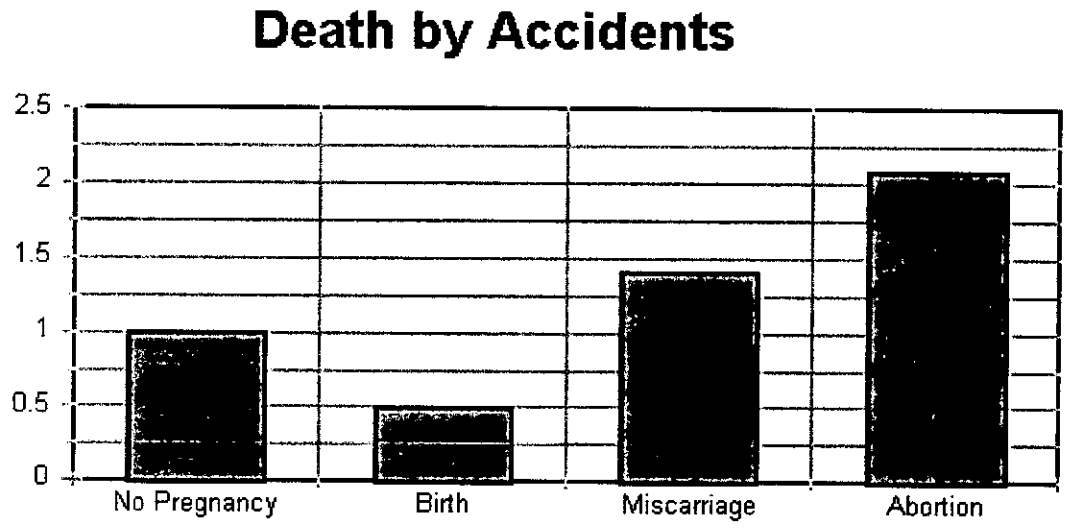
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Voting Sheets

HOUSE COMMITTEE ON JUDICIARY

EXECUTIVE SESSION on HB 1116

BILL TITLE: prohibiting partial-birth abortions.

DATE: 3/15/00

LOB ROOM: 208

Amendments:

Sponsor: Rep. Craig Rowe OLS Document #: 3781-h Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Motions: (OTP), OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Woods

Seconded by Rep. Soltani

Vote: _____ (Please attach record of roll call vote.)

Motions: OTP, (OTP/A), ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Rowe

Seconded by Rep. Rowe

Vote: 5-16 (Please attach record of roll call vote.) Failed

CONSENT CALENDAR VOTE: _____

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Loren J. Jean, Clerk

HOUSE COMMITTEE ON JUDICIARY

EXECUTIVE SESSION on HB 1116

BILL TITLE: prohibiting partial birth abortion

DATE: 3/15

LOB ROOM:

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: 13-8 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Loren J. Jean, Clerk

OFFICE OF THE HOUSE CLERK

2000 SESSION

JUDICIARY

Bill #: HB 1116 Title: _____

PH Date: ___/___/___ Exec Session Date: 3/15/00

Motion: OTPA "Amendment" Amendment #: 3781-H

MEMBER	YEAS	NAYS
Mock, Henry P, Chairman		✓
Peterson, Andrew R, V Chairman		✓
Jacobson, Alf E		✓
Keans, Sandra B		✓
Bergin, Peter F		✓
Dokmo, Cynthia J		✓
Jean, Loren J, Clerk		✓
Rowe, Robert H	✓	
Ford, Nancy M	✓	
Withee, Dennis J	✓	
Dudley, Terri C		✓
Picconi, Al J	✓	
Soltani, Tony F		✓
Woods, Phyllis L		✓
Wall, Janet G		✓
DePecol, Benjamin J		✓
Pratt, John M		✓
Craig, James W	✓	
Lasky, Bette R		✓
Mitchell, McKim W		✓
Solow, Martha S		
Wood, Jane		✓
TOTAL VOTE:	5	16

