Approved 2-25-85
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 a.m./p.m. on February 14, 1985 in room 423-S of the Capitol.

All members were present except:

Rep. Williams, excused

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Secy. to Committee

Conferees appearing before the committee:

Representative Jessie Branson
Ms. Margaret Bearse, Chairman Joint Board of Health, Lawrence/Douglas County
Ms. Kay Kent, Director of Joint Dept. of Health, Lawrence/Douglas County
Dr. Sandra Shaw, Bert Nash Mental Health Center
Mr. Paul Klotz, Assoc. Community Mental Health Centers.
Representative John Sutter
Barbara Sabol, Secy. Department of Health and Environment
Ms. Darlene Stearns, State Coordinator Religious Coalition for Abortion Rights in Ks.
Pat Goodson, Right to Life
Dr. Lauren Welch, Surgeon
Katherine Wahlmeier, Right to Life
Jerry Slaughter, Ks. Medical Society
Harold Riehm, Ks. Association of Osteopathic Medicine
Tom Bell, Ks. Hospital Association
Adele Hughey, Comprehensive Health Clinic, Overland Park, Ks.
Mr. Hannes Zacharias,
Ms. Barbara Reinert, Planned Parenthood

Visitor's register, (see Attachment No. 1.)

Chair called meeting to order and recognized Representative Branson, sponsor of HB 2186, and she gave a brief overview of why this bill was requested. It is to allow joint city-county health departments to contract with non-profit mental health centers.

HB 2186

Ms. Margaret Bearse, Chairman of Joint Board of Health, Lawrence/Douglas County, and she presented printed testimony, (see Attachment No. 2.), for details. She stated their Joint Board of Health contracts with Bert Nash Community Mental Health Center presently, and by trial and error have evolved a system which works well. They have however discovered this was not permitted under present statutes, and they are now requesting such statutes to make this procedure allowed. Attachments show organized structure, and her comments were, i.e., the bill is permissive; applies to localities that already have a Joint Board of Health, and not without precedent, since K.S.A. 19-4002 permits establishing a board to contract for certain services. She urged for passage of this bill.

Ms. Kay Kent, Director of Joint Dept. of Health, Lawrence/Douglas County spoke to the support of HB 2186, saying there is no current statutory provision for city involvement in mental health centers, and that is why they feel this legislation is so important. The city wants to be involved in this process she said. Ms. Kent and Ms. Bearse both then answered questions from committee.

Dr. Sandra Shaw, Bert Nash Mental Health Center asked for support of HB 2186, and she then answered questions, i.e., this is funded by county levy and currently the city is not involved in the funding; yes, any Douglas County resident is eligible for care at their center.

HB 2186 continues:

Mr. Paul Klotz, Association of Community Mental Health Centers spoke briefly on HB 2186, stating their Association had reviewed this legislation and feels it would not adversely affect any of the Mental Health Centers, and he supports the bill in behalf of Bert Nash Mental Health Center, but takes no position on the bill Association wide. They see no problem with the bill, particularly since this is a permissive bill.

Mr. Hannes Zacharias, Management Analyst, City of Lawrence then spoke to HB 2186, giving city of Lawrence's support to this bill. The city commission gave their unanimous support at a meeting this week. He then answered questions from committee.

Hearings concluded on HB 2186.

Hearings on HB 2052 began:

Representative Sutter, as sponsor of this bill, gave printed testimony to members, (see Attachment No. 3.), for details. He explained that HB 2052 requires every medical facility, i.e., hospital, physicians and ambulatory surgical centers, to keep records and submit annual reports to the Secy. of Health and Welfare for all pregnancies terminated. Further, follow-up forms on the condition of the patient is also mandatory, and he encouraged committee to seriously consider HB 2052 favorably.

Barbara Sabol, Secy. of Health and Environment spoke to HB 2052, see (Attachment No. 4.), for details of her testimony. She said the Department of Health and Environment is the repository of these reports, and they have no objection to changing language in the bill, i.e., word "hospital", to "medical care facility", and pointed out that if "ambulatory surgical centers", are also included, it might help to reduce health care costs, since most terminations are done in the first three months, could be and many are done, in ambulatory surgical center settings. She reported they feel their office presently receives 90% reportings of terminations, and sees the follow-up reporting portion of the bill as a regulatory burden to the state. Has no objection to the reporting of termination of pregnancies, but does feel the expansion of this follow-up reporting would serve no real purpose. There was then some discussion on the fiscal impact of this bill, i.e., $16,000 is the figure reached by their department. She had figures substantiating a reduction in the numbers of pregnancy terminations. There then was some discussion that if this legislation is enacted, and there is failure to comply by reporting agencies, should there be a penalty imposed for non-compliance.

Darlene Stearns, State Coordinator for Religious Coalition for Abortion Rights, in Kansas, stated one of their main goals is to maintain the availability for safe and legal abortions, and support regulations that serve to that end. Section (c) of the bill is where they have problems with HB 2052. She commented it is rather an unusual request for a patient to fill out a form 6 months after the fact, and most of these people would not have the proper medical knowledge to effectively fill out these follow-up forms. Further, many of these people are mobile and it is difficult to locate them.

Pat Goodson, Right to Life, gave printed materials to members, (see Attachment No. 5.) for details. She had conflicting reports than those of Secy. sabol in regard to the decreasing numbers of abortions in the state, and feels the 90% reporting is also an incorrect figure, saying their figures show that 2/3 of abortions are not reported. Their group feels the follow-up reporting is very necessary as to addressing public health concerns in regard to complications following pregnancy terminations. She gave figures of numbers of abortions done in a particular clinic in Overland Park. She then answered numerous questions from committee.

Dr. Lauren Welch, a surgeon spoke to HB 2052, and gave printed testimony, (see Attachment No. 6.), for details. He said, it is amazing how few people know about complications which can occur as the result of an abortion. He listed seversl, i.e., perforation of the uterus, laceration or perforation of the cervix, hemmorhage, infection, stress, kidney failure, etc. He feels strongly every woman who is considering abortion must be informed of these complications before giving her consent for the operation, and anything less would be blatant exploitation. Further, he feels that only 20% to 30% of these patients have proper follow-up, and that 6 months is not nearly long enough for follow-up reports. He answered many questions from committee,

HB 2052 continues:

i.e., as a lay person, how many of these complications could be identified properly on this proposed follow-up report; no, he said he would not send out a follow-up form for all other types of surgeries, because induced abortion is rather unique since it is so controversial, and that most surgeons acquaint patients with complications that might occur after other types of surgery.

Mr. Jerry Slaughter, Exec. Director of Kansas Medical Society spoke to HB 2052, in that their Society takes no position on abortion, only that if abortions are to be done they should be done by physicians in a medically appropriate setting. Their concerns, i.e., the additional reporting requirements for physicians; lines 43-54 that require physicians to distribute follow-up forms 6 months after the medical complications may have occurred. We see this he said, as creating many administrative problems in trying to contact former patients who may have moved, and it also raises the question of invasion of patients privacy. Their Society, he said, is reluctant to get too deeply involved in this emotional and controversial subject, but does feel that if physicians are asked to be data collectors for the state, there be justification for the requirement from a public health standpoint, and they feel that is not the instance in this legislation. He then answered questions.

Mr. Harold Riehm, Ks. Association of Osteopathic Medicine, spoke in opposition to HB 2052, in that their Association feels it isn't really medically necessary and serves no real health purpose for the patient. Further, feels this is an over-dosing or reporting required of physicians.

Tom Bell, Kansas Hospital Association had printed testimony, (see Attachment No. 7.), for details. He stated the Kansas Hospital Association takes no particular stand on abortion, but feels that HB 2052 in Section 1, (c), creates one more regulatory burden under which hospitals in the state must operate. Hospitals are already required to keep written records and submit annual reports to the Secretary of Health and Environment with regard to termination of pregnancies, and they feel the purpose of the extra follow-up form is unclear.

Adele Hughey, Comprehensive Health, Overland Park, Kansas then spoke to some comments earlier in todays testimony about 6,000 abortions a year being done at their facility, and said, they do not perform that number of abortions. This figure was given to reporters by demonstrators that were outside their clinic and then appeared in the newspaper. The reporter later checked with the clinic and found in truth, they do not do that number of abortions a year. We report to the state, she said, and the Secretary of Health and Environment knows the number of abortions performed per year at our facility. She then answered questions from committee.

Katherine Wahlmeier, Right to Life, Hays, Kansas distributed materials to members, see (Attachment No. 8,8a,8b,8c), for details. She urged committee to vote for HB 2052. She explained her hand-out was, i.e., personal testimony from some Women Exploited by Abortion, (WEBA); lists as to trimesters medical complications and types of abortion used; publication of Ortho Pharmaceutical; articles from medical sources regarding PI disease. She stated she feels this bill is designed so that continuing protection of the health of these women in Kansas who have pregnancies terminated can be offered.

Barbara Reinert, Planned Parenthood, stated their Association has a strong interest in accurate reporting, but isn't sure that the follow-up questionaire would really serve any public health purpose.

Hearings closed on HB 2052.

Chair asked wishes of committee in regard to minutes for Feb. 7,11,12,13th, and Rep. Green moved minutes be approved as written, seconded by Rep. Cribbs, and motion carried.

Meeting asjourned at 3:03 p.m. Next meeting, Monday, February 18, 1985, 1:30 p.m.

Date: 2-14-5

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
Kay Kent	Lawrence-Douglas County Health Dept	336 Missouri, Lawrence
Margaret Bearse	Law Dg Cnty Jt Bd of Health	1215 W 25 Ct Lawrence
Paul Mudd	Right to Life	Gorham, Ks. 67640
Mary L Mudd	" "	" "
Robert Jacobs	" "	" "
John L Hagen	" "	Hays Kansas
[illegible]	RIGHT TO LIFE	HAYS, KS
Nickie Stein	KS St. Nurses' Assn.	Topeka
Cleta M. Renyer	Right to Life	Sabetha, Ks
Betty Jean Petty	Right To Life	Sabetha Ks
Catherine Wahlmeier	Right-to-Life	Hays, Ks
Lynne Bessin	none	Overland Park, Ks
Pat Goodson	Right To Life	Shawnee
HAROLD E. KIEHN	KS ASN. OSTEOPATHIC MED	TOPEKA
Darlene Starrs	Religious Coalition for Abortion Rights	Topeka
Lauren Welch	none	Wamego
Sandra Shaw	Bert Nash Community Mental Health Center	336 Mo. Suite 202 Lawrence, Ks. 66044
Ric Silber		DOB

Date: 2-14-5

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
KEITH R LONDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
Barb Ranert	Planned Parenthood	"
Jan McGuire		Wichita
Mark Bertrand		"
[illegible]		Wichita
Lee Hunkeyer	Right to Life of Kansas	Shawnee, KS
Adele Hughey	Comprehensive Health	Overland Park
BJ SIBBOL	KDH&E	Topeka
Gigi Cohen	Kanas NARAL	Lawrence, KS
Betty Armstrong	Comprehensive Health	Overland Park

Attm. #1
2-14-1985

Attm. # 2
2-14-5

LAWRENCE-DOUGLAS COUNTY HEALTH BOARD

336 Missouri
Lawrence, Kansas 66044

February 14, 1985

TO: House Public Health and Welfare Committee

FROM: **Margaret Bearse**, Chairman, Lawrence-Douglas County Jt. Board of Health

RE: In support of **House Bill 2186** permitting establishment of a joint mental health board

In Lawrence and Douglas County we have a joint city-county health department. We contract with Bert Nash Community Mental Health Center, a non-profit corporation, for mental health services. Through the years, by trial and error, we evolved a system of citizen oversight and policy-making that worked well for us. Unfortunately, we discovered that it was not permitted under the statutes. As soon as we learned this we began re-organizing, but the new structure is not as effective and efficient in the use of citizens' time and interests. This bill would permit us to return to approximately our former method of operation.

The attached chart shows our current organization. The Mental Health Advisory Committee sits on the Board of Directors of the Bert Nash Community Mental Health Center. They attend monthly meetings and are well aware of the mental health programs and financing. Yet they do not have the responsibility to approve or disapprove the contract for services.

The Joint Board of Health, on the other hand, has this responsibility, but little direct knowledge of the operation of Bert Nash. The Joint Board felt uncomfortable signing this contract with no more information than the statutes require (an annual financial report) so we have begun asking for more reports from Bert Nash to familiarize ourselves with their activities and gauge compliance with the contract.

We believe it would be better to have a joint board of mental health which could have both the special knowledge about mental health activities and the responsibility to contract for them.

I would like to make three observations about the bill.

First: the bill is permissive. No locality need do this unless they want to.

Second: it is fairly specific. It applies to those localities that already have a joint board of health and have determined it is more practicable to contract for mental health services.

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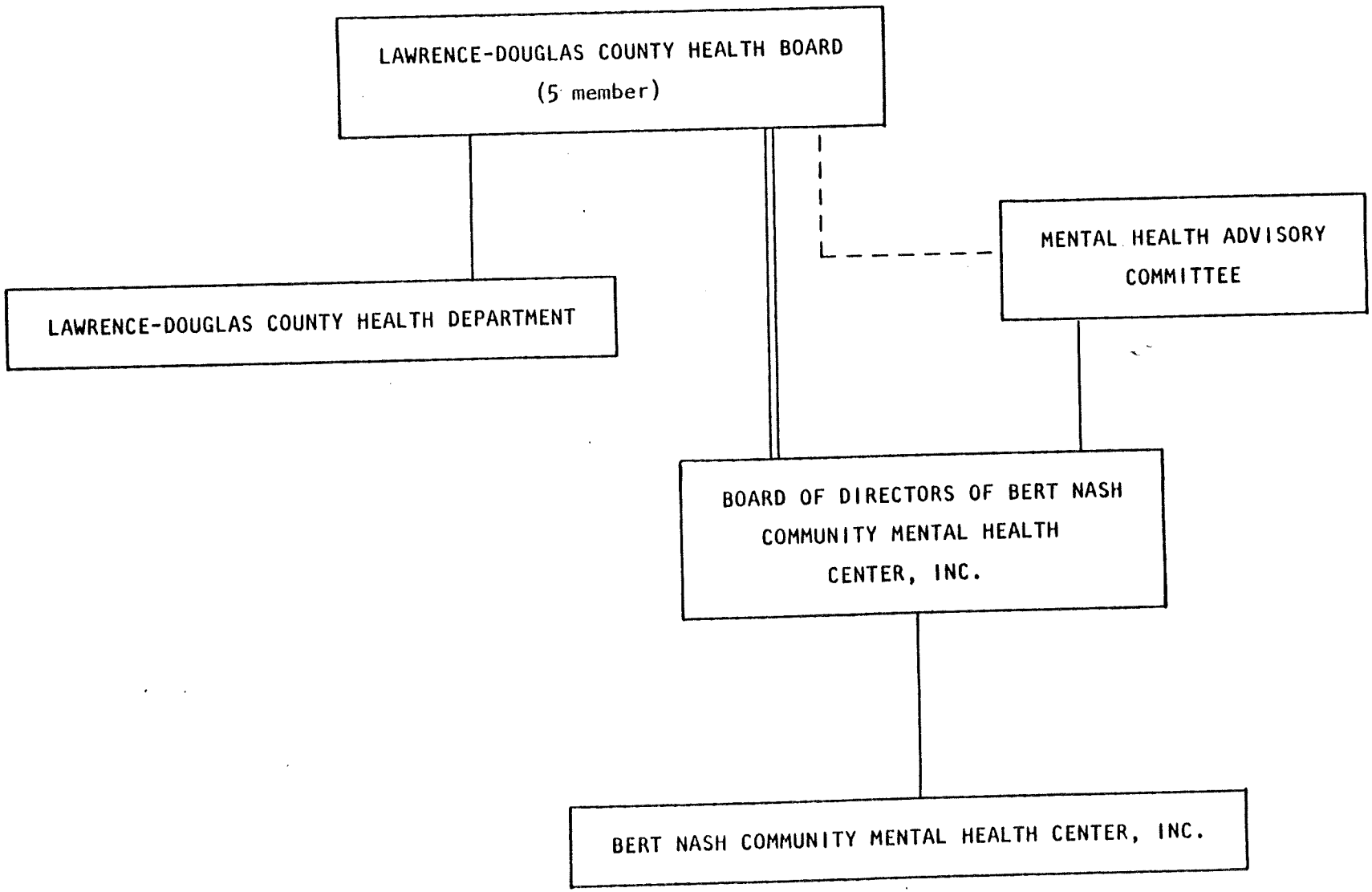
Testimony: House Public Health & Welfare Comm.
From: Margaret Bearse, Chmn., Lawrence Douglas Co. Jt. Board of Health
Date: February 14, 1985

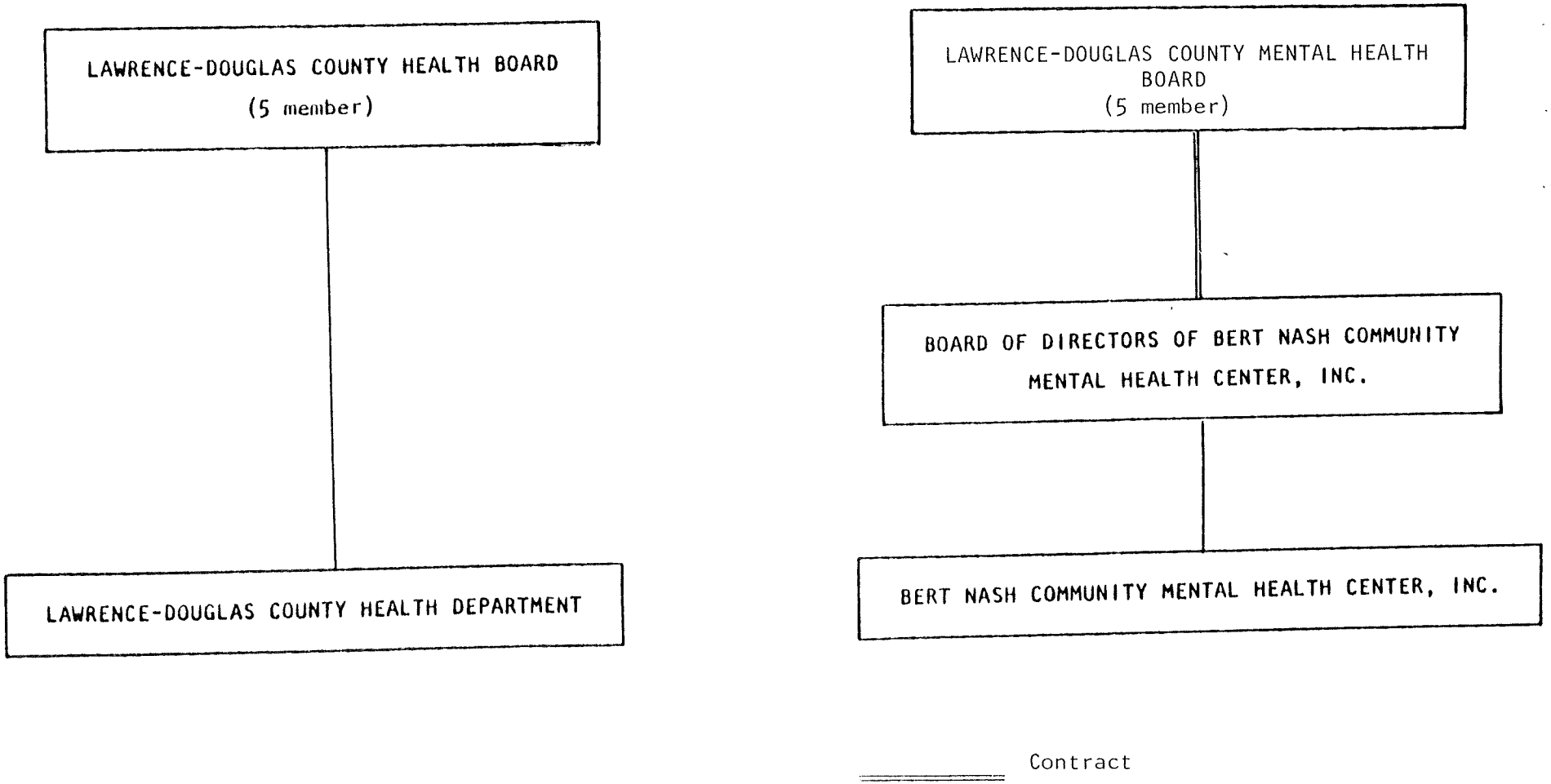
Third: it is not without precedent. K.S.A. 19-4002 permits establishing a board to contract for certain services.

Therefore, I believe this bill permits us to operate more effectively without interfering with other localities.

ORGANIZATIONAL STRUCTURE



PROPOSED ORGANIZATIONAL STRUCTURE
allowed by
House Bill No. 2186



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HB 2052
PUBLIC HEALTH & WELFARE COMMITTEE
FEBRUARY 14, 1985
REP. JOHN F. SUTTER

MR. CHAIRMAN AND MEMBERS OF PUBLIC HEALTH & WELFARE COMMITTEE:

KSA 66-445 AMENDED IN 1975 REQUIRES EVERY HOSPITAL TO KEEP WRITTEN RECORDS IN PREGNANCIES CAREFULLY TERMINATED (ABORTIONS) AND TO SUBMIT AN ANNUAL REPORT TO THE SECRETARY OF HEALTH ON A FORM PRESCRIBED BY THE SECRETARY..

HB 2052 REQUIRES EVERY MEDICAL FACILITY, WHICH INCLUDES HOSPITALS, ABORTION CLINICS, VARIOUS PHYSICIANS AND AMBULATORY SURGERY CENTERS, TO KEEP RECORDS AND TO SUBMIT AN ANNUAL REPORT TO THE SECRETARY.

ALSO, SECTION C REQUIRES THOSE VARIOUS MEDICAL CARE FACILITIES TO SEND FORMS TO ALL KANSAS RESIDENTS SIX MONTHS AFTER THE ABORTIONS INQUIRING WHETHER ANY COMPLICATIONS HAVE OCCURED AND SUBMIT THOSE FORMS ANNUALLY TO THE SECRETARY OF HEALTH AND AT NO TIME WILL ANY NAME BE EXPOSED.

IT IS ESTIMATED THAT BETWEEN 27 TO 30% OF THE ABORTIONS REPORTED IN KANSAS IN 1983 WERE REPEAT ABORTIONS. ALSO, ABOUT 35 STATES HAVE SOME FORM OF ABORTION REPORTING LAWS.

IN PRESIDENT REAGAN'S STATE OF THE UNION MESSAGE TO CONGRESS LAST WEEK, HE EXPRESSED CONCERN ABOUT THE ABORTION ISSUE AND WOULD ENCOURAGE CONGRESS TO INITIATE LEGISLATION FOR THE UNBORN.

HB 2052 ONLY SPEAKS TO THE ISSUE OF REPORTING ALL ABORTIONS BY ALL MEDICAL CARE FACILITIES AND FOLLOW-UP FORMS ON THE CONDITION OF THE PERSON, THEREBY GIVING MEDICAL KNOWLEDGE TO OUR DEPARTMENT OF HEALTH.

I ENCOURAGE THIS COMMITTEE TO SERIOUSLY CONSIDER HB 2052 AND TO PASS IT OUT FAVORABLY, WITH OR WITHOUT AMENDMENTS.

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KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

B. Sabol

TESTIMONY ON H.B. 2052

PRESENTED TO: HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

FEBRUARY 14, 1985

This is the official position taken by the Kansas Department of Health and Environment on House Bill 2052.

BACKGROUND INFORMATION:

According to K.S.A. 65-445 enacted by the 1969 legislature, all hospitals have been required to report annually to the Kansas Department of Health and Environment all pregnancies which are lawfully terminated on forms prescribed by the Secretary of the Kansas Department of Health and Environment. In addition to the required reporting by hospitals, other facilities have participated on a voluntary basis. Statistical data from these combined sources have been published each year in the Annual Summary of Vital Statistics since 1970. According to national reports issued by the Communicable Disease Center, Atlanta, Georgia, the Kansas information is equivalent to reporting systems in other states of similar size. Recent trends reflect yearly decreases in the number of terminations, 1979-1984, with no apparent change in the reporting system. Medical complications reported by the system are less than one percent (1%).

STRENGTHS:

The change from "hospital" to the term "medical care facility" would include "ambulatory surgical centers" and would be appropriate since 90% of terminations are performed during the first 3 months of pregnancy and those patients do not require hospitalization.

