Approved 2-28-86
Date

MINUTES OF THE Senate COMMITTEE ON Federal and State Affairs.

The meeting was called to order by Senator Edward F. Reilly, Jr. at
Chairperson

11:00 a.m./p~~m.~~ on February 25, 19 86 in room 254-E of the Capitol.

All members were present except: Senator Morris and Senator Vidricksen were excused.

Committee staff present:

Mary Torrence, Assistant Revisor of Statutes
Sharon Efird, Secretary

Conferees appearing before the committee:

Bill Gilfillan, Vice President, Kansans for Life
Mike Cavell, Topeka attorney
Dr. Nancy L. Toth, Family Physician, Topeka
Mrs. Linda Heim, Topeka
Mary Garberg, Women Exploited by Abortion, Kansas City
Kent Vincent, Kansas Association of Evangelicals
Dr. and Mrs. Gerald L. Mowry, Manhattan

Senator Arasmith moved that the Minutes of the meeting of February 21, 1986, be approved. Seconded by Senator Daniels. Motion carried.

The Chairman announced that today's hearing would be testimony by proponents of SB 577 - consent to abortions performed on minors; defining crimes relating to abortion.

The first conferee, Bill Gilfillan, Vice President of Kansans for Life, Topeka, an organization associated with the National Right to Life Committee, supports the Parental Consent Bill because it makes good common law and makes for healthier families. He feels if informed parental consent is required for minor medical procedures it should consistently be required for abortions as well. His testimony is Attachment #1.

Mike Cavell, an attorney in private practice in Topeka, distributed a constitutional overview of SB 577. He said he had reviewed most of the constitutional decisions of the United States Supreme Court with regard to abortion as well as helped prepare the draft of SB 577. (Attachment #2) His testimony is an analysis and review of the bill from a constitutional perspective.

Dr. Nancy L. Toth, a family physician from Topeka, presented testimony in support of section 1(b) of the bill. (Attachment #3) In her experience as a physician, she has found it difficult to communicate with the adolescent age group (12 to 18). She has also found that these adolescents often do not consider the serious and sometimes permanent medical, emotional and psychological consequences of abortion. Ambivalence is another common characteristic of the adolescent age group. She feels the bill places the burden of decision in the hands of the parent which in turn promotes the health of the teenager and may improve the relationship between the daughter and parent.

Mrs. Linda Heim, a registered nurse and counselor of girls and women at a crisis pregnancy center, spoke as a nurse and parent. From her observations and insights of the adolescent age group, she found often that teenagers are seeking to protect the parent from hurt, disappointment and embarrassment and to avoid a confrontation when actually they need the parent's protection and counsel. They should be aware of possible complications from the procedure, both mental and physical. The parent should be there to see that teenage girls follow the safest pre-operative and post-operative procedures. She distributed copies of chapters from New Perspectives on Human Abortion giving details of possible complications. (Attachment #4)

The next conferee, Mary Garberg from Kansas City, represented Women Exploited by Abortion. Through her experience of having had an abortion and in dealing with teenagers on an abortion hotline, she feels girls aren't able to deal alone with the physical pain and mental aftermath of abortion -- the nightmares, flashbacks, lack of self-confidence and being able to fit back into normal teenage activities. Abortion is not the answer or the problem. She feels strongly that the problem is teenage sex. This is what parents should be speaking out against. And, parents should also bear the guilt of abortion. She had no written testimony.

Kent Vincent of the Kansas Association of Evangelicals in Topeka distributed a position paper (Attachment #5) and a copy of a letter written by Dr. Donald B. Rinsley of the Colmery-O'Neil VA Medical Center in Topeka (Attachment #6). In his opinion, the solution to the problem of teenage pregnancy is not the taking of life but love and care provided that teenager by caring parents or a caring home with people who understand and appreciate the problem. He feels most adolescents (under 18) are not mature enough to make the decision -- parents should take that responsibility. The Topeka chapter of the Association is preparing to provide caring homes, where parental homes are not available, for pregnant girls under the age of 18 until the birth.

Mrs. Cathy Mowry spoke next, on behalf of herself and her husband, an obstetrician/gynecologist in Manhattan. Their statement is Attachment #7. They feel it is a compelling state interest to protect minors against their own immaturity; foster the family structure; and protect the rights and responsibilities of parents to rear their children. They have a strong concern about how "informed consent" is to be determined and they urged amending SB 577 to require a standard abortion consent form which is scientifically factual, informative and descriptive, so that the patient knows as much as the abortionist. They suggested the committee look closely at the wording in several other lines of the bill.

The statements of Robert Runnels, Jr., Executive Director of Kansas Catholic Conference, and Dr. Robert W. Conroy, Associate Director of the C.F. Menninger Memorial Hospital, were distributed to the committee. (Attachments #8 and #9) They were unable to attend the meeting.

Mike Cavell, a Topeka attorney, was asked to respond to the concern for the need for an informed consent form. It was his opinion that the United States Supreme Court continues to affirm that the actual relationship between a physician and the pregnant minor has to be left to the minor and that physician, allowing the physician the freedom to determine how much information should be given. At this point he feels the best constitutional avenue to take is to continue as we do in other types of medical procedures, allowing the physician and the patient to gauge exactly the extent of the information that needs to be passed back and forth so that an informed consent can be obtained.

Senator Walker agreed that the real key is a clear definition of informed consent; it often means nothing in a surgical procedure. Mr. Cavell clarified that informed consent in SB 577 is between the "emancipated minor" and the "physician" or, in the case of a "minor," between the "parent" and the "physician." What is needed is a clear understanding of informed consent.

Senator Reilly announced that opponents to SB 577 would be heard on Wednesday, February 26, 1986.

The meeting adjourned at 12:12 p.m.

#1

Kansans for Life

3601 S.W. 29th Street, Suite 241, Topeka, KS 66614
(913) 272-9242

Hearing for the PARENTAL CONSENT BILL -
Senate Bill 577

The Parental Consent Bill Makes Good Sense. Here's why:

1. The Parental Consent Bill (S-577) would require a teenage girl to obtain her parents written and informed consent before she could have an abortion. Right now a teenager must have parental consent before a school nurse will give her an asprin. When she decides to get her ears pierced, the store owner will make sure she has her parents permission. If she needs a tonsilectomy , a hospital would inform her and her parents about the procedure, possible risks, and after effects and obtain their written permission prior to the procedure. Yet right now state law does not require a teenage girl to obtain parental consent to have an abortion. Children who in the eyes of the state do not have the necessary maturity to drive a car by themselves are currently legally allowed to navigate this momentous decision alone. If informed parental consent is required for such minor medical procedures, we think it consistent to require written informed parental consent for abortions as well. It's common sense.

2. The Parental Consent Bill also makes good family sense. There's no doubt about it, it is terribly hard for a teenage girl to tell her folks she's pregnant. However, from time to time, teenagers do have to talk with mom and dad about hard things: discussing things like report cards. It's understandable to want to hide these kinds of things, but in order for parents to be good parents, they must be aware of the status quo. It's hard enough to find out your daughter's pregnant; it's even harder to find out that she didn't really go to Overland Park to go shopping; she's home now and already had the abortion.

3. The Parental Consent Bill makes good legal sense. In 1983 in Planned Parenthood v. Ashcroft, Parental Consent Bills such as S-577 recognized as constitutional by the U.S. Supreme Court. The Parental Consent Bill Makes provisions for medical emergencies and provides practical contingencies. Furthermore, if the teenage girl wants the abortion and mom and dad don't - she may obtain judicial consent from a local district judge at no cost to herself and be entitled to an abortion.

We urge you to support the Parental Consent Bill because it makes good common law, it makes for good consistent medical practice, it makes for healthier families and it makes good common sense.

Bill Gilfillan
Vice President
Kansans For Life
February 25, 1986

Sen. Fed. & State Affairs
2/25/86 Attachment 1

Attachment #1

#2 Prepared by KFL
M.C. Cavell

SB 577

Constitutional overview:

1. The State of Kansas can legislate abortion and even prohibit it under certain circumstances:
   --the tirmester tests Roe v. Wade 93 SCt 705 (1973)
   --there is no absolute right to an abortion on demand Roe v. Wade
2. The State of Kansas has particular legislative ability concerning abortions on minor children:
   --because minors lack experience, perspective and judgment to avoid choices that could be detrimental to them Bellotti v. Baird 99 SCt 3035 (1979)
   --States may therefor validly limit a minor's right to choose for herself in making an abortion decision Bellotti v. Baird
3. Section 1(b), SB 577:
   --These are precisely the basis for state regulation of a minor's abortion decision that the Supreme Court has already recognised as valid state interests Bellotti v. Baird and Planned Parenthood v. Danforth 428 US 52
4. Parents have first rights to exercise care, custody and control of minors; this includes the abortion decision:
   --SB 577 merely preserves that first right Bellotti v. Baird and Planned Parenthood v. Danforth.
5. Section 3, SB 577:
   --This is the same parental consent requirements already recognised as constitutional and tested in a number of Supreme Court cases Bellotti v. Baird, Planned Parenthood v. Danforth, Planned Parenthood v. Ashcroft, 103 SCt 2517 and

Attachment #2

H.L. v. Mathison 450 US 398.

6. Section 4, SB 577:

--If a child chooses not to obtain parental consent or a parent refused that consent, a judicial alternative must be provided. Section 4, SB 577 is, in substance, already approved and tested by a number of Supreme Court cases Planned Parenthood v. Ashcroft.

--The district court can waive the parental consent requirement if (a) it finds the minor is mature enough to decide on her own or, if not (b) it finds that nevertheless, the abortion would be in her best interest. Planned Parenthood v. Ashcroft.

7. The Emergency Override

--Section 5, SB 577

#3

Presenter: Dr. Nancy L. Toth, Family Physician
Graduate of Kansas University Medical School
Family Practice Residency at Scott Air Force Base
Board Certified in Family Practice 1979

Purpose: To discuss section 1(b) of the Parental Consent Act
Senate Bill #577

Informed consent is a concern of every practicing physician in the state of Kansas. This is true not only because of the malpractice climate, but also because it is important that the patient understand the procedure, its risks vs. benefits and alternative forms of treatment in order for the patient to help determine what is best for her.

However, in my experience as a physician, I have found it particularly difficult to commiunicate with the adolescent age group (12 to 18). In the medical setting this group is generally quiet, reserved, embarrassed, and self-conscious, offering only minimal information when questioned. Many times they are unable to cite their own past medical history with any accuracy, or even give much history as to why they are present in the office, usually depending on the parent to explain the problem. They are not aware of drug sensitivities, allergies or past immunization status, information that parents ordinarily possess. They tend to have difficulty in articulating what was just explained to them, let alone transmit this information later to a parent. This results in follow-up phone calls from parents wanting to know what transpired in the office. Of course, the older the patient is, the less a problem this is. Nevertheless, this medical information is important to the physician as he or she makes decision regarding the adolescent patient's care.

It is also typical for this group as a whole to be interested in immediate relief from painful or frustrating situations and exhibit less concern for long term consequences. Little thought is given to the serious and sometimes permanent medical, emotional, and psychological consequences of abortion [genital tract infection, bleeding, hemorrhage requiring transfusion, perforation of the uterus or bowel, embolism, varying degrees of infertility, ectopic pregnancy, future miscarriages, premature births, uterine rupture, post-abortion psychosis, suicide].

Ambivalence is another common characteristic of the adolescent age group. The teenager may vacillate between wanting total independence and wanting to be taken care of; they desire adult privileges yet reject adult responsibilities; one moment there is love and respect for parents, the next resentment and hostility. This lack of assuredness enters into their decision-making process causing difficulty in coming to a final decision, then being assailed by self-doubt after it is made.

Consequently, with these characteristics of looking for the most expedient solution and being strongly ambivalent about any decision it is readily apparent that the adolescent needs wise counsel and strong support from those who love them in making such serious decisions.

What about post-abortion complications? Will the adolescent who has secretly obtained an abortion receive medical care as expeditiously if the parents are uninformed? Or will the tendency be for her to delay receiving medical care and thus jeapordize her health? This concerns me as a physician.

As a parent I am concerned that not requiring parental consent in this very important matter suggests that parents really do not have the best interests of their children at heart; that children have more wisdom and knowledge than their more mature parents. This implies a disrespect and disregard by the state for parental authority, responsibility, knowledge and understanding of his/her children. The relationship between many parents and teenagers may already be strained. Adding to this a teenager's decision to obtain an abortion without parental consent only increases the rift between them. On the other hand if the parents are informed and involved in the decision-making process, an opportunity is created for the family to pull together and work through the crisis.

In summary, I see the Parental Consent Bill as serving several needed purposes. It takes the onus of the decision to abort, give up for adoption, or keep the baby off of the immature adolescent and places it in the hands of the parent. This promotes the health of the teenager and may improve the relationship between daughter and parents. I believe that section 1(b) of Senate Bill #577 is accurate.

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10. W.J. Cates et al.: Abortion deaths associated with the use of prostaglandin F2 alpha. *Am. J. Obstet. Gynecol.* 127(3):219-222, 1977.

11. D.N. Menzies and D.F. Hawkins: Therapeutic abortion using intra-amniotic hypertonic solutions. *J. Obstet. Gynecol. Brit. Cwlth.* 75:215-218, 1968.

12. G. Wagner et al.: Induction of abortion by intraovular instillation of hypertonic saline. *Dan. Med. Bull.* 9:137-142, 1962.

13. M.E. Loskutov and O.A. Vasilievich: Single stage plastic repair of the urinary bladder, vagina and ureters after extensive chemical necrosis. *Urol. Nefrol. (Mosk.)* 32(4):57-58, 1967.

14. M.P. Gangai: An unusual surgical injury to the ureter. *J. Urol.* 109:32, 1973.

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16. N.K. Sen and S.K. Banjersee: Haematuria and haemoglobinuria in induced septic abortions. *J. Obstet. Gynecol. India* 26(5):647-651, 1976.

17. S.N. Rous, F. Major, and M. Bordon: Rupture of the bladder secondary to uterine vacuum curettage: A case report and review of the literature. *J. Urol.* 106:685-686, 1971.

18. R.F. Mattingly and H.I. Borkowf, op. cit., p. 452.

19. C. Dimopoulos et al.: Avulsion of the ureter from both ends as a complication of interruption of pregnancy with vacuum aspirator. *J. Urol.* 118:108, 1977.

20. J.F. Jewett: Saline abortion and lupus erythematosus. *N. Engl. J. Med.* 294(14):782-783, 1976.

21. "Surgical Aspects of Abortion," in H.R.K. Barber and E.A. Graber, eds., *Surgical Disease in Pregnancy* (Philadelphia: W.B. Saunders Co., 1974), p. 491.

22. R. Slunsky: Urinary incontinence in pregnancy. *Z. Geburtshelfe Perinatol.* 165:329-335, 1966.

23. C. Tietze and S. Lewitt: Joint program for the study of abortion: Early medical complications of legal abortion. *Studies in Family Planning* 3(6):107-113, June 1972. Issued by the Population Council, New York, New York.

24. C. Tietze and the Abortion Surveillance Branch of the Family Planning Evaluation Division, Bureau of Epidemiology, Center for Disease Control, "Comparative Risks of Three Methods of Midtrimester Abortion," *Morbidity and Mortality Weekly Report*, issued by HEW (November 1976), p. 370.

25. M. Bulfin, "Deaths and Near Deaths with Legal Abortions" (Paper presented at the convention of the American College of Obstetricians and Gynecologists, Disney World, Florida, October 1975).

#4

Linda Hein

MATTHEW J. BULFIN, M.D.

11

Complications of Legal Abortion: A Perspective from Private Practice

A double tragedy recently occurred in Atlanta, Georgia, as an aftermath of legal abortions in two teenage girls. A 19-year-old died after seven days in a coma following her abortion. The second teenager, a 15-year-old, suffered such severe cardiac and cerebral anoxia that she lapsed into a most precarious condition with an extremely poor outlook.

It is incongruous that these two catastrophes should occur on the same day in the same clinic in Atlanta. Atlanta is the home of the Abortion Surveillance Branch of the Center for Disease Control, which is a division of the Department of Health, Education and Welfare of the United States government. The Abortion Surveillance Branch repeatedly maintains that abortion is safer than childbirth, that the serious complication rate for legal abortion is less than 1 percent, and that the safest method of birth control is one that uses abortion as a backstop for contraception failures.

The Abortion Surveillance Branch may be missing vital input for its mortality and morbidity studies by not seeking information from the physicians who see the complications from legal abortions—emergency room physicians and the obstetricians and gynecologists in private practice. The doctors who do the abortions and the clinics and centers where abortions are done should not be the only sources from which complication statistics are derived.

In 1976 the United States reported the highest number of legal abortions in the world—a total of 988,267.[1] Of those countries which reported abortions by woman's age, the United States had the highest percentage of teenagers (32 percent) who obtained legal abortions. In

contrast, only 2 percent of Japanese women who obtained abortions were teenagers. Clearly, the American teenager should be given the facts about abortion complications.

Never before have women undergone abortion operations in such vast numbers. In 1972, as a gynecologist in private practice, I began seeing a marked increase in the number of patients who had undergone legal abortion operations. With this increase, I also began seeing patients with significant complications—both mental and physical—following their legal abortions. Because of this concomitant occurrence I began keeping an office log listing the patient's name, age, and type of complication.[2]

From January 1972 to June 1979, I saw 802 patients who had undergone legal abortions. Of these 802 women, 159 (19.9 percent) suffered mental or physical complications of such magnitude or duration as to be considered significantly disabling. Even though 643 patients (80.1 percent) had essentially negative findings upon examination and review of medical history, my impression is that the great majority of these women viewed their experience as painful, traumatic, and one that they would like to forget.

The following table summarizes the diversity of complications seen in this group of women following their legal abortions.

CLASSIFICATION OF TYPES OF COMPLICATIONS
IN 159 PATIENTS FOLLOWING LEGAL ABORTIONS

	No.	%
Sepsis, peritonitis, endometritis, salpingitis, abscess	41	25.79
Mental and psychologic sequelae	23	14.47
Hemorrhages: recurrent and disabling	20	12.58
Infertility: repeated miscarriages	14	8.81
Re-operations: laparotomy, hysterectomy and D&Cs	13	8.18
Uterine and cervical trauma: perforations, lacerations	12	7.55
Second trimester syndrome (fetus expelled: patient unattended)	8	5.02
Menstrual dysfunction: oligomenorrhea and amenorrhea	8	5.02
Pelvic pain syndrome	8	5.02
Abortion done: patient not pregnant	4	2.52
Hysteria following expulsion of recognizable fetal parts	3	1.89
Marital breakup	2	1.26
Severe kidney damage	2	1.26
Resection of ileum: colostomy	1	.63
TOTAL	159	100.00%

Sepsis, Peritonitis, Endometritis, Salpingitis, and Pelvic Abscess (41-25.79 percent)

The above type of problems represented 25 percent of all significant complications seen. Ascending infections from lack of asepsis or inattention to strict surgical technique gave rise to many of the near-fatal complications.

A 17-year-old patient required complete extirpation of her reproductive organs because of far advanced pelvic abscesses intractable to antibiotics and medical management. Following her "lunch hour" abortion she had become critically ill with endometritis and peritonitis from a perforated uterus.

Another 17-year-old was hospitalized for five days for a 105° fever with sepsis and peritonitis following her clinic abortion in which the uterus had been perforated. The serious medical problem was compounded by the patient's total concealment of the true nature of her illness from her parents, and her expectation that I, as her physician, would not divulge the cause of her problem to her parents. Fortunately I was able to keep this confidence because of her recovery.

Mental and Psychologic Sequelae (23-14.47 percent)

Among these patients there were all stages of distress, anxiety, and remorse. Several of these patients became pregnant again within one year after their abortion to help expunge the guilt which they felt so deeply.

A 32-year-old with three children was coerced by her husband and mother to undergo an abortion because of a nervous breakdown a year previously. The trauma she felt from "destroying her baby" never left her, and her psychiatric problems became greatly aggravated by the experience. She has suffered loss of self-esteem and has feelings of hostility toward her husband and mother.

Hemorrhages: Recurrent and Disabling (20-12.58 percent)

A 23-year-old suffered a hemorrhage the day after a clinic abortion in a nearby city. She instructed me, as I was making arrangements for her hospitalization, not to tell her husband the true nature of her problem as "he would kill her" if he found out she had had an abortion; he had had a vasectomy two years previously. Fortunately, she required only blood replacement—no re-operation was necessary.

Infertility (14-8.81 percent)

A 16-year-old patient underwent a saline abortion in 1972 at the urging of her mother. The saline abortion was painful and greatly

I strongly urge that a more accurate and comprehensive system for reporting the complications of legal abortions be instituted. Abortion clinics should be required to document their mortality and morbidity rates and publicize the rates of their postoperative follow-ups. Many abortion clinics see only 20 to 30 percent of their patients for post-abortion checkups. Obviously, meaningful statistics will be difficult to obtain when the majority of patients having abortions may not report back to the clinic where the abortion was done. It is also most important to know what percentage of women undergoing abortions are actually pregnant; the number who are not pregnant and who undergo abortions needlessly is not insignificant. My own experience in the Fort Lauderdale area causes me to raise this question.

We should be most wary of the rising abortion rates, especially in teenagers. The number of teenage girls who have had to have hysterectomies in the aftermath of severe abortion complications is unfortunately not known, even with improving efforts at abortion surveillance. The number of females who have lost their reproductive capacity because of post-abortion endometritis and sepsis cannot be accurately delineated. It is only recently that meaningful studies have been made on women who have undergone more than one legal abortion; the findings on what happens to these patients' reproductive potentials are not encouraging.

The 1 percent complication rate for legal abortions often cited by the Center for Disease Control may be correct for the university medical center, but their figure could well be challenged by the private practitioners who work in areas where the neighborhood abortion clinics do most of the abortions.

NOTES

1. U.S. Department of Health, Education and Welfare, Center for Disease Control, "Abortion Surveillance 1976" (Atlanta: August 1978).

2. The diversity of complications that occurred in 54 teenagers, seen in private practice, following their legal abortions has been described in a recent issue of the *Southern Medical Journal*. See Matthew J. Bulfin: A New Problem in Adolescent Gynecology. *Southern Medical Journal* 72:967, 1979.

MYRE SIM, M.D.

12
Abortion and Psychiatry

As upwards of 95 percent of legal abortions are performed on psychiatric grounds, the relationship between pregnancy, abortion, and psychiatry merits serious consideration.

Historical Background

In the United Kingdom, until 1967 when the Abortion Act was passed, the medico-legal aspects of abortion were still governed by the Criminal Abortion Act of 1861. It was an offense to procure or attempt to procure an abortion, and anyone doing so was guilty of a felony. The law relating to therapeutic abortion was not so clear; where there were strong medical indications, such as saving the mother's life, the law did not intervene. Unlike other indications for surgical intervention, there was no medical consensus, and psychiatrists used their authority to bend the law to what they regarded as the correct interpretation. An individual psychiatrist could therefore practice several standards which were in no way dependent on the strictly medical aspects of the problem. However, this did not deter some from publicizing their views. Bleuler stated:

> In the Protestant part of Switzerland the sensibilities of the people demand an attitude that is more favourable to abortion and I should let social considerations count with the legal. Plain legal determinations exist nowhere: one has to fall back on local and customary interpretations.[1]

It should be noted that Bleuler, a psychiatrist, did not speak of psychiatric indications but of "legal determinations," thus remaining

protracted: it lasted 48 hours before the patient expelled the fetus. Complications of fever and endometritis developed, prolonging her hospital stay. The following year she married the boy who had impregnated her, but since then she has suffered three miscarriages and harbors deep resentment toward her mother.

Uterine and Cervical Trauma:
Perforations and Lacerations (12-7.55 percent)

An 18-year-old underwent a suction curettage abortion in her 10th week of pregnancy. After the abortion was seemingly completed, the physician attempted to insert an IUD into the uterus. When the IUD could not be located after insertion, it was determined that the uterus had been torn and that the IUD had been inserted into the abdominal cavity. Laparotomy was necessary for removal of the IUD and repair of the laceration in the anterior uterine wall.

A 19-year-old, 10 weeks pregnant, underwent suction curettage abortion at a clinic in a large metropolitan area. During the procedure she experienced excruciating pelvic pain radiating to her upper abdomen. The physician stopped the operation, instituted antishock measures, and transferred her to a nearby hospital where her condition was deemed critical from internal hemorrhaging—laparotomy was performed. A uterine rupture and laceration of the bowel were found. The uterine rent was repaired, resection of 14 inches of bowel was done and a colostomy was performed. The patient suffered a stormy postoperative course, was hospitalized for 41 days, and required psychiatric care after her release from the hospital.

The patients who had abortions done during the first month of pregnancy often had little or no anesthesia. These patients had great discomfort and tended to experience endometritis and residual pelvic pain for months afterwards.

A high percentage of the patients I saw with serious complications evidently had the length of the pregnancy underestimated by the doctor doing the abortion, with resultant cervical lacerations, hemorrhaging, uterine perforations, and retained placental and fetal tissue. Some of these patients thought to be under 12 weeks pregnant were actually in their 14th to 16th week, and the fetal size caused serious problems through retained limbs and skull fragments. Determining gestation age can be much more of a challenge than would be suspected: it is apparently just as easy to err in estimating fetal size at the time of abortion as it is in guessing the weight of the baby before delivery. The complications associated with a miscalculated abortion can be life-threatening for the mother.

Assembly-line abortions tend to be associated with a higher rate of retained tissue, fetal parts, hemorrhage, and infection necessitating hospitalization and prolonged postoperative management. Antibiotics, blood transfusions, and repeat curettage were often needed by patients suffering these complications.

Some of these patients confided to me the great lengths to which they went in order to conceal their true identities. Eleven of these patients admitted to giving false names and addresses at the abortion clinic, as they in no way would risk the chance that their true identities might be learned.

DISCUSSION

The experiences of the author in dealing with abortion complications are really not much different than the experiences of those physicians who actually do the abortions. At the annual meeting of the Planned Parenthood Physicians in 1977 at Miami Beach, doctors who do thousands of abortions were gathered together to share their experiences and perfect their expertise. These abortionists have seen complications ranging from serious to catastrophic, and they had many words of caution for the neophytes in the audience. They admitted to making errors in clinical evaluations of the stage of gestation; first trimester abortions became second trimester abortions with their increased morbidity and mortality rates. There was genuine fear among them of winding up with a live fetus through miscalculations of stages. They were also apprehensive about using pitocin and prostaglandins in patients who had previous abortions and uterine scar tissue.

Avulsion of the fetal head was one of the more gruesome complications that could and did happen, especially in early second trimester abortions. A fetal skull with its sharp spicules left behind in the uterus created a critical complication.

The Abortion Surveillance Branch of the Center for Disease Control publicizes the increase in abortion complications as pregnancy advances. Second trimester abortions carry higher morbidity and mortality rates and a much higher incidence of adverse mental and psychologic sequelae.[2]

When it is apparent that thousands of women have ceased using their birth control pills because of the mandatory disclosure of all the possible side effects and dangers of oral contraceptives, it is only reasonable that these women be given the same information concerning the possible dangers of abortion as well as the actual complications and side effects that occur.

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16. T. Lakomy: Analysis of lesions and acute complications after artificial interruption of pregnancy. *Ginek. Pol.* 39:863-68, 1968.

17. S. Lembrych and S. Mosser: The course of pregnancy, birth and puerperium after artificial interruption of the first pregnancy. *Zbl. Gynaek.* 94 (No.5):164-68, 1972.

18. S. Lembrych: "The course of pregnancy, birth and lying-in after the artificial termination of the first pregnancy." *Human Life Review* 1 (1975):90.

19. S. Lembrych and J. Kubick: *Gin. Pol,* in press.

20. E. Lunow, E. Isbruch, and B. Hamann: Gynecological early complications as consequence of legal interruptions of pregnancy. *Zbl. Gynaek.* 93:49-58, 1971.

21. K. Miltenyi and E. Szabady: The problem of abortion in Hungary; demographic and health aspects. *Demografia* 7:303, 1964.

22. Y. Moriyama and O. Hirokawa: *Harmful Effects of Induced Abortion.* Family Planning Federation of Japan; Tokyo, 1966.

23. R. Palmer: Consequences of gynaecological operations in their relationship to pregnancy. *Rev. Fr. Gynecol. Obstet.* 67:175-80, 1972.

24. M. Renkielska: Poloznicze powiklania po Sztucznym Poronnienia. *Ginekol. Pol.* 49 (No. 5):389-93, 1978.

25. J.A. Richardson and G. Dixon: Effects of legal termination of pregnancy on subsequent pregnancy. *Br. Med. J.* 1 (No. 6021):1303-4, 1976.

26. I. Roszkowski: Niektore Problemy Wewnatrzmacicznego rozwoju Czhowieka. *Ginekol. Pol.* 44:787-91, 1973.

27. D.H. Russell and N. Chayet: Abortion laws and the physician—Part 2. *New Eng. J. Med.* 276:1250, 1967.

28. H.J. Seewald et al.: Clinical and hysterosalpingo-graphics findings postinterruption. *Zbl. Gynaek.* 95:710-13, 1973.

29. C.P. Sporken: Critical thoughts about induced abortion, seen from the Christian point of view. *Kath. Artsenbl.* 46 (No. 10):263-77, 1967.

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RICHARD A. WATSON, M.D.

10

Urologic Complications of Legal Abortion*

Abortion is the second most commonly performed surgical procedure in America today. Since its legalization by the U.S. Supreme Court in January 1973, there has been an explosive increase in the number of legal abortions performed. It is estimated that between 900,000 and 1.2 million legal abortions are performed in America each year. In 1976, the United States reported the highest number of legal abortions in the world, and in Washington, D.C., the number of legal abortions exceeded the number of live births.[1]

It thus becomes crucial that all physicians realize this surgical procedure, often described as "safe" and "simple," is not without risk of serious, indeed life-threatening, complications. Among the organs in danger of inadvertent damage are those of the urinary system. The following is a review of urologic complications that have occurred following induced abortions in each trimester.

Third Trimester Complications

Hysterotomy, an incision into the uterus, and hysterectomy, the removal of the uterus, are the two methods most commonly used to terminate pregnancy in the third trimester. The risks of urologic complications during comparable nonabortive procedures—Caesarean section at term and simple hysterectomy—have already been well estab-

* The opinions or assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense.

lished.[2] Inadvertent damage to the kidneys, ureters, bladder, and urethra has been reported as a complication of these procedures. The risks of such injuries may well be greater when either procedure is undertaken for abortion late in pregnancy.

Green and Resnick note:

> Hysterotomy was the most common method of mid-trimester abortion prior to the 1960s. Today it is used in less than 1 percent of abortions and then usually because other techniques have failed. Medically, it is an unacceptable technique, because the risk of maternal death is 10 times greater than that [in] an obstetrical delivery. . . . Causes of death include cardiac arrest during surgery, pulmonary emboli, peritonitis and massive hemorrhage after vaginal hysterotomy. In addition, those who survive the procedure must be subjected to Caesarean section for subsequent pregnancies because of the risk of uterine rupture with a myometrial scar.[3]

An example of urologic involvement is presented by Maternik, who describes a 41-year-old woman who underwent a hysterotomy abortion that was complicated by laceration of the uterus and avulsion of the bladder dome.[4] Emergency hysterectomy and cystoplasty were performed. The total capacity of the patient's reconstructed bladder seven months later was only 90 ml, and a cystogram showed vesicoureteral reflux on the right.

Second Trimester Complications

Abortion by amnio-infusion is the procedure most frequently used to terminate pregnancy during the second trimester. In saline amnio-infusion, fluid in the amniotic sac is replaced by hypertonic 20 percent saline solution. Instillation is followed by the death and expulsion of the fetus.

Adachi reports renal failure in two women, ages 19 and 22, who underwent saline abortion in the 20th and 14th weeks of pregnancy, respectively.[5] Both patients subsequently hemorrhaged and developed hemolytic anemia, hemoglobinuria, and acute renal failure. Only after prolonged hospitalization, and, in the latter case, two courses of peritoneal dialysis, did normal renal function return.

A third case of acute renal failure following saline abortion is reported by Eisner and Piver.[6] A 31-year-old woman in good health underwent saline amnio-infusion in the 26th week of pregnancy. Postoperatively, she developed anemia, fever, hypotension, and renal failure. She underwent two courses of peritoneal dialysis. Her 66-day hospital stay was further complicated by infection and by protracted bleeding from erosive gastritis. Hypertension in the range of 160-170/

105-120 responded to medication. An intravenous pyelogram seven months later showed no calcification or decrease in size of renal mass. One year after the procedure, however, the patient's blood urea nitrogen was 48, (normal $\leq$ 20) and her creatinine was 2.0 (normal $\leq$ 1.0).

Although acute tubular necrosis is more common than acute cortical necrosis, the presence of red cell casts, the almost total anuria, the development of hypertension, and the persistent azotemia in this patient all point to the possibility of acute cortical necrosis, usually fatal in the obstetrical setting.[6]

A second and fatal case of renal cortical necrosis following a medical abortion in the 13th week of pregnancy is described by Glants et al.[7] A 35-year-old woman was readmitted to the hospital three days after abortion, with renal failure secondary to heavy blood loss. Despite repeated hemodialysis over a 90-day period, renal function did not return. Congestive failure and pulmonary edema developed. The patient was transferred to a center for renal transplant, but did not survive.

Morrison et al. report consumptive coagulopathy and acute renal failure in a 16-year-old girl who underwent abortion via saline amnio-infusion at 18 weeks' pregnancy.[8] Her 27-day hospital stay, described as "rather complicated," included transfusion of three units of blood and two courses of hemodialysis. Renal biopsy showed focal tubular necrosis with fibrin deposition. Acute renal failure secondary to disseminated intravascular coagulopathy (DIC) was the final diagnosis.

In view of the severe consequences which can occur with this procedure, Morrison et al. conclude that it is mandatory that each patient in whom intra-amniotic saline is used for abortion (1) undergo serial hematologic evaluation; (2) be hospitalized; and (3) have serial electrolyte assays.[8]

As an alternative to saline abortion, prostaglandin F2 alpha has recently become available commercially as an abortifacient for specific use in the second trimester of pregnancy. It is most commonly administered by intra-amniotic instillation. Labor and delivery are expected within 24 hours after injection.[9]

Initial hopes that prostaglandins would avert renal complications following abortion dimmed with a study by Cates et al.[10] They report six deaths following prostaglandin-induced abortions, including that of a 33-year-old woman who developed overwhelming clostridial and staphylococcal sepsis complicated by coagulation defects and acute tubular necrosis.

In a study of 10 women who underwent prostaglandin abortion, Leslie and Laufe report one case of gross hematuria associated with nausea, vomiting, diplopia, headache, fever, tachycardia, and hypertension in a 16-year-old girl.[9]

Finally, in all amnio-infusion-induced abortions, regardless of the agent used, the probing needle itself presents a threat to the bladder and other parauterine structures. In their review of 52 saline-induced abortions, Menzies and Hawkins note two instances of inadvertent vesicle perforation.[11] The first patient postoperatively delivered the 120+ ml of saline per urethram. She then developed hematuria and a urinary tract infection. A second amnio-infusion administered a week later resulted in abortion. Consequences of bladder perforation with an amniocentesis needle were more serious in the second patient; in spite of continuous bladder drainage, she developed gross hematuria, gross labial edema, and urinary infection. Her fever ultimately responded to antibiotic therapy, and the pregnancy was terminated by vaginal hysterotomy. Other authors record one instance of needle perforation of the bladder in 330 saline-induced abortions.[12]

An extraordinary complication is reported by Loskutov and Vasilievich.[13] During a medical abortion with injection of paracervical cellulose, a 3 percent solution of liquid ammonia was mistakenly introduced. The error was not detected until seven days later. The patient had been complaining of painful, frequent urination and gross hematuria. By the seventh day, she noted that necrotic tissue was passing per vaginam during urination.

Subsequent evaluation revealed that the entire anterior aspect of the vagina, as well as the posterior and lateral walls of the bladder, had necrosed, leading to the formation of a common cavity and total urinary incontinence. Progressive scarring of the ureters caused hydronephrosis on the right with marked renal colic and a reactive ileus; pyelonephritis and renal failure ensued. Bilateral pyelostomies were performed. While these relieved the renal failure, they did not avert the formation of urinary fistulas in both flanks.

Seven months later, the patient underwent an extensive one-stage plastic repair of the urinary tract and was released from the hospital after an additional 28 days. She has subsequently regained control of urination with a 160 ml capacity bladder. There is reflux on the left, but no significant obstruction to drainage. The patient when seen last was doing well.

First Trimester Complications

The first trimester pregnancy is frequently terminated by dilation and curettage. If the uterine wall is inadvertently perforated, the sharp, blindly wielded curette is free to assault surrounding structures, including those of the urinary system.

Gangai reports a 23-year-old woman in the 12th week of pregnancy for whom the surgeon underestimated the stage of pregnancy.[14] Four

days after the patient underwent dilation and curettage, a mass was palpated in the right lower quadrant. Her hematocrit had dropped from 38 percent to 22 percent. An excretory urogram revealed extravasation of contrast material on the right. Exploration on the fifth postoperative day disclosed complete avulsion of the renal pelvis and the entire ureter on the right. A urinoma had formed and surrounding tissues were macerated. Right nephrectomy was required. A review of the initial specimen labeled "products of conception" revealed over 17 cm of maternal ureter. In retrospect, the physician recalled removing an elongated tube, but assumed it to be part of the umbilical cord. The patient experienced a stormy postoperative course, but did recover.

Hardt and Borgmann report a 21-year-old woman who developed peritonitis following abortion by dilation and curettage.[15] Eight days postoperatively, a second dilation and curettage was performed for continued bleeding. Retained portions of the placenta were removed, and it was discovered that the uterus had been perforated. Ten days later, the patient was thought to be well and was discharged from the hospital. She returned one week later with recurrent abdominal pain, high fever, and leakage of urine per vaginam. Examination revealed costovertebral tenderness on the right and urine in the vaginal vault. Cystoscopy showed the bladder to be intact, and no vesico-vaginal fistula was visible. An excretory urogram revealed hydronephrosis on the right with marked dilatation of the ureter down to an area of extravasation in the distal third ureter. Retrograde studies confirmed these findings and showed 6 cm of distal ureter were damaged. Transabdominal exploration confirmed the preoperative diagnosis of uretero-uterine fistula. The damaged segment was excised, and an end-to-end urethrostomy was performed. Evacuation of a hematoma, resection of a walled-off pocket, and a hysterectomy were also undertaken. Histologic evaluation revealed a portion of the fetal skull imbedded in the resected intra-abdominal tissue. Postoperatively, the patient recovered quickly and an excretory urogram performed six months later showed her kidney to be normal.

A fatal case of renal failure is reported by Sen and Banjersee.[16] An 18-year-old nulliparous woman developed symptoms of generalized sepsis following an abortion by dilation and evacuation in the 12th week of pregnancy. Her condition steadily deteriorated despite conservative medical treatment. Oliguria, hematuria, and progressive renal failure set in. The patient died of septicemia on the fourth day.

In an effort to reduce the risks of dilation and curettage, physicians performing abortions are increasingly turning to the vacuum aspiration technique during the first trimester of pregnancy. In vacuum aspiration the cervix is dilated, an aspirator introduced into the womb,

and suction of - 70 mm Hg rapidly produced. This rapid force shears the conceptus from the uterine wall with less loss of blood than occurs with standard curettage. Rous et al. report a 27-year-old woman in her 12th week of pregnancy who underwent an abortion using the aspiration technique.[17] The vacurette was passed two times without success, and two attempts at ring forceps extraction were required to bring about delivery of the conceptus. The patient was taken to the recovery room in satisfactory condition but soon thereafter was found in shock. A Foley catheter released grossly bloody urine. Laparotomy revealed a 2 cm hole in the posterior wall and two smaller rents at the base of the bladder; the ureters were spared. A large perforation covered almost one-half of the anterior wall of the retroverted uterus, and an avulsion of the right uterine artery accounted for 1500 ml of free blood in the peritoneal cavity. An emergency hysterectomy and primary closure of the bladder lacerations were performed. The patient's subsequent recovery was uneventful, and an excretory urogram performed 17 days postoperatively was within normal limits. The author theorizes that the uterine perforation occurred at time of cervical dilation. The vacurette was then placed in direct proximity to the bladder wall; its abrupt suction force perforated the bladder and evacuated its contents. In retrospect, the physician recalled seeing a sudden rush of clear, yellow fluid during suction, but assumed it to be amniotic fluid. Mattingly and Borkowf anticipate that this case report may herald the beginning of a series of similar complications.[18]

A serious complication of suction abortion has since been reported by Dimopoulos et al.[19] A 28-year-old woman was admitted to the hospital in shock after an unsuccessful surgical attempt to interrupt a three-month pregnancy by suction curettage. An emergency exploration revealed that the suction apparatus had been passed through an inadvertent perforation in the cervix. The shearing force of the suction then perforated the bladder and avulsed the entire length (22 cm) of the right ureter. The right parametrium and the peritoneum overlying the right iliac vessels had also been ruptured. The right kidney was surrounded by hematoma. An emergency nephrectomy and oophorectomy were performed on the right. Abortion was completed by hysterotomy. The patient recovered and was discharged after nine days of hospitalization.

Therapeutic Abortion for Urologic Indications

Several renal diseases may be exacerbated during pregnancy. Therapeutic abortion has been advocated to rescue the kidneys, but therapeutic abortion itself carries risks for the patient.

Jewett reports a 21-year-old woman who had mild lupus nephritis manifested by proteinuria, hematuria, and hypertension.[20] She was

treated with oral prednisone. Because of her lupus nephritis, a therapeutic saline-induced abortion was performed in the 19th week of pregnancy. Within four hours after the procedure, the patient became comatose, and gross hematuria was noted. Subsequent respiratory arrest was treated with intubation, only to to followed by evidence of DIC with bleeding around the endotracheal tube, per vaginam, and into the cerebro-spinal fluid. Six units of whole blood were transfused, and heparin therapy was instituted. Severe hypertension (230/120) failed to respond to vigorous therapy. The patient's coma became progressively more profound. Expulsion of the fetus produced no clinical improvement, and the patient died. The autopsy report attributed her death to lupus erythematosus crisis and DIC secondary to mid-trimester abortion. The death was classified as preventable, and responsibility was assigned to the physicians concerned.

Jewett recognizes that the threat of lupus nephritis crisis occurring in the first trimester of pregnancy is serious, but he points out that massive doses of steroids, if instituted early, may get the patient through her pregnancy.[20] It is true that more serious threats of crisis exist at term and in the postpartum period, but experience indicates that induced abortion is even more dangerous for the patient with lupus, regardless of the method used or the stage of gestation. It is probably safer to treat the patient with increasingly large doses of steroids and attempt to deliver a living child than to induce abortion. If the nephritis does progress, it is likely that the fetus will die and abort spontaneously—perhaps the least traumatic course. The saline-induced abortion is particularly dangerous for a patient with lupus because of the heavy salt load that must be sustained in the face of hypertension and compromised renal function.[20]

Other similar studies show the dangers of saline-induced abortions in patients with renal disease or hypertension.[11, 20, 21]

Urinary Incontinence

In a study of 530 patients, Slunsky detected varying degrees of urinary stress incontinence in 23.7 percent of women who underwent elective abortion in the 8th to 12th weeks of pregnancy.[22] Of these patients, 92.7 percent exhibited only a mild degree of incontinence, but 6.3 percent showed moderately severe symptoms. None was totally incontinent. The incontinence, initially attributed to pregnancy, continued after abortion. This incidence of 23.7 percent is nearly double that seen in women whose pregnancies were carried to term (12.6 percent). Incontinence was more frequent and more severe in older women; it occurred in 40.9 percent of women over 40. Incontinence was also more common and pronounced in multiparous women, in women who

aborted late in pregnancy, and in women with predisposing conditions such as cystocele and uterine descensus. Slunsky urges a more careful investigation for urinary incontinence in women undergoing induced abortion.[22]

Urinary Tract Infections

Bacterial invasion of the urinary system may occur following induced abortion, but accurate statistics on this complication are not available. Difficulty in assessing its incidence is compounded by a tendency of physicians to lump all urinary infections—regardless of site, severity, or clinical consequence—under the title of "urinary tract infections." In a 1972 review of 72,988 abortions, 349 urinary tract infections were reported: 109 occurred following suction abortion, 6 following dilation and curettage, 103 following hysterectomy abortion, 84 following saline amnio-infusion, and 44 following hysterotomy.[23]

Tietze et al.,[24] in the Center for Disease Control (CDC) Mortality and Morbidity Report for November 1976, compared the risks of three methods of mid-trimester abortion. They found that urinary tract infections occurred more frequently, to a statistically significant degree, in patients who had saline-induced abortions, versus those who underwent abortion with the dilation and extraction technique.

Important to note is the inclusion by the CDC of urinary tract infections among those complications defined as "delayed," i.e., those *ordinarily* occurring after the patient has been discharged from the hospital.[23] It is possible that many serious infections of the urinary system are not being reported in situations where postabortion follow-up is brief or is relegated to a physician not directly involved with the procedure.

Incidence

Accurate statistics on the incidence of urologic complications of abortion are not available; preliminary reports suggest that such complications are relatively infrequent. It must be noted, however, that urinary complications have been reported in association with every abortion technique currently in use. In view of this fact, and given the large and escalating number of abortions being performed daily throughout the nation, no complication should be dismissed as too infrequent to be of consequence.

SUMMARY AND CONCLUSIONS

Diverse and sometimes life-threatening urologic complications have been encountered in induced abortions performed in all three trimesters of pregnancy. Surgical intervention in the third trimester may result in injury to the bladder and ureters. Amnio-infusion in the second trimester presents a threat of mechanical damage to the bladder and a compromise of renal function, particularly in patients with pre-existing renal disease or hypertension. Dilation and curettage and vacuum aspiration may endanger the bladder and ureters in first trimester abortions; urinary incontinence and various urinary tract infections may result.

Some of the most catastrophic complications have occurred in teenage girls. As the majority of these abortions are done for social reasons, these serious complications and deaths are especially tragic.[25]

Clearly, abortion is not a risk-free procedure. Complications such as those described should be borne in mind by physicians who counsel women about abortion. Moreover, an appreciation of these risks should alert physicians to the need for high quality pre- and postoperative care for the patient undergoing induced abortion.

NOTES

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New Perspectives on Human Abortion

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ALETHEIA BOOKS
UNIVERSITY PUBLICATIONS OF AMERICA, INC.

Frederick, Maryland

ISBN: 0-89093-380-4

Library of Congress Catalog Card Number: 81-51983

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THE KANSAS ASSOCIATION OF EVANGELICALS
Position Paper: "The Sanctity of Human Life" 1-15-85

The unborn child is a human life with a body personally fashioned by God (Job 10:8-12). Each custom-made body has it's unique design fashioned at the moment of conception, when as yet there were no members or substance (Psalm 139:13-16). This body has biological life from God through his or her parents (Gen. 2:2; Acts 17:26). God speaking in the Scriptures makes no effort to distinguish between pre-natal and post-natal life. In the New Testament, both are clearly in view with the use of one greek word. At Luke 1:41-44, the child in view is clearly unborn. In the words of Elizabeth,"...the baby in my womb leaped for joy." At Luke 18:15 the same word is used of the children who were brought to Jesus that He might touch them. Clearly these are already born. Therefore, human life begins at conception-each one specially.

Also identified as beginning with conception is the uniquely human attribute of response to God. Just as John the Baptist could leap for joy at Jesus' presence within the womb of Elizabeth, so David is aware that his sinful, disobedient nature was uniquely his even before birth (Psalm 51:5-8).

The unborn child is worthy of co-equal status with all the rest of mankind for one essential reason: Adam was made in the image of God (Gen. 1:26-27). By procreation this image was passed on to Adam's children (Gen. 5:3). This imago dei, of course, is spiritual, rather than physical. Bearing testimony to God's design, humans have similarities with God, and specifically, a capacity for fellowship with the Creator which distinguishes the human from all the rest of creation. Man has personality: mind, will, emotions and ego. God's character is perfect, man's is imperfect. Still, man is a moral being with conscience, heart and relationship to God, whether he honors God or not. Within that similarity lies the difference between man and animal - the image of God.

From the beginning, the destruction of the one form of life created in God's image did not sit well with our Heavenly Father (Gen. 9:6). We cannot, as a nation today, avoid God's judgment when our laws bring swift justice to those who dare harm our national bird, but ignore the carnage of abortion. As Christians in Kansas, we cannot rest content while it is perfectly legal in our state to murder a baby anytime before it departs naturally from the womb.

> Rescue those being led away to death; hold back those staggering toward slaughter. If you say, `but we knew nothing about this,' does not he who weighs the heart perceive it? Does not he who guards your life know it? Will he not repay each person according to what he has done?
>
> Proverbs 24:11-12

Cooperating Together for the Faith of the Gospel

Sen. Fed. & State Affairs
2/25/86 Attachment 5

Kent Vincent
#5b

Colmery-O'Neil
Veterans Administration
Medical Center

2200 Gage Boulevard
Topeka KS 66622

Veterans
Administration

February 21, 1986

In Reply Refer To:

Hon. Ed Reily, Chairman
Federal and State Affairs Committee
The Kansas Senate
The State Capitol
Topeka, Kansas 66612

Dear Senator Reily:

I have recently learned that there is legislation before your Committee having to do with the matter of abortion in the case of minor females, and I should like to share with you my view on that important subject.

Over the past 25 years we have been witness to the progressive erosion of the power of the family in shaping young lives, the decline of public education, permissive sexuality and situational ethics as personified and epitomized in the so-called Playboy Philosophy. Happily, the excesses and aberrations of those benighted years have begun to recede.

A most important aspect of that recession has been a slow return to the basic values on which our nation has been built. Parental responsibility is an absolute necessity for the maintenance of those values and the viability of our society. For these and related reasons, it is important—no, imperative—that minor girls make known to their parents or legal guardians any attempt they might make to abort from themselves a viable fetus. Parents must know of such a matter, absent a judicial waiver. I hope that your Committee will favorably report upon such legislation as would make mandatory such parental disclosure.

(The above view is my own and does not necessarily represent that of the Veterans Administration, this Medical Center or any agency of the United States government.)

Most sincerely,

Donald B. Rinsley, M.D., F.A.P.A.
Associate Chief for Education
Psychiatry Service

Clinical Professor of Psychiatry
University of Kansas School of Medicine

DBR:mtf
blind copy: Mr. Vincent

Sen. Fed. & State Affairs
2/25/86
Attachment 6

"America is #1—Thanks to our Veterans"

Attachment #6

#4

February 25, 1986

Dr. and Mrs. Gerald L. Mowry
2007 Arthur Drive, Manhattan Kansas 66502

To the Federal and State Affairs Committee

Sen. Ed Reilly, Chairman

We are here to speak in behalf of SB 577 because we also believe that it is a compelling state interest to protect minors against their own immaturity; foster the family structure, and protect the rights and responsibilities of parents to rear their children.

We have several questions about the wording of the bill. Line 0054 states a definition of "informed consent" which implies (if applied to Lines 0072-3) that the physician (or his agent) must personally confer with and present information to the parents.

How is "informed consent" to be determined? It seems possible that the abortionist can make that decision on the basis of personal bias and personal gain.

Surgical consent forms do not usually carry detailed information about the surgery and its probable risks. A standard consent form states that the patient understands and consents to whatever she was told by the surgeon or his agent.

For an abortion, who will determine how much information must be disclosed to gain consent...the abortionist?

We raise the question from the viewpoint of girls who tell us that they had no idea that their "pregnancy" was actually a real baby. They use the words they have been taught at school, in gym class, by teachers, public health personnel, in magazine articles, and so forth. They say they thought "it" was a "piece of tissue," "the products of conception," "my period coming." When they deliver a tiny dead infant, complete with fingers and toes, or find out later what the vacuum extractor extracted, they are horrified and shocked. They are unprepared for the violent cramps and sickness they feel. Most say they would never have had an abortion if they had been told the truth. As a practical statistical matter, 85% of the girls who are told the truth about abortion by the Robert Pearson agencies choose not to abort their babies.

In many cases there is no referring physician to counsel or inform them. Young girls, after a home pregnancy test, refer themselves to abortion clinics ...often with the assistance of a girl or boy friend no more mature or informed than they are. It would be naive to expect abortion clinic personnel to inform a prospective "client" of the facts which would cause her to turn away.

Can SB 577 be amended to require that a standard abortion consent form be drawn up which is scientifically factual, informative and descriptive, so that the patient knows as much as the abortionist knows.

Those who object to such full and fair disclosure would deny the patient, and her parents, a fully informed CHOICE.

Line 0105 combined with Line 0109-10 seem to subvert the whole purpose of the bill. Under what circumstances should a minor's identity be protected if she elects not to seek parental consent...if the purpose of the bill is to protect the family and the right of parents to care for their minor children?

Line 0141 could easily be applied to any circumstance. A serious contingency is covered in Lines 0169-73.

Lines 0238,0245,0250 The words "available" and"immediately available" are subject to the interpretation of the minor or the abortionist unless a specific definition is included in the bill.

If the minor is in Kansas City or Wichita for an abortion and her unsuspecting parents are in Manhattan...or Hays...or Independence, are they therefore not "immediately available" and how much time or effort should be required so that their rights to care for their daughter are protected?

TESTIMONY - S.B. 577

SENATE FEDERAL AND STATE AFFAIRS COMMITTEE

Tuesday, February 25, 1986 - 11:00 a.m.

KANSAS CATHOLIC CONFERENCE
BY: Robert Runnels, Jr., Executive Director

Mr. Chairman, members of the Senate Federal and State Affairs Committee, my name is Bob Runnels, I am Executive Director of the Kansas Catholic Conference and speak under the authority of the Roman Catholic Bishops of Kansas.

It is a pleasure for me to be with you today and give testimony in support of S.B. 577.

Communication within a family is a privileged relationship. And one of the highest priorities is education in sexuality.

Parents and home comprise the first and most important matrix for forming attitudes and imparting information.

Others also play roles in the process by which children and young people come to understand sexuality and their value of it. Among influences for good or ill are peers, schools, and media.

The principle of parental involvement must be paramount in a child's life. A child with a pregnancy problem needs the strong support of parents during perhaps the most frightening challenge a child would have to face in her young life.

It is inconsistent with reality not to have parental support during this trying pregnancy period.

Finally, can we deal out the parents who have given so much of their lives to raise a child ... but rather have this troubled child turn to strangers for advise and consent who

quite often are involved in financial gain from the abortion trade?

Speaking for the Kansas Catholic Conference I urge you to favorably recommend for passage Senate Bill 577.

****

February 21, 1986

To Whom It May Concern:

I am Robert W. Conroy, M.D., Associate Director of the C. F. Menninger Memorial Hospital. However, I am speaking on behalf of myself, and this is not an official statement of The Menninger Foundation.

I have tried in my professional career as a physician and psychiatrist to strengthen the family in any way I can. I have also been a champion for appropriate parental guidance which I feel is most supportive to our young people. I am very concerned that young women under the age of 18, without parental or guardian consent, can have an abortion. This, in effect, separates the young woman from appropriate support and guidance that could be offered from the parents or guardian. Young people also, because of their immaturity may feel under tremendous pressure to make a decision which could have an impact on them for life. In addition, a young person making such a difficult and unilateral decision may for years have to live with a very unsettling secret which could be detrimental to their peace and tranquility. Although it is certainly difficult for a young woman to talk with her mother and father about a pregnancy, I feel in the long run it will be beneficial for both to have it out in the open. It is apparent that the law supports such a stand in every other area except abortion.

I, therefore, support the bill that would indicate that no person should perform an abortion on an unemancipated minor unless she has the written consent of both parents and legal guardian. I think this law supports our family system and helps parents to be in an appropriate position of offering guidance, support, and help to their young person. A vote against this bill, I feel, would be a vote against the family.

Sincerely,

Robert W. Conroy M.D.

Robert W. Conroy, M.D.
Associate Director
C. F. Menninger Memorial Hospital

jb

Sen. Fed. & State Affairs
2/25/86 Attachment 9