Printed: 12/30/1999

OFFICE OF THE HOUSE CLERK

2000 SESSION

JUDICIARY

Bill #: 1116 **Title:** _____

PH Date: ____/____/____ **Exec Session Date:** 3/15/00

Motion: OTP **Amendment #:** _____

MEMBER	YEAS	NAYS
Mock, Henry P, Chairman	✓	
Peterson, Andrew R, V Chairman		✓
Jacobson, Alf E		✓
Keans, Sandra B		✓
Bergin, Peter F		✓
Dokmo, Cynthia J		✓
Jean, Loren J, Clerk	✓	
Rowe, Robert H		✓
Ford, Nancy M	✓	
Withee, Dennis J		✓
Dudley, Terri C	✓	
Picconi, Al J	✓	
Soltani, Tony F	✓	
Woods, Phyllis L	✓	
Wall, Janet G		✓
DePecol, Benjamin J		✓
Pratt, John M		✓
Craig, James W		✓
Lasky, Bette R		✓
Mitchell, McKim W		✓
Solow, Martha S		
Wood, Jane	✓	
TOTAL VOTE:	8	13

Printed: 12/30/1999

OFFICE OF THE HOUSE CLERK

2000 SESSION

JUDICIARY

Bill #: 1116 **Title:** _____

PH Date: ___/___/___ **Exec Session Date:** 3/15/00

Motion: ITL **Amendment #:** _____

MEMBER	YEAS	NAYS
Mock, Henry P, Chairman		✓
Peterson, Andrew R, V Chairman	✓	
Jacobson, Alf E	✓	
Keans, Sandra B	✓	
Bergin, Peter F	✓	
Dokmo, Cynthia J	✓	
Jean, Loren J, Clerk		✓
Rowe, Robert H	✓	
Ford, Nancy M		✓
Withee, Dennis J	✓	
Dudley, Terri C		✓
Picconi, Al J		✓
Soltani, Tony F		✓
Woods, Phyllis L		✓
Wall, Janet G	✓	
DePecol, Benjamin J	✓	
Pratt, John M	✓	
Craig, James W	✓	
Lasky, Bette R	✓	
Mitchell, McKim W	✓	
Solow, Martha S		
Wood, Jane		✓
TOTAL VOTE:	13	8

Printed: 12/30/1999

Committee Report

MAJORITY
COMMITTEE REPORT

COMMITTEE: **Judiciary**

BILL NUMBER: **HB 1116-FN**

TITLE: prohibiting partial-birth abortions.

DATE: March 15, 2000 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☒ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

The committee heard complex medical and legal testimony regarding abortion procedures and the potential health consequences of the proposed restrictions for pregnant women. The majority concluded that legislators should not regulate medicine in a way that undermines the safety of women's health or interferes with the privacy of the decision-making between a woman, her family and her doctor. In addition, several provisions of the bill are clearly unconstitutional and directly interfere with a woman's right to privacy as established in Roe v. Wade. Efforts were made to address the constitutional flaws in the bill with a proposed amendment, however, the sponsors were not in favor of the amended version. HB 1116-FN is legally flawed and detrimental to women's health.

Vote 13-8.

Rep. Sandra B. Keans
FOR THE MAJORITY

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Judiciary

HB 1116-FN, prohibiting partial-birth abortions. INEXPEDIENT TO LEGISLATE

Rep. Sandra B. Keans for Majority of Judiciary: The committee heard complex medical and legal testimony regarding abortion procedures and the potential health consequences of the proposed restrictions for pregnant women. The majority concluded that legislators should not regulate medicine in a way that undermines the safety of women's health or interferes with the privacy of the decision-making between a woman, her family and her doctor. In addition, several provisions of the bill are clearly unconstitutional and directly interfere with a woman's right to privacy as established in Roe v. Wade. Efforts were made to address the constitutional flaws in the bill with a proposed amendment, however, the sponsors were not in favor of the amended version. HB 1116-FN is legally flawed and detrimental to women's health. Vote 13-8.