WEAKNESSES:

Expansion of the reporting system does not promote a valid public health purpose. There is no public health or medical research evidence to warrant a followup regarding medical complications. This legislation appears to be a regulatory burden and may unnecessarily contribute to the cost of health care.

DEPARTMENT'S POSITION:

There is no known public health reason to exapnd the reporting system.

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BIRTH-RELATED MORTALITY

This section examines mortality as it relates to pregnancy, childbirth, and infancy. For discussion purposes it is divided into five subdivisions: (1) induced abortions; (2) fetal deaths (stillbirths); (3) Perinatal Period III mortality; (4) infant deaths; and (5) maternal deaths.

INDUCED ABORTIONS

The Kansas liberalized abortion law was enacted in July, 1970, and from that time through 1982, 142,742 abortions were reported in Kansas. There were 11,107 abortions reported in Kansas in 1982.

The number of abortions reported in Kansas from 1971 to 1982 are shown below. The decline in the number of abortions reported in Kansas in 1974 and 1975 is attributable to the reduction in the number of out-of-state residents having abortions performed in Kansas since the 1973 United States Supreme Court ruling which legalized abortion in all states. The number of abortions reported in Kansas in 1982 represented an 8.5 percent decrease from the 1981 total of 12,137.

Number of Abortions Reported in Kansas by Year

Year	Number
1982.....	11,107
1981.....	12,137
1980.....	13,381
1979.....	13,901
1978.....	10,904
1977.....	10,898
1976.....	11,597
1975.....	10,860
1974.....	10,871
1973.....	12,612
1972.....	12,248
1971.....	9,472

Summary statistics are available only for those 9,343 abortions reported by hospitals and clinics participating in our abortion reporting system during 1982.

In 1982, 5,520 abortions or 59.1 percent of the 9,343 reported in the State, were performed for Kansas residents. Of the 3,823 nonresidents who had abortions in Kansas, 84.4 percent (3,225) were Missouri residents. Residents from other states included those from Illinois (246), Nebraska (100), Iowa (90), Oklahoma (79) and Texas (20). Sixty-three patients represented other states.

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Kansas Residence Summary:

The following analysis refers to the 6,153 abortions reported for Kansas residents, regardless of where the abortion occurred.

Occurrence: In 1982, the Kansas Department of Health and Environment received statistics on 633 abortions performed in other states for Kansas residents. Of those 633 abortions, 522 (or 82.5 percent) occurred in Missouri, and 94 (or 14.8 percent) occurred in Oklahoma.

SELECTED INDUCED ABORTION STATISTICS
FOR DECEMBER AND CUMULATIVE TOTALS FOR THE YEAR

KANSAS, 1984

	DECEMBER	JANUARY - DECEMBER
TOTAL ABORTIONS...	1,058	5,778
RESIDENCE		
IN STATE.....	572	3,808
OUT OF STATE....	486	1,970
UNKNOWN.....	-	-
AGE GROUP OF PATIENT		
UNDER 11.....	-	-
11 YEARS.....	-	1
12 YEARS.....	1	2
13 YEARS.....	-	6
14 YEARS.....	14	49
15 YEARS.....	25	120
16 YEARS.....	49	247
17 YEARS.....	70	349
18 YEARS.....	95	472
19 YEARS.....	87	491
20-24 YEARS.....	372	2,085
25-29 YEARS.....	193	1,083
30-34 YEARS.....	90	533
35-39 YEARS.....	49	255
40-44 YEARS.....	11	72
45 AND OVER.....	1	4
UNKNOWN-NS.....	1	9
RACE OF PATIENT		
WHITE.....	942	5,085
BLACK.....	89	559
OTHER.....	23	112
UNKNOWN-NS.....	4	22
MARITAL STATUS OF PATIENT		
YES.....	217	1,231
NO.....	839	4,531
UNKNOWN-NS.....	2	16

	DECEMBER	JANUARY - DECEMBER
PRIMARY INDICATION FOR ABORTION		
MENTAL HEALTH.....	920	3,836
SOCIO-ECONOMIC.....	125	1,807
RAPE.....	1	3
INCEST.....	-	-
FELONIOUS INTERCOURSE.....	2	11
PHYSICAL HEALTH.....	-	10
FETAL DEFECT.....	-	11
EMERGENCY EXISTED...	-	-
OTHER OR NS.....	10	100
METHOD OF ABORTION		
SUCTION CURETTAGE...	1,055	5,707
SHARP CURETTAGE.....	1	19
INTRA-UTERINE SALINE INSTILLATION.....	2	7
INTRA-UTERINE PROSTA-GLANDIN INSTILLATION.....	-	7
HYSTEROTOMY.....	-	-
HYSTERECTOMY.....	-	-
OTHER.....	-	37
UNKNOWN OR NS.....	-	1
NUMBER OF DAYS IN HOSPITAL		
LESS THAN 1 DAY.....	1,056	5,745
1 DAY.....	-	8
2 DAYS.....	-	8
3 DAYS AND OVER.....	-	4
NOT STATED.....	2	13

	DECEMBER	JANUARY - DECEMBER
NUMBER OF OTHER TERMINATIONS		
NONE.....	973	5,304
ONE.....	65	366
TWO.....	8	57
THREE.....	4	15
FOUR.....	2	7
FIVE OR MORE.....	2	6
UNKNOWN-NS.....	4	23
PREVIOUS INDUCED ABORTIONS		
NONE.....	709	4,045
ONE.....	251	1,292
TWO.....	73	312
THREE OR MORE.....	21	101
UNKNOWN-NS.....	4	28
NUMBER OF LIVING CHILDREN		
NONE.....	720	3,667
ONE.....	174	1,007
TWO.....	114	783
THREE.....	35	217
FOUR.....	8	60
FIVE OR MORE.....	3	28
UNKNOWN-NS.....	4	16
NUMBER OF PREVIOUS PREGNANCIES		
NONE.....	486	2,602
ONE.....	251	1,343
TWO.....	170	941
THREE.....	82	520
FOUR.....	44	200
FIVE.....	10	89
SIX.....	7	41
SEVEN OR MORE.....	6	29
UNKNOWN-NS.....	2	13

SELECTED INDUCED ABORTION STATISTICS
FOR DECEMBER AND CUMULATIVE TOTALS FOR THE YEAR

KANSAS, 1984

WEEKS GESTATION	DECEMBER	JANUARY - DECEMBER
LESS THAN 8 WKS.	109	982
8 WEEKS	191	1,104
9 WEEKS	168	810
10 WEEKS	140	727
11 WEEKS	108	541
12 WEEKS	121	538
13 WEEKS	33	121
14 WEEKS	26	153
15 WEEKS	8	64
16 WEEKS	30	136
17 WEEKS	23	92
18 WEEKS	32	108
19 WEEKS	13	54
20 WEEKS	11	73
21 WEEKS	9	56
22 WEEKS	9	44
23 WEEKS	6	42
24 WEEKS	13	64
25 AND OVER	-	-
UNKNOWN-NS	8	69

CHILDREN BORN ALIVE NOW DEAD	DECEMBER	JANUARY - DECEMBER
NONE	1,047	5,725
ONE	6	23
TWO	2	3
THREE	-	-
FOUR	-	-
FIVE OR MORE	-	2
UNKNOWN-NS	3	25

STERILIZATION PERFORMED	DECEMBER	JANUARY - DECEMBER
YES	15	90
NO	1,039	5,664
UNKNOWN-NS	4	24

COMPLICATIONS OF ABORTION	DECEMBER	JANUARY - DECEMBER
NONE	1,049	5,721
HEMORRHAGE	2	4
INFECTION	2	12
UTERINE PERFORATION	-	5
CERVICAL LACERATION	-	4
RETAINED PRODUCTS	5	25
OTHER	-	2
UNKNOWN-NS	-	5

NUMBER OF HOSPITALS PERFORMING ONE OR MORE ABORTIONS 5

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COMPLICATIONS OF INDUCED ABORTION
by Lauren A. Welch, M.D.
February 14, 1985

With induced abortion legal and prevalent today, I am amazed at how few people in general know about the complications which are known to occur as a result of the operation. I am also amazed at how many physicians, including myself, have been unaware of the frequency and the severity of these complications.

After searching through the medical literature to prepare for today's presentation, I have divided the complications of induced abortion into two groups: immediate complications (those which occur at the time of, or soon after the operation), and late, or delayed complications (those which occur anytime from several weeks to several years after the abortion). Please understand, I make no attempt to list all of the possible complications, only those most frequently recognized.

Some of the immediate complications are:

1. Perforation of the uterus (2, 3, 7, 8, 9): Perforation of the uterus by an abortionist's instruments may of course also injure adjacent bladder and intestine. (Incidence .34%)

2. Laceration or perforation of the cervix (2, 3, 8, 9): (Incidence .93%; combined incidence of #1 and #2 .14% to 1.27%)

3. Hemorrhage (1, 7, 9, 14): Bleeding from within the uterus itself, with production of a large blood clot, which the newly assaulted uterus is unable to expel (the so-called "Post Abortion Syndrome"(1)). (Incidence .03% to .34%)

4. Retained parts (3, 7, 8, 9, 14): These parts can be of either placenta, or baby, especially the head, since calcification

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occurs early and makes the head difficult to crush with the abortion instruments. (Incidence .56%)

5. Significant infection (2, 3, 7, 8, 9, 14): This may be salpyngitis (infection in the fallopian tubes), endometritis (infection inside the uterus), sepsis (infection in the blood), peritonitis (infection outside the uterus and inside the abdomen), bladder infections. (Incidence .5% to 1.5%) 89% of all abortion patients develop a fever post-op (7).

6. Stress Incontinence (14): Damage is done to the muscles and/or nerves which control the flow of urine from the bladder, so that when a woman coughs or sneezes, she wets her pants. (Incidence 23.7% to 40.9% acutely)

Other immediate complications I discovered in doing a literature search of the complications of induced abortion, but for which I could not find frequency are:

7. Kidney failure (14)

8. Heart failure (14)

9. Lung failure (14)

10. DIC (disseminated intravascular coagulopathy) (11, 14): This results from the using up of clotting materials in the blood, such that the woman who has had an abortion can no longer form clots, and she bleeds into her various body tissues and out of her various body orifices.

If we now consider the total incidence of all of the above complications for which I was able to find statistics, the total incidence of immediate significant, serious surgical complications following induced abortion approaches 4%. Bear in

mind that this figure excludes numbers 6 through 10. If #6 were included the complication rate would be between 28% and 45%.

Consider that the complications 1 through 5 can require hysterectomy for cure, and all but number 6 can be fatal! What is the mortality rate of abortions? The U.S. statistics most often quoted are those published by the Abortion Surveillance Branch of the CDC (Center for Disease Control). These suggest a mortality rate of about 5/100,000 abortions. The range is from 1.1/100,000 for suction abortions, to 208/100,000 for hysterotomy abortions. If there are about 1.5 million induced abortions a year in the U.S., then about 75 women die each year in our country as a result of induced abortion. I will address the probable inaccuracy of these figures in a moment.

Now for the more serious, and more common, delayed complications of induced abortion.

1. Chronic pelvic inflammatory disease (PID) (8, 9): If an infection of the fallopian tubes or uterine cavity is not treated appropriately post abortion (and sometimes even if it is) it can lead to a smoldering, chronic infection in the pelvic organs. This frequently requires hysterectomy for cure.

2. Infertility (2, 4, 7, 8): Women who have had abortions may develop infertility secondary to infection and scarring in the fallopian tubes, PID, obliteration of the uterine cavity from infection or aggressive scraping at the time of the abortion, or secondary to hysterectomy (Incidence 8%-10% after one abortion, perhaps as high as 20% after three or more abortions)

3. Ectopic or tubal pregnancy (4, 8, 9): The risk of this

possibly fatal complication may be increased ten times in the post abortion woman. The etiology is probably impaired parastalsis and/or fallopian tube narrowing/scarring from infection.

4. Spontaneous abortion (miscarriage) (3, 4, 5, 8, 9): This occurs twice as often in women who have had an induced abortion, in both the first and second trimester. Spontaneous abortion may occur because of scarring of the uterine cavity, making it unable to support a placenta. (Incidence 30-40%)

5. Incompetent cervix (3, 5, 8, 9): This is probably the cause of some of the spontaneous abortions, especially those occuring in the second trimester. Incompetent cervix occurs after a tear or laceration of the cervix at the time of an induced abortion. (Incidence 10% (8))

6. Toxemia of pregnancy (3): This sometimes fatal complication of subsequent pregnancies may be 5 times more likely in the post abortion woman.

7. Premature birth (4, 5, 7, 8, 9), and

8. Decreased birth weight (4, 7, 8, 9, 10): These two late complications of induced abortion are probably due to cervical incompetence and/or cervical infection in an abraided uterus with infection traversing the amnionic sac surrounding the baby.

9. Prolonged labor (4, 9): This may occur because the cervix is scarred and tough, so it requires more force to dilate it (cervical dystocia), or it may occur because the uterine muscle has been damaged and can no longer contract with the force it possessed prior to the induced abortion (uterine atony).

10. Perinatal mortality (death of the baby shortly before or shortly after birth) (5, 8)

11. Breech presentation (bottom first, instead of head first) and other abnormal fetal presentations at the time of labor and delivery (10)

Numbers 7 through 11 may also be secondary to placental abnormalities resulting from previous induced abortions:

12. Placental insufficiency (3): The placenta is unable to adequately support the nutritional requirements of the baby.

13. Placenta previa (5, 9): The placenta attaches at or near the opening of the cervix, so with dilatation of the cervix, the placenta tears and hemorrhage occurs. This is fatal to the mother and the baby unless immediate cesarian section is done.

14. Premature separation of the placenta (5, 9, 10): The placenta separates from the inside of the uterus before the baby is born. Bleeding from the mother and baby occurs with risk of loss of life of both without cesarian section.

15. Need for manual extraction of the placenta (3, 8, 9): The placenta will not separate from the inside of the uterus after the baby is born, and must be forcefully dug out by hand.

16. Post-partum hemorrhage (3, 9): This may result either from placental abnormalities, or from uterine atony.

17. Stress incontinence (14): As already mentioned this is a very common immediate complication of induced abortion. However, most women's stress continence resolves, and only 6.3% of those initially affected develop chronic stress incontinence.

The psychological affects of induced abortion have received even less publicity. However, they certainly do exist (2, 8, 12). Serious psychological sequelae of induced abortion are reported to occur in anywhere from .2% to 20% of post abortion women.

18. Guilt: There is no doubt that this is a significant complication following induced abortion. Of women who have had abortions, 20%-25% admit guilt feelings, another 10% actively suppress their guilt feelings, and 10% develop "impaired mental health" as a result of their abortions (8). It is interesting that according to one report, 63% of women who have had an induced abortion will deny it to another doctor in another hospital, and 1.6% will deny it later to the doctor who performed the abortion, at the hospital where it was done (3).

19. Suicide: There may be an increased risk of suicide among women who have had an abortion. This risk is especially serious in teenagers (13), among whom the overall incidence of suicide is on the rise already. Appropriately, the suicides commonly occur on the due date of the baby who was aborted.

The Abortion Surveillance Brance of the CDC compiles statistics on abortion from those abortion centers which report to it. In general their reported incidence of immediate serious complications of induced abortion is lower (less than 1%) than the ones I have presented here (about 4%). Likewise, their figures for delayed complications are much lower. In considering the validity of their statistics, we must take into account two things: first, not all states require that all abortion providers report their complications, and second, of those abortion providers who do report

complications, no more than 20-30% of their patients are ever seen in follow up (2). This would mean that any statistics published by the CDC should be viewed with guarded skepticism. A more accurate reflection of the incidence of abortion complications might be obtained by multiplying their figures by a factor of 3 or 4, to compensate for the 70-80% of patients who are not followed (and therefore their complications go unreported). The fact is that most immediate complications following induced abortion are seen in emergency rooms by physicians who did not do the abortion, and therefore the abortions do not get reported. Most late complications are seen several weeks to several years later by another physician in the office. These likewise therefore also do not get reported.

On the basis of what I have learned by preparing this information for you today, I have concluded certain things. First of all, the frequently quoted "less than 1%" complication rate following induced abortion in the U.S. is quite obviously incorrect. In an extremely well equipped, well staffed university medical center, maybe such an outcome is achievable. However, I fearfully suspect that my 4% estimate may even be too low, if all of the office and clinic abortions were to be included.

Regarding the true incidence of late complications from induced abortions in the U.S., nobody really knows, and only a fool would pretend to know. Because of the duration of the problems, it will take at least 20 years of close follow up of post abortion women to get a realistic idea of the scope of their problems. So far, we don't even have adequate follow up of the

immediate complications.

The only way we can begin an accurate, honest evaluation of the complications of induced abortion in the U.S. is to require all abortion providers (clinics, doctors' offices, hospitals) to follow all their post abortion women, and report all complications for ideally the next 20 years. Realizing that this would not be possible, we should also require all health care providers who later identify a complication of induced abortion, to report it.

Most importantly every woman who is considering an abortion must be informed of these complications before giving her consent for the operation. Anything less would be blatant exploitation.

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Attm. #7
2-14-5

REMARKS OF THE KANSAS HOSPITAL ASSOCIATION
BEFORE THE
PUBLIC HEALTH AND WELFARE COMMITTEE

February 14, 1985

Mr. Chairman and members of the Committee, the Kansas Hospital Association appreciates the opportunity to offer testimony regarding House Bill 2052.

The Kansas Hospital Association is opposed to Section 1 (c) of House Bill 2052 in that it creates one more regulatory burden under which hospitals in this State must operate. As you know, hospital personnel are already spending much time preparing forms required by state and federal agencies with regard to termination of pregnancies. Hospitals are already required to keep written records and to submit an annual written report to the Secretary of the Department of Health and Environment. Therfore, the purpose of the extra form required by Section 1 (c) is unclear.

This law would cost the State approximately $16,000 to administer. This figure, of course, does not include increased costs to hospitals and the ultimate increased costs for consumers. For these reasons, the Kansas Hospital Association recommends that Section 1 (c) of House Bill 2052 be deleted.

Attm. #7
2-14-85

Attm #8

TESTIMONY BEFORE KANSAS HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

February 14, 1985 presented by Catherine Wahlmeier 2-14-5

Mr. Littlejohn, members of this committee. Thank-you for allowing me to present this testimony in favor of House Bill 2052. My name is Catherine Wahlmeier, Hays is my home. As a wife, mother, homemaker, non-practicing registered nurse and member of the Right to Life of Kansas INc. I urge you to vote in favor of H.B. 2052.

As a member of the medical profession, I've often seen and had to refer to statistics put out by the Center For Disease Control in Atlanta, Ga. In order for them to issue statistics, the data to them has to be complete/ in the matter we are dealing with, abortion, I question the validity of any of their figures since not all the abortions are reported, as the Right to Life of Ks. Inc. has long contended. Please refer to the sheet numbered (1)"Who Gets Abortions" EVen if Kansas were the only state that was so lax in reporting, it would make a definite difference in the statistics. Abortion has been sold to this nation as a 'service' to women--DEVASTATION would be a better word to des cribe it. Dr. Wanda Poltawske, a psychiatrist with extensive experience in family and marriage counseling, recently stated at a conference in Japan "A general assessment of the psychical effects of abortion is difficult. This is due to the enormous number of cases which would have to be investigated in order to obtain statistics, the lack of systematic medical supervision of the patients after abortion, the unwillingness on the part of women to disclose to their physicians the fact of a past abortion, the physicians attitude in favor of abortion, and the fact that the effects may appear many years after the actual abortion has taken place."

If you'll refer to sheet no (2), you'll find personal testimony from some Women Exploited By Abortion. Sheet no (3) gives medical complications from abortion, listed as to trimesters and types of abortion used.

From a reprint originally appearing in Orthopanel 14, a publication of the Ortho Pharmaceutical Corporation, Dr. Carol Cowell, chief of pediatric and adolescent gynecology in The Hospital for Sick Child in Toronto, Canada, speaks to the "Problems of Adolescent Abortion". In one study of 83 abortions performed on girls between ages 14-18, 51 were by suction curettage and 32 by intraamniotic saline exchange injection. Of the 51 suction abortions, 10 had immediate complications, and 7 required readmittance for delayed complications. One girl was readmitted for septic shock, with a fever of 106 (she was a healthy girl and did survive). We had only one perforation, requiring laparotomy to rule out hemorrhage, damage to the bowel etc.

Attm #8
2-14-5

A total of 12 patients of the 32 undergoing saline abortions had immediate complications, 6 requiring readmission. Most had low-grade fevers, mostly due to pelvic inflammatory disease. Please refer to sheet no. (4) onwhich you will find 3 articles from medical sources regarding PID disease.

Dr. Cowell stated "Our policy was to see every girl routinely post-abortally for a six-week check-up, and then every three months or earlier if problems developed. THIS FOLLOW UP IS WHERE THE TRUE MEASURE OF MORBIDITY REVEALS ITSELF." THis statement by a doctor--I wonder just how many wives, mothers daughters, sisters and girl friends here in Kansas are getting that kind of follow-up after there abortions.

On sheet no. (4) you'll find another way in which abortion-on-demand is affecting us. That is by such a severe drop in reproduction that we are now below replacement rate. How can this be healthy?

Let me conclude my testimony with this opinion by Dr. Wanda Poltawska, "The destruction of the woman's own child in her womb simultaneously destroys the very deepest structure of her femininity and has an immediate impact on her soul. Medicine itself cannot cure her conscience. We must appeal to theology rather than to medicine. On the other hand, the task of medicine is to eliminate abortion."

Until we come to that desired goal, at least let it be known the TRUTH about the number of abortions and the complications thereof in the State of Kansas. Thank-you!

Respectfully submitted,

Catherine Wahlmeier

Mrs. Catherine M. Wahlmeier
413 W. 14th St.
Hays, Kansas 67601

attn: 8-a
2-14-5

WHO GETS ABORTIONS?

otes that you should remember out this chart include the follow-g:

A) With only seven percent of the opulation, non-white women ceive over 30 percent of the abor-ons in our nation (genocide?).

B) Unmarried women are receiving over 75 percent of the abortions in our country.

C) No specific age group (i.e., teens) acquire most of the abortions; it appears to be evenly spread among ages below 19 to over 25.

Conclusion: Killing in our nation, per Planned Parenthood goals, is going on where Margaret Sanger would have wanted it to – among the minorities, and among those women who no longer cherish virginity. In a society that places a high price on "freedoms," it is interesting that women who are unmarried are now slaves to butchers.

haracteristics of women obtaining abortions – United States, 1972–1981

	Percentage distribution*									
haracteristics	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
eported number f legal abortions	586,760	615,831	763,476	854,853	988,267	1,079,430	1,157,776	1,251,921	1,297,606	1,300,760
esidence										
Abortion in-state	56.2	74.8	86.6	89.2	90.0	90.0	89.3	90.0	92.6	92.5
Abortion out-of-state	43.8	25.2	13.4	10.8	10.0	10.0	10.7	10.0	7.4	7.5
ge										
≤19	32.6	32.7	32.7	33.1	32.1	30.8	30.0	30.0	29.2	28.0
20-24	32.5	32.0	31.8	31.9	33.3	34.5	35.0	35.4	35.5	35.3
≥25	34.9	35.3	35.6	35.0	34.6	34.7	34.9	34.6	35.3	36.7
ace										
White	77.0	72.5	69.7	67.8	66.6	66.4	67.0	68.9	69.9	69.9
Black and other	23.0	27.5	30.3	32.2	33.4	33.6	33.0	31.1	30.1	30.1
larital status										
Married	29.7	27.4	27.4	26.1	24.6	24.3	26.4	24.7	23.1	22.1
Unmarried	70.3	72.6	72.6	73.9	75.4	75.7	73.6	75.3	76.9	77.9
umber of live births†										
0	49.4	48.6	47.8	47.1	47.7	53.4	56.6	58.1	58.4	58.3
1	18.2	18.8	19.6	20.2	20.7	19.1	19.2	19.1	19.5	19.7
2	13.3	14.2	14.8	15.5	15.4	14.4	14.1	13.8	13.7	13.7
3	8.7	8.7	8.7	8.7	8.3	7.0	5.9	5.5	5.3	5.3
≥4	10.4	9.7	9.0	8.6	7.9	6.2	4.2	3.5	3.2	3.0
ype of procedure										
Curettage	88.6	88.4	89.7	90.0	92.8	93.8	94.6	95.0	95.5	96.1
Intrauterine instillation	10.4	10.4	7.8	6.2	6.0	5.4	3.9	3.3	3.1	2.8
Hysterotomy/hysterectomy	0.6	0.7	0.6	0.4	0.2	0.2	0.1	0.1	0.1	0.1
Other	0.5	0.6	1.9	2.4	0.9	0.7	1.4	1.6	1.3	1.0
Weeks of gestation										
≤8	34.0	36.1	42.6	44.6	47.0	51.2	52.2	52.1	51.7	51.2
9-10	30.7	29.4	28.7	28.4	28.0	27.2	26.9	27.0	26.2	26.8
11-12	17.5	17.9	15.4	14.9	14.4	13.1	12.3	12.5	12.2	12.1
13-15	8.4	6.9	5.5	5.0	4.5	3.4	4.0	4.2	5.2	5.2
16-20	8.2	8.0	6.5	6.1	5.1	4.3	3.7	3.4	3.9	3.7
≥21	1.3	1.7	1.2	1.0	0.9	0.9	0.9	0.9	0.9	1.0

Excludes unknowns. Since the number of states reporting each characteristic varies from year to year, temporal comparisons should be made with caution.
†For 1972–1977, data indicate number of living children.

Reprinted from *Morbidity and Mortality Weekly Report,* Centers for Disease Control, July 6, 1984, page 374.

WEBA: VOICES OF EXPERIENCE

A new dimension has been added to the Heritage House '76 pro-family, pro-life resource center. In addition to We Care, our emergency pregnancy service, we have now added to our routine beehive of activity the Arizona state headquarters for Women Exploited By Abortion (WEBA).

We are indeed pleased to have one of our faithful employees, Karen Sullivan, accept the leadership of Arizona WEBA. No one on our staff is more committed to the pro-life cause than Karen. This excerpt from her personal testimony helps explain her dedication to the principles of WEBA:

"I did not escape the aftermath of abortion. I had nightmares and reoccurring dreams about my baby. I couldn't work my job. I just laid in my bed and cried.

"Once, I wept so hard I sprained my ribs. Another time while crying, I was unable to breathe and I passed out. At the time I was living in California and was unable to walk on the beach because the playing children would make me cry. Even Pampers commercials would set me into fits of uncontrollable crying.

"But, do you know when it hurts the worst? It hits hardest on the day the baby would have been born. September 27 is still a hard day for me."

Arizona girls who have suffered similar trauma are grateful for Karen's comforting shoulder for support. The psychological and emotional merits of WEBA could not be expressed more lucidly than they are in the following letter:

"Dear Karen,

"I was really glad to hear from you and to receive the information that you sent. I find comfort in the poem and in the prayer that was in the brochure.

"You will never know how hard it is for me to write this letter, and I have been trying for a week now. I have never accepted what I did, especially to the child that I will never watch grow, nor will I ever forgive my ex-husband for persuading me to kill my baby. There are very few people who know what I have done – I am so ashamed!

"Ten years ago this March – one month after my son's first birthday – my husband told me to make a choice, him or the (unborn) baby. What a wrong choice! I wish I would have asked Christ to help me then. They say that people learn from their mistakes, but how do you ever learn to forgive yourself for killing a part of you. I can't believe that I let that man convince me to kill something that was conceived from love. My baby never hurt anyone and yet I destroyed it. I hate myself for that.

"Then to make things worse six months later, due to complications, I had to get a hysterectomy. Now I have to live with the fact that I can no longer have any children. I do have three great children, but I so desperately miss my unborn baby.

Karen Sullivan with son Scott, 2½.

You will never know how many times that I prayed to God, "Just let me wake up and find it was just a nightmare!" But it isn't and now I just pray God to give me the strength day by day.

"I hope that someday they change the law again to make abortion illegal. Some of the women I know that have had abortions won't even talk about it because it hurts so deeply and all they want to do is forget.

"I don't see how they can forget. Every time I see a baby or an expectant mother, I want to die. The memory will never go away. I tried to make it go away by alcohol and drugs. The only thing that helps is to pray to Christ and right now I find greater peace in that than in anything.

"Karen, if any of this will help anyone, then share it with them. Also tell them that they have to live with themselves from now until the day they die, and when they are awakened at night by a baby crying (and there is no baby), it's their baby crying from heaven hoping to be heard by the one who refused to let it be born.

"If there is anything that I can do to help, I would be more than happy to. Women who contemplate abortion need to know about the aftermath and the destruction that it will cause, for it not only takes away the life of the unborn child but will destroy the life of the one taking away that life.

"I hope to hear from you soon, and again thank you ever so much. I don't feel so alone now, just knowing others feel the same as I do."

Little wonder that WEBA has become such a dynamic attribute to our nation's pro-life effort.

By Virginia Evers. Mrs. Evers may be contacted at Heritage House '76, P.O. Box 730, Taylor, AZ 85939.

attm. #8-B
2-14-5

DID YOU KNOW ------ THE LIFE YOU SAVE MAY BE YOUR OWN? ABORTION INTERRUPTS AND DESTROYS HUMAN LIFE!

(DUE TO LACK OF SPACE, WE HAVE LISTED ONLY THE MOST SERIOUS COMPLICATIONS)

OUTPATIENT CLINIC ABORTIONS (ABORTIONS OF FIRST TRIMESTER OR FIRST THREE MONTHS.)

COMPLICATIONS TO THE MOTHER FROM D&C AND SUCTION ABORTIONS

1. Sudden death of the mother
2. Hemorrhage
3. Pulmonary embolism (blood clot to lungs)
4. Cardiac embolism (blood clot to heart)
5. Cerebral embolism (blood clot to brain)
6. Shock
7. Sterility
8. Blood transfusions
9. Perforation or rupture of the uterus
10. Hysterectomy (in case of perforation)
11. Emergency surgery to repair bowel (in some cases of perforation)
12. Anesthetic accidents (in cases of emergency surgery)
13. Allergic reactions to drugs or transfusion
14. Serum hepatitis
15. Acute infections (3 to 4 days after abortion)
16. Septicemia (blood poisoning)
17. Pelvic cellutitis (generalized tissue inflammation)
18. Peritonitis (inflammation of lining of abdominal cavity)
19. Endometritis (inflammation of lining of uterus)
20. Myometritis (inflammation of muscle layer of uterus)
21. Salpingitis (inflammation of fallopian tubes)
22. Transplacental hemorrhage (Rh problem)
23. Urinary tract infections
24. Pelvic thrombophlebitis (inflammation of veins plus blood clot)
25. Anemia
26. Menstrual disorders
27. Continuous bleeding (retained tissue)
28. Pain syndrome (headache, abdominal pain and tenderness)
29. Scarring of cervix - leads to cervical weakness and later miscarriage
30. Cervical weakness or incompetence (predisposes to later miscarriage)
31. Premature labor
32. Ectopic pregnancy - tubal (400% increased risk after abortion)
33. Infertility (due to scarring and adhesions - Asherman Syndrome)
34. Mental disorder, multiple
35. Prolonged labor
36. Premature births

ABORTIONS ARE 100% FATAL TO THE BABY!

HOSPITAL ABORTIONS (ABORTIONS OF SECOND AND THIRD TRIMESTER- FROM FOURTH MONTH TO TERM)

COMPLICATIONS TO MOTHER FROM SALINE OR SALT ABORTIONS

1. Sudden death to mother
2. Hemorrhage (severe drop in blood clotting ability of mother)
3. Shock
4. Blood transfusions
5. Allergic reactions to drugs or transfusions
6. Serum hepatitis
7. Anemia
8. Kidney pathology
9. Central nervous system disorders
10. Convulsions
11. Coma
12. Permanent brain damage
13. Pyrexia (high fever)
14. Mental disorders, multiple
15. Complications in later wanted pregnancies

attm. #8.
2-14-1985

HOSPITAL ABORTIONS (HYSTEROTOMY - SURGICAL REMOVAL OF BABY THROUGH INCISION INTO UTERUS)
FOURTH MONTH TO FULL TERM

POSSIBLE COMPLICATIONS TO MOTHER

1. Sudden death to mother
2. Implantation endometriosis (displacement of uterine tissue causing continual monthly distress)
3. Shock
4. Hemorrhage
5. Blood transfusions
6. Allergic reactions to blood and drugs
7. Serum hepatitis
8. Septicemia (blood poisoning)
9. Thrombophlebitis (inflammation of vein with clot)
10. Tranplacental hemorrhage (in Rh negative mother leads to Rh problems)
11. Cesarean Section (necessary in later pregnancies to prevent rupture of hysterotomy scar)
12. Anesthetic accidents
13. Endometritis (inflammation of lining of uterus)
14. Myometritis (inflammation of muscle layer of uterus)
15. Salpingitis (inflammation of fallopian tubes)
16. Peritonitis (inflammation of lining of abdominal cavity)
17. Pulmonary embolism (possible sudden death due to blood clot in lungs)
18. Cardiac embolism (blood clot in the heart)
19. Cerebral embolism (blood clot in the brain)
20. Paralytic ileus (type of bowel obstruction)
21. Multiple mental disorders

HOSPITAL ABORTION (PROSTAGLANDIN - SPECIFIC DRUG USED TO PRODUCE LABOR AND DELIVERY)
AFTER THE THIRD MONTH

POSSIBLE COMPLICATIONS TO MOTHER

1. Possible death of mother
2. Massive hemorrhage (when cervical instillation method is used)
3. Severe uterine contractions
4. Uncontrollable vomiting
5. Uncontrollable diarrhea
6. Fever
7. Tachycardia (excessive rapid heart beat)
8. Tachypnea (abnormal rapid breathing)
9. Allergic reactions (bronshospasm)
10. Severe headaches
11. Dizziness
12. Inflammatory reactions at site of injection
13. Serum hepatitis (tranfusion related)
14. Multiple mental disorders

THE MOST DISTRESSING COMPLICATION OF SALINE AND HYSTEROTOMY ABORTIONS ARE THE NUMBER OF LIVE BABIES BORN FROM THESE PROCEDURES -- THEY SURVIVE THE ABORTION ONLY TO FACE PREDIATL DEATH FROM EXPOSURE AND NEGLECT !!!

POSSIBLE LONG-TERM COMPLICATIONS IN LATER WANTED PREGNANCIES DUE TO PREVIOUS ABORTION

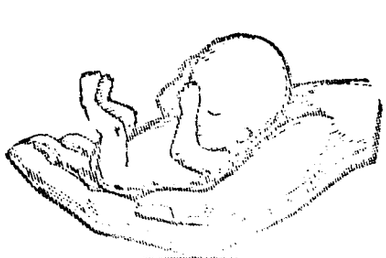
1. Spontaneous miscarriage (due to scarring and weakening of cervix)
2. Sterility
3. Infertility
4. Increased risk of stillbirths
5. Placenta previa (premature separation of placenta)
6. Adherent placenta (placenta difficult to expel at time of delivery)
7. Premature labor
8. Prolonged labor
9. Premature births
10. Menstrual distress and irregularity
11. Frigidity
12. Marital problems
13. Multiple mental disorders

OUR MOST PRIZED POSSESSIONS -- OUR UNBORN CHILDREN

ARE BECOMING OUR MOST ENDANGERED SPECIES

DID YOU KNOW! THERE ARE APPROXIMATELY 25M COMPLICATIONS THAT CAN OCCUR FROM INDUCED ABORTIONS. COMPLICATIONS OCCUR IN 1 OUT OF 3 TEENAGERS AND 1 OUT OF 4 ADULTS. REFERENCES AND CASSETTES OF "DID YOU KNOW" RADIO PROGRAM ARE AVAILABLE. WRITE TO: NORA STROPPEL, R.N.; c/o RADIO PROGRAM, ADDRESS BELOW

[illegible] LIFE
Southern Illinois, Inc.
P.O. Box 507
[illegible], Illinois 62222



Belleville Area
Right to Life
P.O. Box 386 - Belleville, Ill. 62221
A NON-PROFIT, TAX DEDUCTIBLE ORGANIZATION

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Pelvic Inflammatory Disease and Abortion

Women under 20 who have abortions are at increased risk of pelvic inflammatory disease (PID) if Chlamydis trachomatis is present in their cervix, according to Erik Quigstad, M.D., of Oslo, Norway.

Quigstad and his associate tested 97 women admitted to an Oslo hospital for trachomatis and gonorrhea prior to the abortion and at a four-week follow-up.

Twenty-two women studied (four percent) developed PID post-abortion. Pre-abortion, 14 of the 22 were found with chlamydiae in the cervix (64 percent).

It should be noted that PID was contracted even though the abortion took place at Ullevaal Hospital in Oslo, Norway.

British Journal of Venereal Disease, June 1983, p. 185.

More Post-Abortion PID

Another study of 876 Swedish women undergoing legal vacuum aspiration abortions was undertaken to determine if the presence of Chlamydia trachomatis was associated with post-abortion pelvic infection.

Subjects in the study had a cervical and urethral culture for C. trachomatis. One or both cultures were positive in 57 women (6.5 percent). Of this group 12 (21 percent) developed endometritis and 8 (14 percent) developed salpingitis within one month, post-abortion. Women who had negative cultures at the time of the abortion subsequently developed endometritis (6.6 percent) or salpingitis (.6 percent).

Women with a past history or evidence of pelvic infection at the time of the abortion were excluded from the study.

S. Osser and K. Persson, Post-abortion Pelvic Infection Associated with C. trachomatis and the Influence of Humoral Immunity *Fertility News*, 17: 3: 4, Autumn 1983.

Pelvic Inflammatory Disease and Secondary Infection

Perihepatitis or inflammation of the peritoneal covering of the liver, which occurs secondarily to pelvic inflammatory disease, is frequently associated with Chlamydis trachomatis but is often not recognized, according to Dr. J. B. Kurtz of Radcliffe Hospital, Oxford.

In England, it is thought that perihepatitis may account for ten percent of all hospital admissions for acute cholecystitis, or inflammation of the gallbladder.

Lancet, May 7, 1983, p. 1044.

Present Convenience, Future Decline

Very few states have birth rates high enough to maintain their populations, according to figures published in October by the Population Reference Bureau.

Demographers say a rate of 2.12 births per woman (over her reproductive lifetime) is needed to maintain a population. The national rate is now 1.8 per woman.

The accompanying data also shows the number of births per 100 deaths in the second column, a figure which reflects the relative youthfulness of some regions.

The Population Reference Bureau based its compilation on statistics from the National Center for Health Statistics (birth rates for 1980) and the Census Bureau (birth-to-death ratios for 1980 to 1983).

	Birth rate	Births per 100 deaths
New England		
Maine	1.7	159
New Hampshire	1.7	180
Vermont	1.7	173
Massachusetts	1.5	138
Rhode Island	1.5	133
Connecticut	1.5	148
Middle Atlantic		
New York	1.6	145
New Jersey	1.6	142
Pennsylvania	1.6	133
East North Central		
Ohio	1.8	172
Indiana	1.8	180
Illinois	1.9	182
Michigan	1.8	184
Wisconsin	1.9	182
West North Central		
Minnesota	1.9	205
Iowa	2.0	168
Missouri	1.9	158
North Dakota	2.1	222
South Dakota	2.4	200
Nebraska	2.0	183
Kansas	2.0	187
South Atlantic		
Delaware	1.8	187
Maryland	1.6	180
Dist. of Col.	1.5	136
Virginia	1.6	188
West Virginia	1.8	147
North Carolina	1.6	173
South Carolina	1.8	201
Georgia	1.9	203
Florida	1.7	129
East South Central		
Kentucky	1.9	172
Tennessee	1.7	166
Alabama	1.9	174
Mississippi	2.2	199
West South Central		
Arkansas	2.0	158
Louisiana	2.2	232
Oklahoma	2.0	191
Texas	2.1	259
Mountain		
Montana	2.1	214
Idaho	2.5	278
Wyoming	2.4	370
Colorado	1.8	269
New Mexico	2.2	303
Arizona	2.1	237
Utah	3.2	500
Nevada	1.8	230
Pacific		
Washington	1.8	214
Oregon	1.8	193
California	1.9	224
Alaska	2.3	517
Hawaii	2.1	375

New York Times, Oct. 14, 1984.