HOUSE JUDICIARY REPORTS
March 16, 2000

HB 1116, an act prohibiting so-called "partial-birth" abortions. INEXPEDIENT TO LEGISLATE
Rep. Sandra Keans for Judiciary: The Committee heard complex medical and legal testimony regarding abortion procedures and the potential health consequences of the proposed restrictions for pregnant women .The majority ~~felt~~ INCLUDED that legislators should not regulate medicine in a way that undermines the safety of women's health or interferes with the privacy of the decision-making between a woman, her family and her doctor. In addition, several provisions of the bill are clearly unconstitutional and directly interfere with a woman's right to privacy as established in Roe v. Wade. Efforts were made to address the constitutional flaws in the bill with a proposed amendment, however, the sponsors were not in favor of the amended version. HB 1116 is legally flawed and detrimental to women's health. Vote 13 – 8.

Sandra B Keans

HB 1511, an act requiring parental notification before an abortion may be performed upon unemancipated minors. INEXPEDIENT TO LEGISLATE
Rep. _____ for Judiciary
This bill would require medical providers to provide written notification to the parent(s) of all young ~~woman~~ women under the age of 18 seeking to obtain an abortion. The bill would establish a judicial review process in the NH district courts for minor women who feel that they cannot involve their parents due to abusive or other threatening family circumstances. While the committee was very supportive of encouraging parent-daughter communication and adult involvement at the time of a crisis pregnancy, ~~we~~ the majority did not believe mandating such communication would result in improved relationships between parents and their teenage daughters. Compelling evidence from other states suggests that this measure will not result in improved familial communication, nor will it reduce the number of teens who are sexually active, who get pregnant, who seek abortions or who give birth. The bill will, however, place a significant financial and scheduling burden on the court system with an undeterminable fiscal impact. It may also endanger the lives of young women who delay or forgo medical care due to fear of forced parental involvement. Vote 13 – 8.

HB1116

The minority of the committee believed that the people of N.H. do not want to allow this barbaric procedure,* ~~that~~ partial-birth abortion kills a baby in the process of being born, ~~and~~ is never necessary to preserve the ~~life~~ life, health or future fertility of the woman, and is in fact an unrecognized medical procedure which is dangerous to women

*to be performed in this state.

Rep. Phyllis Woods

COMMITTEE REPORT

COMMITTEE: **Judiciary**

BILL NUMBER:

TITLE:

DATE: CONSENT CALENDAR YES ☐ NO ☑

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☑ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

Vote 13 - 8

Rep.
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

MINORITY
COMMITTEE REPORT

COMMITTEE: **Judiciary**

BILL NUMBER: **HB 1116**

TITLE: prohibiting partial-birth abortions.

DATE: March 15, 2000 CONSENT CALENDAR YES ☐ NO ☒

☒ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

The minority of the committee believed that the people of New Hampshire do not want to allow this barbaric procedure, partial-birth abortions, to be performed in this state. Partial-birth abortion kills a baby in the process of being born, is never necessary to preserve the life, health, or future fertility of the woman, and is in fact an unrecognized medical procedure which is dangerous to women.

Rep. Phyllis L. Woods
FOR THE MINORITY

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Judiciary

HB 1116, prohibiting partial-birth abortions. OUGHT TO PASS

Rep. Phyllis L. Woods for the Minority of Judiciary: The minority of the committee believed that the people of New Hampshire do not want to allow this barbaric procedure, partial-birth abortions, to be performed in this state. Partial-birth abortion kills a baby in the process of being born, is never necessary to preserve the life, health, or future fertility of the woman, and is in fact an unrecognized medical procedure which is dangerous to women.

COMMITTEE REPORT

COMMITTEE: **Judiciary**

BILL NUMBER: **HB 1116**

TITLE: prohibiting partial-birth abortions.

DATE: 3/11/00

CONSENT CALENDAR YES ☐ NO ☐

☑ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

Vote 8-15

Woodcock

Rep.
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT