Approved: 3-25-96
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 13, 1996 in Room 526-S of the Capitol.

All members were present except:

Committee staff present:
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Billy Boyle, Assistant to State Representative Susan Wagle
Judith E. Koehler, attorney, Americans United for Life, Chicago
Jane Doe #1
Jane Doe #2
Herbert C. Hodes, M.D., Overland Park
Fran Belden, Women's Health Care Services, Wichita
Ellen Brown, Planned Parenthood

Others attending: See attached list

Hearing on HB 2938 - The woman's right-to-know act

Billy Boyle, assistant to State Representative Susan Wagle, presented Representative Wagle's testimony to the Committee in support of **HB 2938** and noted that the word "choice" is used as a propaganda tool in order to deceive women and place them under the control of fathers who want to avoid responsibility, parents who want to protect reputations, well-meaning friends who might not know all the possible physical and psychological side effects of abortions, and abortion providers whose main goal, most often, is turning a profit. It was also pointed out that the legislation being considered today is patterned after current Pennsylvania law and that similar legislation has also been passed in Louisiana. Information was provided regarding the proposed link between induced abortion and breast cancer. (See Attachment 1)

Judith E. Koehler, Senior Legislative Counsel, Americans United for Life, also testified in support for **HB 2938** and noted that the abortion-breast cancer link has been established by a preponderance of data, consisting of results of twenty-two independent studies published in twenty-two medical and medical research journals from around the world from patient records dating back as far as 1940. Ms. Koehler also provided printed material to the Committee on this issue. (Attachment 2)

Jane Doe #1 and Jane Doe #2 both appeared before the Committee and spoke of their experiences regarding having an abortion. (Attachment 3 and 4)

Speaking in opposition to **HB 2938** was Herbert C. Hodes, M.D., who stated that the use of the term "untrained and unprofessional counselors whose primary goal is to seek abortion services" is an insult to all of those involved in a woman's medical care. He noted that these comments are designed to further inflame the issue and are not based on fact, and acknowledged that breast cancer is a "growing epidemic" but heart disease is the single most frequent cause of death among middle-aged women. Additional material was also provided to the Committee on this issue. (Attachment 5)

Fran Belden, Mental Health Counselor, Women's Health Care Services, also spoke in opposition to the bill. Ms. Belden noted that the vast majority of teens involve at least one of their parents in the abortion decision, and that most parents are supportive of their daughters. She felt that the one big problem is the parent trying to force a daughter into an abortion. Other material on this issue was provided to the Committee. (Attachment 6)

Ellen Brown, Planned Parenthood, testified in opposition to **HB 2938** by reading remarks prepared by Anne Moore, a single parent telling of her experiences with having an abortion. (Attachment 7)

Written testimony was received from the following individuals, as well as additional letters and comments: Peggy Jarman, ProChoice Action League, (Attachment 8); Barbara Holzmark, National Council of Jewish Women, (Attachment 9); The Rev. Lynn NewHeart, Planned Parenthood, (Attachment 10); Carla Mahany, American Civil Liberties Union, (Attachment 11); Mary Spaulding Balch, National Right to Life Committee, (Attachment 12); Douglas Johnston, Planned Parenthood, (Attachment 13); Darlene Greer Stearns, League of Women Voters of Kansas, (Attachment 14); Monica Neff, Kansas National Organization for Women, (Attachment 15); Beatrice Swoopes, Kansas Catholic Conference, (Attachment 16); Jane Doe #3 and Lisa Woodin, Wichita, (Attachment 17);letters and comments from individuals and Women's Health Care Services, (Attachment 18); and testimony in support of the bill from State Senator Nancey Harrington, (Attachment 19).

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for March 14, 1996.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 3-13-96

NAME	REPRESENTING
Lynn Newkirk	Planned Parenthood of MMEK
Herbert Hodes, MD	Herbert Hodes, MD
ERIKA FOX	PLANNED PARENTHOOD of MMEK
Marina Julian	KFL, Hutchinson
Carol Moritz	KFL Hutchinson
Jennifer Lathrum	KFL - KC Region
Pat Adair	" " "
Gary Grimes	" " "
Glenda Ryan	CWA
Beatrice Swoopes	KANSAS CATHOLIC CONF
Melissa Wangemann	Hein Elect & Weir
Cleta Reniger	Right to Life of Ks.
Ryan Mavis	Ks. Health Institute
Kelly Kultala	KTLA
Meg Hennagir	KMS
Monica NEA	Ks. N.O.W.
Darlene Greer Stearns	LWV of KS
Ruth Kofas	Comprehensive Health for Women
Betty Armstrong	Comprehensive Health for Women

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 3-13-96

NAME	REPRESENTING
Rita Gottlieb	Health Midwest
Erin Oppenheller	Intern
[illegible]	ACLU
Carla Mahan	ACLU
Barb Lisher	self
Ellen Brown	Planned Parenthood of Mid-MO & Eastern KS
Dot Nance Hagen	Ashbury U. Methodist / P.P. Mo & Ks
Judith E. Koehler	Am. United for Life
Whitney Damron	Kansas Bar Assn.

State of Kansas
House of Representatives

Susan Wagle
Speaker Pro Tem

Testimony--Woman's Right to Know Act
Senate Public Health & Welfare Committee
March 13, 1996
H.B. 2938

Thank you Chairperson Praeger, Vice-Chairperson Langworthy, and members of the Public Health & Welfare Committee, for the opportunity of addressing you about the need in Kansas for expanding our present informed consent law. In 1992, I was instrumental in getting passed our present informed consent statute relating to abortion. It was my intent at the time to empower Kansas women involved in a crisis pregnancy by giving them all the material facts and possible alternatives to abortion in order that they might make an informed "choice." Without full disclosure, I believe the word "choice" to be a propaganda tool; a tool used to deceive women and place them under the control of fathers who want to avoid responsibility, parents who want to protect reputations, well-meaning friends who might not know all the possible physical and psychological side effects, and abortion providers whose main goal, most often, is turning a profit.

Attached to my testimony is a copy of the current Kansas statute and a copy of the consent form now being used by Dr. Tiller in Wichita. I believe that Dr. Tiller and other abortion providers in Kansas have made a mockery of legislative intent. It was very clear to me when we debated K.S.A. 65-6706 in 1992 that the legislature wanted each woman to be informed of alternatives to abortion. We assumed that an honest discussion about adoption possibilities would take place. We also envisioned that each woman would be informed of her legal right to obtain financial support from the father, or to receive state financial assistance, such as Aid to Dependent Children, if she should choose to keep her baby. We thought an effort would be made to connect a woman in crisis with nonprofit agencies such as HopeNet, which not only provides needed medical attention for the mother and child, but also provides for the mother an education so that she might eventually become self-sufficient and support herself and her child.

REPRESENTATIVE, 99TH DISTRICT
BUTLER/SEDGWICK COUNTIES
14 SANDALWOOD
WICHITA, KANSAS 67230

Senate Public Health & Welfare
Date: 3-13-96
Attachment No. 1

Instead, as you can see, the form I have attached to this document states in item #2 that "[t]he alternative to abortion is vaginal delivery or caesarean section at the end of the pregnancy." What real choice does such a disclosure offer a woman in crisis? I assure you that in Kansas today, positive discussions about viable alternatives often do not take place. The word adoption is not mentioned. The physical characteristics of the fetus about to be aborted are not disclosed. The risks associated with abortion are not disclosed. Simply put, women in Kansas are not empowered with noninflammatory, scientifically accurate information critical to making the best decision for their well being and the well being of their preborn infant.

The legislation being considered today is patterned after current Pennsylvania law. The United States Supreme Court has determined that this legislation is constitutional under the restraints of Roe v. Wade. Similar legislation has also been passed in Louisiana. I have available for committee members the booklets and directories of helping agencies which are made available to women in those states who are considering an abortion. I believe you will agree upon examination of these materials that they are not biased, either towards promoting an abortion or towards carrying the preborn to term. I have received numerous calls from women supporting the "Woman's Right to Know" Act. Some of those women are coming forward today to tell of their abortion experiences. For most of them, their decision to abort was made because they felt they had no alternatives. Many of them were young at the time and they had nowhere to go and no one to talk to. For some of them, the decision they made has become a vivid nightmare -- one they revisit often, and one they are still working through. Some of the women today will call themselves "Jane Doe" in order to protect their identities. I ask Chairperson Praeger, other members of this committee, and any press observing today to respect their wish and need for privacy.

(l) Except as necessary for the conduct of a proceeding pursuant to this section, it is a class B misdemeanor for any individual or entity to willfully or knowingly: (1) Disclose the identity of a minor petitioning the court pursuant to this section or to disclose any court record relating to such proceeding; or (2) permit or encourage disclosure of such minor's identity or such record.

History: L. 1992, ch. 183, § 5; July 1.

65-6706. Abortion; informed consent required. (a) No abortion shall be performed or induced unless:

(1) The woman upon whom the abortion is to be performed or induced gives her informed consent; or

(2) a medical emergency compels the performance or inducement of the abortion.

(b) Consent to an abortion is informed only if the physician who is to perform or induce the abortion or another health care provider informs the woman, in writing not less than eight hours before the abortion, of:

(1) The nature of the proposed procedure or treatment and of those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the abortion;

(2) the gestational age of the fetus at the time the abortion is to be performed;

(3) the medical risks, if any, associated with terminating the pregnancy or carrying the pregnancy to term; and

(4) community resources, if any, available to support the woman's decision to carry the pregnancy to term.

(c) If a medical emergency compels the performance or inducement of an abortion, the attending physician shall inform the woman, prior to the abortion, if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert the woman's death or to avert substantial and irreversible impairment of the woman's major bodily functions.

History: L. 1992, ch. 183, § 7; July 1.

65-6707. Same; severability clause. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

History: L. 1992, ch. 183, § 8; July 1.

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Women's Health Care Services, P.A.
George R. Tiller, M.D., DABFP, Medical Director
5107 E. Kellogg, Wichita, Kansas 67218
(316) 684-5108
1-800-882-0488

Dear Prospective Patient:

I am Dr. George Tiller, a 1967 graduate of the University of Kansas School of Medicine, a diplomat of the American Board of Family Practice. My medical practice has included legal and safe abortion services for thousands of women since 1973 here in Wichita, Kansas.

The 1992 Kansas abortion law requires that I provide certain written information to patients seeking abortion services at least eight hours before an abortion is performed. This document will satisfy the basic notification requirement. We will provide you with additional detailed information before your procedure, as we have always done.

1) The nature of an abortion procedure is to medically induce the termination of a pregnancy.

2) The alternative to abortion is vaginal delivery or caesarean section at the end of the pregnancy.

3) The risks of an abortion are related to the duration of the pregnancy. Generally speaking, an abortion performed early in a pregnancy is safer than one performed later in the pregnancy. The generally recognized minor (non-hospitalization) complications such as infections, laceration, and incomplete or retained material in the uterus vary in occurrence from one to five per one hundred abortions (1/100 to 5/100) at five to six weeks up to as much as five to ten per one hundred abortions (5/100 to 10/100) at later stages.

   The major (hospital type) complications of transfusion, hemorrhage, amniotic fluid embolism, laceration, infection, and uterine perforation vary in occurrence from one per eight hundred abortions (1/800) at five to six weeks up to two major complications per one hundred abortions (2/100) at the latest gestation. We believe that, in the vast majority of patients, abortion is safer than full term delivery at all legal stages.

4) Based on the first date of your last menstrual period or an ultrasound evaluation, the gestation of your pregnancy is estimated to be _____, plus or minus 11 to 14 days.

5) The generally recognized medical risks associated with carrying the pregnancy to full term delivery or caesarean section at term include but are not limited to the following: unplanned major surgery, hemorrhage, transfusion, blood clots in legs, blood clots in the lungs, hysterectomy, major infection, cervical laceration, vaginal laceration, rectal laceration, perforation of the uterus, injury to bowel/bladder, major and minor emotional problems, amniotic fluid embolism, cervical incompetence, major and minor depression, and even death.

   The types of medical risks (listed above) associated with abortion, are, in general, the same as those associated with carrying the pregnancy to term. The medical risks of an early abortion (5-12 weeks) and a second trimester abortion (13-26 weeks) occur at a lower rate than at full term delivery or caesarean section. The medical risks of an abortion in the third trimester may occur at about the same rate as full term delivery or caesarean section. The death rate for abortion is less than the death rate for full term delivery.

6) Community resources available to support a woman's decision to carry a pregnancy to term include Lutheran Social Services, Planned Parenthood of Kansas, YWCA, Self-Help Network of Kansas, Family Consultation Service, United Way First Call for Help, United Way Center, Childcare Association of Wichita, Kansas, Children's Service League, Episcopal Social Services, and United Methodist Urban Ministry.

By signing below, you acknowledge that you have read and understood the information above, and that you have received this information eight hours prior to your abortion.

SIGNATURE: _____

Note to Patient: Please see the back of this form for important information about your visit.

Women's Health Care Services
Visit Checklist

All patients

___No one will be allowed in the clinic without photo identification.
___Bring your signed Informed Consent (the other side of this sheet).
___Arrive with a full bladder.
___Drink no alcohol 24 hours prior to your visit.
___No children are allowed in the clinic.
___The fee will be collected prior to the procedure.
___No personal checks will be accepted.
___Remember to park in our fenced parking lot.
___Our security staff will be on duty and will scan you electronically and check in all handbags prior to allowing you into the clinic.
___Minors: You will need a parent to accompany you **OR** have a notarized Waiver of Notification and be accompanied by person 21 years of age or older.

One-day patients

___If your appointment time is at 12:00 noon or after, eat nothing after 8:00 a.m. the morning of your appointment. After 8:00 a.m., you may drink only coffee, tea, or water.
___If your appointment is on Saturday morning, eat nothing after 12:00 midnight the night before your appointment. After midnight, you may drink only coffee, tea, or water.
___We request that you bring only one person with you.
___The person accompanying you will be asked to wait outside while we do your sonogram and collect your fee, unless you are a minor. We will then invite him/her inside.
___You will need to have a person accompanying you to receive the preoperative medication which relaxes you for your surgery.
___Plan to be in the clinic for 3-4 hours.

Two-day patients

___You may eat a light breakfast the first day.
___Bring along $10.00 for your prescription.
___Plan to be in the clinic for 3-4 hours the first day.

Out-of-town patients

___You must stay in Wichita until you are released from our care. Call us for hotel information, if you wish.
___If you use a cab, use American Cab Company. They are pro-choice. Their number is (316) 262-7511.
___Bring a supply of sanitary pads.
___No luggage is allowed in the clinic.

Four-to-five-day patients

___Bring along $75.00 for your prescriptions.

AMERICANS UNITED FOR LIFE

Public Interest Law & Education

343 S. Dearborn Street
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312. 786-2131, *fax*

Abortion-Breast Cancer Link
Judith E. Koehler
Senior Legislative Counsel
March 13, 1996

I. The Epidemiological Statistical Link Between Induced Abortion and Breast Cancer.

A. The abortion-breast cancer (ABC) link has been established by a preponderance of data, consisting of results of twenty-two independent studies published in twenty-two medical and medical research journals from around the world, as early as 1957 (Segi, et al.), and from patient records dating back as far as 1940 (Watanabe and Hirayama, 1968). Of these twenty-two studies, seventeen show an overall increased risk among women who have had any induced abortions, eleven with statistical significance. Only one study (Burany, 1979), from Yugoslavia, was clearly inconsistent with increased risk.

B. The observation of the ABC link has been highly consistent. While inconsistencies are often cited, these arise from results of studies wherein induced abortion has been lumped together with spontaneous abortion (miscarriage), which has not generally been associated with increased risk of breast cancer. There are straightforward reasons why there is a difference between induced and spontaneous abortion in terms of breast cancer risk (for discussion, see II B).

Regarding the consistency of the observation of the link between induced abortion and breast cancer, one must keep in mind that there are no risk factors which are universally observed to be associated with increased risk, even though they are universally recognized. For example, there are studies which find no association between breast cancer and a family history of breast cancer (Hirohata et al., 1985), although a family history of breast cancer is nonetheless universally recognized as a risk factor.

C. Even some advocates of abortion rights do not appear to dispute that there may be a connection between abortion and breast cancer, or the need for scientific research on this matter. When Louisiana adopted the ABC warning language that is printed in its woman's right to know booklet, the task force that approved the language was composed of pro-choice members, pro-life members, and state bureaucrats. Further, Louisiana's ABC language was not challenged in subsequent court proceedings.

D. The most recent epidemiological studies have confirmed the ABC link repeatedly. The ABC link received major media attention in November 1994, when a National Cancer Institute-sponsored study was

published in the Institute's Journal. The author, Dr. Janet Daling et al. of the Fred Hutchinson Cancer Research center in Seattle, Washington, reported a statistically significant, overall 50 percent increase in the risk of breast cancer among women who reported having had any induced abortions. Since then, a Harvard university study of women in Greece found a 51 percent risk increase (Lipworth et al., 1995), a study in the Netherlands found a 90 percent risk increase (Rookus and van Leeuwen, 1995), and a multicenter study in the U.S. found a 23 percent overall risk increase (Newcomb et al., 1995), all statistically significant.

E. The ABC link cuts across racial lines. Although most studies on the ABC link were of all white or mostly white women, the four studies on Asian (Japanese) women all showed increased risk, averaging approximately a 100 percent overall risk increase (Hirohata et al., 1985; Nishiyama, 1982; Segi et al., 1957; Watanabe and Hirayama, 1968), and the one study on African-American women showed an average overall risk increase of over 200 percent (Laing et al., 1993).

F. The ABC link increases women's breast cancer risk independently of and in addition to the known effect of delaying first childbirth (or first full-term pregnancy), which may be caused by abortion or other means. Of the twenty-two independent studies on the ABC link, fourteen subtracted out the effect of delayed first full-term pregnancy. Ten of these studies reported increased risk with induced abortion, six of them significantly so. Moreover, four out of seven studies which examined risk among childless women also found increases risk.

G. The consistent observation of the ABC link is not the result of bias in recall-based epidemiological studies. Several researchers have attempted to make a case that the consistent association of induced abortion with increased breast cancer risk is due to response bias. In other words, these scientists hypothesized that breast cancer patients are more likely to tell the truth about their abortion history than healthy women (control subjects) are (Lindefors-Harris et al., 1989, 1991; Rosenberg, 1994; Michels, 1994).

However, the only report claiming to verify this hypothesis was a questionable paper which relied on the preposterous supposition that women with breast cancer are likely to imagine abortions they never had (Lindefors-Harris, et al., 1991). On the contrary, evidence against the response bias is legion: Howe et al. (1989) found a 90 percent overall increased risk among New York State women in their prospective, computer record-based study, a type of study which is not subject to recall bias. They also found, with respect to statements made about previous abortions, that there was

no difference between patients and controls in the tendency to misreport abortions. Daling et al. (1994) found no evidence of recall bias in a study of cervical cancer. (Recall bias would have shown up as an apparent risk increase.) Lipworht et al. (1995) found a 51 percent overall risk increase among Greek women who reported any induced abortions, having already established that "healthy women in Greece report reliably their history of induced abortion."

H. Risks are much higher in certain sub-groups of women who have induced abortions. Daling et al. (1994) found that, although the overall risk increase due to abortion was 50 percent , risk was more highly elevated among American women who had an abortion (or first abortion) before the age of eighteen (15- percent) or over the age of thirty (110 percent). They also found that the overall risk was higher for women who had a family history of breast cancer (sister[s], mother, aunt[s] or grandmother[s] with breast cancer; 80 percent), particularly for women who had had an abortion before age eighteen (risk increase immeasurably high since all twelve such women in the study were in the cancer group) or after age thirty (270 percent).

I. The ABC link is independent of gestational age of the fetus. Neither of the two studies which examined this variable fund a significant difference between the risk elevation associated with abortions before or after nine weeks (Daling et al., 1994; Rookus and van Leeuwen, 1995). Thus, there is no reason to suspect that abortion techniques which terminate pregnancies earlier (such as RU-486) will ameliorate the risk increase associated with induced abortion.

II. The Biological Basis of the ABC Link

A. Estrogen excess is acknowledged to be the culprit behind most know breast cancer risk factors, and estrogen excess from induced abortion is no exception. Women who enter puberty earlier in life and/or enter menopause later in life have greater lifetime exposures to cyclic, high levels of estrogen secretion by their ovaries, and they are at higher risk of breast cancer. Estrogen (specifically the predominant ovarian molecular form, estradiol) is the best known promoter of breast tumor cell growth. When a women becomes pregnant, her ovaries begin secreting ever-increasing levels of estradiol, which rise far beyond non-pregnant levels. The effect of all this estradiol is to make the breast tissue grow, other hormones act to make the breast cells differentiate into cells that can produce milk. This is generally acknowledged to be the mechanism by which a first full-term pregnancy early in life (before many abnormal cells accumulate in the breasts) confers a

measure of lifetime protection against breast cancer (MacMahon et al., 1970; Krieger, 1989).

An abortion prevents the differentiating effect of late pregnancy. Thus, the breasts are left vulnerable to attack from cancer cells because they have accumulated the net, growth-promoting effect of high estradiol levels for several weeks. Second, in the case of an early first pregnancy, the delay or first full-term pregnancy also increase the risk independently.

B. Spontaneous abortions, which are not generally associate with excess breast cancer risk, are generally associated with subnormal estradiol levels. Most early studies on the ABC link did not differentiate between spontaneous abortion. Since the overall trend was, however, generally in the direction of increase risk (MacMahon et al., 1970), it was believed that any early (first or second trimester) pregnancy termination was associated with increased risk. However, many recent studies have demonstrated increased risk with induced, but not spontaneous, abortions.

This is consistent with what is known about the hormone levels of early pregnancy. Over twenty years research have demonstrated that in pregnancies that go on to abort spontaneously, estradiol levels do not rise above normal, non-pregnant levels (Kunz and Keller, 1976; Witt et al., 1990; Stewart et al., 1993). Levels of progesterone, another ovarian steroid hormone from which estradiol is made, and which is essential to maintain the pregnancy are also subnormal, and that is why such pregnancies usually abort spontaneously. Therefore, in first trimester spontaneous abortions, whether due to inadequate fetal stimulation or abnormal ovarian response, there is not significant estrogen overexposure, and no increased breast caner risk.

C. Studies of normal human breast tissue support the age-related patterns of increased breast cancer risk with induced abortion. The patterns described above of greater risk increases for women who have had any abortions before age eighteen and after age thirty (Daling et al., 1994) parallel results of laboratory analyses of norma human breast tissue (from mammoplasty). Russo et al. (1992) found higher proportions of more primitive (less differentiated; more prone to become cancerous) tissues in specimens form teenagers and from women over age thirty.

D. The ABC link is supported by experimental work in laboratory animals. Russo and Russo (1980) found that rats whose first pregnancy was aborted artificially were more likely to develop beast cancer (78 percent of the test population) after subsequent exposure to chemical carcinogen, than were similarly treated rats

who were allowed to carry the pregnancy to term (6 percent) or rats who were never allowed to get pregnant (71 percent).

III. The Public Health Impact of the ABC Link

A. There are already thousands of excess cases of breast cancer each year due to the ABC link (in the U.S. alone), and tens of thousands to be expected in the next century.

The first cohort of American women to be exposed to legally induced abortion is now in the fifth decade of life, when the risk of breast cancer is 1.5 to 2 percent. Most studies indicate approximately a 50 percent overall increased risk due to abortion. With approximately one million women (and girls) a year exposed to induced abortion, a conservative estimate would place at 7,500 to 10,000 the number of excess cases of beast cancer per year currently arising among American women. Although this number is frighteningly large, it is still small in relation to the total number of cases of breast cancer arising each year (about 200,000), and so it is easily overlooked.

More ominous is the projection for the future: Since lifetime breast cancer risk is currently estimated to be about 12 percent, a 50 percent risk increase due to abortion would put the estimate at 6 percent of a million, or 60,000 excess cases per year, once the first post-Roe v. Wade cohort reaches old age in the mid-21st century.

The most recent studies of the ABC link, which include more older women who were exposed to legal abortion, show the same trends in relative risk as earlier studies, suggesting that such projections as given above are realistic. Moreover, the one study of African-American women (Laing et al., 1993) suggests that it may be even worse: They found a 50 percent risk increase in women under forty, but it rose to 180 percent among women in their forties, and to 370 percent for women age fifty and over.

B. When the ABC link is factored in, the risk of dying form abortion is found to exceed the risk of dying form childbirth by order of magnitude. The American Medical Association claims, in its 1992 Council Report (Gans et al., 1992), that the risk of dying in childbirth is twelve times higher than the risk of dying from an abortion. However, this only takes account of the risk of immediate death. But a 50 percent breast cancer risk increase due to abortion would raise average lifetime breast cancer risk from approximately 12 percent to 18 percent, and increase of 6,000 per 100,000. Even assuming a cure rate of 75 percent, mortality due to beast cancer would increase by 1,500 per 100,000. Since the risk of dying in childbirth in the U.S. is only 5 per 100,000 the ultimate risk of death from an abortion would be increase by a factor of about 300.

Whether or not that happens is, of course, crucial to any assessment of Newt Gingrich's first year as Speaker and of the immediate Republican future. But it's already clear that Gingrich has had an extraordinary run. From sometime in the fall of 1994, when he really caught the wind of history, throughout most of this year, when he rode it with virtuosity, Gingrich has stood astride American politics and changed its course, perhaps fundamentally. That he's looking battered is understandable (even if he has invited some of the rough treatment). But, for the next year, Republicans and the Speaker himself will have to undertake a Contract with Survival, working to keep Gingrich and what he has done from wiping away their 1994 gains. That would be a cruel irony, indeed. But, as any professor should know, history is full of those. □

May Cause Cancer

If there is a way to reduce the incidence of breast cancer, shouldn't American women be told about it?

JOEL BRIND

ON November 4 of last year, the *Journal of the National Cancer Institute* (NCI) published a study that the media have treated as an unscientific scare story, the way they should have treated the Alar and PCB cancer scares of years past. The study, by Dr. Janet Daling, et al., found a significant overall increase in breast cancer among Washington State women who had had one or more induced abortions (as opposed to spontaneous abortions, or miscarriages, which were not associated with increased risk).

The spin doctoring began immediately—and not just in the popular media, but in the professional medical press. In fact, even as the Daling study rolled off the press, it was undercut by an accompanying editorial warning that "neither a coherent body of knowledge nor a convincing biologic mechanism has been established." Articles critical of the study continued to appear well into this summer.

To be sure, one ought to be extremely wary of raising public fears on the basis of any one study in isolation. This is especially important when one is considering such a high-incidence, potentially lethal disease as breast cancer (now estimated to strike about 12 per cent of American women), and such a high-incidence posited risk factor as induced abortion (over 1.5 million a year). If even the modest, 50 per cent overall risk increase found in the NCI study holds up, that would result in 40,000 to 50,000 additional cases of breast cancer a year, once the post-*Roe* v. *Wade* cohort starts to reach the age range at which breast cancer becomes more likely. Clearly, the fears engendered by such a study would affect a great many people.

On the other hand, if the study *does* prove valid, it is important to note that the posited risk factor is almost exclusively a matter of personal choice, and therefore avoidable in a way that environmental risk factors may not be.

In this case, however, the study is not isolated. Evidence of a possible connection between abortion and breast cancer has been published quietly since as far back as 1957.

The attack on the Daling study began, as I say, with a debunking editorial in the same issue of the NCI *Journal*, written by Boston epidemiologist Lynn Rosenberg. Her own work in the field, published by the *American Journal of Epidemiology*, was seriously flawed because the breast-cancer patients in her study were, on average, 12 years older than the cancer-free control patients. Since the risk of cancer increases with age, this was an egregious methodological error. Not surprisingly, her study evidenced a relative risk (RR) of breast cancer among women who had had one or more induced abortions of only 1.2 to 1.3 (i.e., a 20 to 30 per cent elevation in risk). This risk increase was reported as not statistically significant.

Perhaps that explains why her study was publishable in an American medical journal. The same *American Journal of Epidemiology* declined to publish an age-matched study of New York State women by Dr. Holly Howe, et al., of New York State's own Department of Health, a study which found a significant relative risk (RR) of 1.9 for breast cancer among women who had had any induced abortions. The Howe study was finally published in the English *International Journal of Epidemiology* in 1989.

While the *American Journal of Epidemiology* did not publish the Howe study, it did (in 1991) publish a comparison of studies done in Sweden which claimed to "explain the tendency toward increased risk of breast cancer which . . . appears to be associated with induced abortion" by a hypothesis called "response bias." According to this hypothesis, cancer-free women are more likely to deny abortions they had, while women with breast cancer are more likely to report their abortion history accurately. While the response-bias hypothesis is plausible and worthy of testing, the only evidence the study provided was that breast-cancer patients reported abortions of which the computer had no record. It is on this that the 1991 paper bases its assertion that patients tend to "overreport abortions"—that is, to imagine abortions they never had.

Despite the absurdity of this evidence, the response-bias argument was mobilized to attack the Daling–NCI study. Harvard epidemiologist Karin Michels reported it to the *New York Times* as fact when the Daling study came out: "That [i.e., patient-recall-based data collection] is a flaw in the study design because women who had breast cancer are more likely to disclose an abortion than women who did not develop breast cancer." Lynn Rosenberg, in her editorial, suggested "the possibility of reporting bias" as a "limitation" of "major concern" in the Daling study, even though the Daling study itself soundly debunks the reporting-bias theory. So did the Howe study: while it revealed some misreporting of prior induced abortions

Mr. Brind is a professor of biology and endocrinology at Baruch College of the City University of New York, where he has been teaching since 1986. His research on the connections between reproductive hormones and human disease has included breast cancer since 1982.

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either as being spontaneous abortions or as not having occurred at all, it also revealed that the misreporting "occurred similarly among the cases and the controls."

THE first study (in 1957) to show a significant association between induced abortion and breast cancer (relative risk=2.6) was performed and published in Japan, and subsequent reports with similar results were also published overseas. Another large, age-matched Japanese study (1982) showed risk to rise steadily with the number of induced abortions (RR=2.5 for one abortion, up to 4.9 for four or more). American studies showing significant risk increases among women on the West Coast (1981; RR=2.4 for abortion terminating a first pregnancy) and on the East Coast (the 1989 Howe study) were published in England. Similar findings from France (1984; RR=1.2 for one abortion, 1.6 for two or more), Denmark (1988; RR=3.9 for abortion terminating a first pregnancy), and the former Soviet Union (1978; RR=1.7 for any abortion) also popped up in European journals. In addition to the 10 epidemiological studies cited thus far, another 12 case–control studies have appeared in the peer-reviewed medical literature. Four (two in the United States and one each in France and Italy) showed no overall trend of increased risk (RR=0.9 to 1.1); three (one in America and two in Japan) showed risk elevations that did not achieve statistical significance (RR=1.2, 1.5, and 1.5, respectively); and four recent studies showed significant risk elevations, two in American women (RR=1.23 and 3.1), one in Greek women (RR=1.51), and one in Dutch women (RR=1.9). In fact, the only case–control study showing a negative association between induced abortion and breast cancer was a 1979 Yugoslavian study which was atypical in other ways as well. For example, it showed no evidence of the universally recognized protective effect of having children.

As late as 1992, the influential *New England Journal of Medicine* published an apparently comprehensive review of breast-cancer risk factors which inexplicably made no mention of the A-word, despite the fact that 13 out of the 14 case–control studies published by that time were consistent with increased risk.

In 1993, Harvard's Walter Willett,

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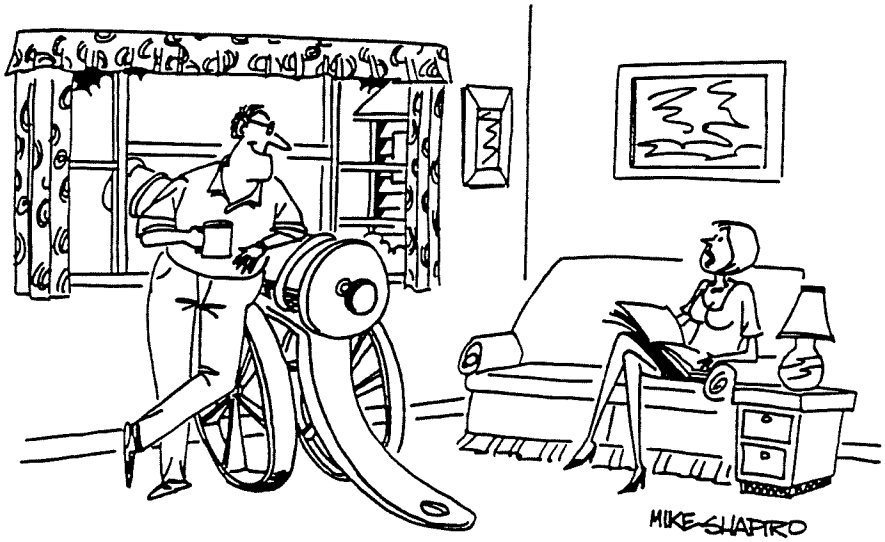
the epidemiologist among the four authors of the *NEJM* review, called this author "particularly sleazy in comparing a risk of breast cancer among women who elect to have an abortion with those who carry the pregnancy to full term." Willett's attack got curiouser and curiouser: "Of course the risk is higher among women having an abortion, not because abortions are a risk factor, but because a full-term pregnancy is protective." In fact, most studies correct for the protective effect of early full-term pregnancy. (Most studies also correct for such variables as number of children, use of oral contraceptives, and miscarriage.) They indicate that abortion *further* increases risk independently.

Earlier that year, the very same Dr. Willett had wasted no time in telling the world of a modest (though statistically significant) 65 to 85 per cent increased incidence of prostate cancer among men who had undergone vasectomy. The story was instantly picked up by the national media, even though the posited connection had theretofore been the subject of only a half-dozen epidemiological studies, with conflicting results. Subsequently, the subject was freely discussed in the *Journal of the American Medical Association* and other journals. Apparently, the possible risks of a minor surgical procedure for men is open for discussion in America. Not so for abortion.

Adding to the confusion is the fact that many studies over the years have failed to distinguish between induced and spontaneous abortion. This was true of 32 studies published between 1960 and 1994. Results of these studies have indeed been conflicting, some showing increased risk, some decreased risk, and some no effect. That is not surprising, given the difference in the effects of induced and spontaneous abortion.

The reasons for those differences are straightforward. The first trimester of a normal pregnancy is marked by a surge of hormones from the mother's ovaries, including progesterone, to maintain the pregnancy, and estrogen, which makes the breasts grow. Most known breast-cancer risk factors act via some form of overexposure to estrogen. Normally, the high estrogen levels of early pregnancy are counterbalanced by other hormones late in the pregnancy, which differentiate the breasts into milk-producing organs, thus rendering them permanently less susceptible to cancer. However, if the pregnancy is artificially terminated, the growth-stimulating effects of the estrogen surge help primitive and/or abnormal cells to grow into potential cancers. Contrariwise, as more than twenty years of research have shown, most first-trimester spontaneous abortions are characterized by subnormal secretion of ovarian hormones, including estrogen, whether because of inadequate stimulation by an abnormal fetus or because of an inadequate response by abnormal ovaries. Clearly, the failure to distinguish between spontaneous and induced abortion is a fatal weakness in any study.

Other confounding variables, such as socioeconomic class, race/ethnicity, and diet may also contribute to apparent increases in breast-cancer risk, and these are controlled for (sometimes well and sometimes not so well) by the selection of an appropriate control group. All in all, the best evidence for the real existence of a link between induced abortion and breast cancer is that it has been repeatedly observed in so many studies in different countries of widely varying ethnicity, diet and other lifestyle factors, and baseline breast-cancer incidence, and over a time span of almost four decades.



"Really, Harry, must you constantly flaunt the Second Amendment?"

THE American medical media's wall of silence on the possible link between abortion and breast cancer was first breached in December 1993 in the African-American *Journal of the National Medical Association*. As Dr. Amelia Laing, et al., noted in the introduction to their age-matched Howard University study of over 1,000 black women, "Breast cancer is the leading cause of cancer mortality in black women," and "among women under the age of 50, the mortality rate in whites has declined, while it has increased in blacks." Thus (with black women also heavily overrepresented among abortion clients) there was a compelling interest in publishing their findings of significantly elevated risk among black women with any induced abortions (RR=2.7), risk which steadily rose with age until it reached 4.7 in the fifty-and-over group (which made up the majority of the study population).

The Howard University study was ignored by the mainstream popular press. Even the *Philadelphia Inquirer*, which heralded the Daling–NCI study, made no mention of the Howard study in a 3,000-word feature story on breast cancer in black women, written two months after the Daling–NCI story.

The media also have ignored three additional studies published this year that reconfirmed the significant findings of the Daling–NCI study. One of these, a study of women in Greece, constituted part of the doctoral thesis of Harvard epidemiologist Loren Lipworth. Among Lipworth's co-authors is the same Karin Michels who was interviewed about the Daling–NCI study by the *New York Times*, which reported: "Ms. Michels said she had reviewed in detail 40 published studies on abortion and breast cancer and had found no evidence of an increased risk." This story appeared one week after the Lipworth study she co-authored—which confirmed Daling's finding of 50 per cent increased risk—was submitted to the *International Journal of Cancer*.

Reporters are unquestionably in a difficult position when the people they

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should be able to turn to for accurate information refuse to provide it. Even Dr. Clark Heath, vice president of epidemiology and surveillance research at no less than the American Cancer Society, cited the unsubstantiated "reporting bias" argument when queried by a reporter about the Daling–NCI study, as reported by the *Washington Times*. He reacted as one hardly concerned, let alone alarmed, about a potential cancer risk that women might avoid, if given an informed choice: "Overall, it's a bit of a wash," he said.

One would have presumed that someone in Dr. Heath's position would be familiar with the considerable body of epidemiological data that has been gathered around the world for decades. One might also have expected him to point out a particularly disturbing fact in the Daling–NCI study: of the more than 1,600 women in the study, there were 12 who a) had had one or more abortions before age 18 and who b) also had a family history of breast cancer; all 12 were in the cancer-patient group, making the relative risk incalculably high for women with both of these risk factors. But that disturbing finding didn't make the news either.

Instead, denial from high places has even turned to outright disinformation. Dr. Devra Lee Davis, Senior Advisor to the Assistant Secretary for Health, juxtaposed, for the *Washington Post* (March 14, 1995), the long-standing legality of abortion in Japan with the fact that Japan has "the world's lowest breast-cancer rate." Dr. Davis thus suggested the absence of a connection between abortion and breast cancer. But all four Japanese epidemiological studies show a higher incidence of breast cancer among the small minority of Japanese women who have actually had any abortions.

Even more brazen was a piece written for the February 1995 *Elle* magazine by Assistant Surgeon General Susan Blumenthal, in which she said that "the [Daling–NCI] study did not consider the effect of birth-control pills," adding that "it is vital to rule out the effect of the Pill in any study of breast-cancer risks." It is also vital to get your facts straight. Not only did the Daling study "consider the effect of birth-control pills," but the possible effect of oral contraceptives on breast-cancer risk was a major focus of the study. My call to Dr. Blumenthal's office was returned by her assistant Teddy Fine, who doubted that a published correction was possible, since "the water is so far past the bridge at this point."

Yet five months further downstream, the pre-eminent professional journal, *Science*, skewered *New York Times* reporter Lawrence Altman for having given the Daling study any credence whatsoever back in 1994 (his story had run under the headline: "New Study Links Abortions and Increase in Breast Cancer Risk"). "Inevitably," said Charles Mann in the *Science* article, "public attention was directed to a risk that is unlikely to be real." Mann based this conclusion entirely on the assumption that Karin Michels was telling the truth. All Mann did was wrap her lie in more elegant imagery, as he called the Daling study "the one positive result in a sea of negative data." My polite corrective letter to the editor of *Science* drew only a form letter expressing "regret" over "space restrictions."

Most recently, on September 30, the literal eve of "Breast Cancer Awareness Month," the English medical journal *The Lancet* published an apparently comprehensive review article, "Breast Cancer: Cause and Prevention," by Drs. B. S. Hulka and A. T. Stark of the University of North Carolina. Claiming, "We focus on primary prevention," these authors somehow failed to mention the most obviously preventable risk factor for breast cancer: induced abortion.

One needn't look very far to find the motivation behind the increasingly desperate attempts to prevent public access to the considerable body of evidence of a connection between induced abortion and breast cancer: the reputation of abortion as safe for women is crucial to the "pro-choice" movement. The American Medical Association staunchly maintains that the risk of dying in childbirth is 12 times greater than the risk of dying from an abortion. Now, the risk of dying in childbirth is less than 5 in 100,000. If the overall increase in breast-cancer risk caused by induced abortion is even the modest 50 per cent suggested by numerous studies, that would raise lifetime risk from 12 per cent to 18 per cent—an increased incidence of 6,000 per 100,000 women who have had any abortions. Even with a breast-cancer cure rate of 75 per cent, the increase in the death rate from induced abortion would calculate out to 1,500 per 100,000, making abortion 300 times more likely to result in death to a woman than childbirth. But mentioning that would be *very* un-PC. □

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ABORTION AND CANCER

by Judith E. Koehler

QUIETLY AND WITH LITTLE NOTICE from the press, state legislatures have started requiring that women be informed of the cancer risk associated with abortion. As a result, it may soon be common knowledge that having a baby at a young age modestly reduces a woman's lifetime risk of breast cancer, while having an abortion may increase it.

In September 1995, Louisiana became the first state to require that women considering elective abortion receive information about the association between abortion and breast cancer, known as the ABC link. At least 24 hours before an abortion is scheduled, the woman must be given a booklet prepared by the state. While acknowledging that "several studies have found no overall increase in the risk of developing breast cancer after an induced abortion" and that "this issue needs further study," the booklet warns that "several studies do show an increased" long-term medical risk. The warning is even stronger for women who have a family history of breast cancer or who themselves have breast disease. Louisiana urges those women to seek medical advice before they consider an abortion.

Montana has followed Louisiana's lead, and the Pennsylvania legislature was sufficiently interested to commission a review of the scientific research. That "meta-analysis" was performed by Dr. Joel Brind, professor of biology and endocrinology at Baruch College of the City University of New York, in collaboration with specialists associated with the Hershey Medical Center, an affiliate of Pennsylvania State University. Their work is currently undergoing peer review. Its publication is expected early this year.

Conveniently for the layman, Brind—whose own research has explored the connections between reproductive hormones and human disease for over a decade—summarized the state of medical knowledge in the December 25, 1995, issue of *National Review*. By his count, 22 relevant studies have appeared in the peer-reviewed medical literature, of which 11 found a statistically significant link between induced abortion and increased incidence of breast cancer, and another 6 found an increased risk, though below the level of statistical significance (a measure indicating 95 percent certainty that a discerned link is real, not simply an effect of random variation). Brind stresses that the evidence for the ABC link has come not only from the United States but also from Europe, Japan, and the former Soviet Union over a period of four decades.

Among the studies that found an increased risk, the magnitude of the increase varies, but Dr. Janet Daling's findings can be taken as illustrative. Her research, published in 1994 in the *Journal of the National Cancer Institute*, suggests that a 22-year-old woman's lifetime risk of developing breast cancer rises from at least 10 percent—the average for women in general—to 15 percent if she has an abortion. If she has a baby, by contrast, her long-term breast-cancer risk drops to 7 percent. Daling's work suggests the risk is highest—indeed, very high—for women who undergo abortions before the age of 18 and who have family histories of breast cancer; of the 1,600 women she studied, 12 fell into this category, and all 12 got breast cancer by the age of 45. The risk-lowering effect of giving birth, by the way, is universally acknowledged. It is explained by the action on the breasts of hormones released late in pregnancy.

Even if the ABC link represents only the modest cancer risk that Daling found, it must affect large numbers of women, for two reasons: The incidence of breast cancer is high and rising; and abortion is the most frequently performed elective surgery, affecting 1.5 million American women a year.

Already breast cancer is the most common cause of death among middle-aged women. Not surprisingly, its rising incidence has prompted legislation in more than a dozen states, mostly to encourage screening, to require that patients be informed of treatment alternatives, or to compel insurance companies to cover particular procedures. Requiring that women be informed of an avoidable likely risk-factor for breast cancer—elective abortion—is in line with this trend.

It is also in line with contemporary standards of informed consent. Even without legislation, courts often hold doctors liable if they fail to inform patients of material risks associated with treatment. Here, it is interesting to note that consumer rights organizations and the American Civil Liberties Union—usually the first to demand that patients be scrupulously informed of all risks—actively oppose requiring informed consent for elective abortion. Even though the ABC risk appears to be highest for minor girls, who are least able to think realistically about the danger of fatal diseases later in life, these organizations suddenly lose interest in protecting vulnerable consumers.

There will always be some women who choose to undergo abortion even if it means their risk of breast cancer rises. But all women, especially the young, should be advised of current scientific knowledge, and doctors have a duty to warn them. Given the reluctance of the normal champions of patients' rights to make this case, lawmakers should step in.

Judith E. Koehler is senior legislative counsel of Americans United for Life.

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Testimony--Woman's Right to Know Act
Senate Public Health & Welfare
Jane Doe

Saturday, June 5, 1993. My boyfriend and I drove to Overland Park for the 9:30 a.m. Appointment for the abortion. As we drove into the parking lot, I remember seeing people picketing outside the clinic. It made me feel so humiliated and ashamed. I walked into the clinic and was shocked to see so many women of all different ages sitting and filling out forms in the waiting room. When the secretary asked me for the consent form, I remembered that I had forgotten it at home. She assured me that it was okay and she gave me another one to sign. Then, I filled out forms pertaining to medical questions. Then the hardest part come... The waiting. After a few minutes, I got to go to a room and had an ultrasound done. I was then led back to the waiting room. I knew that what I had seen in the ultrasound room was a very small distinct figure of a little baby. I kept repeating in my mind that it won't feel anything, I'll leave here and everything will go back to normal.

Two hours later after seeing women going into the back rooms and leaving, my name was called. I asked the nurse if my boyfriend could go with me, she replied "no." I went into a room where there were tools laying on a small table and a nurse come in. She explained to me in detail of the procedure and used the tools to demonstrate. She then gave me a sheet of paper explaining what complications that could occur after the abortion procedure was done. She left the room to give me time to read the information and I signed the bottom of the paper I then was let to the changing rooms where I got dressed for the procedure. I was then given a valium and some foul tasting syrup.

My name was then called and I entered the "abortion room." I remember seeing two beds divided by a curtain. The doctor told me what he was going to do. I remember wanting to ask a few questions because I thought that all doctors were suppose to talk about the procedure that they would be doing. But I was scared and didn't know his name so I laid there and did what he told me to do. (I know his name now, only because his name was on a prescription bottle.) The nurse held my hand and tried to comfort me. I remember the pinch of pain I felt. It, which was the local anesthetic. But that pain was nothing compared to the pain of the

actual procedure. I remember the pain of him using rods of different sizes to stretch out the opening of the cervix. (Which he hardly waited for the anesthetic to take effect.) To this day, I still hear the machine clicking on. To this day I still hear the sucking sound as my baby's life was sucked out. I could feel my baby die. Of course, there was no movement felt. But what I was never told was that there is a bond between a mother and her baby. I remember looking up at the clock. I knew the precise time when that bond was broken and when my baby died...2:28 p.m. I remember the tears flowing down my face as I held that nurse's hand. All I could say was, "I'm sorry, baby, I'm so sorry." That day should never have happened. I live today knowing that I legally "murdered" my baby. All for the price of $350.00. What I didn't mention in this testimony was that I had found out I was pregnant June 3, 1993 -- only two days before the abortion.

I walked into that clinic with so many questions in my head with no one to ask them of. In that abortion clinic there was no way you could go up to a person and ask, "does my baby have a heart, a brain, or even fingers and toes yet? Or will it feel pain if I had the abortion done?" I had these questions but there was no one to ask them of. Doctors (if you even saw them) and nurses were moving girls in and out of the rooms. Actually, I first saw the doctor when I was getting the abortion done. Everything seemed so rushed. I didn't know the gestational age of my baby. The only thing a nurse had told me was that I was carrying an embryo. What was the age of my embryo... Today I know that it was between 9 to 10 weeks old but that day I didn't. The current law, 65-6706, states in (2) the gestational age of the fetus at the time of the abortion. I did receive a stage of growth, but not the age. It also states in 65-6706(4) that community resources, if any, available to support the women's decision to carry the pregnancy to term. I did not receive this either. Unless when driving to the clinic I was suppose to stop at the picketers and ask for this material and a list of alternatives to abortion. In closing, I also feel that time is crucial. The current eight hour time factor should be raised to twenty-four hours. I know in my heart that if I would have received twenty-four hours and some kind of booklet containing information of fetal development, a list of alternatives, and phone numbers of places that would answer my questions... I would have never had the abortion. H.B. 2938 "The Woman's Right to Know Act" should be passed. It helps protect women of all ages who are seeking to have an abortion.

When a woman is deciding on an abortion, they are deciding on a

human life. There should be no pressure in this decision. Some abortion doctors are supporting women's rights. Shouldn't the too, also support a Woman's Right to Know all the alternatives and the development stages of an unborn baby. It is the **Woman's Right** to know this information. The abortion doctors will know that the women that go through their clinics will have received all the important information and the necessary 24 hours time to make their decision. I feel that If "The Woman's Right to Know Act" is passed, it will save hundreds of women from making the mistake I made by having an "unsure" abortion. This is a bill that both Pro-Life and Pro-Choice members can come together and save women from the psychological pain of a fast, unsure abortion. Passing the "Woman's Right to Know Act" will help women in receiving phone numbers of places willing to help to have their babies. Buy it will also help women after abortions feel that they had the time and the information to make the right decision for themselves, no matter what their circumstances. Please diminish "unsure" abortions, pass H.B. 2938. "The Woman's Right to Know Act."
Thank You.

House Health and Human Services Committee
Testimony HB 2938
February 12, 1996
Speaker: Jane Doe # 2

Thank you to the Chairmen Mayans and the members of the Health and Human Service Committee.

One time or another, one might find themselves faced with a crisis situation. On June 3, 1993, I faced a crisis situation, an unplanned pregnancy. Two days later, the crisis situation ended, so did the pregnancy, but not the emotional pain. I go on in life, knowing in my heart that I "legally murdered" my baby. This pain will last forever within my heart. It is the emotional pain after having an abortion. The procedure should have never happened. And the haunting words that are scarred in my mind "if I only knew..." will be the one question that will forever replay itself over and over again.

Thursday, June 3, 1993, knowing that I was late on my menstral cycle, I took a home pregnancy test. The pregnancy test came up positive. I still remember how scared I was and how alone I felt. I knew that I could tell only one person, my boyfriend. He was shocked. I remember hearing his crackling voice over the phone saying, "please don't tell your parents." I didn't tell my parents. Both of our parents had raised us to believe that pre-marital sex is wrong and if you proceded upon that sin and become pregnant, abortion would be a sin to solve that situation. But my boyfriend and I were naive and scared. We both felt that if our parents didn't know about the pregnancy, we could end our little secret and go on with our lives.

Friday, June 4, 1993. I decided on an abortion clinic. It was a clinic located in Overland Park, Kansas. My boyfriend and I drove to the clinic to get the consent forms. There was information along with the consent forms. This information consisted of what I needed to bring and what to do. There was no information of alternatives to an abortion, fetal development, and not even information on the three most-asked-questions. I was upset that I had driven all the way to Overland Park, Kansas for just a sheet of paper telling me what to do, what to bring, what to expect, when not to eat, and that confidentiality is important to them. That night, I sat down with my boyfriend and we read the skimpy information and I

signed the consent form. That same night, I remember talking to my "clump of cells." I remember asking questions in my mind. "I wonder if you are a boy or a girl? Do you have a heart yet? Do you have a brain?" I even asked if it had fingers and toes. But the main question that was pounding in my brain for hours was, "was s/he was going to feel pain that next day?" I wanted so badly to know how far along I was in the pregnancy. I was so full of questions but no one was there to hear the questions or to answer them. I felt so alone, like I was the first and only pregnant unmarried woman in the whole world. I was scared to death, but the thought of something growing inside of me fascinated me. Then the thought again calmed my mind, "it's only a bunch of cells." I remember hearing these words from a pro-choice personnel on television. But was it true? This question and all my other questions were answered too late.

Saturday, June 5, 1993. My boyfriend and I drove to Overland Park to the 9:30 AM appointment for the abortion. As we drove into the parking lot, I remember seeing people picketing outside the clinic. It made me feel so humiliated and ashamed. I walked into the clinic and was shocked to see so many women of all different ages sitting and filling out forms in the waiting room. When the secretary asked me for my consent form, I remebered that I had forgotten it at home. She assured me that it was okay and she gave me another one to sign. Then I filled out a medical history form. Then the hardest part came, the waiting. It felt like days in that waiting room. Finally, they called my name. I was led to a room where there was an ultrasound. The woman gave me a sterile cup and told me where the bathroom was. They needed a urine sample. She then gave me time to undress myself waist down, where she could procede with the ultrasound. She could not get a clear picture so they did the ultrasound with a rod inserted into my vagina. Then a clear picture was formed. I asked her if I could see what she was looking at. She turned the monitor and pointed at a growth. I remember smiling, it fascinated me because I could see a very small distinct figure of a baby. I remember her exact words, "you're definitely pregnant. That's a small growing embryo." She pointed out for me. I remember the questions going through my mind, but one question was answered there on the screen. It wasn't "a clump of cells." I remember wanting to ask my other questions. But the woman pulled the monitor away and said, "I'm finished, you can get dressed now." I remember going back to the waiting room and telling my boyfriend what I had seen. I told him that I think we should leave and that I don't think I could go through with the abortion. But he kept repeating, "We can't

support a baby now, our parents won't help us, shoot, they'll disown us." I decided to stay. I kept repeating in my mind, "it won't feel anything, I'll leave here and everything will go back to normal."

Two hours later after seeing women going into the back rooms and leaving, my name was called. I asked the lady if my boyfriend could go with me, she replied, "no." I went into a room where there was tools laying on a small table and a nurse came in. She explained to me in detail of the procedure and used the tools to demonstrate. She then gave me a sheet of paper explaining what complications that could occur after the abortion procedure was done. I had to sign at the bottom of this paper. I then wanted to ask my questions but the women intimidated me. I could tell she knew her job well. "Get the girls in and get the girls out." I then got dressed for the procedure. I was given a valium and some foul tasting syrup. This syrup was given to me because I had drank orange juice that morning and they were afraid that I would vomit during the procedure. Then my name was called and I entered the "abortion room." I remember seeing two beds divided by a curtain. The doctor told me what he was going to do. The nurse held my hand and tried to comfort me. I remember the pinch of pain I felt, which was the local anesthetic. But that pain was nothing compared to the pain of the actual procedure. To this day, I still that machine clicking on. To this day, I still hear the sucking sound as my baby's life was sucked out. I could feel my baby die. Of course, there was no movement felt. But what I was never told, was that there is a bond. I remember looking up at the clock. I knew the precise time when that bond was broken and when my baby died...2:28 PM. I remember the tears flowing down my face as I held that nurses hand. All I could say was "I'm sorry baby, I'm so sorry,"

I left the clinic with no words spoken. I didn't say one word to my boyfriend or to my family. I didn't eat or sleep for days. I stayed in my room and cried. When the tears would dry, I then would get down on my knees and pray. I remember begging God to give me another chance..praying that the doctor made a mistake and that the baby was still inside me. But I knew in my heart that the baby was gone. I felt so empty. After the sadness came anger. I hated myself. I hated the doctor and everybody elseat that clinic. They didn't tell me that I would feel that way. Sure, they mentioned a little bit of depression, but I was on the verge of committing suicide. I know that the doctor did the procedure but my baby's blood was all over my hands. I was the one who laid there on that table and took away a human-life. I was the one who signed my baby's life

away for the price of $350.00. My baby's only concern was life. It was my resposibility to make sure that that concern was fulfilled but instead I chose death.

Months afterwards I lived a "careless life." I would party to erase the memories but they would always return. I tried to finalize erasing those memories by attempting suicide. I had lost my boyfriend and life just wasn't worth living. The attempt failed. I then became sexually active with a new boyfriend. Again, seven months after the abortion, I found myself pregnant. Instead of buying a home pregnancy test, a friend gave me a phone number to a Crisis Pregnancy Center. They confirmed my pregnancy. They also gave me pamphlets to alternatives and pictures of an unborn babies development. They also gave me phone numbers where I could get help during and after the pregnancy. I chose to have the baby. I didn't have the support of the baby's father but I didn't mind. I knew where I could get the support.

Today, I have a seventeen months old son. I know he can't replace the child I aborted but he does make my life more meaningful. God has plans for me. I am now a born-again christian. I know that I am here today giving my testimony because of Him. I know that I am the voice of hundreds of women in Kansas who are having abortions without looking at alternatives. Yes, there are clinics like Birthright and Crisis Pregnancy Centers that can help women. This is not enough. Abortion clinics need to give out information about alternatives and fetal development. I know that if I would've received this type of information, I would've never went through with that abortion.

When a woman is deciding on an abortion, they are deciding on a human-life. There should be no pressure in this decision. Abortion doctors are supporting Women's Rights. Shouldn't they also support Women's Right to Know all of the alternatives and the development stages of an unborn baby. The abortion doctors will know that the women that go through their clinics will know that they have received all of the important information. I feel that if "The Woman's Right to Know Act," is passed, it will save hundreds of women from making the mistake I made by having an "unsure" abortion. Women will have time and all the information that is needed in making a important decision. Most importantly, it will save women from the haunting question that goes through my mind everyday..."if I only knew."

Thank you!

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My name is Herbert Charles Hodes. I have been in the private practice of obstetrics and gynecology in Kansas for over 18 years. I have been providing abortion services for my patients since my early residency training days at the Kansas University Medical Center for almost 25 years. I feel that I have more experience to speak on this matter than any of the others your have heard, or will hear. **HB 2938** asks to label this legislation as the **"...woman's-right-to-know act."**

The introduction to the bill states that "It is essential to the psychological and physical well-being of a woman considering an abortion that she receive complete and accurate information on her alternatives." I certainly agree, and physicians throughout the country have been supplying this information for over twenty years. Whether or not a facility exists for family planning or abortion, or whether it is my private office in Overland Park; a doctor-patient relationship DOES occur the minute the patient enters the facility---an extension of a physician's practice. At least half of patients DO return to the facility for post-surgical care, and there is AMPLE opportunity for a woman to receive counseling regarding her decision.

The use of the terms "...untrained and unprofessional 'counselors' whose primary goal is to sell abortion services." is an insult to all of those involved in a woman's medical care---the counselors; the nurses and physicians; and, most of all, the **patients.** These comments are designed to further inflame the issue, and are not based on fact. As I stated above, at least half of the patients return for post-abortion follow-up. Since there are only 5 or 6 of us providers in the entire state of Kansas, many patients do not return because of the distances involved. Even those from far away often return years later----since at least one out of three patients is having her second procedure.

Breast cancer is a "growing epidemic," and according to a recent bill introduced to the Senate, it is the single most frequent cause of death among middle-aged women. That "honor," however, belongs to Heart Disease; a disease made worse by cigarette smoking---------but that is not the topic about which we are meeting today. It is generally accepted, however, that smoking causes a 10 to 20 times increase in risk for lung cancer in smokers.

The medical article by Daling, *et al* in the Journal of the National Cancer Institute (1994) is mentioned when the alleged association between abortion and breast cancer is discussed. That article needs to be explored further before placing such significance upon it. It is a study involving 845 white women with first diagnosis of breast cancer, and 961 controls in three contiguous counties near Seattle, WA. It should be pointed out that no women of color were included in this study. Because of the small number of women involved, any under-reporting of legal abortions in the control group would cause an exaggerated change. It is widely accepted that well women often "forget" to mention a pregnancy termination. In addition, evidence regarding spontaneous abortion was inconsistently obtained from both groups of women.

Senate Public Health & Welfare
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Attachment No. 5

The editorial staff of the Journal suggested that the patient be allowed to "...balance her decision after considering all of the issues-------her personal situation, her ability to care for the child if she continues her pregnancy, and her total health implications of continued pregnancy versus induced abortion..." In 1994, the National Cancer Institute released a press statement regarding the article by Daling, stating that ***"...scientific conclusions were not to be taken based on the information at hand at that time."***

The largest study concerning abortion and breast cancer, however, was published in the British Medical Journal in 1989, and involved over twenty years of follow-up in **49,000** Swedish women who had received abortions before the age of 30. Since all health care in Sweden is nationalized, there can be little chance for errors in data gathering; therefore no under-reporting of abortions by well women. This massive report showed **no** indication of an increased risk of breast cancer. In fact, the study suggested there could well be a slightly reduced risk!

In September, 1995, the American College of Obstetricians and Gynecologists (ACOG) released a policy statement which paralleled one that was released by the California Medical Association in May of 1995. Both statements felt **"...that evidence is insufficient to support to support claims that induced abortion has an effect on the later development of breast cancer."**

In the January 24/31, 1996 issue of the Journal of the American Medical Association, another article concerning the alleged abortion/breast cancer connection was published. This study involved almost 10 times as many patients as the Daling study (6888 with cancer, and 9529 controls) in Wisconsin, Massachusetts, Maine and New Hampshire. The study revealed a "weak positive association" between abortion and breast cancer---but **not** significantly different whether induced or **spontaneous** abortions. They also noted under-reporting of abortions in well patients, especially if the abortion was done prior to legalization. There certainly are many other co-factors at play in the twenty years, or more, that follow an abortion; and the possible later development of cancer. The authors felt their data suggested that the association between breast cancer and pregnancy termination was **"...likely to be small, if it exists at all."**

Indeed, the editorial staff of **JAMA** noted the appearance of bills similar to **HB 2938** in at least 10 other states, and felt they were "...premature, in light of the information currently available Full disclosure would require explanation of the inconsistent state of the research" and that the "...positive studies identify only a slight risk---less than or equivalent to the increased breast cancer risk associated with marital status, place of residence, or religion."

Just last month, (February 13, 1996) the U.S. Department of Health and Human Services released a **National Cancer Institute Fact Sheet** which addressed this issue. They pointed out the political and "public information" campaigns currently being discussed "...misrepresent the information in the scientific literature." "There is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion."

Since the data is inconclusive, at best; it seems that the patient should be told the only the known **facts** regarding a decision on whether or not to have an abortion. In my 25 years of providing abortion services, I have been struck by the amount of effort taken by the woman in making her decision **BEFORE** she ever contacts my office. Patients who receive the currently mandated written materials 8 hours before making their appointments KEEP their appointments, and state to me that the materials did not aid in their decision-making process.

Passionate letters from two physicians were supplied to the House in support of **HB 2938.** One of the physicians is a woman who is far too young to have trained in the late 60's and early 70's when I did. She has never seen the women who have been injured by untrained practitioners, or by self-induced methods. She mentions that patients should be told about the risks of any surgical procedure, and I agree. The materials we supply (in writing) carefully spell out the remote risks of the thing she mentions. She states that the developmental characteristics of the embryo/fetus should be revealed, and they are. She states that she has talked with "...many women..." who have regretted a decision to terminate. I am certain that I have been involved in the care of far more women than she over the past 25 years who totally disagree with that comment. None of my patients through the years has ever felt uninformed or hurried in her decision; and as I stated above, at least half come back to me for follow-up care---and one out of three comes back again for an abortion !

The doctor from Manhattan states that patients came to him for follow-up care after abortions because they got none from the individual performing the abortion. That is because abortions are only performed in four counties in Kansas, and only by 5 or 6 doctors. These women came to him because of the distances involved in seeing the abortion provider. In the past 25 years I have treated my own patients for complications at no charge, and the numbers are far less than implied by his letter. I know of no infertile patients out of many thousands; and infertility and tubal ("ectopic") pregnancies are rarely due to a previous abortion. He states "80%" of the patients he asks would never undergo the procedure again. Since at least 33 percent of women have more than one abortion, I do not find that comment to be believable.

It is for all of the comments above, and based on the literature and documents attached; that I must urge you to vote **against HB 2938**. Women **DO** know what they are about to do, and the "Woman's Right to Know Act" would add nothing to improve the existing doctor/patient relationship

Risk of cancer of the breast after legal abortion during first trimester: a Swedish register study

Britt-Marie Lindefors Harris, Gunnar Eklund, Olav Meirik, Lars Erik Rutqvist, Kerstin Wiklund

Abstract

An increase in induced abortions in Sweden has been accompanied by an increase in the incidence of breast cancer of about 40% in women aged 20-44. To assess whether the apparent risk is real the risk of breast cancer was investigated in practically all Swedish women with a history of a legal abortion in the first trimester before the age of 30 during 1966-74 (n=49 000). The cohort was followed up in the Swedish cancer register to identify cases of breast cancer diagnosed more than five years after the abortion until the end of 1984. The number of observed cases of breast cancer was 65 compared with an expected number of 84·5, estimated from the contemporary Swedish population with due consideration to age, giving a relative risk of 0·8 (95% confidence interval 0·58 to 0·99).

Contrary to most earlier reports, this study did not indicate any overall increased risk of breast cancer after an induced abortion in the first trimester in young women.

Introduction

Many epidemiological studies have investigated the risk of cancer of the breast in women who have had one or more abortions.[1-21] Although the findings were not entirely consistent, most indicated increased risk.

Hypotheses regarding the possible association between abortions and an increased risk of breast cancer are based on the premise of incomplete differentiation of the cells in the glands of the breast during the first trimester. The changing concentrations of sex hormones during the second and third trimesters of pregnancy lead to increased differentiation of these cells. Interruption of a pregnancy during the first trimester causes an abrupt cessation of differentiation, which may result in a subsequent increase in the risk of breast cancer.[22-25] A causal association between abortions and increased risk is also supported by experiments on animals.[22 23 26 27]

The association is consistent with the observation that an increase in the number of induced abortions in Sweden (from about 2800 per year in 1960 to more than 30 000 in 1974,[28] without any major change in the number of fertile women during the same period) was accompanied by an increase in the incidence of breast cancer of about 40% from 1961 to 1981 in women aged 20-44.[29] An increased risk if it were real would be of great concern as nowadays many women have a legal abortion; in Sweden there are more than 30 000 legal abortions annually and about 40% of these women are nulliparous at the time of abortion.[28]

This study assessed the risk of breast cancer after abortion induced in the first trimester among women below 30 at that time.

Subjects and methods

Until 1975 legal abortion could be applied for in two ways in Sweden. Regardless of the method of application, all reports were stored in the archives of the National Board of Health and Welfare. Since January 1975, according to a new abortion law, there has been statistical but no individual registration of legal abortions.

For this study a computerised register was constructed from the 166 840 application reports during 1966-74. Applications before 1966 were excluded because too many reports were incomplete. To preserve integrity of the data the computerised information was limited to identification number, county code, and a serial number for reference to the original report. The identification number is unique to an individual person living in Sweden; it is composed of six digits based on date of birth, supplemented with a three digit serial number and a check digit and is not affected by changes in name or address.

A total of 34 909 reports (21% of all applications) did not have a complete identification number. By computerised linkage with countrywide population registers 26 911 records were identified. Finally, 158 842 records (95·2% of all applications) had a complete identification number: 92 969 applicants had been born after 1936 (referred to as the total cohort), of whom 9336 had applied more than once during 1966-74.

Study cohort—Women from the total cohort were included in the study cohort if they fulfilled three criteria: age below 30 at the time of abortion, abortion performed during the first trimester of gestation (that is, within 90 days after the last menstrual period), and Swedish citizenship. (Immigrants tend to leave the country more frequently than Swedes, and a subsequent diagnosis of breast cancer would not be reported in Sweden.) The information was abstracted manually from the original reports.

Index abortion—An abortion as defined in the inclusion criteria was called an index abortion. A woman was not included in the study cohort if she had not had an index abortion, unless she had another legal abortion later during 1966-74 as defined in the inclusion criteria, which thus became the index abortion. The present study was a case-cohort study, based on incidence of breast cancer from the general population statistics[30] and using the stratified ratio method.[30] So far there are no official data in Sweden about the incidence of breast cancer regarding parity.

The number of women in the study cohort had to be estimated (appendix) because manual searches of records of the total cohort were too expensive. The total cohort was divided into four strata according to year of birth and general incidence of cancer of the breast in the different age ranges (table I). The precision of the estimated values was increased by using separate sample fractions drawn from each stratum by computerised random sampling; searches were performed for every record in the samples. (The number of sampled records for each stratum was at least four times that of the rough number of cases of breast cancer in each stratum, to ensure that the random errors from the samples would be much less than those among the cases.)

Women years at risk—In calculating women years at risk allowance was made for an induction period for cancer of five years, the most common period of latency

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shown in research on breast cancer, giving a follow up period from the fifth year after the year of the index abortion to the end of follow up—that is, 31 December 1984. (All women in the study cohort were assumed to be alive at the end of follow up, and all were under 48 at the end of follow up.) To assess risk of breast cancer immediately after a legal abortion calculations were also performed with an induction period for cancer of one year.

Expected number of cases of breast cancer was calculated in each stratum, based on its annual incidence in Sweden with regard to age and calendar year (appendix). Information on diagnosed cases of breast cancer was obtained by computerised linkage of records with the Swedish Cancer Register. The completeness of the registration of cases of breast cancer in Sweden is estimated at 98·2%.[31]

Observed number of cases of breast cancer—The search was made for every woman in the total cohort who had breast cancer diagnosed after the index abortion; women who fulfilled the inclusion criteria in whom breast cancer was diagnosed at least five years after the abortion constituted the observed number of cases of breast cancer.

The ratio between the observed and the expected number of breast cancer cases constituted the relative risk. Different methods were used for estimating variances (appendix).

The maximum follow up periods for the study cohort were 6-8 years (33 000 women), 9-11 years (11 000), and 12-14 years (5000).

Of the study cohort, 41% of women were nulliparous at the time of the index abortion. The corresponding figure in the general population during the same period in the same age groups was 49%.

To study whether the risk of breast cancer increased during the first years after a full term pregnancy in young women the data were analysed for an induction period of one year. Some epidemiological studies have indicated that the risk of breast cancer depends on the total number of abortions or the number before first full term pregnancy, or both.[3,4,15] Because of small numbers 2940 (6%) of the study cohort and 603 (3%) of the nulliparas had had an induced abortion before the index abortion) further analyses of the number of abortions were not expected to increase the power of testing of the main hypothesis.

TABLE I—*Data on total cohort and strata according to year of birth*

	Stratum 1 (1937-42)	Stratum 2 (1943-6)	Stratum 3 (1947-50)	Stratum 4 (1951-60)	Total
o (%) of women in total cohort	7 788 (8)	20 735 (22)	26 525 (29)	37 921 (41)	92 969
stimated No (%) of eligible women in study cohort	2 400 (5)	10 800 (22)	12 600 (26)	23 200 (47)	49 000
ough No (%) of observed cases of breast cancer	43 (29)	60 (40)	32 (21)	14 (9)	149
o (%) of eligible observed cases of breast cancer	11 (17)	31 (48)	14 (22)	9 (14)	65
stimated No (%) of women years at risk	27 200 (7)	93 900 (24)	105 300 (26)	172 900 (43)	399 300
stimated No of expected cases of breast cancer	15·38	35·07	22·62	11·43	
stimated proportions of nulliparous women	0·18	0·28	0·52	0·91	
		Samples			
o of women in each sample	174	240	128	201	
o of eligible women in each sample	54	125	61	123	
xpected No of cases of breast cancer in each sample	0·3456	0·4072	0·1093	0·0606	

TABLE II—*Risk of developing cancer of the breast after legal abortion according to parity*

Parity at time of index abortion	Observed No of cases of breast cancer/ expected No of cases	Relative risk	95% Confidence interval	Estimated No of women years at risk
ulliparous	34/31·22	1·09	0·71 to 1·56	240 000
arous	31/53·29	0·58	0·38 to 0·84	160 000
ll	65/84·50	0·77	0·58 to 0·99	400 000

TABLE III—*Summary comparison of findings of studies on risk of breast cancer after abortion*

tudy	Relative risk	Significant	Induced abortion separately	Defined maximum length of pregnancy (months)
lber *et al*[1]	1	No	No	ND
alaoras *et al*[2]	>1	Yes	No	ND
in *et al*[3]	>1	Yes	No	4
owe and MacMahon[4]		No	No	ND
uasa and MacMahon[5]	>1	Yes	No	ND
avnihar *et al*[6]	<1	No	No	ND
tavraky and Emmons[7]	>1	No	No	ND
oini[8]	>1	Yes	No	ND
hoi *et al*[9]	>1	Yes	No	4
affenbarger *et al*[10]		No	No	ND
affenbarger *et al*[11]	<1	No	No	6
oti *et al*[12]	>1	No	No	ND
elsey *et al*[13]	>1	No	No	ND
ike *et al*[14]	>1	Yes	Yes	3
rinton *et al*[15]	>1	No	No	3
elmrich *et al*[16]	1	No	No	ND
irohata *et al*[17]	>1	No	Yes	ND
aVeccia *et al*[18]	1	No	Yes	ND
wertz and Duffy[19]	>1	Yes	Yes	3
osenberg *et al*[20]	>1	No	Yes	6
lowe *et al*[21]	>1	Yes	Yes	5
resent study	<1	Yes	Yes	3

Results

The observed number of cases of breast cancer among all women in the study cohort was 65 compared with an expected number of 84·5. The corresponding ralative risk was 0·77 (significant at $p<0·05$, table II). The lowest relative risk (0·58) was observed among the women who were parous at the time of the index abortion; the risk among women who were nulliparous (1·09) was significantly higher ($p<0·05$) (table II).

Analyses with an induction period for cancer of only one year showed 71 observed cases of breast cancer (36 in nulliparous women) and 93·57 expected cases (33·61 in nulliparous women), which gave almost the same point estimates of relative risk (nullipara 1·07, para 0·60, and overall 0·76) as an induction period of five years. Thus the present study suggested no major changes in the risk of breast cancer during the first years after an abortion in the first trimester compared with later.

Discussion

Table III summarises the differing results from earlier epidemiological studies. In all but one[21] a retrospective interview or questionnaire technique was used. In two the possibility of recall bias in what is a sensitive subject was discussed.[2,21]

Whether our observed difference in the risk of breast cancer between nulliparous and parous women may be attributed to the postponement of a first birth by the nulliparous women or to a differing effect of termination of an early pregnancy could not be determined from the data available as we did not have information about age in possible cases of a first birth after the index abortion, a variable reported to influence the risk of breast cancer in premenopausal women.[32-35]

The present study included only legally induced abortions—that is, interruption of a healthy pregnancy. Furthermore, the proportion of women in the Swedish population who had had spontaneous abortion, assuming the same age distribution as that of the study cohort at the time of the index abortion, was estimated at less than 0·1.[36] Women who had had an illegal abortion were not identifiable from the data. The incidence of illegal abortions in Sweden in the early 1960s was estimated at 2-4% of all recorded pregnancies.[36] In the mid-1960s improved contraception (with the introduction of the contraceptive pill and permitted use of intrauterine devices) combined with more liberal interpretations of the law regulating

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abortions considerably decreased the number of illegal abortions, as occurred in the United States.[37]

The general population statistics were based on all Swedish women, including the women in the study cohort. A possible contribution from this cohort to the general incidence of breast cancer would shift the relative risks in the present study towards unity. Our results, however, showed significantly decreased risks for women with 100% exposure to induced abortion.

The short follow up in the study is a limitation; only 5000 of the women in the study cohort were followed up for more than 11 years after the induction period. It would therefore be appropriate to perform a similar linkage with the cancer register and subsequent analysis in five, 10, or 20 years.

The design of this study differed from those of previous epidemiological studies on breast cancer in that it was based on a cohort; data were available from almost all (95·2%) Swedish women who applied for legal abortion during 1966-74; information regarding the abortions was reported from the hospitals at the time of the abortion, following mandatory requirements, and not from the women by interview; data on the incidence of breast cancer in the general Swedish population were obtained from the National Cancer Registry (whose completeness of registration of breast cancer in women has been estimated at 98·2%); and an induction period for cancer of five years was allowed. Most of the earlier epidemiological studies showed increased risk among women who had had an abortion; one reason for this could be recall bias. A woman with cancer is perhaps more likely to remember and report a previous abortion than a healthy control,[2 21] and as data in the case-control studies were collected by interview or questionnaires[1-20] recall bias may have influenced their results.

In the original records there was no information about confounding factors such as smoking and family history of cancer, and notes regarding taking of the contraceptive pill, education, and economics were incomplete. Marital state was given but was most probably changed for most of the young unmarried women. These confounding factors have not been considered in analyses of abortions in previous studies, with which our results were compared. If any of them, which increased the risk of breast cancer, were more common among women who have had induced abortion they would tend to change our results towards unity.

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Appendix

The number of women in the study cohort (N) was calculated from each stratum i according to the formula:

$$N = \Sigma N_i = \Sigma(M_i * n_i/m_i).$$

The expected number of breast cancer cases (E_i) was calculated in each stratum from the estimated number of women years at risk, with indirect standardisation and adjustment for age and calendar year according to the formula:

$$E_i = f_i * \Sigma e_{ik},$$

where $f_i = (M_i - C_i)/m_i$; k denotes the number of women sampled in the relevant stratum and ranges from 1 to n_i for stratum i; and e_{ik} is the cumulated expected individual incidence with due regard to age and calendar year.

Variances estimated by different methods—Observed numbers were assumed to follow a Poisson distribution. Expected numbers in each stratum were calculated according to Cochran[38]:

$$V(E_i) \approx N_i^2 * s_i^2 * (1 - m_i/N_i\, m_i,$$

where $s_i^2 = \{\Sigma(e_{ik}^2) - (\Sigma e_{ik})^2/m_i\}/(m_i - 1)$.

Σe_{ik} is the sum of expected numbers of the n_i cases in sample number i and $\Sigma(e_i^2)$ is the sum of squares of the expected values of the n_i cases.

Variance for relative risk was calculated using Ga ual ox- imation formulas[39] (presuming that observed (O) and expected (E) cases were not correlated):

$$V(O/E) \approx V(O)/E^2 + V(E) * O^2/E^4,$$

where $V(\Sigma E_i) = \Sigma V(E_i)$.

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ACOG statement on links between induced abortion and subsequent breast cancer

In response to concerns voiced by patients and Fellows over perceived links between abortion and breast cancer, ACOG's Committee on Gynecologic Practice conducted an extensive review of the pertinent scientific literature. In the course of this research, the Committee became aware that the California Medical Association (CMA) had convened a task force to perform a similar review and that a statement had been issued. As the Committee's conclusions paralleled those of the CMA, a decision was made to adapt it as follows:

Recently questions have surfaced about the potential relationship between induced abortions and subsequent development of breast cancer. As a result, the Committee on Gynecologic Practice reviewed the published literature on this topic and found the evidence to be inconclusive. Some studies reported an adverse effect, some no effect, and some a positive effect. Many of the case-control studies had methodological problems, including probable selection bias in choosing control groups, failure to discriminate spontaneous from induced abortions, grouping pre-and post-menopausal women, and failure to incorporate multivariant analysis to measure the impact of potential confounders. Differential recall of prior abortions between cases and controls is also likely. In a study from Sweden, where comprehensive follow-up data are available, statistically significant recall bias was documented among controls. This recall bias led to a spurious association between induced abortion and breast cancer in the Swedish report.

It is the opinion of the Committee on Gynecologic Practice that evidence* is insufficient to support claims that induced abortion has an effect on the later development of breast cancer.

Adapted from California Medical Association Policy Statement approved by the CMA Board of Trustees on May 13, 1995.

*Level II-2 evidence to support a class C clinical recommendation using the classification of the U.S. Preventive Services Task Force.

Pregnancy Termination in Relation to Risk of Breast Cancer

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Objective.—To evaluate the association between pregnancy terminations and risk of breast cancer.

Design and Setting.—Population-based case-control study in Wisconsin, Massachusetts, Maine, and New Hampshire.

Study Participants.—Cases were women younger than 75 years with a new diagnosis of breast cancer (n=6888), identified from statewide tumor registries. Controls younger than 65 years (n=9529) were randomly selected from lists of licensed drivers, or for older subjects, from lists of Medicare beneficiaries.

Exposures and Outcomes.—Breast cancer risk in relation to spontaneous or induced abortions.

Results.—After adjustment for parity, age at first birth, and other risk factors, pregnancy termination (induced or spontaneous) was associated with a relative risk (RR) of breast cancer of 1.12 (95% confidence interval [CI], 1.04 to 1.21), compared with the risk among women who had never had a termination. Induced terminations were associated with a RR of 1.23 (95% CI, 1.00 to 1.51), which was somewhat greater than the risk associated with spontaneous terminations (RR, 1.11; 95% CI, 1.02 to 1.20). The association with induced abortions was stronger for those performed before legalization of abortion in 1973 (RR, 1.35; 95% CI, 1.01 to 1.80) than after this time (RR, 1.12; 95% CI, 0.84 to 1.49), suggesting a bias in reporting this sensitive procedure.

Conclusions.—A weak positive association was observed between abortion—whether induced or spontaneous—and risk of breast cancer. The increase in risk of breast cancer was somewhat greater among women with a history of induced terminations. However, this association may be due to reporting bias and was not significantly different than the slight risk for spontaneous terminations.

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A FULL-TERM pregnancy, particularly at an early age, reduces breast cancer risk.[1] However, the relation of pregnancies lasting less than full term to risk of breast cancer has been less consistent in epidemiologic studies. Whether induced or spontaneous abortions are considered separately or in combination, some studies have reported a positive association.[2-8]

For editorial comment see p 321.

The increase in risk appeared largely limited to certain subgroups, such as women with pregnancies terminated before the first birth or in young women. In most other investigations,[9-17] including, notably, several large cohort studies,[18-21] no increase in risk was seen. Whether induced terminations—legally available in the United States for more than 20 years—are associated with breast cancer risk is a particularly important public health concern. We examined the relationship of both induced and spontaneous abortions and the risk of breast cancer in a large population-based study.

METHODS

Identification of Cases

All female residents of Wisconsin, western Massachusetts, Maine, and New Hampshire with a new diagnosis of breast cancer and who were younger than 75 years were eligible for this study. Cases were identified by each state's cancer registry during the period April 1988 through December 1991, except for New Hampshire where subjects were enrolled beginning in January 1990. From each state registry, information was available on cancer site, histologic diagnosis, extent of disease, demographics, and follow-up physician. According to an institutionally approved protocol, the physician of record for each eligible case was contacted by mail to obtain permission to approach the subject. Eligibility was limited to cases with listed telephone numbers, driver's licenses verified by self-report (if <65 years), and known dates of diagnosis. Of the 8532 eligible cases, physicians refused contact for 710 cases (8.3%), 463 (5.4%) were deceased, 66 (0.8%) could not be located, and 405 (4.7%) refused to participate.[22] Thus, data for 6888 women were available for analysis, with an overall response rate of 80.7%. The case response rates were highest in New Hampshire (84%) and lowest in Maine (76%). The majority of cases (55%) were from Wisconsin, 27% from Massachusetts, 10% from Maine, and 8% from New Hampshire. Of these cases, 98% had histologic confirmation of invasive breast carcinoma.

Identification of Controls

In each state, community controls were randomly selected from two sampling frames: those younger than 65 years were selected from a list of licensed drivers, and controls aged 65 to 74 years were selected from a roster of Medicare beneficiaries compiled by the Health Care Financing Administration. Computer files of potential controls were obtained annually. The controls were selected at random to have an age distribution similar to that of the cases: 7% younger than 40 years, 19% aged 40 to 44 years, 21% aged

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50 to 59 years, 35% aged 60 to 69 years, and 18% aged 70 to 74 years. This age distribution did not differ among states. Controls had no previous diagnosis of breast cancer and met the same eligibility criterion as cases of having a listed telephone number. Of the 11 329 potential controls, 126 (1.1%) were deceased, 153 (1.4%) could not be located, and 1521 (13.4%) refused to participate. The overall control response rate was 84.2%, and response rates by state were highest in Wisconsin (90%) and lowest in Massachusetts (80%).

Data Collection

Professional staff who received ongoing training interviewed participants using an identical protocol in all states. The study was introduced first by letter and then by telephone as a study of health in women; cancer was not mentioned in this invitation. The 25-minute telephone interview elicited information on reproductive experience, including, for each pregnancy, its outcome and the dates of termination. For each pregnancy lasting less than 6 months, subjects were asked whether it was a miscarriage (including ectopic pregnancy) or an induced abortion. The interview also covered lactation history, exogenous hormone use, physical activity, history of alcohol use, selected dietary items, height and weight, medical history, and demographic factors. Information about the women's personal histories and family histories of breast cancer was obtained at the end of the interview to maintain blinding. The interviewers were unaware of the status of the women as case or control until the end of the interview for 78% of cases and 90% of controls.

Analyses

Only exposure status before an assigned reference date was used in this analysis. For cases, this was the date of breast cancer diagnosis. For comparability, control subjects were assigned a reference date corresponding to the average time from diagnosis to interview for the case group in each state (range, 8 to 21 months). Any pregnancy lasting less than 6 months was considered to be an abortion.[23] Age at first pregnancy termination was the subject's age at the time of the first reported termination of a pregnancy at less than 6 months. Age was defined as the age at diagnosis or reference date. Parity was the number of full-term pregnancies (defined as pregnancy lasting more than 6 months resulting in live birth or stillbirth). Menopausal status was defined as postmenopausal if the subject reported a natural menopause or a bilateral oophorectomy before diagnosis or reference date. Women reporting hysterectomy alone were classified as postmenopausal if the age at reference was at least the 90th percentile of age at natural menopause for the control group (54 years for smokers and 55 years for nonsmokers). Menopausal status was considered to be unknown for women reporting hysterectomy without bilateral oophorectomy if the age at reference was between 42 and 54 years (or 55 years for nonsmokers).

Odds ratios and 95% confidence intervals (CIs) obtained from logistic regression models were used to evaluate relative risks (RRs). Conditional models stratified on age (to approximately 0.10-year intervals) and study site were used to accommodate any case-control age differences in each study state.[24] We also adjusted all analyses for the following potential confounders, shown in Table 1, unless indicated otherwise: age, state, education (no high school, some high school, high school graduate, or beyond high school), parity (nulliparous, parous, or unknown), age at menarche (continuous or unknown), age at first delivery (continuous among parous women), menopausal status (premenopausal, postmenopausal, or unknown), age at menopause (continuous among postmenopausal women), personal history of surgically confirmed benign breast disease (present, absent, or unknown), family history of breast cancer among first-degree relatives (present, absent, or unknown), body mass index (continuous among premenopausal women, continuous among postmenopausal women, continuous among women with unknown menopausal status, or unknown), and average weekly alcohol intake (continuous or unknown). We excluded from analysis eight cases and eight controls who did not know if they had been pregnant and 66 cases and 50 controls who did not know whether the less than full-term pregnancy ended before (abortion) or after (stillbirth) 6 months. We also excluded 407 women (164 cases and 243 controls) who could not provide a minimally complete history of termination, namely, the type of all terminations and their age at the first spontaneous and/or induced termination. After all exclusions, 6650 cases and 9227 controls were available for analysis.

Table 1.—Age-Standardized Percentages of Women With Breast Cancer and Controls*

Risk Factor	Cases (n=6888)	Controls (n=9529)
Age at menarche, y		
≤10	5.0	4.9
11	13.0	12.3
12	22.5	21.3
13	28.7	28.1
14	16.8	17.6
≥15	12.5	14.3
Age at first full-term pregnancy, y†		
≤17	3.7	3.6
18-19	11.3	12.7
20-24	45.9	48.4
25-29	27.8	25.7
≥30	11.2	9.6
Parity		
0	13.7	12.3
1	11.2	10.2
2	26.9	25.4
≥3	47.2	50.9
Family history of breast cancer		
Yes	17.9	11.5
No	79.4	86.5
Unknown	2.7	2.0
Body mass index, quartile group (kg/m²)		
1 (12.95-21.39)	21.1	22.6
2 (21.40-23.50)	19.3	20.8
3 (23.51-26.56)	23.3	23.1
4 (26.57-91.45)	35.0	32.3
Benign breast disease		
Yes	15.3	12.1
No	82.5	86.6
Unknown	2.2	1.3
Menopausal status		
Premenopausal	23.5	23.5
Postmenopausal	67.4	67.2
Unknown	9.1	9.3
Age at menopause, y‡		
≤44	16.8	21.8
45-49	23.8	23.3
50-54	38.0	33.9
≥55	12.1	11.6
Method periods stopped§		
Natural causes	65.2	64.4
Surgery	31.7	34.1
Ovaries retained	14.7	17.5
Ovaries removed	15.7	15.4
Alcohol intake		
Never	19.3	21.9
<2 Drinks/d	44.0	45.2
≥2 Drinks/d	34.2	30.2

*Percentage totals less than 100% are due to unknown values.
†Parous women only.
‡Postmenopausal women only.
§Among postmenopausal women and women with unknown menopausal status.

RESULTS

Early termination of pregnancy was relatively common among cases (n=1810, 27.2%) and controls (n=2378, 25.5%). The vast majority of abortions reported by cases (96.5%) and controls (97.2%) were spontaneous rather than induced.

Compared with all women who had never had a termination, the estimated RR for women reporting a history of either spontaneous or induced abortion was 1.12 (95% CI, 1.04 to 1.21) (Table 2). Compared with nulliparous women without an abortion history, the RR in parous women with a history of abortion was 0.95 (95% CI, 0.82 to 1.11). Parity did not modify the association between termination history and breast cancer risk (P for interaction=.62). These RR estimates differed only slightly from estimates obtained after adjustment only for age and state, suggesting that confounding was unlikely to have introduced substantial bias. Inclusion of the 407 excluded subjects did not alter the risk associated with a history of early termination.

A history of spontaneous abortion was associated with a significant but small increase in risk of breast cancer (adjusted RR, 1.11; 95% CI, 1.02 to 1.20) (Table 3). Similarly, a history of induced abortion was associated with a modest increase in risk of breast cancer (RR, 1.23; 95% CI,

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ble 2.—Relative Risk (RR) of Breast Cancer According to History of Pregnancy Termination and Parity*

Termination	No. of Cases	No. of Controls	Unadjusted† RR (95% CI)	Adjusted‡ RR (95% CI)	Unadjusted† RR (95% CI)	Adj. ‡ RR (95% CI)
All women						
No	4840	6849	1.00	1.00	. . .	. . .
Yes	1810	2378	1.09 (1.01-1.17)	1.12 (1.04-1.21)	. . .	. . .
Nulliparous women						
No	796	1050	1.00	1.00	. . .	. . .
Yes	137	150	1.22 (0.94-1.59)	1.20 (0.92-1.57)	. . .	. . .
Parous women						
No	4009	5744	0.86 (0.77-0.95)	0.85 (0.74-0.98)	1.00	1.00
Yes	1665	2213	0.94 (0.84-1.06)	0.95 (0.82-1.11)	1.10 (1.02-1.19)	1.12 (1.03-1.21)

*CI indicates confidence interval.
†Adjusted for age and state.
‡Adjusted also for education (no high school, some high school, high school graduate, or beyond high school), parity (nulliparous, parous, or unknown), age at menarche (continuous or unknown), age at first delivery (continuous among parous women), menopausal status (premenopausal, postmenopausal, or unknown), age at menopause (continuous among postmenopausal women), personal history of benign breast disease (present, absent, or unknown), family history of breast cancer among first-degree relatives (present, absent, or unknown), body mass index (continuous among premenopausal women and postmenopausal women), and average alcohol intake (continuous or unknown).

1.00 to 1.51). There was little statistical difference in risk according to abortion type (P for interaction=.35). The association with induced abortions was stronger for those performed before legalization in 1973 (RR, 1.35; 95% CI, 1.01 to 1.80), than after that time (RR, 1.12; 95% CI, 0.84 to 1.49), suggesting bias in reporting this sensitive procedure.

Neither age at first spontaneous abortion (P for interaction=.88) nor the age at first induced abortion (P for interaction=.78) modified the association with breast cancer risk (Table 4). Similarly, abortions before first full-term pregnancy appeared to be associated with similar increases in risk as spontaneous (P for interaction=.70) and induced (P for interaction=.42) abortions after first full-term pregnancy. However, there was a suggestion that increasing age at diagnosis was associated with an increase in the risk associated with a history of induced abortion (Table 5).

Finally, we evaluated the risk associated with total number of abortions. When evaluated continuously, neither increasing number of spontaneous abortions (P for interaction=.54) nor increasing number of induced abortions after the first (P for interaction=.91) was associated with breast cancer risk.

Table 3.—Relative Risk (RR) of Breast Cancer According to Type of Pregnancy Termination*

Type of Termination	No. of Cases	No. of Controls	Adjusted† RR (95% CI)
Spontaneous‡			
No	4994	7058	1.00
Yes	1656	2169	1.11 (1.02-1.20)
Induced§			
No	6454	8967	1.00
Yes	196	260	1.23 (1.00-1.51)
Induced before 1973‖			
No	6548	9120	1.00
Yes	102	107	1.35 (1.01-1.80)
Induced after 1973¶			
No	6556	9074	1.00
Yes	94	153	1.12 (0.84-1.49)

*CI indicates confidence interval.
†Adjusted for age, state, education, parity, age at menarche, age at first delivery, menopausal status, age at menopause, personal history of benign breast disease, family history of breast cancer, body mass index, and average alcohol intake.
‡Adjusted also for history of induced termination.
§Adjusted also for history of spontaneous termination.
‖Adjusted also for history of spontaneous termination and induced termination after 1973.
¶Adjusted also for history of spontaneous termination and induced termination before 1973.

COMMENT

In summary, these population-based data suggest that a history of any pregnancy termination may be associated with a slightly increased risk of breast cancer. However, these results do not support a major role of induced abortion in breast cancer incidence. We did not find that this overall modest association for either spontaneous or induced abortions was modified by other factors, unlike studies that have shown risk to be greater in women reporting abortions at a younger age[4] or before a first birth.[2,6]

While a few studies have reported more substantial elevations among subgroups of women following induced abortions, eg, as much as 2.5 among women with an induced abortion before age 18 years,[6] in most studies reporting statistically significant increases, the elevations in risk were modest.

Of the recent case-control evaluations, a few have reported positive associations with either induced abortions[4-7] or both spontaneous and induced abortions combined.[8] In contrast, in most other case-control studies, no or negative relationships were observed.[9-17] Prospective studies—which are not susceptible to recall bias—have generally not found an increase in risk of breast cancer among women reporting induced or spontaneous abortion.[18-21] Two of these studies suggested a decreased risk for induced abortions[19] and induced and spontaneous abortions combined.[18] The large size of these studies, the use of registry records, and generally long follow-up all contribute to the validity of the results.

It is unclear from most of these studies whether the relationship between abortion and breast cancer risk differs in women reporting induced or spontaneous terminations. In each study evaluating both induced and spontaneous abortions, the CIs overlapped.[3-6,11,14,15,17] Based on the results of our study, the modest increase in breast cancer risk appears unrelated to type of abortion.

An explanation for our results that must be considered is bias in the ascertainment of induced abortions. Although induced abortion has been legal in the United States since 1973, the procedure continues to be sensitive for a variety of reasons, with underreporting common.[25-27] A biased association in a case-control evaluation is plausible, because women with breast cancer typically are likely to comply with medical research directed at understanding their illness, whereas healthier control women have less compelling reasons to participate and provide information about a procedure that can be extremely sensitive.[28] This study was designed to minimize such sources of bias by conducting the study in an area where participation rates would be high, using population-based sampling lists for control selection, and mailing an introductory letter to participants to establish the credibility of the research before contact-

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Table 4.—Relative Risk (RR) of Breast Cancer According to Termination History and Age at First Termination

	Type of Pregnancy Termination								
	Spontaneous			Induced†			Induced After 1973†		
Age at First Termination	No. of Cases	No. of Controls	RR (95% CI)*	No. of Cases	No. of Controls	RR (95% CI)*	No. of Cases	No. of Controls	RR (95% CI)*
Never	4994	7058	1.00	6464	8967	1.00	6556	9074	1.00
≤20 y	87	170	0.86 (0.65-1.13)	22	45	0.98 (0.56-1.70)	8	23	0.89 (0.37-2.16)
20-24 y	502	685	1.13 (0.99-1.28)	53	74	1.27 (0.86-1.87)	17	38	1.06 (0.55-2.02)
25-29 y	550	688	1.13 (1.00-1.28)	43	48	1.45 (0.93-2.24)	19	31	1.16 (0.63-2.13)
30-34 y	317	344	1.29 (1.09-1.52)	40	50	1.06 (0.69-1.64)	21	32	0.89 (0.50-1.57)
≥35 y	200	282	0.91 (0.75-1.10)	38	43	1.35 (0.86-2.13)	29	29	1.48 (0.86-2.54)
P trend‡			.97			.67			.42

*Adjusted for age, state, education, parity, age at menarche, age at first delivery, menopausal status, age at menopause, personal history of benign breast disease, family history of breast cancer, body mass index, and average alcohol intake. CI indicates confidence interval.
†Adjusted also for history of spontaneous termination.
‡Evaluated ordinally among women with a history of termination.

Table 5.—Relative Risk (RR) of Breast Cancer According to Termination History and Age at Diagnosis

	Type of Pregnancy Termination								
	Spontaneous			Induced†			Induced After 1973†		
Age at Diagnosis (or Reference)	No. of Cases	No. of Controls	RR (95% CI)*	No. of Cases	No. of Controls	RR (95% CI)*	No. of Cases	No. of Controls	RR (95% CI)*
<40 y									
No	380	868	1.00	423	974	1.00	431	986	1.00
Yes	94	209	1.11 (0.82-1.49)	51	103	1.11 (0.75-1.63)	43	91	1.04 (0.68-1.57)
40-49 y									
No	928	1373	1.00	1164	1698	1.00	1196	1742	1.00
Yes	311	423	1.10 (0.92-1.31)	75	98	1.07 (0.78-1.48)	43	54	1.17 (0.77-1.78)
50-59 y									
No	1038	1488	1.00	1390	1995	1.00	3516	4327	1.00
Yes	383	538	1.04 (0.89-1.22)	31	31	1.39 (0.82-2.34)	8	8§	1.28 (0.46-3.53)
60-69 y									
No	1735	2377	1.00	2311	3121	1.00	...	...	...
Yes	602	765	1.11 (0.98-1.26)	26	21	1.77 (0.97-3.22)	...	...	...
≥70 y									
No	913	952	1.00	1166	1179	1.00	...	...	...
Yes	266	234	1.24 (1.00-1.52)	13	7	2.02 (0.77-5.30)	...	...	...
P trend‡			.46			.09			.63

*Adjusted for age, state, education, parity, age at menarche, age at first delivery, menopausal status, age at menopause, personal history of benign breast disease, family history of breast cancer, body mass index, and average alcohol intake. CI indicates confidence interval.
†Adjusted also for history of spontaneous termination.
‡Evaluated ordinally among women with a history of termination.
§Includes one control in age range of 60 to 69 years.

ing them. Such efforts did indeed yield high participation rates. Nonetheless, a small residual degree of reporting bias that would tend to exaggerate a positive association with induced abortion seems almost inevitable in this study design. Evidence from a Swedish study comparing registry reports of induced abortions with interview data confirms the underreporting of induced abortions among healthy controls compared with newly diagnosed breast cancer cases.[29] Based on the results of this evaluation, an observed increase in risk of up to 50% could be obtained through the use of interview data. Daling et al[6] argue that the spurious increase might be only as great as 16%—similar to differences we observed between RRs associated with spontaneous and induced abortion. We considered whether self-reports of abortions in our study were constrained—perhaps more so by controls than cases—by the illegal status of induced abortions before 1973. We found that the RR for the period before 1973 was higher (RR, 1.35; 95% CI, 1.01 to 1.80) than the subsequent period (RR, 1.12; 95% CI, 0.84 to 1.49), suggesting that cases were more likely to report this exposure than controls in the presence of social and legal constraints. Because older women are more likely to have had induced abortions before 1973, the suggestion of an effect of age on the association between breast cancer risk and history of induced abortion is consistent with reporting bias.

Other biases are unlikely to account for these findings. Selection bias in the choice of our cases and controls was minimized by selecting subjects from the same sampling frames (state residents with listed phone numbers and driver's licenses or Medicare cards) and by high participation rates. Interviewers were successfully blinded to the subjects' disease status, reducing the likelihood of information bias. Since we adjusted for established risk factors in multivariate models, it is also unlikely that confounding from these factors accounts for our results. Although we were unable to validate abortion history, we did assess the reliability of self-reports in a reinterview study.[30] Reassuringly, the Spearman correlation was 0.93 for abortion history reported in the two interviews. Finally, although this was a large study, statistical power was nonetheless limited in some subgroup evaluations and, most notably, the subset analyses of induced terminations. Our study group included women aged 20 to 74 years from several locales, most of whom completed childbearing before legalizaton of abortion. Other studies of this topic have included a more limited age range where the prevalence of induced abortion was higher.

A number of mechanisms have been

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roposed to explain an association between pregnancy termination and breast cancer risk.[35,36] Although the long-term effect of full-term pregnancy is a reduction in breast cancer risk,[1] full-term pregnancy may be associated with a transient increase in risk.[35,36] This effect is possibly due to incomplete differentiation of mammary glands during the first trimester[37] or to early hormonal changes.[38,39] While it is not clear that the mammary changes associated with pregnancy termination would differ between spontaneous and induced abortion, the pregnancy length and the hormonal milieu may indeed be dissimilar. Compared with spontaneous abortion, the duration of pregnancies electively terminated has decreased since 1972, with the majority now performed at less than 8 weeks' gestation.[40] If longer gestation is associated with greater mammary cell proliferation, induced terminations in past decades might be associated with greater risk. (We were unable to evaluate gestation length in our study.) In addition, compared with spontaneous abortion, the hormone levels of women undergoing induced termination reflect normal pregnancy, then fall precipitously.[41] Pregnancies that ultimately spontaneously abort may have lower levels of estrogen, progesterone, and human chorionic gonadotropin.[42,43] Hormone levels likely drop further before the expulsion of the fetus. Thus, the type of termination could possibly influence risk, although temporal changes in pregnancy detection and in abortion practice might attenuate these differences.

In these data, a weak positive association was seen between abortion—whether induced or spontaneous—and risk of breast cancer. The stronger association for induced abortion that was observed when it was illegal argues in support of some degree of reporting bias, [illegible]en a slight degree of bias would ex[illegible]he small association with later-induced abortions. Although our retrospective information on spontaneous termination was unlikely to suffer from bias, studies that do not rely on interviews with cases and controls will be needed to resolve this issue adequately. In the meantime, our data suggest that the risk of breast cancer associated with any pregnancy termination is likely to be small, if it exists at all.

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Abortion and the Risk of Breast Cancer

Is There a Believable Association?

The data presented by Newcomb and colleagues[1] in this issue of *JAMA* add one more valuable piece to a scientifically complex and politically charged jigsaw puzzle, the issue of breast cancer risk and abortion. To date, the epidemiologic evidence on this issue remains inconsistent.[2] Despite some highly publicized studies that support a significant positive association between induced abortion and breast cancer, primarily among inconsistently identified subgroups of women—such as women younger than 33 years with an abortion before a first birth,[3] nulliparous women,[4] women older than 50 years,[5] gravid women with an early or late age at first abortion,[6] women younger than age 40 years,[6,7] or among those with a family history of breast cancer[8]—many studies do not.[9-18] While there is an apparently consistent observation of a modest 10% to 50% elevation in risk in relation to a history of induced abortion,[1,6,8-12,16,17] these estimates have generally not been found to be statistically significant and are subject to conflicting interpretation.

See also p 283.

The slight increase in risk observed in some studies may or may not reflect a real association between induced abortion and breast cancer, given the many limitations of the published investigations. Issues that cloud interpretation include recall bias, choice of the referent group, limited power to evaluate the possibility of age-specific effects, and an inability to confirm the reports of possible subgroups of high-risk women. Recent studies, including that reported by Newcomb et al,[1] provide critical insight into each of these issues.

Perhaps the most important concern is the difficulty in obtaining, especially from control subjects, accurate recall of an event that was illegal in the United States before 1973, and has gained increasingly violent public attention since that time, casting considerable doubt on whether even recent abortions are accurately reported.[19] Newcomb et al[1] report an overall modest 23% increase in risk reflecting a 35% increase among women reporting an induced abortion before 1973, but only a 12% increase among those reporting an induced abortion after that date. Although this difference in risks is not statistically significant, the modest heterogeneity underscores the difficulty in obtaining accurate recall, especially among controls.

The data presented by Newcomb et al[1] do not clarify whether differential recall can partially explain the modestly elevated risks noted among younger women reporting legal induced abortions or among those reporting spontaneous abortions. Other studies have shed some light on this issue.[19-21] Some 40% to 75% of induced abortions[19] and at least 25% of spontaneous abortions[20] are estimated to be unreported. If cases and controls were equally likely to underreport a history of abortion, this nondifferential misclassification could conceal a true relationship of small magnitude. However, if controls underreport their abortion history more frequently than cases, as would be expected, this more probable bias of differential recall could result in a spuriously high estimate of the relative risk.[21] Even a 5% difference in recall between cases and controls would be enough to account for the estimated 11% increase in risk for spontaneous abortion and the 12% increase for induced abortion after 1973 observed by Newcomb et al.[1]

Although this problem of underreporting may not be alleviated entirely in the study by Newcomb et al,[1] it may be minimized because of their use of telephone interviews. In several studies on reporting of the socially sensitive behavior of alcohol use, the anonymity of a telephone interview or a self-administered questionnaire has emerged as preferable to a face-to-face interview.[22-24] In a recent study in which women had a face-to-face interview and a self-administered questionnaire immediately afterward, twice as many women reported a prior induced abortion on the self-administered questionnaire as in face-to-face interviews.[19] This difference could reflect interviewer and study subject rapport that developed by the end of the interview. However, coupled with the findings on alcohol use, these results may indicate the need for a more anonymous method to obtain sensitive information. Thus, although the use of visual memory aids in a face-to-face interview has been documented as improving recall for other reproductive events,[25] use of a telephone interview may be more effective in eliciting information on pregnancy termination.

A second issue is the choice of the referent group,[26] which affects the direction and the magnitude of the relative risk. Newcomb et al[1] and others[17,27] present results comparing abortion among breast cancer cases and controls using two different referent groups: (1) nulliparous women without a history of abortion or (2) parous women without a history of abortion. In the study by Newcomb et al,[1] parous women with a history of an induced abortion had a relative risk for breast cancer of 0.95 when compared with *nulliparous* women without a history of an abortion, but 1.12 when compared with *parous* women without a history of abortion. The latter comparison is consistent with conventional etiologic analyses; women are partitioned into two subgroups to permit formal evaluation of whether risk varies with parity. However, the use of nulliparous women without a history of induced abortion (in other words, women who lack the protective effects of a live birth) as a referent may be instructive[26]; it illustrates the effects of terminating a pregnancy in context with other reproductive choices. Others have not presented analyses using this alternative referent, limiting our ability to make comparisons across studies.

From the Divisions of Epidemiology (Dr Gammon and Ms Terry) and Population and Family Health (Ms Bertin), Columbia University School of Public Health, New York, NY.

Reprints not available.

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e third issue is the possibility of differences in effects across age groups.[26] Most studies, however, have a limited age range or lack a sample of sufficient size to address this issue adequately. Michels and colleagues[27] recently noted that the risk for breast cancer in relation to induced and spontaneous abortions combined was stronger among younger women than it was for older women. This finding suggests that, if interrupted pregnancy has an adverse effect, it may have a transient effect that weakens with age,[26] as parity does.[28] Alternatively, heterogeneity in age-specific results could merely reflect changes in recall bias due to differences in the availability of legalized abortion during a woman's reproductive years.[26] Newcomb et al[1] observe a nonsignificant increase in risk with increasing age that is more consistent with the possibility of differential recall.

The fourth concern is the inability of other investigations to confirm the findings of any one previous study that identified a subgroup of women who may have a particularly high risk. A chronic problem associated with subgroup analyses in epidemiologic studies is that they involve only small numbers of subjects, limiting the stability and repeatability of the results. For example, Daling and colleagues[6] reported a pronounced J-shaped curve with an increase in risk associated with an induced abortion occurring before age 18 or after age 35 years. Newcomb et al[1] and others[12] have not observed such a trend. Thus, efforts to replicate identification of subgroups of women who may be at a higher risk[3-6] usually have been unsuccessful, casting doubt on the original observations.

Notwithstanding the limited and inconclusive evidence just reviewed, appropriate caution and restraint are sometimes lacking in the public discussion of scientific findings about abortion. As of the date we write, bills addressing the possibility of a link between abortion and breast cancer have been introduced in approximately 10 states. Such proposals often appear in bills called "Woman's Right to Know" acts and commonly would require warnings about this risk when "medically accurate," although it is unclear how that would be determined. Some proposals would require women to be informed of a "possible" or "potential" increased risk of breast cancer from induced abortion; others would direct the state to study the issue. An effort in one state to require that women be warned, at least 10 days before an abortion, that abortion doubles the risk of breast cancer was unsuccessful, as were proposals in other states to limit the ability of minors to consent to a "substantial cancer risk" and to post warning signs in clinics. The fate of bills has varied from state to state. Some are still pending, and new bills will likely be introduced. The Woman's Right to Know Act recently passed in Montana was preliminarily enjoined on November 28, 1995, subject to further legal proceedings.

At present, legislative efforts appear premature, in light of the information currently available. Full disclosure would require explanation of the inconsistent state of the research, the methodological limitations that cloud interpretation of the research, the possibility that positive findings could be real or artifactual, and the fact that most positive studies identify only a slight risk—less than or equivalent to the increased breast cancer risk associated with marital status, place of residence, or religion.[29] Further research may clarify whether an association between abortion and breast cancer exists. This process may be impeded by concerns that investigators (and journals) will lose control over their findings, and that positive studies will garner more attention t negative, but equally meaningful, ones. Resolution of the question is likely to be promoted by lively and vigorous scientific debate of the full range of issues and considerations.

In summary, publication of the study by Newcomb et al[1] highlights the difficulty of obtaining accurate recall of abortion, as well as the many inconsistencies observed across the numerous epidemiologic studies that have been published to date, probably due to the widely varying methods used. Although many investigators appreciate the complexity of the abortion–breast cancer issue and the methodological obstacles that prohibit a consensus at this time, the consequences of misinterpreting this limited information are already clear.

Marilie D. Gammon, PhD
Joan E. Bertin, JD
Mary Beth Terry, MA

We thank W. Douglas Thompson, PhD, and Judith Jacobson, PhD, for their valuable comments on earlier drafts of this Editorial.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
National Cancer Institute
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NATIONAL CANCER INSTITUTE FACT SHEET

February 13, 1996

Risk of Breast Cancer Associated With Abortion

A public information campaign is currently stating that women who have had an induced abortion are more likely to develop breast cancer and to suffer a deadlier form of the disease. In fact, these statements misrepresent the information in the scientific literature. Three recent reviews published in scientific journals have assessed more than 30 studies and concluded that the available data on the relationship between induced abortions or spontaneous abortions (miscarriages) and breast cancer are inconsistent and inconclusive. Some studies indicate small elevations in risk, while others show no risk associated with either induced or spontaneous abortions. No study could be found that directly links induced abortion with a deadlier form of breast cancer. In addition, the scientific rationale for an association between abortion and breast cancer is based on limited experimental data in rats, and is not consistent with human data. There is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion.

Studies that have attempted to evaluate the association between abortion and breast cancer have been limited by small numbers of study subjects, inappropriate comparison groups, inability to separate induced abortions and spontaneous abortions, and incomplete knowledge of other potentially pertinent lifestyle factors. Perhaps the most serious potential weakness relates to the inaccuracy of reporting of abortions in retrospect. Indeed, results from a study that examined the accuracy of reporting abortions, indicate that women *with* breast cancer are more likely to accurately report having had an abortion than women *without* breast cancer, possibly leading to a false association between abortion and breast cancer.

An article published on November 2, 1994 by Daling and others in the Journal of the National Cancer Institute illustrates the difficulty of drawing conclusions. Daling studied the relationship between breast cancer and abortion for young women. The results, based on self-reports of abortions, indicate that induced abortion was associated with 1.5 times the average risk of developing breast cancer. In epidemiologic terms, this increase in risk is considered relatively small compared with the 10 to 20-fold increase in risk for lung cancer among smokers. More important, some inconsistencies in the findings of the Daling study were puzzling, as risk did not vary consistently with number of abortions, woman's age at abortion or length of pregnancy, nor did the study show an increase in risk associated with spontaneous abortions. An accompanying commentary by Rosenberg, in the same journal, concluded that "While the findings of Daling et al. add to the limited evidence that induced abortion increases the risk of breast cancer, neither a coherent body of knowledge nor a convincing biologic mechanism has been established." At the time of publication, the National Cancer Institute also released a press statement regarding the article, concluding that "Taken together, the inconsistencies and scarcity of existing research do not permit scientific conclusions."

In the January 24, 1996 issue of the Journal of the American Medical Association, a report by Newcomb and others showed induced abortions associated with a slight elevation in the risk of developing breast cancer. This article indicated an increased risk amounting to about 1.25 times

average risk. Here too, the results cannot be considered strong evidence of a cause-and-effect relationship. The authors themselves state that "...our data suggest that the risk of breast cancer associated with any pregnancy termination is likely to be small, if it exists at all." This article was also accompanied by a commentary that discussed the problems in interpreting data relating to the effects of induced abortion. The commentary concluded that "Although many investigators appreciate the complexity of the abortion-breast cancer issue and the methodological obstacles that prohibit a consensus at this time, the consequences of misinterpreting this limited information are already clear."

In summary, as stated above, there is no evidence of a direct relationship between breast cancer and either induced or spontaneous abortion. The available studies do not permit definite conclusions about the relationship between breast cancer and either spontaneous or induced abortions.

The risk of breast cancer increases with age, from about 1 in 2,525 for a woman in her thirties to about 1 in 11 for a woman during her seventies. Risk factors include a family history of breast cancer, early age at menarche, late age at menopause, late age at the time of the first full-term birth of a child, obesity, and certain breast conditions. The increased risk of developing breast cancer associated with each factor varies, from 1.5 to 4 times average risk.

It is important that women discuss their individual risk of breast cancer with their physicians.

For further information about breast cancer, please contact the Cancer Information Service at 1-800-4-CANCER.

1-800-ACS-2345

Document 002039

ABORTION AND BREAST CANCER

The possibility that abortion (spontaneous or induced) might increase the risk of breast cancer has been examined in at least twenty epidemiologic studies since 1981. Although some studies have suggested an increased risk in some women, others have found no such evidence. Some studies describe elevations in risk for women with breast cancer at very young ages and with an abortion before their first live-birth; others find no increases at any age. Positive findings have in general been limited to narrowly defined subgroups of women, such as women with multiple miscarriages before a first live-birth, women who have not had a subsequent full-term pregnancy after an abortion, and women who have had only one live-birth following an abortion. Not all studies have adequately controlled for other important risk factors (e.g., age at first birth, parity, etc.), making it difficult to judge the validity of results. In addition, many studies before 1981 did not distinguish between induced and spontaneous abortions.

A study reported in the Nov. 2, 1994 issue of JNCI concerns induced abortion and risk for breast cancer discusses whether an association exists, but the findings are not conclusive. The research, conducted by Janet Daling, Ph.D., Fred Hutchinson Cancer Research Center, Seattle, Washington suggests that women age 45 or younger who have had induced abortions have a relative risk of 1.5 for breast cancer compared to women who had been pregnant but never had an induced abortion. A relative risk of less than 2 is considered small and usually difficult to interpret in this type of research. Such increases may be due to chance, statistical bias, or effects of confounding factors that are sometimes not evident. Dr. Daling did not find a consistent pattern of increasing or decreasing risk associated with age at abortions. The risk did not vary by the number of abortions, or by whether abortion preceded a full-time pregnancy, or by length of time to diagnosis of breast cancer. Women aged 45 or younger who had miscarriages were not found to be at increased risk for breast cancer.

CONCLUSION

Taken together, the inconsistencies of existing research do not permit definitive scientific conclusions. Epidemiologic studies may be useful in reaching more definite conclusions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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January 9, 1995

Luella Klein, M.D.
Director, Women's Health Issues
The American College of
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409 12th Street, S.W.
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Dear Dr. Klein:

Thank you for your letter of January 9, regarding studies of the relationship between induced abortion and breast cancer. The Division of Reproductive Health at the Centers for Disease Control and Prevention is preparing a detailed review of such studies for publication. Although the manuscript is not yet complete, the review of available studies is complete. From that review, I conclude that the available epidemiologic studies are inconsistent and inconclusive. Thus, no causal association between induced abortion and breast cancer has been demonstrated.

Efforts to study the relationship between induced abortion and breast cancer are complicated by observations that pregnancy, per se, alters the risk of breast cancer. For example, there is evidence that pregnancy may increase the risk of breast cancer diagnosis at a young age but reduce the risk at an older age (Pathak, et al., Int J Cancer 1986;37:21-5) (Janerich and Hoff, Am J Epidemiol 1982;116:737-42) (Ron, et al. Am J Epidemiol 1984;119:139-40) and evidence that birth causes a transient increase in risk of breast cancer (Bruzzi, et al. Br Med J 1988;297:1096-8) (Lambe, et al. N Engl J Med 1994;331:5-9). Whether terminating a pregnancy modifies the effects that pregnancy itself has on breast cancer risks is unclear at present.

I have included statements from the National Cancer Institute (NCI) and the American Cancer Society (ACS). Both were prepared in response to the article by Daling, et al., reported in the November 2, 1994 issue of the Journal of the National Cancer Institute. As you can see, the NCI has concluded that, "...the inconsistencies and scarcity of existing research do not permit scientific conclusions" and the ACS has concluded that, "...the inconsistency of the findings and the uncertainty about this literature does not permit definitive conclusions about the relationship between breast cancer risk and spontaneous or induced abortion."

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I hope that this is helpful. If I can help further, please let me know.

Sincerely yours,

Bert Peterson

Herbert B. Peterson, M.D.
Chief, Women's Health and Fertility Branch
Division of Reproductive Health
National Center for Chronic Disease
Prevention and Health Promotion

What You Should Know About Abortion

When you condense the issue of abortion down to its salient points, you find it is really about a woman's right to decide what to do with her own body. Should a woman be forced to give birth when she does not or cannot carry a pregnancy to term? Our basic laws, even those that are being challenged in the courts, say "No." In this country, you have the right to decide your own destiny as a woman.

If you are faced with an unexpected or unwanted pregnancy and you are considering abortion, here are the essential facts.

Why Women Have Abortions

Many of life's decision can be put off. However, one decision that cannot wait is the decision about whether or not to continue a pregnancy. This difficult decision needs to be made as soon as possible. Often it is helpful to talk with someone such as your partner, a close friend, or perhaps a professional counselor.

There are many reasons why a woman chooses to have an abortion. Some women believe they are too young for the responsibility of parenthood, some are not in a permanent relationship and worry about single parenthood, some simply cannot afford to have a child, some do not want their life's plans interrupted, some are concerned they will not be a good mother, some resent the pregnancy and just want it to be over with. There are as many reasons as there are pregnant women.

No one has the right to judge your reason for wanting an abortion. If you choose to terminate the pregnancy, an abortion can be safely performed up to 18 weeks in our office.

What Is An Abortion?

Abortion is the removal of the pregnancy tissue. Dr. Hodes performs two medical procedures for abortion in our office:

- **First-trimester pregnancy:** A woman is considered to be in the first trimester of pregnancy if less than 13 weeks have passed since her last menstrual period. The procedure for first trimester abortion is called vacuum aspiration or suction curettage. This is an exceptionally safe procedure performed in our office. Here, the doctor inserts a closed speculum into the vagina, opens it to hold the vaginal walls apart and numbs the cervix with a local anesthetic. The physician gradually widens (dilates) the cervix by inserting a series of narrow, tapered rods. Then, he inserts a small tube (cannula) which is attached to a suction machine. The machine empties the contents of the uterus through the tube. Lastly, the doctor carefully checks the walls of the uterus to be sure no tissue remains. The entire procedure takes less than a minute. Some women experience menstrual-type cramping, during and for up to an hour after the procedure.
- **Mid-trimester pregnancy:** Less than 5% of abortions in the United States are performed in the second trimester of pregnancy. Most of these are performed using dilatation and evacuation (D&E). The D&E procedure requires considerable skill on the part of the physician but is basically an expansion of the vacuum aspiration method described above. To perform the abortion, the doctor uses suction as in first-trimester procedures, but also uses forceps to remove the tissue that is too large to pass through the suction tube. The procedure takes from 3-5 minutes, and a woman may be given pain medication intravenously to help her feel more comfortable during this procedure.

Your Experience In Our Office

We want your experience to be as physically and emotionally comfortable as possible. Thus, we have structured your experience to provide all the medical attention you will need. Your visit with us, lasting about an hour, will include:

- **Testing:** We will do a urine pregnancy test and, if needed, a sonogram. Dr. Hodes will then talk with you about the procedure and perform a physical examination.
- **The procedure itself:** Dr. Hodes will give you a local anesthetic to minimize any discomfort. The procedure lasts only about a minute.
- **Recovery:** After the procedure, you will rest in the recovery room. You will receive follow-up instructions prior to being discharged.
- **Follow-up:** It is very important to have a follow-up exam 1-3 weeks after your procedure. There is no charge for this follow-up visit.

Is Abortion Safe?

Abortion is considered one of the safest surgical procedures available. But, abortion has not always been so safe. Before abortion was made legal, many women died or had serious medical problems after attempting to induce abortions on their own or going to an untrained practitioner who performed abortions in unsanitary conditions. Since legalization, women have benefited from significant advances in medical technology and greater access to high quality services.

When You Need Our Help

You will find Dr. Hodes to be a compassionate gynecologist who has consistently fought for a woman's right to choose her own destiny. Women feel very comfortable in his care. Dr. Hodes is board certified by the American Board of Obstetrics and Gynecology, and is a Fellow of the American College of Obstetricians and Gynecologists.

A WOMAN'S CHOICE
OBSTETRICS & GYNECOLOGY
Health care designed with you in mind

Herbert C. Hodes, M.D., FACOG
Diplomate, American Board of Obstetrics and Gynecology
4840 College Boulevard
Overland Park, Kansas 66211
(913) 491-6878

5-20

COMMUNITY RESOURCES AVAILABLE TO SUPPORT DECISION TO CARRY PREGNANCY TO TERM

MISSOURI

BIRTHRIGHT	444-7090
CRITTENTON CENTER	765-6600
CLAY COUNTY HEALTH DEPT	781-1600
JACKSON COUNTY HEALTH DEPT	881-4424
L.I.G.H.T. HOUSE	361-2233
MO RIGHT TO LIFE	444-4211
PLATT COUNTY HEALTH	329-5759
ST LUKES OB CLINIC	756-1701
TRUMAN MEDICAL CTR OB CLINIC (EAST)	478-1180
TRUMAN MEDICAL CTR OB CLINIC (WEST)	556-3516

KANSAS

CHRISTIAN FAMILY SERVICES	491-6751
CRITTENTON CENTER	765-6600
DOUGLAS COUNTY HEALTH DEPT	843-0721
FRANKLIN COUNTY HEALTH DEPT	242-1873
GENTLE SHEPHERD	432-1353
JOHNSON COUNTY HEALTH DEPT	791-5660
JOHNSON COUNTY HEALTH DEPT (OLATHE)	782-9400
K U MEDICAL CENTER	588-6290
RIGHT TO LIFE OF EASTERN KANSAS	299-9047
WYANDOTTE COUNTY HEALTH DEPT	321-4803
SHAWNEE COUNTH HEALTH DEPT	233-5141

Health care designed with you in mind.

HERBERT C. HODES, M.D., FACOG

4840 COLLEGE BOULEVARD • OVERLAND PARK, KANSAS 66211 • (913) 491-6878

5-24

INFORMED CONSENT for ABORTION PROCEDURE

In accordance with ***Kansas Law (H.B. 2646)***, the following information is being provided to you in written form at least **eight (8)** hours prior to a proposed Abortion Procedure.

The Abortion Procedure itself will be that of a Dilatation and Suction Aspiration Curettage ("D & C"). It will be performed by H.C. Hodes, M.D. using local anesthetic injections ("paracervical block").

The procedure consists of numbing the cervix with 2 or 3 injections of *Lidocaine*, a local anesthetic. After waiting several minutes for the area to become numb, Doctor Hodes will dilate the cervical opening to the uterus using sterile plastic rods. A surgical suction device will then be used to remove the pregnancy tissue from the uterine cavity. The actual procedure itself takes from 30 seconds to a minute or two, depending on the duration of the pregnancy.

The HEALTH RISKS of an abortion are much less than those of most other surgical procedures, and far less than those associated with a full-term delivery. Some of the possible complications include:

Hemorrhage (excessive bleeding), or Infection ----------less that 1 per 350
"Missing "an early pregnancy----------less than 1 per 1000
Uterine perforation, organ damage, hospitalization,
emergency hysterectomy, sterility----------less than 1 per 10,000
Death----------less than 1 per 200,000

For full-term pregnancies, the rate of Cesarean Section delivery is about 1 per 4 deliveries. The death rate following vaginal deliveries is around 15 per 100,000; and 20 to 30 per 100,000 for Cesarean Sections.

Today, at this time, you have these **four (4)** Choices:

1. Waiting, and thinking more about your decision.
2. Continuing the pregnancy, and planning for an adoption.
3. Continuing the pregnancy, and raising the child.
4. Ending the pregnancy, by having an abortion.

Also provided to you today is a partial list of **COMMUNITY RESOURCES** that are available to support your decision to carry the pregnancy to delivery, should you desire to do so.

Based on the information you provided us today, you are approximately _____ **weeks** pregnant. If you decide to carry the pregnancy to term, you would deliver on approximately: ____/____/____.

I hereby certify that the above information was received by me in writing at least **eight (8)** hours prior to the performance upon me of an abortion procedure by H.C. Hodes, M.D.

DATE: ____/____/_____

SIGNED: _____

TIME: _____ **AM / PM**

5-22

CONSENT for ELECTIVE ABORTION

PLEASE INITIAL

____ 1. I, _____, AGE: _____, hereby consent to the performance upon me of an abortion by suction "D & C" under a local anesthetic ("Paracervical Block") by H.C. Hodes, M.D. The abortion procedure today is being done at MY request, and with MY consent..

____ 2. I further consent to the performance of any additional emergency procedures which may be indicated because of unforeseen conditions arising during the abortion.

____ 3. I have disclosed to Dr. Hodes my complete medical history; especially with regard to any **allergies** or adverse reactions to medications or anesthetics; any previous surgical procedures and / or abortions; as well as telling him of **any medications** I have taken since my last menstrual period.

____ 4. I believe I am no more than 20 weeks pregnant. My last menstrual period began on: ____/____/____; and it **WAS / WAS NOT** normal.
(CIRCLE ONE)

____ 5. I understand that there are very few complications from an abortion, and certainly much less than those arising from a full-term delivery. Any surgical procedure involves risk of possible complications (up to death) which could occur *without any fault of Dr. Hodes.*

____ 6. **SOME** of the possible complications of abortions are as follows:

a. Retained blood clots and/or tissue requiring re-suction , or D & C	< 1: 100
b. Hemorrhage (Excessive bleeding) , or Infection	< 1: 500
c. Ectopic ("tubal") pregnancy outside of the uterus	< 1: 500
d. "Missing" an early pregnancy (and still being pregnant)	< 1: 1000
e. Failure of the blood-clotting mechanism (disseminated intravascular coagulopathy , "D.I.C.") with need for extensive blood replacement	< 1: 1000
f. Uterine perforation with damage to other organs (bladder, intestines) , hospitalization, major surgery, hysterectomy	< 1: 10,000
e. Death	< 1: 250,000

____ 7. I realize that such complication(s) can be caused by my own medical condition, or my conduct; by the treatment of follow-up physicians; or may occur spontaneously **without** the fault of any person.

____ 8. If there are **any** problems after the abortion , I agree to notify Dr. Hodes as explained in the *AFTERCARE INSTRUCTIONS.* I understand that my failure to promptly notify Dr. Hodes may lead to delay of proper treatment, and could cause further complications. I understand that if I seek other medical treatment without the prior instruction of Dr. Hodes to do so, I may **not** hold Dr. Hodes responsible for subsequent medical expenses, or any loss experienced as a result thereof.

____ 9. I agree to undergo a post-abortion exam in one (1) to three (3) weeks; and that failure to do so shall absolve Dr. Hodes of all medical, legal, or financial responsibility for **any** abortion -related problems that might arise at a later date.

____ 10. I acknowledge that it is MY responsibility to ask Dr. Hodes ANY questions that I have pertaining to the abortion; or to this consent form **BEFORE** I sign this form below.

____ 11. I certify that I have read , initialed, and fully understand this consent form.

SIGNED: _____ **DATE:** ____/____/____

5-23

rge R. Tiller, M.D., DABFP Medical Director
hy Reavis Nursing Coordinator
Dena Vog[illegible] Administrative Director
Frances Belden, M. Ed., NCC Mental Health Counselor
Peggy Jarman Public Relations

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FAX (316) 684-0052

Women's Health
Care Services P.A.
"Team Care"

To: Senate Public Health and Welfare Committee Members
From: Frances Belden
Re: H.B. 2938

My name is Fran Belden. I have a Master's Degree in Counseling, am a Nationally Certified Counselor, and am registered as a Professional Counselor by the state of Kansas. The current Kansas compromise abortion law has been in effect since July, 1992. I have worked as a member of the staff of Women's Health Care Services and Dr. George Tiller since 1989. I work primarily with teens and with two types of support groups. One, patients--many of whom are teens, and two, significant others, many of whom are parents.

In considering this bill I think it might be helpful to contrast it with what is currently happening. You have heard or will hear from others about its impact on adults. I will concentrate my testimony on the impact it will have on teens.

The vast majority of teens involve at least one of their parents. Though most parents are supportive of their daughters, one big problem I see in these situations is the parent trying to force a daughter into abortions. The current law requires they accompany the minor into counseling sessions and we have to be especially alert to detect any ambivalence on the part of the teen arrange private counseling, and often must return to the parents indicating to them that the procedure cannot be done because their daughter does not want it.

There are, however, a small number of teens who choose not to involve a parent. The reasons vary from abusive situations to a sincere belief that "I made this mess and it is therefore my responsibility to deal with it." Some have parents who are ill and feel they just cannot further burden them. Since the law went into effect, only 89 patients have used the judicial by-pass That is approximately 2 per month, which contrasts with approximately 30 per month who come with their parents.

A teen who decides to get a judicial by pass must

1. talk with me (this can be done by phone) to process her decision and her options,
2. wait often one to two weeks for the judicial appointment to be scheduled,
3. come to the clinic for a 30-60 minute counseling session (accompanied, of course by a person at least 21 years of age),
4. keep the appointment with the attorney and the judge,

Senate Public Health & Welfare
Date: 3-13-96
Attachment No. 6

5. finally, return to the clinic for the appointment.

Logistical problems for young women are huge when getting a judicial by-pass (especially when they live outside of Wichita). Issues of transportation, finding someone to accompany them, and missing school are the largest problems. The court sets the date and time. She and I do not. She must be prepared to accept whatever that date and time are. That is frequently impossible so we then start over. Most of the time, we receive a one day notice of the appointment. Many teens trying to insure their confidentiality must call me each day to see if the appointment with the judge has been made. If they call each afternoon, they may learn they must be in Wichita the following morning. You can imagine the logistical nightmare that can be for a teen.

Now add for that teenager a 24 hour waiting period from consent that must be given, according to this bill, in person. The judicial by-pass will effectively be taken away as an option for nearly 100% of our teens. For a teenager our current system is almost impossible. A teen will likely be unable to spend a night away from home, out of her city of residence. Imagine a teen from Kensington, Kansas or Dodge City or Great Bend. The difficulty of getting away from school for a day now becomes two days. The difficulty with transportation which now requires a car for a day means a car that will be needed overnight. Finding an adult friend or relative to accompany her now means finding someone to be available two days - loss of time from work, spending dollars they may not have, and ignoring any and all other responsibilities for two days instead of one.

This is simply impossible. Maybe that is its purpose. Please do not do this to our teenagers. You have burdened them enough.

Some of you believe the rhetoric from people who are opposed to anyone ever having a legal abortion. You believe the abortion mill, cattle pen, money grubbing charges made by those who want to take this option away from women everywhere. I want to end my remarks to you today by reading to you a couple of letters we have received from patients. Just a few comments representative of the hundreds we could share. I have enclosed a sampling of those letters in addition to what I will read to you now.

I respectfully request that you do not support this bill. Thank you.

NABCO
NATIONAL ALLIANCE
OF BREAST CANCER
ORGANIZATIONS

October 26, 1994

"Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion"
by Daling et al. (a)

Comments by the National Alliance of Breast Cancer Organizations (NABCO)

In the *Journal of the National Cancer Institute* article made available today, Dr. Janet Daling and colleagues report on their study that they feel establishes a link between induced abortions in young women, particularly when they occur after eight weeks of gestation, and subsequent risk of developing breast cancer. A number of previous studies have explored a possible link without conclusively establishing one (b). Dr. Daling's is the first study published in a major medical journal to characterize induced abortion as being "associated with nearly a doubling of subsequent breast cancer risk". (c) NABCO advises that the results of this study be interpreted with caution.

The authors themselves conclude that lack of statistical power an corroborating studies "argue against a firm conclusion at this time (d)." A link between abortion and breast cancer may or may not be borne out in large, prospective, controlled studies that are necessary to establish a specific causal relationship, independent of other epidemiological, behavioral and familial factors. NABCO supports continued investigation into all aspects of increased breast cancer risk in women, so that a means for the prevention of breast cancer may be discovered.

The study's conclusions will be well-publicized, and will reach many lay people and medical professionals who have limited background and context about the complexities of breast cancer, a leading women's health problem. It is crucial that lack of background and political considerations do not divert women's attention from compliance with life saving early-detection, dingnosis and treatment programs for breast cancer, the most common form of cancer in women in the United States.

-000-

(a) Daling et al., "Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion", *Journal of the National Cancer Institute*, Vol. 86, No. 21, November 2, 1994, pages 1584-1592.
(b) See attached overview article, *NABCO News* , Vol. VIII, No. 1, January 1994, page 2.
(c) Daling, *JNCI*, p. 1592.
(d) Daling, *JNCI*, p. 1592.

See attached "Issues Raised..." Statement
Contact: Stacy Charney, (212) 889-0606, ext. 3007

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The National Breast Cancer Coalition
a grassroots advocacy effort

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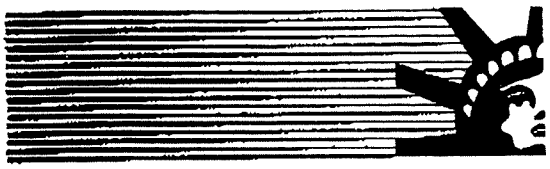
POSITION STATEMENT ON ABORTION AND BREAST CANCER

Recently some organizations that are part of the anti-choice movement have begun a campaign publicizing that abortion increases the risk of breast cancer. This assumption is based on the selective use of some epidemiologic studies which show a slight increase in breast cancer risk after abortion. It ignores the numerous studies which have shown no relationship or a reduced risk of breast cancer.

Breast cancer issues have been receiving more national attention due largely to the efforts of the NBCC to educate the public and government of the need for more research to end this devastating epidemic. It is not surprising that organizations that have no interest in or concern for women with breast cancer are using this increased awareness to further their own agendas. Any organization's use of misleading information regarding the link between breast cancer and abortion to promote its own political gain rather than a concern about breast cancer should be condemned as a deception to the American public.

The NBCC supports more research to answer questions regarding any possible link between breast cancer and abortion. In particular, the Coalition calls for an international collaboration to evaluate all of the existing data. Until such time that conclusive scientific evidence exists, women should not feel the pressure of misleading propaganda intended to influence their decisions.

NARAL *Promoting Reproductive Choices*



MANDATORY WAITING PERIODS AND THE FREEDOM TO CHOOSE

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

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

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

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

State-Imposed Waiting Periods Create Substantial Obstacles

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

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

National Abortion and Reproductive Rights Action League

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

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

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

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

State-Imposed Waiting Periods Cause Dangerous Medical Delays

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

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

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

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

6-6

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

Waiting Periods Increase Exposure To Anti-Choice Harassment

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

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

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

Waiting Periods Do Not Foster Informed Decision-Making

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

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

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

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

1/9/95

6-7

Notes

1. Stanley K. Henshaw and Jennifer Van Vort, "Abortion Services in the United States, 1991 and 1992," *Family Planning Perspectives*, vol. 26, no. 3 (May/June 1994): 103.
2. Alan Guttmacher Institute, *Press Release*, Feb. 1994, 3.
3. Fawn Vrazo, "A Preview of Limited Abortion," *Philadelphia Inquirer*, 14 Sept. 1992, A1, A6.
4. Alan Guttmacher Institute, *Press Release*, Feb. 1994, 2.
5. *Ibid.*
6. ABC, "World News," 14 Aug. 1992, 3 (transcript on file with NARAL).
7. Telephone conversation with Administrator of Fargo Women's Health Organization, 14 Apr. 1993.
8. National Abortion Federation & Planned Parenthood Federation of America, *Undue Burdens: The States' Experiences* (Washington, D.C.: April 1993).
9. Rebecca Buckman, "Abortion Clinics Say Clients Don't Rush Into Procedure," *Indianapolis Star*, 12 July 1992, 1, 10.
10. American Medical Association, "Induced Termination of Pregnancy Before and After *Roe v. Wade*, Trends in the Mortality and Morbidity of Women," *JAMA* vol. 268, no. 22 (Dec. 1992): 3238.
11. Willard Cates, Jr. and David Grimes, "Morbidity and Mortality of Abortion in the United States," *Abortion and Sterilization*, Jane Hodgson, ed. (New York: Grune and Stratton, 1981): 158; Rachel Benson Gold, *Abortion and Women's Health: A Turning Point for America?* (New York: Alan Guttmacher Institute, 1990), 29-30.
12. National Abortion Federation, "Economics of Abortion" (1991) (factsheet); Stanley K. Henshaw, "The Accessibility of Abortion Services in the United States," *Family Planning Perspectives*, vol. 23, no. 6 (Nov./Dec. 1991): 251.
13. Alan Guttmacher Institute, *Press Release*, Feb. 1994, 3.
14. National Abortion Federation & Planned Parenthood Federation of America, *Undue Burdens: The States' Experiences* (Washington, D.C.: April 1993).
15. ABC, "World News," 14 Aug. 1992, 3; Sara Rimer, "Abortion Foes' Boot Camp Ponder Doctor's Death," *New York Times*, 19 Mar. 1993, A12; NBC, "World News Tonight," 20 Feb. 1993, 2 (transcript on file with NARAL).
16. NBC, "World News Tonight," 20 Feb. 1993, 2.
17. Brief of the American College of Obstetricians and Gynecologists, *et al.*, *amici curiae* in support of Petitioners at 21-22, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 112 S.Ct. 2791 (1992) (Nos. 91-744, 91-902).

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Breast Cancer and Abortion

Comments by Allan Rosenfield, M.D.
Dean, Columbia University School of Public Health

The etiology of breast cancer has undergone extensive scrutiny during the past two decades, a time during which incidence of the disease, at least in Western countries, has apparently increased. Despite the clear implication of reproductive factors in the pathogenesis of breast cancer, such as age at menarche and menopause and the demonstrable protective effect of at least one full-term pregnancy early in a woman's reproductive years, conclusive demonstration of increased risk from other factors remains elusive.

The hypothesized link between breast cancer and abortion is especially problematic. Among the reasons for this uncertainty is that some research studies have found risk factors that are epidemiologically small. At the same time, studies have proved contradictory; at least one has suggested that there could well be a reduced risk for breast cancer as a result of an induced abortion in the first trimester. Moreover, previous studies have suffered from problems of selection, size, reporting bias, failure to control for all factors, and failure to distinguish between spontaneous and induced abortion.

While a new interview-based, case-control study* by Janet R. Daling and others, reported in the *Journal of the National Cancer Institute*, characterizes induced abortion as being "associated with nearly a doubling of subsequent breast cancer risk," the authors report that the study's limitations "argue against a firm conclusion at this time" and call for further research. It would be wise for women and all other interested individuals to take this caution at face value. In the words of a *Journal* editorial that accompanied the report, "[I]t is difficult to see how [the study results] will be informative to the public."

Among the concerns are that this study is only one of some 20 studies that have reached different conclusions, that it lacked objective measures for establishing pregnancy duration, and that it contained the possibility of reporting bias. Although the reproductive lives of women taking part in the research occurred mostly after the legalization of abortion, the issue of abortion is still emotionally charged. A breast cancer diagnosis may very well influence a woman's recall or disclosure about her reproductive history.

The Daling study, like many others that have preceded it, must be interpreted scrupulously, professionally, and in the proper context. Above all, the complexities of this issue warn against interpretations influenced by abortion politics. Continued investigation into the risk factors for breast cancer is critical in order for all women to be fully informed and in control of their health. For the moment, no one should base a decision on whether or not to continue a pregnancy on the basis of one study.

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* Janet R. Daling, Kathleen E. Malone, Lynda F. Voigt, Emily White, and Noel S. Weiss, "Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion," *Journal of the National Cancer Institute*, November 2, 1994, 86:21, 1584-1592.

Testimony to the Senate Public Health and Welfare Committee
March 1996
By Anne Moore

Good afternoon. My name is Anne Moore. I am 30 years old; and a single parent. My son is 13 years old. I had my son when I was 17. I was in high school. I missed the prom. It was October of 1982. I had the option of getting an abortion, but chose to continue my pregnancy because I was idealistic. I went on welfare after my son was born. As I recall, I received about $83 a month and foodstamps. It wasn't enough to live on.

These were some of the most difficult days of my life. It was a struggle both financially and emotionally. My parents were very helpful, but it was a tremendous struggle.

I am proud of the fact that I was eventually able to get off welfare, but in 1988 I found myself pregnant again—despite the fact that I had used birth control. I thought about what to do immediately and at length. I knew I didn't want to have another baby.

At least a week passed before I went to a clinic to seek an abortion. During that week I dwelled on my choices. It was an intensely personal decision that I did not take lightly. My thoughts were consumed with what to do. Once I made my decision I wanted to get it over with. I wanted the first available appointment.

I want to explain my thinking process clearly enough so you will understand this decision is not litely considered. My impression from the bill and its proponents is that women just aren't smart enough to carefully consider their options. An additional wait mandated by the government would have had no effect on my decision because I knew full well what I was getting into. I had thought about it for seven days. The fact is, there is a built in waiting period. Women do not call in immediately once they know or think they are pregnant.

I considered the basic options:

- continue the pregnancy
- adoption
- abortion

I based my decision on personal experience. I know how hard it is to raise a child especially on welfare. I also knew, of course, what abortion meant. I've heard anti-choice people talk about abortion as

if no one knows what abortion means. It means ending the pregnancy. It means no longer being pregnant. This is not rocket science. Mandating lengthy specific medical information be forced upon women—who have already thought long and hard about their decision—is condescending and can only add to stress. (Do women have the option to opt-out of this forced counseling?) I was given such information and I'm sure that is still the case.

At the clinic I took part in group counseling before my abortion. I found this group counseling very helpful. A sense of camaraderie developed between many of the women and quite frankly, others asked questions that I had not thought of. It was all very helpful. The nurses explained the risks and the method of the procedure. During the procedure I felt like I knew what was happening. The actual procedure took less than five minutes. It was painful, but that did not last. (I've had a baby and that was far more painful.)

I was given the opportunity for post-abortion counseling, but I passed. What I felt most of all was a great deal of relief. I was glad I was no longer pregnant because I knew from experience how difficult it is to raise a child alone and with limited resources. I choose to dedicate myself to my son rather than an uncertain future, perhaps back on welfare. I know from experience that living on welfare is not an easy life for mothers or their children.

I urge you to defeat HB 2938. It is an unnecessary intrusion in the lives of women that will provide no positive benefit. The bill would more than anything hinder and harass women seeking to make an intensly personal decision about their body and their lives.

Thank you.

In February of 1985, I found myself with an unexpected and unwanted pregnancy. I was a 4th year medical student at the time and unmarried. I had no financial resources other than the student loans that I was living on. I was looking forward to beginning my internship in another six months or so and following that, three years of a rather grueling neurology residency.

When I told my partner that I was pregnant, his response was "Your a pain in the ass". He offered me no support whatsoever and told me that whatever I did was my decision and that he didn't really want to know about it. My family would have gone ballistic if I told them so I could not go to them for help. I did speak to a few friends who offered me emotional support.

I agonized greatly over my options. My partner was, until that time, someone who I thought I loved and being pregnant was something I took fairly seriously. I had no money and my option was to drop out of medical school and try to find a job until I could get on my feet and then resume my training. That would have made life very difficult as I really wasn't trained to do anything else except be a physician. I was not finished with internship so I could not work as a physician and I had student loans which would become due as soon as I graduated medical school. Raising a child alone during internship and residency would have been phenomenally difficult given the hours I would have to work and the money I would be making. I was not about to go to a crises pregnancy center which I felt would give me a lecture on Jesus Christ and give me the phone number to the Welfare Office. I called Planned Parenthood and scheduled an appointment.

It was at least a week before I could get into Planned Parenthood in Albany, New York. During that time I discussed my problem with friends and with my sister. I spent many sleepless nights considering my options. When I got to Planned Parenthood I was talked to for quite some time by a very sympathetic counselor. She again tried to run through my options. Should I continue the pregnancy? At no time did she try to coerce me one way or the other.

I finally came to the decision to have an abortion. I felt this was truly my only option given the stage of my education and earning capacity. Planned Parenthood referred me to a local gynecologist. I spent at least two hours at his office talking to his nurse, again going through my options. Should I continue the pregnancy? I did have a chance to see the ultrasound of my embryo. I went through with the abortion.

About a year later I married and tried to become pregnant. For four and a half years I tried unsuccessfully to conceive. After undergoing surgery I finally was able to. During that time I did have feelings of guilt and some regret about my abortion. I really would have preferred to continue the pregnancy had it been economically feasible for me. There were times when I felt guilty that I had aborted.

At no time during those difficult years did I think that abortion should be made illegal so that no one would have to go through what I was going through. I knew it was going to be a difficult decision from the outset. The fact is had abortion been illegal back in February of 1985 I would have had one anyway. My husband and I eventually adopted a child and seven months later I became pregnant.

I had many opportunities before my first appointment to think over my options. I knew a lot about abortion having observed many of them as a medical student. I had time at Planned Parenthood to discuss my options with a counselor and again at the abortion physicians office with his nurse. There were many opportunities for me to turn back. An artificially imposed 24 hour waiting period would have been ludicrous. I had already made up my mind and had had a chance to ponder my options by the time I made the appointment. I think most women find themselves in this circumstance. One does not make a decision overnight. Also, logically one cannot usually get an appointment that day or the next day to talk about an abortion with an abortion provider. In my case I had to wait a couple of weeks because my pregnancy was so early that they felt the abortion might not be successful if I didn't wait. To impose a waiting period and require exposure to someone opposed to abortion would simply be harassment and, emotional abuse. This treats women as children unable to make their own decisions.

If somebody had come up to me before I had my abortion and offered to support me and my child until I got on my feet certainly I would have continued the pregnancy. I doubt that very many women are going to find this offer to them. I doubt again that the anti-abortion elements are going to offer support of this fashion. That to me is the most substantial issue. If each of the abortion foes would offer to personally support a mother and child for as long as it took for them to have a financially viable life, then perhaps this would have some meaning.

Iris A. Brossard M.D.

END

TOTAL P.02

March 6, 1995

Approximately four years ago (1992) I was a divorced single mother with a three year old daughter. My daughter and I were was living with my parents and barely scraping by. My ex-husband was not paying child support and I was paying $100 a week for full-time child care so I could work.

I had been on birth control pills for approximately ten years and never gotten pregnant (except once which was intentional and resulted in my beautiful daughter) and I guess I got a little careless. Once or twice a month I would forget to take my pill everyday and eventually it caught up with me. Sometime in August I began to suspect that I was pregnant. By the time I had it confirmed by my doctor I had pretty much decided what I was going to do. I think it is important to note here that, from the minute a woman even begins suspecting she is pregnant or that she could be pregnant, she is weighing her options. The possibility of becoming pregnant for any woman is always there. Its not something you only think about every once in a while. You don't wait for the doctor to confirm it before you start thinking about what you are going to do if you are. (Consequently, by the time you actually get around to making that phone call to the clinic to schedule an appointment, a great deal of thought has gone into it.)

I was in no position to put myself, my parents and especially my daughter through more hardship and struggling. We were barely making it by as it was. Mentally, I was already frazzled trying to make it by on my own and could not deal with another child. So, after talking over the options with the father and deciding that we were not ready to have a child, I decided to have an abortion.

I knew there were restrictions on how long I could wait to have an abortion so I didn't wait to wait too long. Consequently, after a week or so I called the clinic and scheduled an appointment. I knew a girl at one of the clinics and she told me that I would need to come in beforehand for "counseling" and talk with them about the procedure because of a State imposed waiting period. I told her it wasn't necessary and asked her if this was a requirement. She told me there was no way around it, they were required by law to do it. I cannot tell you how much this infuriated me. It was going to be difficult enough for me to swing time off from my job to have it done, let alone to get more time off for "counseling" that I didn't want or need!

Think about it, if you consider the time that elapses between the time a you first suspect you are pregnant, until you actually has it confirmed by a doctor (which is usually quite a while), then the time it takes you personally to make this decision, more than a just few weeks have gone by. Then you have to worry that you've waited too long! And then it will be too late. I truly believe that this is their goal, to leave such a small window of opportunity open that it is practically impossible to get an abortion at all.

Trust me, by the time a woman has called the clinic to schedule her appointment, her decision has already been made. In my case, I knew from the beginning what I was probably going to do, but I still waited to make that call. To force women to further delay carrying out their decision is demeaning and cruel. It only delays the inevitable.

I terminated my pregnancy at 7 weeks. I have no regrets. I know I made the right decision.

Approximately one year later I got married to this wonderful man and on October 11, 1996, we became the proud parents of a brand new baby boy. We are very happy. I don't know if things would have worked out as well if we had decided on another course of action. I know I would have always felt guilty about "trapping" him into marrying me. I know my daughter was not ready for more major changes in her life, as none of us were. What I do know is by waiting, we made the best decision. A mutual decision that would lead us on to a long and happy marriage based on trust and friendship forever. We are all extremely happy, devoted and productive people, ready now to raise our new son in a healthy, happy home..

I believe that God forgives those who make mistakes (my mistake was getting pregnant). I know that I have forgiven myself and that is what really matters the most.

Thank you.

Casey E. Sloan

Feb. 17, 1996

Dear Legislators,

Recent testimony has been heard on the floor to illustrate how medical practitioners coerce women into hurried abortions. You need to also hear the truth from an experienced woman who has been there.

I am a 43 year old woman, married 20 years and my husband and I have two children. Early in our marriage after birth control failures due to recent uterine surgery, I had two pregnancies we chose to terminate. Both times I was counseled at length beforehand about fertility and birth control. At the time I found it mildly irritating, after all, I was an educated woman who had had a uterine fibroid--I knew exactly how and when I had conceived, but I understood why the counseling was necessary. There are many women who need access to this type of information and the options for receiving unbiased medical answers to women's reproductive health care questions seem to be dwindling each year.

After counseling, I was accompanied through each step of the way, my hand was held during the two-minute procedure and the doctor was careful to question me again beforehand: do you understand that this procedure will terminate your pregnancy and are you ready for me to begin? Afterwards I was observed for quite some time to make sure I was recovering well and to see if I had any questions before being released to go home.

My experiences are common among women who've had an abortion. Health care workers are caring and thorough when it comes to helping women who desire an abortion. They do not take the procedure lightly, just as women, who've already made the decision to seek an abortion, also do not make this decision lightly. Women, bearers and nurturers of children, know the emotional, financial and intellectual costs of motherhood, and should not be subjected to harrassment or manipulated into viewing fetal development in terms of *someone else's* definition of when life begins. I am also familiar with cases of pregnant friends, whose unhappy boyfriends have hauled them unwillingly into a clinic to prevent a pregnancy from coming to term. Doctors and counselors easily detect cases where the women genuinely desire the pregnancy to continue, and refuse to perform abortions in such cases. No reputable doctor would act under these circumstances. Thus they try to prevent this from happening by interviewing the patient at the outset to determine that she is truly there of her own free will. The claim that doctors would ramrod these women through abortion procedures without giving them time to think and talk about the choice they have made is ridiculous. We must respect a woman's right to choose her family size--it is her *legal* right--and help her at a time when she has made a difficult decision, not hinder and harrass her.

Sincerely,

Debbie W, East Wichita

l hoice Action League • P.O. Box 3622, Wichita, KS 67201 • 316-681-2121

Dedicated • Determined • Decisive

To: Senate Public Health and Welfare Committee
From: Peggy Jarman
Re: H.B. 2938

Since *Roe vs. Wade* became law in 1973, 104 abortion bills have been introduced into the Kansas Legislature. All but one of these bills was introduced and supported by people who were trying to restrict and/or outlaw abortion services. One hundred three bills introduced and supported by people trying to make abortion services illegal or so restrictive that legality would be a totally moot point. All but ONE. That one exception was a bill that became known as the Kansas compromise abortion law. The one bill in all my 16 years of working to ensure access to safe and legal abortion services that I supported. The one bill that passed. The one bill that became law. The only one out of 104 bills. It was a bill that frustrated many activists; many did not like it; many did not want it. But it was important to seek a compromise; to try to find a way to live together by addressing legitimate concerns of the citizens of this state. That bill required hard work by many people. It is a law now and has been since signed by a pro-life governor, Joan Finney. That law ensures quality care of patients, as much as any law can, and access to abortion services. The bill that is before you today, number 103 in the past 26 years, like the 102 before it attempts to restrict abortion services to the point that legality will not be an issue. That's almost four abortion bills each year which have been used to divide us, politicize, emotionalize, patronize, and exploit us. It ignores the compromise abortion law, because it is a law that does not keep people from accessing abortion services. Just like the 102 bills that have taken your time in the past, this bill, also introduced and supported by people who want to restrict and/or outlaw abortion, is designed to do just that - only this time it has been disguised by a very misleading title.

First, I want to address the incorrect information that was reported from the House of Representatives. The following charges were made:

1. The current law is not being followed. To read one line from a consent form and suggest that this is all the information that is being given patients is extremely misleading. Clinics are in full compliance with the law. The current law requires the following information:
   a. Risks and alternatives to the procedure.
   b. Gestational age of the fetus.
   c. Medical risks of the abortion and carrying the pregnancy to term.
   d. Community resources applicable to her decision.

2. The intent of the law is not being followed. There was an amendment offered during the 1992 debate in the House that was a duplicate of this bill. That amendment failed. It did not pass. The intent of that bill was as the intent of this one: to make abortions more difficult, less accessible, more expensive. Rather, a compromise was suggested in the Senate, one that would provide information that was appropriate, but in a way that would not interfere with access. The compromise informed consent is what we have as law today and obviously does represent the intent of the legislature. That compromised passed. The intent is to provide medically accurate information. The intent is strictly adhered to. It just does not represent the intent of the anti-choice amendment as introduced in the House. It is simply not what people who are opposed to abortion want because it does not keep women from accessing abortion services.

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3. Nola Foulston, District Attorney, Sedgwick County, had to stop a third trimester abortion in Wichita because the woman could not speak or understand English. There is no evidence whatever that Nola Foulston had to stop a third trimester abortion in Wichita. There have been only two Russian woman at our clinic. One was from New York; she spoke impeccable English as did her husband. The other was fluent in written English. We have interpreters available for any patient needing assistance. The facts are that Nola Foulston has never had to stop any abortion in Wichita due to lack of consent or any other reason.

4. A friend of mine testified in favor of this bill. A total stranger asked me to meet with her. She wanted questions answered before making a decision. I spend several hours with her as did members of our staff and members of the Planned Parenthood staff. I had never seen her prior to that meeting; I had not seen her again until the day of the House hearing. That meeting did not make us friends. Why anyone would report such is beyond my comprehension.

Second, I want to address the undue burden aspects of this bill. It is quite possible that this legislation will not be constitutional in Kansas. Clinics in this state are concentrated in and only in the Eastern part and are few in number. Not at all like the large numbers of clinics scattered throughout the state of Pennsylvania Women traveling from central and western Kansas will have to spend an extra night away from homes, families, and jobs. The additional emotional impact will be large. The financial impact is undisputed. Incidentally, it was also reported on the floor of the House that women now have to spend an extra night due to the eight hour waiting period. That is not true. If this bill becomes law, a woman would need, at a minimum, an additional $100. A woman working at a minimum wage job would lose an extra full day of pay plus have the added expense of hotel and food. That amount would be increased for any woman going to the Kansas City area where costs are higher for motels. Additionally, child care costs could add to that cost if the woman had children someone had to keep at home. If, as we would hope, a husband or friend accompanied the woman, he or she would also lose additional time from work making it more difficult for a woman to have the support we would want her to have. In fact, this additional expense will likely deny her that support.

Third, I am presenting to you a packet of information with letters from national cancer groups including the American Cancer Society and the National Cancer Institute who indicate no evidence of a link between breast cancer and abortion.

In conclusion, H.B. 2938 is inappropriate medically, inadvisable financially, and unnecessary for women. Women are morally, emotionally, spiritually capable of dealing with complex health care decisions including abortions. Do not demean us further by legislation that is designed to deny us access under cover of our right to know.

Please do NOT support H.B. 2938.

NATIONAL COUNCIL OF JEWISH WOMEN
GREATER KANSAS CITY SECTION

March 13, 1996

Testimony of Barbara Holzmark, Kansas State Public Affairs, Chair
National Council of Jewish Women
8504 Reinhardt Lane
Leawood, Kansas 66206
(913) 381-8222

Regarding: HB 2938

Dear Members of the Senate Public Health and Welfare Committee.

I write to you today in opposition to HB 2938.

Having just returned from the "40th" National Convention of the National Council of Jewish Women, (NCJW) and reaffirming our Strategies, Principles and Resolutions, I speak on behalf of 90,000 members across the United States, representing 200 sections with nearly 1100 members in the Greater Kansas City Section alone. To accomplish its Mission, the NCJW works through a program of research, education, advocacy and community service to improve the quality of life for women, children and families and strives to ensure individual rights and freedoms for all. Specifically, Strategy 4 clearly states we will work to ensure individual liberties and civil rights. We therefore, endorse and resolve to work for "the protection of every female's right to reproductive choice, to safe and legal abortion, and to the elimination of obstacles that limit reproductive freedom".

HB 2938 specifically puts obstacles on women seeking abortion services in all forms. To further restrict our current law would place undue obstacles too many times to enumerate. Financially, the state burden would be in excess of $ 100,000.00 the first year alone, not counting legal costs to defend against claims of unconstitutionality's. I urge you to oppose HB 2938 in the sake of taxpayers dollars, legislators time and the health and dignity of Kansas women.

5750 W. 95th STREET, SUITE 113
SHAWNEE MISSION, KANSAS 66207-2969
(913) 648-0747

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Testimony
of
The Rev. Lynn NewHeart
Planned Parenthood of Mid-Missouri and Eastern Kansas
March 13, 1996
before the
Senate Public Health and Welfare Committee
of the Kansas Legislature
in opposition to
House Bill No. 2938

I am the Reverend Lynn NewHeart, Chaplain at Planned Parenthood of Mid-Missouri and Eastern Kansas. I have been with Planned Parenthood for almost six years. A large portion of my job involves working with, and counseling with women who are seeking abortion services. I am also an ordained minister of the Christian Church (Disciples of Christ).

Upon reading HB2938, I was immediately struck by several inaccuracies in the first section. The bill states, about women who seek abortions, "They do not return to the facility for post-surgical care." This sounds as if post-surgical care is neither available or utilized, both are incorrect. Follow-up visits, two to three weeks after an abortion, are strongly encouraged in most clinics, even provided free of charge in some, and many woman do make and keep these appointments.

The bill also states that there is "little opportunity to receive counseling concerning her decision," and, "Many abortion facilities or providers hire untrained and unprofessional counselors whose primary goal is to sell abortion services." Once again, in my experience in a clinic in which abortion is one of the services provided, and being affiliated with other clinics which do the same, both of these statements are inaccurate.

Women seeking abortion often call into the clinic to obtain information, discuss their options and speak about the emotions of having to make such a decision. Some, who do not resolve their decision after a phone call, will schedule to come into the clinic to speak further about their concerns before making a decision. Always, for every woman who comes into the clinic for an abortion, we sit down with her after she has read and filled out the paperwork, seen a video tape of the information on the procedure, risks and aftercare instructions, and we then go over any questions she may still have, confirm her decision (after verifying that she is aware of all of her options) and discuss any issues she may wish to discuss.

If at any time the woman indicates that she may need more time to make her decision, additional counseling time is offered. There have been times when the staff have not felt good with the level of comfort a woman has expressed regarding her decision and so the staff member sends the woman home, refusing to do the abortion that day, so that she has more time to resolve the issues. Sometimes those women do come back for an abortion and sometimes they do not. As Chaplain, I have talked with women who were sure of their decision to have an abortion but just

wanted to talk about the religious aspects of making that decision. We give every woman every opportunity for counseling for as long as it takes for her to make a decision that she deems is best for her in her particular circumstances. We also provide post-abortion counseling, at no cost, for anyone who desires it. All of the people I have known who work in this area are following these procedures because they are committed to helping enable woman to make good decisions for themselves, not because they are trying to "sell abortion services."

One of the concerns of the bill is that women seeking abortion be given "accurate scientific information", and yet throughout the bill there is language that is not scientifically accurate. Using terminology such as "unborn child" and "mother " and "father" is not scientifically accurate. The term fetus, or embryo when applicable, fits within scientific definitions. The use of value-laden terms like "unborn child" seems to be inconsistent with the desire for medical, scientific accuracy.

Passage of HB2938 would result in making it very difficult to obtain abortion services for some women, impossible for others. Whereas a mandatory trip into the clinic, at least 24 hours before an appointment, might be experienced as only a nuisance for a few women, it would serve as a barrier to service for many women who struggle with transportation problems, child care, or missing work. Even without a waiting period, it is often difficult for women to manage the necessary logistics of getting to the clinic for an appointment depending on her financial, family and employment situations. I speak with a different woman, at least weekly, who is spending a great deal of time and energy just trying to make everything work so that she can make it to her appointment. It is challenging enough for women who live in town. To require out-of-town patients to make an additional visit to the clinic often will mean an additional day of work missed, payment for a hotel overnight, and the difficult tasks of obtaining child care for two days. The political climate surrounding abortion necessitates confidentiality like no other surgical procedure. The challenge to maintain privacy, while making these additional arrangements, would present yet another burden.

Another barrier to obtaining abortion services would be created by the increase in cost. Paying a physician to provide the informed consent counseling could very well more than double the price of abortions. The counseling usually takes much longer than the actual abortion itself, so the additional increase in physicians' salary would have to be passed on to the patient just to cover costs. Since most insurance companies do not cover abortion services, and Medicaid will not cover abortion services (except currently for rape or incest victims), the cost of an abortion is usually out of pocket. A single woman with children, dependent on AFDC and foodstamps just to feed and clothe her children, has a very difficult time finding several hundred dollars "out-of-pocket". Many women already struggle to obtain the necessary fees in a timely manner (since the price only increases as they wait to obtain funding). A substantial increase will result in making abortion impossible for many women because of cost alone.

With the terrorist-induced shortage of physicians willing to provide abortion services in the U.S., tying up physician time to provide counseling, a service another adequately trained staff member can well perform, will also serve to make skilled physician availability a much scarcer resource. Ultimately, more women would have reduced access to an important and necessary

medical service that is already hard to find in many areas.

Having counselled with women seeking abortion for almost 6 years, it has been my experience that the vast majority of patients have already spent a good deal of time thinking about their decision even before they call to make an appointment. Many have involved people close to them in their decision-making process, taking into account a multitude of factors. Several weeks ago a woman told me that she felt her decision to not have another child was the most loving, caring and decent option for the sake of her existing three children. Another child, she felt, would place a financial, emotional and physical burden on the family that would cheat the others out of the love and care she and her husband wanted desperately to provide. To assume that women cannot make decisions regarding their bodies and regarding the decision to become parents without a physician-delivered lecture from the government, or that they need a state-imposed "waiting period" is nothing short of misogynistic.

It is also demeaning to women to assume that the difficult and complex decision to terminate a pregnancy would be, or should be, affected by seeing pictures or drawings of fetuses at two-week developmental intervals. Although the decision to terminate a pregnancy might be a simple decision for some women, it is never an easy one. The couple who have just made the heartwrenching decision to terminate a planned and wanted pregnancy because of severe fetal anomalies requires special care and attention. To force them to view pictures of developing fetuses could cause emotional harm that would never exist with a more caring approach to counseling. Medically sound informed consent happens for other surgical procedures without such unnecessary, emotionally-evocative visual aids.

In conclusion, HB2938 has within it several factors which are troubling from the standpoint of what is good for the patient. Grossly inaccurate information and value-laden language exists within the text. The proposed conditions for informed consent would produce a cost-inhibitive procedure for many women. The 24-hour waiting period would make it impossible for some women to exercise their constitutional right to an abortion. And finally, the tone and content of mandated information to be given to women are both unnecessary and potentially harmful to the patient's emotional well being. Please do not allow passage of HB2938.

TESTIMONY IN OPPOSITION TO HOUSE BILL 2938
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
WEDNESDAY, MARCH 13, 1996

Good morning. Thank you for this opportunity to address our concerns regarding House Bill 2938. My name is Carla Mahany. I am the Associate Director of the American Civil Liberties Union of Kansas and Western Missouri.

We have several major concerns to address regarding this effort to harass women who choose to have an abortion procedure in Kansas and to restrict women's access to safe and legal abortion services in Kansas.

First, I would like to distinguish this legislation from the portions of the Pennsylvania statute which were upheld by the US Supreme Court in Planned Parenthood v. Casey in 1992.

The most glaring difference between the two concerning the 24-hour waiting period requirement is that the Kansas bill requires the woman seeking abortion services to make two separate visits to the site of the procedure in order to be given state-mandated information "in person" and specifically with a physician.

We do not know for certain whether the US Supreme Court would have found the two-trip requirement unconstitutional because they have not addressed this specific issue; there have been some lower court decisions on this point, however, and there is a trend in those decisions to disallow a two-visit requirement as presenting an unconstitutional "undue burden."

The enduring legacy of Casey was in fact to introduce the "undue burden" test for determining the constitutionality of any legislation in the country which sets up barriers to women seeking abortion services. By stating the Pennsylvania law was not unconstitutional "on its face," the Court pronounced that a factual record establishing the effect of these barriers would have to be established. In other words, the decision regarding what constitutes an undue burden is a highly fact-based inquiry for the courts, and is determined by the difficulty presented to the women of that state to comply with the specifics of that state's law.

The most recent lower court decision finding an in-person visit constitutionally infirm is in the context of an Indiana 18-hour waiting period law with certain counseling required "in the presence" of the pregnant woman. A Woman's Choice v. Newman, No. IP95-1148-C H/G, D. Indiana, November 9, 1995. This statute has been enjoined on several grounds, but the two-trip requirement

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was the issue most extensively discussed in the opinion. The federal district court found that, notwithstanding the Supreme Court's upholding of a 24-hour waiting period in Casey, the plaintiffs in Indiana presented enough evidence to establish that the likely effect of the two-trip requirement would be to reduce the number of abortions in the state by 11-14%, and that this effect would be likely to be caused by the burdens of the law rather than the persuasiveness of the counseling. Therefore, the Indiana requirement imposed an undue burden that is unconstitutional under Casey.

Given the rural geography of Kansas and the unavailability of abortion services west of Wichita, we believe House Bill 2938 would present an equally significant undue burden for the women of Kansas by requiring two visits separated by at least 24 hours. As you are aware, the trip from the town of St. Francis in the northwest corner of the state to Wichita is a very long distance -- over 350 miles. Inevitable additional delay would result from this law, and undoubtedly there would be a statistically provable reduction in the numbers of procedures attributed to the two-visit requirement alone.

The civil remedies created by HB 2938 establish a cause of action for the death of a fetus if a physician violates the act. Section 8(b). There is no requirement that a physician must first be found to have acted intentionally or even negligently in order to be liable for damages. In other words, he or she may be liable for damages, even if he or she inadvertently violated the law. We argue that this violates due process of law.

We also would like to point out that this bill requires that a woman be given a copy of the state materials and they must be read to her if she is unable to read them. The Court in Casey allowed such materials to be offered. We are troubled that HB 2938 would make some women who do not wish to receive these materials an unwilling participant in the state's campaign of propaganda, especially given the inflammatory, unnecessary and inaccurate information required to be imparted by this onerous legislation.

Please oppose House Bill 2938. Thank you very much.

Testimony of Mary Spaulding Balch, J.D., Director, State Legislation Department, National Right to Life Committee. Committee hearing on House Bill 2938, "A WOMAN'S RIGHT TO KNOW."
February 12, 1996

Let me begin with a legal analysis of HB 2938 since I know that that is a major concern of many of you. This bill is constitutional. I base this conclusion on the fact that in 1992, the United States Supreme Court upheld Pennsylvania's informed consent law which is substantially the same as this bill, Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. ---, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992).

The Pennsylvania law requires that the physician inform the woman of the risks of abortion and the probable gestational age of the child; that a qualified health care worker inform the woman of her right to review printed materials including alternatives to abortion, available medical assistance for bringing her child to term, scientifically acurrate information on the development of the unborn child, as well as the legal responsibilities of the father. It also contains a 24-hour waiting period so that the woman can reflect on the information she received.

The Pennsylvania law protects rights. It protects women. Contrary to what some would have you believe, it does not outlaw abortion under any circumstances.

H.B.2938 asks that you give this same protection to the women of Kansas.

The Joint Opinion of Justices O'Connor, Kennedy, and Souter in the Casey case recognizes that a state has a legitimate interest in enacting this type of legislation:

> **In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed. If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible.**[1]

Casey also upheld a 24-hour waiting period. The Court said, "The idea that important decisions will be more informed and deliberate if they follow some period of reflection does

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[1] *Casey.*, 505 U.S. at ---, 112 S.Ct. at ---, 120 L.Ed.2d at 718.

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not strike us as unreasonable, particularly where the statute directs that important information become part of the background of the decision."[2]

Chief Justice Rehnquist and Justices White, Scalia, and Thomas point out the obvious in their decision when they say,

> **That the information might create some uncertainty and persuade some women to forgo abortions does not lead to the conclusion that the Constitution forbids the provision of such information. Indeed, it only demonstrates that this information might very well make a difference, and that it is therefore relevant to a woman's informed choice. [cite omitted].**[3]

Policy Analysis

This bill is good policy. The decision whether to have an abortion is a traumatic one. It is not made better by ignorance. As many women realize, the issue is complicated. Many women who undergo abortions face years of psychological pain and turmoil and too many women experience physical problems. A woman needs to be aware that abortion is not an escape from her problems. Often it compounds them.

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

Informed consent legislation is not an attack on personal freedom, but a guarantee of it. It is constitutional. It safeguards a woman's right to know and to make informed decisions. It is a reasoned and compassionate response to the needs of concerned pregnant women. It is good legislation.

Right now, the law in Kansas is denying the women of Kansas their right to know the basic facts about abortion. It permits the use of forms composed by the abortion provider as being in compliance with the 1992 Kansas abortion law. This allows them the freedom to slant what little information they must reveal in jargon and heap advocacy around the meager information the current law demands. What is worse, it is presented as complete and objective. It isn't.

Those who call themselves "pro-choice" are refusing to guarantee the women of Kansas the fundamental information they need to make an informed choice about their

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[2]Id., 505 U.S. at ---, 112 S.Ct. at ---, 120 L.Ed.2d at 720.

[3]Id., 505 U.S. at ---, 112 S.Ct. at ---, 120 L.Ed.2d at 775.

reproductive health. The women of Kansas have a right to know the truth about abortion. If a woman is to have a real choice, she must have access to all the material facts about her situation. Without full disclosure, "choice" is just a political slogan. Emptied of substance, "choice" means nothing more than subjecting a woman to the control of others -- fathers who want to avoid responsibility -- parents that are more protective of reputation than the physical and psychological well-being of their daughters -- friends who do not know about real alternatives -- abortion providers fixated on making a sale. The decision to have an abortion is life changing for the child who is destroyed and for the woman who must live with the decision. Kansas must act to ensure that the woman has access to all the relevant information.

More and more emphasis is being placed on the importance of patient autonomy - the right of the patient to decide for him or herself what treatment is in his or her best interest - as a basic, if not primary, consideration in physician disclosure. The exception is abortion. It is obvious that a paternalistic bias permeates the abortion process. Those who oppose informed consent legislation often do so on the basis of concern for the anxiety of the pregnant woman. This attitude is degrading and denigrating to the rationality of women. Someone who withholds information from the woman is attempting to make the decision for her. The decision is not made by the woman and her doctor, but by the doctor alone, who is often a male, and often employed by the abortion provider.

Are we making abortion a special case? In a sense, "Yes." Abortion must be treated differently so as to be treated the same. Abortion providers have proven themselves unworthy of the self regulatory system enjoyed by most of the medical profession. Abortion procedures are hurried and impersonal. The physician-patient relationship is negligible. Having an abortion is not a visit with your family doctor and Kansas cannot rely on the good-will of the medical profession in this context to protect women. Women need to be informed about the medical risks associated with abortion and given an opportunity to view information about agencies that provide alternatives to abortion. Kansas needs to provide scientifically accurate information about the development of the unborn child because no one else is doing so.

In 1994, 4% of all abortions were performed in doctor's offices. 80% were done in abortion facilities that perform at least 1,000 a year, while 23% were done in facilities performing at least 5,000 a year.[4] When deciding Roe v. Wade, the Supreme Court envisioned the woman and her physician consulting together to consider all the factors relevant to her decision, looking at the potential medical complications, psychological harm, and possible impact on her life, her family, and her future. Needless to say, the Supreme Court was not seeing the reality of abortion then and this vision is even more ridulous today. With the kind of assembly line conditions of today, abortion doctors don't have the time to read the woman's records. Little or no real physician-patient relationship exists in the abortion context. The doctor is a stranger.

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[4]Henshaw & Van Vort, Abortion Services in the United States, Family Planning Perspectives, May/June1994, at 106 (Table 5).

To argue for a woman's right to abort her unborn child and emphasize the woman's "right to choose", is inconsistent with opposing this bill. One cannot credibly advocate that women have the right to abort their unborn child and at the same time deny them the information to do so in a responsible and intelligent way. It is like saying you have a right to vote, but not a right to know for whom you are voting. A woman who is denied information relevant to her decision is not free to make a meaningful choice. When her role as a rational and responsible person is denied, she is misled into believing that she has no real alternatives, that the unborn child she carries is a clump of tissue with an unexplained gestational age, and that abortion is an easy and safe solution to her problems. A woman who decides to have an abortion under these circumstances is not "choosing." She is a mere pawn in a paternalistic abortion system, subject to the manipulation of social pressures.

Anyone who desires to defend a woman's "right to choose" should demonstrate equal vigor in attempting to ensure that every woman considering an abortion is provided with the information necessary for an informed decision. In this way can a woman make her own decision, a decision she will live with, a decision she will know was hers after events can no longer be altered.

Conclusion

In conclusion, I urge you to support the woman's right to know act. What Kansas women don't know will hurt them and this act tries to prevent that hurt. I have seen women torn up inside from the pain abortion brings. I am not unrealistic; I know women will decide to have an abortion despite the facts, but at least the decision will be theirs. And whenever a woman decides to carry her child to term, that will be one more life saved -- saved because a woman presented with the truth chose to embrace life rather than reject it. If you deny women the truth, you deny them that opportunity.

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Planned Parenthood®

Of Kansas, Inc.

Testimony against House Bill 2938
By Douglas Johnston
Public Affairs Coordinator, Planned Parenthood of Kansas
Senate Public Health and Welfare Committee

House Bill 2938 purports to address a problem: that women are at risk from abortion trauma syndrome. Planned Parenthood of Kansas is absolutely opposed to this unnecessary and misleading bill.

Post-abortion trauma is a myth.

While there is no medical or psychiatric evidence that there is post abortion stress, there is evidence that waiting periods in fact will increase medical risk as well as the financial and personal problems women face.

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

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

While it is certainly true that someone might later regret having had an abortion, this is not the feeling of most women who have undergone that procedure. The evidence is overwhelming from the best sources that abortion trauma is a myth, not a problem.

Wichita--2226 East Central, Wichita, Kansas 67214-4494 316 263-7575
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Government mandated "counseling" is unnecessary and an inappropriate use of governmental regulatory authority.

Counseling with clear and objective information has always been an integral part of abortion services at Kansas abortion providers.

This bill appears to be aimed at limiting access to a legal medical procedure rather than strengthening the quality of medical practice in Kansas.

A careful reading of the bill reveals that it is written on the assumption that pregnancy alternatives to abortion are not mentioned or encouraged at family planning and Planned Parenthood clinics or between a doctor and his/her individual patient. At all women's clinics which Planned Parenthood of Kansas is associated with the entire range of pregnancy alternatives has been made available to clients without emphasis or pressure to choose any one. This includes discussing social services which are available to pregnant women of low income and referrals to appropriate services if a woman chooses to continue her pregnancy.

A woman's decision regarding her pregnancy is a very personal one and the role of counselors is to provide her with full knowledge of her options from abortion to continuing the pregnancy and adopting out her child or keeping her child.

There appears to be the assumption of the sponsors of HB 2938 that the decision to choose an abortion is one easily made and readily changed by receiving counseling regarding "a father's liability" and benefits available for prenatal care, childbirth and neonatal care.

No woman chooses abortion gladly or lightly nor is her decision likely to be changed by the statement that she can sue her partner for child support or compete for increasingly scarce resources from the social service system.

Undue Burden.

The bill requires two trips to the provider's office because the information must be provided "in person." A federal court in Indiana recently enjoined a similar law because a two trip requirement could lead to women obtaining abortions later in pregnancy or not

obtaining them at all. The court's conclusions were based on a study of the impact of a similar law in Mississippi.

The bill requires the woman be given a copy of the state materials and they must be read to her if she is unable to read them. In contrast, the Pennsylvania statute in Planned Parenthood v. Casey, required only that the woman be offered the information. The Court, in approving the requirement as "reasonable" described it as one in which the woman is "informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term." (112 S. Ct. 2791, 2824 [1992]). What are women to do if they do not wish to hear the mandated information? Are they expected to just sit and listen like good little girls and take it like bad medicine? If they want to opt out is there only option to lie by signing the affadavit that they were given the information? **House Bill 2938 could make many women the unwilling recipients of the state's mandated information.**

The bill requires information be given on the yet to be proven link between abortion and an elevated risk of breast cancer. The physician must give this information regardless of his or her opinion of its medical relevance or accuracy. In contrast the Casey statute required only that the woman be given information on "those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo an abortion." **In this way, the HB 2938 violates the holding in Casey that the state may require only the giving of information that is truthful and not misleading.**

Implicit in providing informed consent to a patient is the duty to explain not only the procedure and the risks of the procedure, but also the alternatives and the risks of the alternatives. It is well documented that the risk of maternal mortality with a first trimester abortion is less than one seventh that of the risk of childbirth. Will the state publish the fact that the risk of dying from childbirth is seven times greater than the alternative?

The process of providing true informed consent is complex, personal, and best left up to the physician who is caring for the patient.

24 Hour Waiting Period
A 24 hour waiting period is an unfair burden and unfair barrier to women seeking abortion services.

The American Medical Association found legislated waiting periods often caused delays of 4 to 6 days. The same AMA report concluded that mandatory waiting periods undermine medical safety. Basically the later the stage, the greater the risk associated with the procedure. Keep in mind that the rate of complications in abortion procedures is less than 1% of cases.

Definition of Abortion
The bill defines abortion as "use of any instrument, etc., with intent to terminate the pregnancy of a woman" and excludes delivery of "an unborn child prematurely in order to preserve the health of both the mother and her unborn child." This would seem to sweep within the definition of abortion premature deliveries that are necessary for the health of the woman, but not necessary for the health of the fetus, but which are not "abortions" since the intent is to deliver a live fetus. Unless the procedure also fell within the definition of "emergency" the woman about to undergo such a premature delivery would have to listen to information about "abortion" and its alleged link to breast cancer, etc., information totally inappropriate to the procedure she is about to undergo.

Civil remedies.
The bill creates a cause of action for death of the "unborn child" if the physician violates the act. There is no requirement that a physician must first be found to have acted intentionally or even negligently in order to be liable for damages. In other words, he or she may be liable for damages, even if he or she inadvertently violated the law. Is this not a violation of due process?

THE LEAGUE
OF WOMEN VOTERS
OF KANSAS

TO: MEMBERS OF THE KANSAS SENATE
FROM: DARLENE GREER STEARNS
RE: HB 2938

I am a registered lobbyist for the League of Women Voters of Kansas. The League opposes HB 2938. The League position on Reproductive Freedom is as follows:
" Protect the Constitutional right of privacy of the individual to make reproductive choices".
Rather than expand on the League position I offer two personal experiences which I believe speak to some of the erroneous statements in HB 2938.

The first speaks to the counseling provided by clinics in Kansas.Several years ago I was part of a group assisting women seeking abortions with funds, transportation and information. A woman I helped had been institutionalized from time to time, found herself pregnant and needed transportation. The stage of her pregnancy required her to go to Women's Health Care Center in Wichita. On arrival she had all the necessary tests, counseling, which included basic abortion information, individual concerns, options, etc. At the end of the session the counselor told her they could not perform the abortion because they felt she was incapable of making an informed consent. She wept, tried to correct her statements and answers to questions but the counselor was firm but compassionate in her refusal. Clearly this contradicts the charge of inadequate counseling, that clinics are interested only in promoting abortions, and not concerned with the patient.

The second case was a woman with two small children living in a battered woman's shelter. She needed funds and transportation and needed to bring her children with hersince she could not leave them at the shelter. We drove to Johnson County where she went through all the necessary procedures while I took care of her children. On the trip back she told me I, along with Battered Women's Task Force, had taken one more step in saving her life. Had we needed to wait another day, as required in HB 2938,it would have meant two trips for all of us. There are not always those willigg and able to help these women. They often have no family, no job, no future without that help. Placing barriers of travel, extended counseling and extra costs in their way can be disastrous. Women with families, money and resources have always been able to obtain abortions. Those who have problems are the poor, the young, the alone and HB 2938 puts barriers to those women which they probably cannot cross.
Kansas has an informed consent law. The League opposed that law and all others restricting a woman's right to choose abortion, but accepts these and has not attempted to overturn those laws. In a climate of frustration, and indeed anger, with government interference in citizen's affairs, and erosion of rights of the individual, it is strange we continue to see attempts to place serious barriers to an individual making a very personal, private, medical decision. The League requests defeat of this bill.

Respectfully,
Darlene Greer Stearns

Darlene Greer Stearns
112 Woodlawn
Topeka, Ks. 666(
913-235-3757

Senate Public Health & Welfare
Date: 3-13-96
Attachment No. 14

Kansas National Organization for Women

P.O. Box 15531, Lenexa, KS 66285-5531

Senate Public Health & Welfare Committee
Testimony in Opposition to HB 2938
March 13, 1996

Submitted By: Monica Neff
(913)-842-6496

Honorable Chair and Distinguished Members of this Committee:

On behalf of the Kansas Chapter of the National Organization for Women, I am in full opposition to HB 2938. In fact, I know that the assumptions and the insinuations made throughout this bill that women in Kansas are not receiving quality comprehensive services through our family planning clinics is untrue.

Women, consistently express through letters and phone calls the appreciation and gratitude they feel for the respectful comprehensive quality services they received from these clinics.

Presently, these clinics provide comprehensive family planning services to women and men addressing contraceptive options, prevention and treatment and of sexually transmitted diseases including HIV and AIDS, screening for certain types of cancer, assistance with a variety of gynecological concerns and all the options a woman could consider if she is pregnant. These options include giving birth, providing for an adoption or having an abortion. When a woman has made her decision and all of questions have been answered, appropriate referrals and services are provided to support her in her choice.

The deep concern and respect given to women along with these clinics' professionalism, medical protocols and quality medical care should be commended. However, this bill states that the "primary goal" of these clinics is to"sell abortions services". This is blatantly false and attempts to distort and undermine the comprehensive professional services presently being provided through these clinics to women from Kansas and elsewhere.

This proposed legislation would totally sabotage these reputable medical family planning services now provided to women by forcing numerous governmental mandates and materials on them personally and on their physicians. Such as:

(1.) Forcing women to read or have read to them , governmentally mandated material prior to being allowed to proceed with an abortion decision.

Concern: Who is going to decide the contents of this material? Will these materials be as comprehensive on options to women and scientifically objective and pertinent as what is presently being provided and used?

How can this be, if throughout the text of this bill the scientific term "fetus" is never used? Also, is the state willing to pass legislation and respond to all the ramifications this bill would provide for, especially since numerous religious beliefs are written into this bill's text? In particular HB 2938 legislates a definition that life begin's at the "conception of an unborn child".

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(2.) Forcing women then to wait an extended time period of 24-hours after being forced to read highly suspect and possibly biased mandated governmental materials.

Concerns: Both of these mandates are highly disturbing and insulting to the intelligence and inherent moral authority women and men have as human beings to make decisions concerning our individual bodies and lives.

Governmentally legislating to these "certain" physicians special regulations regarding medical protocol, procedures, patient contact and time lines hinders access for women to appropriate timely medical services relating to abortion.

This provision would also create an undue burden and hardship, especially for rural women, to access abortion services as an option. Many women already face long distances to travel and a mandated 24-hour extended waiting period would further prohibit many from exercising their rights to this medical procedure. Additional time off from work and/or family, and harsh barriers for many due to increased costs for lodging, additional meals, possible child care needs, lost income and increased medical costs passed on by physicians due to the additional mandates put on their time and procedures to perform abortion services could effectively abolish this option.

(3.) Forcing physicians to verbally and in person to subject their female patients to state governmentally mandated material supposedly pertinent to the possible procedures the physician may perform.

Concerns: Why are only family planning clinic physicians being mandated and regulated by the state of Kansas regarding their medical practice? If this is acceptable, why then are not all physicians being mandated to submit governmentally mandated material regarding many other medical procedures that are performed on women and men?

(4.) Requiring the state of Kansas to create a directory of all services that is geographically indexed which lists "public and private agencies and services available to assist a woman through pregnancy, upon childbirth and while her child is dependent, including but not limited to, adoption agencies". This is portrayed in the bill as a comprehensive directory to be developed and funded for by the state.

Concern: If this bills so called intent is to provide women with "complete and accurate information and alternatives", why then does this directory of resources not include family planning gynecological services including pregnancy prevention and abortion services?
Is this directory to be required at only family planning clinics or all clinics and hospitals serving womens' needs? If so, how can it be considered "comprehensive" if it leaves out reproductive family planning services including those who provide abortions?

Is the state of Kansas willing to mandate and fund such biased materials that would be distributed under the guise of a comprehensive directory of services to women?

(5.) Requiring the state of Kansas to set up and staff a 24-hour a day telephone line in which this directory and other mandated materials will be disseminated to women calling in. Also, this bill requires that such materials shared must include a statement to the women saying that "the state of Kansas strongly urges you to contact these public and agencies willing to help you carry your child to term prior to making a final decision about abortion".

Concern: Is this not a clearly biased and inappropriate request being made to these women on behalf of all the citizens of the state of Kansas?

This entire legislation would create 12 new statutes which would create serious undue financial, emotional and possibly medical burdens that could limit access to Kansas women's right to safe and legal abortion.

The fiscal note for HB 2938 is $146,801 for fiscal year 1997 and an additional $97,751 for fiscal year 1998, totaling $244,552. Is the state of Kansas willing and prepared to pay nearly $250,000 to undermine and essentially destroy the quality professional and appropriate medical services presently being provided through our Kansas' clinics? To replace it with even more governmental interference and regulation in the personal lives of women, their families and their physicians. I hope not.

This provisions of this bill does not appear to want women to be more informed, but rather deceived and deterred from having professional comprehensive information on reproductive choices and services, including their right to legal abortion.

For these reasons mentioned, and many more, I am vehemently opposed to HB 2938. Also, I am in support of the other opponents and their testimonies given today against this bill. Therefore, I respectfully ask that you vote to oppose all portions of HB 2938 on behalf of the women in Kansas, their families and their future rights to reproductive health, choices, and access to all medical services.

Thank you for your attention and consideration.

TESTIMONY

H.B. 2938

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
Wednesday, March 13, 1996

KANSAS CATHOLIC CONFERENCE
Beatrice E. Swoopes, Program Coordinator

Chairwoman Praeger, members of the Public Health and Welfare Committee -- my name is Beatrice Swoopes, Program Coordinator for the Kansas Catholic Conference, which represents the Roman Catholic Bishops of Kansas. Thank you for the opportunity to speak to the provisions of H.B. 2938.

The Kansas Catholic Conference supports and encourages the passage of legislation which will enable women anticipating abortion to be educated and informed about the medical and psychological consequences of their actions, as well as feasible alternatives.

A woman deciding whether to carry her baby to term needs the support of family and needs good information. Oftentimes she has neither. She needs time to reflect on the medical information available from competent scientific research. Also she needs to know that the people caring for her at such a traumatic time are qualified to counsel her and meet her physical needs.

Today many church organizations (including our own) give counseling and support to concerned pregnant women, but

this information may not be readily accessible at the time of the planned abortion.

H.B. 2938 which addresses a "woman's right to know" is a good approach. It would guarantee a woman's thorough understanding of the physical and mental aspects of the abortion procedure she is contemplating. It would also help alleviate the confusion and the tragic aftermath of a decision made many times out of fear and panic.

The proposed legislation offers a woman a comprehensive package of services as she faces one of the greatest challenges of her life.

We support passage of H.B. 2938.

Jane Doe #3

The expediency of abortion encourages women to be weak, dependent, and incapable of dealing with unexpected challenges. This mentality tells women they must depend on abortion to solve their problems for them. Abortion has been sold to women under false premises. We have been lied to, manipulated, and exploited. For too long we have remained silent, too ashamed to speak out. No longer am I willing to be silent.

I was sixteen at the time of my crisis pregnancy. Scared and unaware of what to do, my boyfriend and I took the abortion pamphlet offered to us by the health clinic nurse and scheduled an appointment. I used the identity and birth date of someone else for fear there were restrictions for girls my age. To my surprise very little information was asked of me and very little was given to me. Prior to my abortion, no attention was given to alternatives, what the procedure entailed, or fetal development. No time was allowed to consult with the doctor about the nature of the physical and emotional risks of abortion. In fact, no conversation between the doctor and I took place.

When the abortion was finally over and I was able to walk to the waiting room, my boyfriend asked me if the doctor told me if the baby was a boy or girl. It was at that moment I began to realize the magnitude of my decision. This uniformed decision, this "right" was filled with sufferings and regret. The abortion killed not only my child; it killed part of me.

Physically, I have healed from the abortion, despite not returning for follow up care. Unfortunately, the emotional trauma has been excruciating and has ranged from depression and hellish nightmares to utter grief. There is no way you can feel the pain that I have felt or understand the emptiness that I feel inside knowing I made the wrong decision. What a difference simple information like that proposed by the "Women's Right-to-Know" Act would have made.

To my knowledge, abortion is the only surgery for which the surgeon is not obligated to inform the patient of the exact nature of the procedure. We need to ask ourselves why. Since abortion is provided as a commodity not as a medical necessity, it's only logical that abortionists or anyone who profits from it would reject medical standards. Simply put, the abortion industry like any big businesses resist government regulations for fear it might reduce their profits.

How then, can anyone in good faith first of all support an industry that destroys human life, but also presents itself under the guise of medicine but repudiates the obligations, codes, and oaths of medicine, specifically informed consent?

The destruction of human life is an irreversible event which has altered my life and countless others. What a tragedy to make a life changing decision such as this without all the facts. There is no liberty in a society that encourages irresponsibility through the concealment of information, especially regarding abortion.

I urge you to be responsible and pass this bill.

I sat in the waiting room with my husband, scared and confused not knowing what was going to happen to me. I sat looking at a girl across from me, she looked to be about 13 or 14 and she was crying. I remember a lady sitting next to her and I guessed she was her mother. The mother looked like she didn't have a care in the world.

The girl started crying harder and whispered something to her mother and she (the mother) responded with "Shut Up your having this done and that's it"!! I felt sorry for the girl, but I had my own feeling's to deal with. As I sat there I thought about my own children and I wanted to be with them. I got called back and was taken into a small room with other people watching TV.

We all sat there and said nothing I was so scared and no one wanted to talk to me. I was called again and I thought finally I can talk to someone. I was taken into a room no bigger than a broom closet, in there was a table and two chairs, on the table were some papers and a paper medicine cup that looked to have about 8 pill's in it.

The papers were my chart. The lady sat down and I thought finally I have someone to talk to but she didn't want to hear anything I had to say. She asked me to sign a paper to have the abortion and that's when I started to say what I was feeling, I told her I didn't want to have this done , I was scared and I didn't know what they were going to do to me. I asked what was going to happen & all she did was write something down and told me to take the pills in the cup, she said they would help me to relax, I took the pill's and started to crying she just sat there writing and after a few minutes asked me to sign the paper again and I said no I don't want this to happen and she stood up & said she'd be back I thought she was going to get me some help but she came back with my husband and she told him I wouldn't sign the paper he got really mad because I was disobeying and said either I have this done or I stay there. I was scared, I didn't want to be left there I had just moved to Kansas a few months before and didn't know anyone, I signed the paper.

In the abortion room I was asked to undress from the waste down and get up on the table and into the stirrups & not move!

The doctor came in and said nothing, I felt him touch me and I reached for my husbands hand and he reluctantly gave it to me and yelled " Don't move! I heard a loud noise and felt pain I squeezed my husbands hand and told him it hurt and he told me to shut up! The noise stopped and I was told to dress no one helped me off the table they took my husband out and shut the door.

I dressed and after a few minutes I was taken to an office where other girls were I was given a small cup of juice and told to sit on the couch for awhile after about ten minutes a lady came in with a sheet she told me to wrap it around me and pull down my pant's so she could check my bleeding she then said I was fine and could go home.

This was three years ago at Wichita Family Planning Inc.

I thought with a name like that I could get help, the right kind of help not the wrong.

My feeling's now are that I feel cheated and used. I think that when I said no I should have been able to talk to someone. I should have known my option's I should not have been pushed into having the abortion they should have let me leave instead of getting my husband.

I feel now that the people in the abortion business don't care about the girl's that go in there , all they care about is the money as long as they have a "YES" from someone whether it be the girl or someone off the street they'll do the abortion.

We need the right to know so these girl's can be educated on every aspect of abortion BEFORE it is performed NOT after It's a little late then!

Lisa Worden
Wichita KS

17-3

Dr. George R. Tiller and Associates
5101 East Kellogg
Wichita, Kansas 67218

Troy, New York
12182
August 10, 1989

Dear Dr. Tiller and "friends":

This is a letter I feel compelled to write and send, not only to thank you but to help myself as well. I have a new feeling about mysely... a very good feeling. I feel as though I can do anything and do it well. I've decided to go back to school part-time (evenings) for my masters degree; this is something I have procrastinated about for two years. I will be teaching physics and anatomy at the high school level as well, which I thoroughly enjoy. I hope to get certified in education and work towards a masters degree in molecular biology.

Now, I must tell you that you are very lucky to have the staff that you do. Besides being the best "hand-holders" in Kansas they are remarkable women. Never did I imagine my experience at women's Health Care services would be like it was. Although I journeyed to Kansas alone and scarred, I never felt alone with you and your staff. Their support and attitude meant more to me than you can imagine; hence I am sure of your buttons' motto "Attitude is EVERYTHING!" Thank you to your staff, especially Kathy, Sylvia, Paulette, and Edna; you all were a foundation of courage for me. I know I am a horrible patient - I'm terrified of everything including needles you made me forget about some of my self-doubts and gave me confidence in ME! I would like

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to thank you for allowing me to put my dreams back in focus. For a week, my vision and goal were blurred. I had lost sight of all of my plans for the future, but now I can continue with those plans. Please accept my sincere thank you for making all of this possible. You are a special group of people with a power which is tremendous... giving women their dreams. I will never forget you AND I believe in all of you because you believed in me.

Sincerely,
Kimberly

November 26, 1992

Dear Dr. Tiller and Your Staff,

I have so much to say, so much going on in my head-but words on paper seem so inadequate to express how I feel for the man you are and the much needed services you provide to women on a daily basis under such horrendous circumstances. I will never forget the caring, understanding and superb medical attention that you gave to my sister Debbie, Dennis and myself during the week we spent with you. It seems appropriate that I write this on Thanksgiving Day.

Childless at age 38, who would have ever dreamed that Debbie and Dennis would have conceived this child. The miracle of life. We were all elated. Our lives had been changed forever. When we found out at 15 weeks that we would welcome a little girl into our family, our prayers had been answered. For the past 7 months, Debbie and Dennis, myself, and our families planned and prepared for the birth of little "Logan Elizabeth". Who would have ever guessed it would turn out this way? I'll never forget that day in October when Stacy and I accompanied Debbie for her final sonogram in Erie. I knew immediately that something was not quite right with my little niece, although at that time we did not know how severe. The next few days were a blur for all of us and very devastating for Debbie. When the prognosis came out of Pittsburg that our baby had no chance of survival, we soon shifted our attention to Debbie and her well being.

And that's when we came to you...We were tired, apprehensive, distraught, and in emotional turmoil. It was unthinkable that we had to travel half way across the country to do what was best for Debbie, Dennis and our baby. But after our trip, given the same circumstances, I would travel half way around the world to be with you and your staff. You guys were wonderful, like angels sent from heaven to guide us along this difficult journey. From the time we set foot in your center until the moment we left, you were not only attentive to Debbie's medical needs but were acutely attuned to our emotional needs also. Your perception and understanding of those needs made the loss of my only niece a little less destructive. You knew what we needed at every moment and saw to it that those needs were taken care of.

The opportunity to see my niece, Logan Elizabeth, and hold her in my arms allowed me to say goodbye and let the healing process begin. I'm sure that it had the same effect on Deb and Dennis. I'm just sorry that all the rest of the Significant Others in Logan's life did not experience the same closure that we did.

Debbie and Dennis were at ease and very comfortable with all of you. Debbie talked openly and honestly for hours on

end with Dennis and I while we were in Wichita. Her dreams, goals, and feelings about her daughter will never be forgotten by any of us. Although Debbie doesn't talk about her experience much any more, I know each and everyone of you will always have a special place in her heart. You gave dignity to the death of her daughter. With your help, Logan slipped quietly and peacefully away from us with no pain or suffering. What more could we ask for.

On this day of giving thanks, I want to thank you all... Kathy, Edna, Fran, Stacey, Jackie, Stephanie, Tracy and especially you, Dr. Tiller, for the assistance you gave to my sister, Debbie, my brother-in-law, Dennis and my niece, Logan Elizabeth. I love them all and am not sure where we would be now without all of you.

The impact that little Logan Elizabeth had on our lives in such a short time is incomprehensible. She will always be with us. PEACE be with all of you.

With much gratitude,

Sharon

Sharon

February 13, 1993

Dear Dr. Tiller and Staff,

I'm writing to express heartfelt thanks and love for your kind and gentle treatment for our situation. I'm just sorry it's taken me so long to do this - it's almost a month now and thanks to all of you there's some symbol of normalcy in our home once again.

My daughter, Ta-Aqua, has returned to school and back to life as we had known. She's doing fine and her grades are wonderful, without your kindness and consideration it could've easily been different. I'm grateful that you were there for us and will be there for so many others in the same or similar situations.

You've literally given us new hope and life, and for that I'll always remember you. In some way I feel as if it was fate for me to meet others in the same situation and become lifetime friends with them, gratitude and thanks seem to be less than enough. I hope your staff knows how warm and special they are and their kindness is above board. I also want to say a special hello to Edna, the sunshine of every day we were there, and to all of the staff - they were all beautiful and kind people.

I'll never forget the experience, and I'm also grateful for the opportunities that you have allowed my child to seek out and find. To those I felt close to here's a special hello - Fran, Amy and Cathy - you're all special and kind, stay as sweet as you are. I'll always remember those warm friendly smiles and pleasant hello's - you helped ease the pain more than you know. THANK'S AGAIN!! You were all wonderful.

Sincerely,

Ms. (Ta-Aqua's Mom)

P.S. Keep smiling and wearing your buttons, because truly, ATTITUDE IS EVERYTHING!! Once again, thanks so very much for doing what you do and being who you are.

February 12, 1993

Dear Dr. Tiller and Staff:

It was a very nice surprise to receive the letter from your clinic a few days ago inquiring about how my daughter is getting along six months after having beeen to see you. Once again, I am so amazed at the care, thoughtfulness and interest you take in each of your patients.

The experience we had in coming to your clinic was one I have had a hard time putting into words. What was a terrible, desperate situation with my daughter became a truly uplifting experience I will never forget. Never have I known people to be more loving, friendly and helpful than we found you and your staff to be. The relationship formed with the other people (patients, parents or friends) there at the same time also was unique. Somehow, we all seemed to come to love each other in a beautiful Christ-like way in just those few days we spent together supporting each other through the ordeal. But it was your lovely clinic which made that possible. The beautiful furnishings in the comfortable waiting room, the video and personal talks with you, Dr. Tiller, and our group sharing session led by dear Fran all made us feel, finally, that everything possible was being done to make everything "OK". We came to realize that there could be a bright future to look forward to. I highly commend the "Step Plan" toward changing one's life for a new direction. That is something that would be good for anyone to consider.

We are very pleased to be able to say that our daughter seems to have finally turned her life around. Just a few days ago, she brought home the first good report card from school since she started in high school three years ago. She has also re-established relations with most of her old friends. And she is pleasant and usually agreeable at home again; helpful and a joy to have around. She will be 17 in May and seems to be on the right path now to a happy, successful life.

You are all thought of often there at the clinic in Wichita. You are all truly some of the finest people anywhere! It is my prayer that God will continue to protect you and make it possible for you to continue with your work. How could some of the so-called Christian people be against what I found to be a "little bit of heaven" on earth?

Sincerely,

Betsy T.

18-6

Dear Dr. Tucker and Staff, 3-22-88

I would like to thank you for your concern and tender loving care while I was a patient at your clinic. All of you made my Dad & feel at ease and kept us well aware of all the risks concerning my situation. It is good to know that someone cares and believes in you at a time of desperate need and insurity. I really liked the group sessions. I felt much better about myself and realized I was not the only person caught in a situation such as this. Thank you again for caring and understanding.

Sincerely,
Anita.

18-7

September 4, 1992

Dr. Tiller and Staff:

Where do I begin? You did so very much for my 11-year-old niece, Tara, through the entire week we were at the clinic. I could never possibly find the words to express how thankful I am to you all. I know you have probably heard this before, but you will never know how greatly you have touched my life. When I walked out of the doors of the clinic for the last time, August 1, 1992, I knew my life would never be the same.

We came to you during a time of great anguish and loss. Anguish over a very devastating situation surrounded with a lot of sorrow over the loss of innocence. Innocence that was stolen from a child whom I hold very near and dear to my heart. And with that there was a tremendous amount of self-blame and guilt over my inability to see what was happening. I love that child more than life itself and would do anything to have spared her the sorrow she has had to endure a great majority of her still very young life. But, what's done is done and I can no longer continue to lay the blame. I can only go on from here and help her to heal and become the very best person she can be. She may have been victimized at a young age, but she will not grow up to be a victim of her circumstance! She is still very much a child, (THANK GOD FOR THAT), and just as a child she will heal faster, stronger, and better than most. With much counseling, support, and love, we will all be okay!!

As for me, you and your staff have had a lot to do with my personal healing process. I did not realize how strongly I had been affected by this until I came home and spent many a day away from her. As I sat and pondered upon my days at the clinic, I came to realize the need for not only the freedom to choose, but the need for a safe haven to go to after the choice has been made. You provided that in the most effective manner.

You all went above and beyond the call of duty for all who came to you. People like you all are hard to come by in a society such as ours. I truly thank God for you all! Please know you have my highest praise and deepest thanks!!

Thank you for taking one of the worst situations of my life and making it one of the best experiences I have ever had. I honestly think I learned more in those five days than in many years of schooling.

Good Luck and Best Wishes to you all!! Continue on with your fight and as you stand for your beliefs know that you do not stand alone! As a very wise man once said, "You could have missed the pain, but you'd a had to miss THE DANCE!"

Sincerely, Jana

P.S. Edna, I owe you an extra special THANK YOU. Tara would not have made it as easily without you! I love you for that!! (KEEP SPEAKING YOUR MIND TO THE OPRAH SHOW!!) May God be in all you endeavor!!

18-8

August 10, 1994

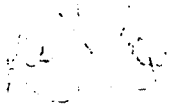
Dear Dr. Tiller and Staff,

I would like to thank you for all of the love and care that you gave to my husband and me. Although it was the most difficult time for us, your professional and personal help guided us when we needed it most. I know that this must be difficult time for you all with the recent murder of the doctor in Florida, and I wanted to write and tell you that we recognize your bravery and respect your strength to do what you believe is right.

When I came back to Rochester and visited my doctor who referred you, I told him that I would be more than willing to speak with anyone else that he refers to you. I know the fear we felt before coming to Wichita, and I believe that we could help them by explaining not only what exactly will take place, but also, we could help to alleviate some of their fear by describing the care, love and strength you provide.

We will always be able to remember our daughter without guilt. I cannot adequately express what a gift that is to us. You gave us a choice to do what we felt was best for everyone, and now we can continue to live with our love and memories of our daughter, Madeleine.

Sincerely,



Leslie A.

18-9

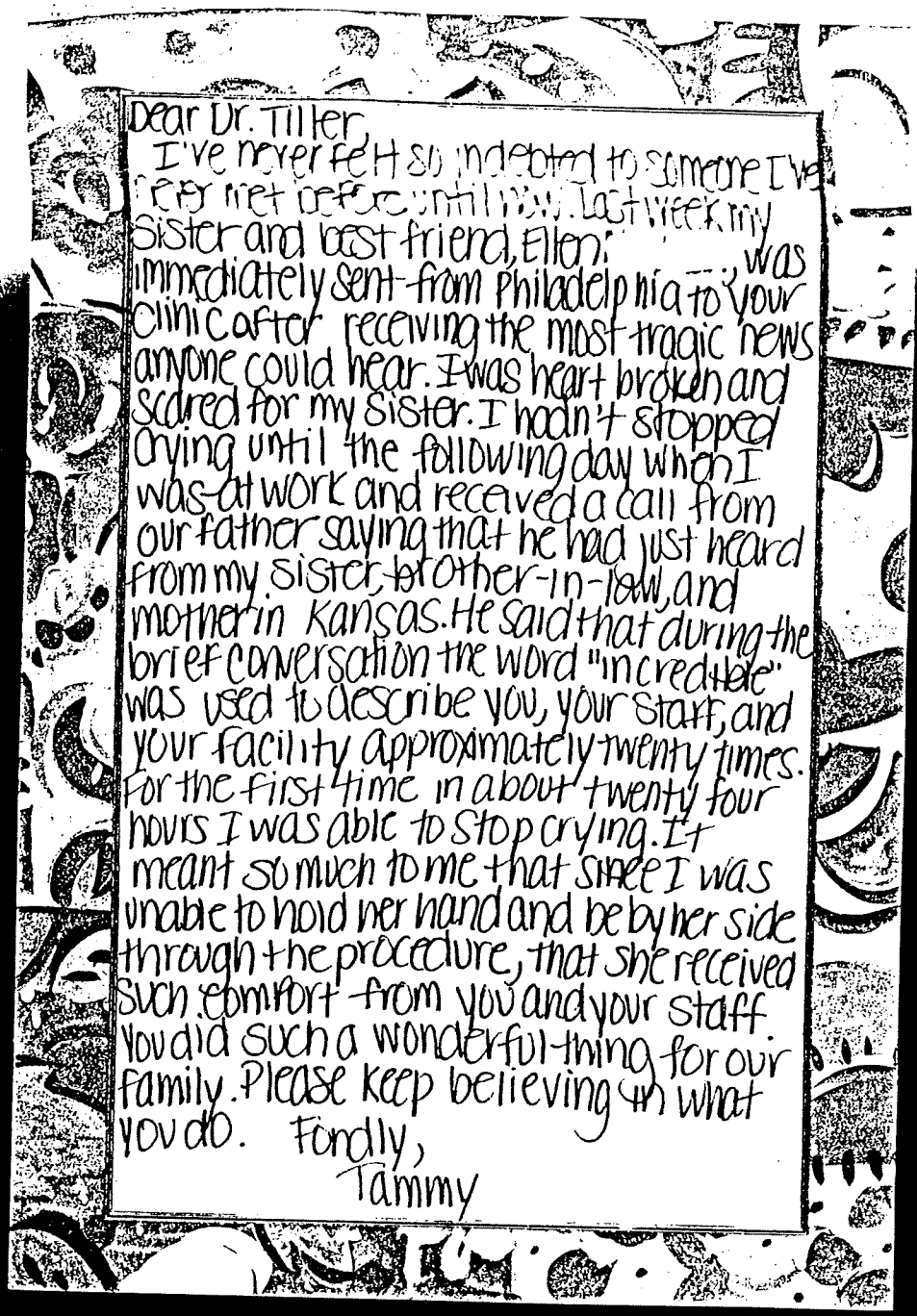
Dear Dr. Tiller & Staff,

We wanted to let you know how much we greatly appreciated your kindness and understanding during our time of need. We received all the love and support that any couple would hope for. I hope your clinic is able to be available far into the future for all the other people who have similar circumstances as we did. You were all truly there for us when we needed you most.

Thanks so much

Sincerely,
John & Joyce

18-10



Dear Dr. Tiller,

I've never felt so indebted to someone I've never met before until now. Last week my sister and best friend, Ellen, was immediately sent from Philadelphia to your clinic after receiving the most tragic news anyone could hear. I was heart broken and scared for my sister. I hadn't stopped crying until the following day when I was at work and received a call from our father saying that he had just heard from my sister, brother-in-law, and mother in Kansas. He said that during the brief conversation the word "incredible" was used to describe you, your staff, and your facility approximately twenty times. For the first time in about twenty four hours I was able to stop crying. It meant so much to me that since I was unable to hold her hand and be by her side through the procedure, that she received such comfort from you and your staff. You did such a wonderful thing for our family. Please keep believing in what you do. Fondly,

Tammy

D. Dr. Tiller & Staff,

I just wanted to write & tell all of you how wonderful I think you are & thank you for taking such good care of me. When I came to you, I was very scared & very unhappy. However, after seeing & hearing what you are and discovering how my life would change for the better, I realized I was in very good hands. You & your staff made me feel comfortable & I knew everything was going to be alright. You all showed me that somebody cared & that I wasn't going to have to go through this alone.

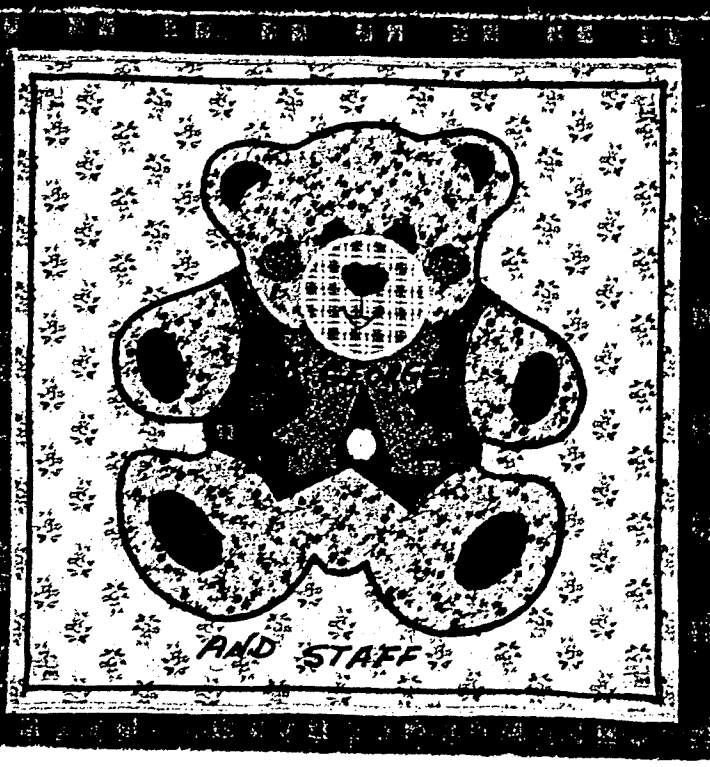
Well, everything is ~~begin~~ beginning to look brighter & I feel like I can do whatever I set my mind to. I've had my down moments but I just remember all that you said & it gives me the strength I need to succeed. I'm going to make my dream of being a great nurse come true, but I couldn't have done it without all of you. I didn't think I'd be anybody but now I know I <u>am</u> somebody. I want to thank you all again for the caring, the words of encouragement, & the gift of a bright future. I will miss you all **but** you'll be in my thoughts because I now have something to look forward to & it would have never happened if you hadn't been there.

Thanks again!

Love,

Michelle

18/2



NO WONDER THERE'S SUCH
WARMTH BEHIND
THE THANKS THIS BRINGS YOUR WAY,
YOUR SPECIAL KINDNESS
BROUGHT SUCH HOPE -
IT REALLY EASED MY DAY...

AND WHEN ANY GROUP OF PEOPLE
DOES THE THOUGHTFUL THINGS
YOU DO,
IT'S HARD TO FIND
WORDS WARM ENOUGH
TO THANK EACH ONE OF YOU!

DEBORAH

March 4, 1992

To Everyone,

I wish to express my sincere thanks to all of you for making the hardest decision in my life a little easier.

It is hard to believe that in today times with all these new technologies that the abortion issue seems to be going backwards. I had to deal with the fact that the child I had carried for seven months was very sick and probably wouldn't have lived till it's first birthday. Making the decision to terminate my pregnancy was hard enough then I found out that the only place this could be done was two thousand miles away from home. I think that is absolutely absurd.

Everyone of you made my mother, mother-in-law and myself feel very welcome. We got to know people from all over the United States that were having the same problems. Each of you should be commended for the work you do, right down to the clinic volunteers and guards that stand outside.

Thank you all for believing that the decision to do with my body is mine alone. If you need my help or my families help for any reason you know how to contact me. I consider you all part of my family.

Sincerely,
Sudden

In Loving Memory:
Daniel Joseph

18-14

1/11/93

Dear Dr. Tiller and Staff,

I would like to take this opportunity to thank you and your staff. For giving me a chance to achive my goals in life. You were all very caring and considerate, your explanation of the whole procedure was very comforting. I feel that every individual should be given a new chance on life, and to continue with there dreams.

Thank you again,

C.V.

New York

May 8, 1988

Ruth .

Kentwood, MI. 49508

Women's Health Care Services
5107 E Kellogg
Wichita, KA. 67218

Dear Dr. Tiller and Staff:

We made the 890 mile drive home safely and everything is looking much better in every way -thanks to you all. Surely you have boxes of thank-you notes beyond those displayed in the office. You do a great service to rebuild lives. Our daughter was 14 when she was the victim of several statutory rapes by a 30 year old man. She was 15 when we finally found out and she felt that her life was over. Thanks so much for a new start.

My husband made out the card before I remembered that the Clinic that refered us had lost their brochure. We are sending one to them with letter (copy inclosed.) We will also take one brochure to the Planned Parenthood office when we take Jenny for her checkup. We shall keep one for anyone who may find need of it after the word of our predicament gets around.

Again please accept our heart felt thanks. What would we have done without you all?

Ruth & Jenny

18-16

May 8, 1988

Ruth

Kentwood, MI. 49508

Heritage Clinic
425 Cherry SE
Grand Rapids, MI. 49503

Dear Sirs:

Last Tuesday, you advised us of a clinic in Wichita, KA. that would admit patients who were beyond 22 weeks. We went there and can vouch for Dr. Tiller and his whole staff. They are not only very kind and sensitive but most professional. Please do not hesitate to refer other late patients to that facility. We are inclosing a brochure from "Women's Health Care Services" of above named city and feel free to give my name and phone number to anyone who wants some first hand information. We cannot praise the doctor and staff too highly.

Thank you again for your refural. We are,

Ruth

James & Ruth [illegible]

538-8524

18-17

February 16, 1993

Dear Dr. Tiller, Edna, Cathy, Fran, Tracy, and all of you who helped us but whose names I've forgotten:

We've thought of you often since we were at your clinic the week of Christmas.

I can't put in words how difficult it was for us to decide to ask for the help that you eventually provided. We loved our unborn child so much.

Only after much consultation and agonizing did we decide that we loved our child too much to allow her to be born to a life of suffering. It was the most kind, loving decision we could make, for a child who was as wanted an any child could be.

Many tears have been shed, and continue to be shed, for our daughter. Our comfort is our belief that she's in a place where she's whole and happy.

We've often said how grateful we are that you were there to help us through our difficult situation. Our families are also grateful you provided us with an option, and were so kind to us. Among other things, it must take courage to continue your work.

We are especially thankful for your kind, sensitive, supportive, and professional care. The options you provided for our precious daughter - baptism, naming her, holding her, cremation, pictures - have facilitated our healing process. We remain in contact with the "other couple from Minnesota" (Jerry and Cindy) who were at the clinic the same time we were.

Gradually, we are healing. Our two-year-old continues to brighten our days. We are optimistic of having a healthy sibling for Eric in the future. I'm taking high dose folic acid in hopes of decreasing future pregnancy risk.

Friends from Minnesota,

Amy and Todd J.

18-18

Dear Mr. Tibbs,

The kitten and all wishes to you to keep Darling Princess till she is old but I like and to thank you for everything you have done for us.

My husband and I came to you a year ago March 12 at Thirty five miles Station to Kenmetti & Darby Wilkes Syndicate (and other multiple shareholders) Texas. We was the hardest and saddest thing we ever had to do but Princess had made the right choice and that is what we have got — THE BEST! It went to your wife would not be making it this trip tomorrow!

Every eight hours she will keep Mamma & Daddy up all night, feeding time we billed a very healthy baby boy named Craig Tibbs, weighing 6 lbs 14 oz on Feb. 28, 1973.

Thank you so much D. Tibbs, Princess and baby Chris are sweet. All must figured if it wasn't for you. You are truly a Friend!

We also want to thank the staff for all their help and compliments and should there be Corky ever Texas and Mexico you will always Welcome!

Yours truly,

Robert & Vicki

Christmas New York

18-19

3/14/90.

Dr. Tiller and Staff,

I just wanted to write and tell you all "thank you". The warm, gentle service I received at the clinic made a pretty traumatic time in my life more comfortable. Looking back, it's as if this minor setback in my career and life goals never even happened. I can't begin to imagine how my life would be at this very moment if I hadn't been able to come to your facility.

For all the other girls that may be reading this letter and find it encouraging, it should be. All the letters you all should prove to you that you're in the right place and you're making the right decision.

I hope that the clinic can continue to function in a safe environment without interference from the govt. or other outsiders. The service you provide is greatly needed and appreciated. My family and I are grateful for your help. Thank you so much.

Tiffany.

10/90 - 20.

Dear Dr. Tiller & Staff,

Just a short note to thank-you again for all of your help & support during our recent tragedy. I was told by my new doctor (one that believes in womens rights) that I can start trying to get pregnant again in January. Hopefully soon I'll be able to send you a picture of our happy HEALTHY baby.

Thank you so very much for everyth.

Kathi & Bill R.

18-21

Modena, Italy 04-17-92

Dearest Dr. Tiller,

Words will never be able to express my gratitude that I will always feel for you.

You gave me back my smile.

Endless thanks, and a strong hug.

18-22

July 94

Dear Dr Dilley and staff

The help you gave
meant such a lot,
and, hopefully, you'll know
This comes with
lots more gratitude
than words
could ever show.
Here's a great big hug
from Jane to thank
you all for helping
me!

Love Always
Jane

November 5, 1973

Dr. George Ziller,

Thanks to you and your staff for caring to the sick of my granddaughter (Marianne) Even though I was not there in Kansas with them, I received daily progress reports & I was very pleased with your Women's Health Care Service facility.

Our family will remain thankful and grateful to you. We like to be able to get them in touch with you who might be in a similar situation.

Sincerely,
Ozzie

18-24

Chicago
1994

Dear Natalie Davis

Dr. Filler and staff, you
may not remember me but
I remember all of you guys
especially Lana, Angie,
Dr. Filler. I felt that I at
least owe you all a letter
of thanks because without
you guys I probably wouldn't
be able to finish school or
be a teen. I think you all
are [illegible]
[illegible]
is here. I just want to say
thanks.

Love Natalie

18-25

Dear Dr. Tiller and staff,

I just want to tell you all thanks for everything. Thanks to you I can finally start to be back on track. I am a lot happier now, and everything seems to be going on. If it wasn't for you all I would be a total mess. I was very scared when I went down there. But thanks to you and your staff, I felt so comfortable. After I met all of you I knew that I would have good care of me. I am so grateful for you, Dr. Tiller because if it wasn't for your practice lots of girls that don't want to have their babies would have to, but thanks to you we have a 2nd chance to pursue our goals in life. Your counseling meetings really helped me out a lot because I thought I was going through alone, but then I realized that I am not the only girl who had this problem. And talking to you made me feel so much better about myself. I would just like to tell all the girls that come into that office not to worry because they are in the very best hands. Thank-you for helping me out! I thought that all my goals that I had just disappeared because of what happen but you made me realize that just because I made one mistake does not mean my life is over, it's just starting. Thank-you.

Love,
Breana

I went to see my doctor last Friday and he said that everything looks ok.

18-26

I KNOW THAT I HAVE MADE THE RIGHT DECISION
I KNOW THAT IT'S OK
I JUST HAVE TO KEEP MY GOALS IN MIND
AND TRY TO ACCOMPLISH THEM EVERYDAY.

I HAVE TO KEEP MY HEAD UP HIGH
AND LOOK ON DOWN THE ROAD
FOR I AM NOT THE ONLY ONE
I HAVE NOT TRAVELED ALONE.

I PLAN TO MAKE SOME CHANGES IN MY LIFE
TO HAVE MADE THIS ALL WORTHWHILE
I'LL DO WHAT HAS TO BE DONE
AND I'LL CARRY ON MY FACE A SMILE.

NOTHING IN LIFE IS EASY
AND THIS MAY HAVE BEEN ONE OF THE TOUGHEST
BUT IF YOU BELIEVE AND PERSEVERE
YOU CAN OVERCOME THE ROUGHEST.

IN WHATEVER YOU DO
NEVER LOOK BACK
KEEP GOING FORWARD
ALL OF YOUR GOALS YOU MUST ATTACK.

TIFFANY A.
1992

Dr. Dr. Miller & Faith

Well I'm sure you can all remember me Joanne (March 2 to 5). I just thought that I would write to you but first I'd like to thank you all because if you hadn't of been there I would of had to have a baby at the age of (15) and that would have ruined my life. But you guys were great and made my future very better. Now it's been almost 2 weeks I'm healing great and almost ready to get my life started again. But I will never forget what I've put you guys and to deal with such a stupid thing because it's another life that I had to go through. I also learned that I can talk my family anything and they'll help me. I know I had alot of problems you guys had to deal with such as: I climbed twice, I had bad cramps and the worst of all, I had an allergic reaction to the epidural and that caused alot of suffering for me. But it just meant to my thanks to Dr. Miller for believing I could go through with it. Cathy for being patient and understanding. Dr. Ida for being kind, caring and wonderful and taking care of me and Faith. And the rest of the staff for being so helpful. I hope you enjoy this as a present it would make me feel good even though I live in Toronto, Canada. We still will try to keep in touch and I love you all.

Love ya all like family,
Joanne

P.S. Please also say to Rhonda, Cathy & Miller it would mean alot to me please.

P.S. Tell Rhonda that I love the T-shirt

18-28

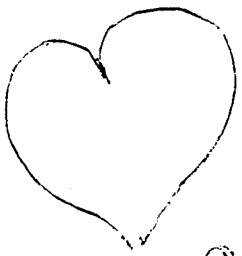
Date
7/29/96

Dr. Harris and staff,

Thank you for giving my life back. I am so glad that you guys helped me out. I am so glad that you guys did this for me it made me so happy. I am so glad I got this done. You guys really helped me out. I am so glad we came to you guys for this. If we have any ~~probles~~ problems we will call you or come back. I am doing really good on my pills. I take them every day. I feel much much better after I got this done I really do. Thank you guys for getting me out of trouble. Well I got to say good by. I will right you back as soon as I can.

Sorry so short.

Yours,
Truely
Amanda
Xoxoxo



18-29

Dear Dr. Keller and Staff ~

Thank you for all your support during my recuperation. I think when you do so many procedures as your clinic does, and when it's done so quickly and efficiently it would be easy for the clinic to lose its caring attitude and regard for the patient. But, what I found at your clinic was a caring, supportive atmosphere that was very nonjudgmental. I want to thank you with all my heart for that. You helped me through one of the most difficult decisions and times in my life by warmness and caring.

Thank you again.

Very sincerely yours,

Rebecca

18-30

DEAR DR. TILLER;

HELLO, HOW ARE YOU? I AM FINE, THANKS TO YOU AND YOUR STAFF. MY MOTHER SENT ME THIS BOOK TO SEND YOU. SHE IS VERY THANK-FULL TO YOU FO. WE (MY MOTHER + I) DO NOT KNOW WH WE WOULD HAVE DONE WITHOUT YOU. WE HAVE NO WORDS THAT CAN EXPRESS OUR GRATITUDE TO YOU. THANK-YOU VERY MUCH, GOD-BLESS YOU DOCTOR AND YOUR STAFF TOO.

YOURS SINCERELY
PORTIA

You know somethin'?
You make the world nicer
just by being in it.

18-31

January 18, 1986

To Whom It May Concern:

Three times within the past few days I have driven by your facility. Each time I have seen some half-dozen adults on duty with pro-life signs brandished at me.

It occurred to me today that many of us support your work and your facility, yet we do not stand out there demonstrating our support to passersby.

So I turned around and entered your waiting room to inquire how I might make my support known. Edna, an old friend (I didn't know she worked there), said I should write my support.

Therefore, this letter to you.

I may not carry a sign. I may not stand on your corner. But I do support your efforts to maintain a woman's right to choose regarding her own body and life.

Sincerely,

William Hubert

William Hubert

18-32

To: Dr. Tiller and
His Staff

9-30-85

I guess the best way to start this letter is to say what's been on my mind since the operation. Thank you so very much for giving me a new life! I still don't know wether any complications will arise, but whatever happens I am so grateful to you for giving me a second chance at life. I was scared to go on the pill because of the side effects. Now I feel the risks are nothing compared to the risks involved in getting pregnant. I've learnt my lesson the hard way. Thank you so much for all you've done. I do plan to go through with the medical check-ups, and I pray that everything will be okay not only for myself, but for all the girls that went through this with me. I hope that you can continue to save the lives of women, Dr. Tiller. I have enclosed the letter you requested. Once again, thanks.

Tata

18-33

To: [illegible]
December 3, 1985
last

Jodi the staff at the correctional
clinic. Smile
Hello, Sorry it took so
long to write but I
didn't forget you all.
I thank the staff for doing
so much on a wonderful
film. I know I made a
mistake and I truly pray
God, but need to turn to
Him more. Just wanted to
update the Arrochar work
may end outside, which
stinks. If we get to State
then we have Kids, without
the chains. I recruitment may
be in July to Dec. but
I can graduate. Study all
still some, must fulfill
but that's only 2 days
Then I am [illegible]

18-34

Construction & General Laborers' Union

LOCAL NO. 1329
(A. F. L.)
IRON MOUNTAIN, MICHIGAN 49801

R. ALESSANDRINI, Business Manager
North U.S. 2, P.O. Box 863
Phone 774-6070
Iron Mountain, MI 49801

Dennis Schaefer
C. ALESSANDRINI, Jr., Sec. - Treasurer
North U.S. 2, P.O. Box 863
Phone 774-6070
Iron Mountain, MI 49801

Dear Dr. Tiller + Staff,

I wish to express my heartfelt thanks to you and your staff for your comittment and excellent care for my daughter Anita. I do not know what we would have done without you. It is people like yourselves that make me see that there is hope in this world.

Your staff's excellent care and attitude helped us through a difficult time.

Please keep up your important work. I also know what it is to stand for a belief in human rights. The Union is also knocked about, but what would conditions + wages in the workplace be without us. — Hang in there, don't let the S.O.B's get you down!

President
Dean Romagnoli

Dean F. Romagnoli

18-35

Dr. George R. Tiller
5101 E. Kellogg
Wichita, KS. 67218

July 15, 1991

Dr. Tiller:
This will be a formidable week for you. I had some tough weeks a few years ago, struggling with the decision of what to do about an unwanted pregnancy. Thankfully, I had a choice and someone like you to help me when my decision was made.

You are a caring, brave and talented man. Please, please HANG IN THERE. I shudder to think of what will happen if the few, like you ,who are willing to take a stand in favor of choice are defeated. There are so many of us out here who appreciate you and what you are doing. Know that we are here and know that we care.

With much admiration and support,

Lynda C.

18-36

Dr. George Tiller 6-20-91
5107 E. Kellogg
Wichita, KS

Dear Dr. Tiller (and Staff),

Amidst the siege of media and protest, I thought you might like to hear from a Kansas woman who supports your right to do the work you do at your clinic. I applaud the stand you've taken on legal abortion in our State. Women all over Kansas may not know it, but they have a champion in you.

Incidentally, as a very young child, I was a patient of your father. He treated our entire family and my mother considered him a trusted friend. I have no doubt that he would be proud of your firm convictions.

Sincerely-

Michelle [illegible]

18-37

4-20-88

I want to thank you once again for everything you and your staff done for me. I feel really fine as nothing had happen. No pain what so ever. I feel this was the best for myself, my children and David. I love all 3 of them very much. But I know way back in my mine and heart I wish it could have been. Just wasn't timing & my age. I have two beautiful children, and my David that loves me very much.

I am sending my love to all of you. Thank's very much.

Donna.

18-38

March 21, 1988

Dear Staff, "Hi" Hope everyone is doing fine. Myself - I couldn't be better! I owe all of you - so many thanks! You've helped me to put my life and future back on the right track! Hate all of you were a part of that. Thanks again.

Here is my Doctor's Report for my week & three week check-ups. I'm fit as a fiddle - and Ready for Spring weather.

Love to you all

"Happy Easter"

Bye
Waverly,

Cindy

18-39

DR. TILLER + "ALL" –

Words can not express my gratitude to you for virtually saving my life. You all, through your support, love, and care, gave me the strength to begin a new life.

Hope you're happy today.
I know I am,
just because of you.

I am doing very well; quite anxious to begin my vigorous training routine to get back into shape for basketball!
From the bottom of my heart...
THANK YOU... Kathy

Dr. Chen 06-24

I just wanted to write a little letter to thank you and your staff. My mother and I were very impressed with your facility! Everyone was very polite, and patient. You were able to make a very bad experience good. You had alot of support from my family, boyfriend, and my friend. They've been there and are still there for me. I just went for my three week check-up and everything is fine. I will return to work tomorrow. Emotionally, I'm doing well too. My boyfriend was here great! He made me smile and listed my worries when I really needed it. Again thanks for everything! The smiles, hugs,

18-41

and hand squeezes were really appreciated! THANKS!*

Love-
Denise

18-43

Dear Dr. Tiller and staff,

Everyone makes mistakes in their life and wish there was away they could change it or make it better.

I thank you Dr. Tiller for being there when we needed a way to fix the mistake in judgement that was made.

I can never repay you enough for help. I only pray we think of you often we remember the joy you have given us and can live through.

Best wishes, God bless love to you and your staff.

Thank you very much.

Karen C.

Jessica

Prospect, Kentucky 40059

Dr. Tiller + Staff,

I wanted to thank you so much for everything you all have done for me. It was a very hard thing for me to go through but the comfort and understanding you all gave me helped so much. The support group helped me a great deal also. I think that is a very good idea. I was glad you had that. It was neat talking to all the other girls and knowing others were going through the or re things I was going through.

I'm back to work now and back with my school work.

My mom and I are alot closer and I feel like I can tell her things now whether its big or small. So I'm real happy about that. This summer we are going to Fort Worth, Texas and we might stop by in Wichita so if we do I will stop by and say hi, hopefully it will be on different terms Right?!

Thanks for everything!

Love,

Jessica

P.S. Think about me when you watch the Derby on T.V.

18-44

Dear Dr. Tiller & Staff,

I shall always remember your kindness & compassion in my unfortunate situation. I don't know what I would have done if I were forced to have a baby with the severe abnormalities my baby had. I thank God every day that there are people like you to help people like me. Dr. Tiller I want to thank you once again for the kindness & respect you gave to me & my husband. This world needs more people like you. The care I was given was unique & I told my doctor I don't feel I would have been treated better anywhere else. I know I will vote to keep you in practice to help others as you have helped me. I still cannot believe my baby is gone - that she was so sick - I only hope & pray to God to give me & Dennis another chance at having another "healthy" baby.

10-15

The help you gave
meant such a lot,
and, hopefully, you'll know
This comes with
lots more gratitude
than words
could ever show.

May God Bless all of you & keep you & your families health. I will never forget you. Thank you for everything.

Sincerely,
Donna

(P.S.) Dr. Tiller & Tracey
Thanks so much for the letters re: my insur. I know they will help.

18-46

Dear Dr. Tiller and Staff,

On Tuesday morning I was ready to leave for work and the only problem on my mind was what kind of pasta should I make for dinner. There was no way I could know that that night I would be sleeping in Wichita, over 2,000 miles from home.

That morning I was expecting my 1st grandchild and that evening I was sharing grief.

That morning I was thinking of how busy my schedule looked and that evening the calendar came to a halt.

Many folks have written you fabulous poems and poigniant prose. They think of the power of words but my mind is thinking of the inadequacy of words. Political words ring hollow and are so rigid not allowing for exceptionalities. Families in great crisis don't always fit the molds some politicians have created.

...r me there are also no words to ...press my gratitude for all you ...ffered me, my daughter Ellen ...nd son-in-law Scott. You offered ...fety and sameness at a time of ...eat heartache. Your compassion, ...isdom and dedication will always ...e remembered. I feel that a little ...ece of each of you will be with ...e always.

With Heartfelt Affection,

Sussie
Ambler, Pennsylvania

January, 1996

July 6, 1994

Dr. Tiller & staff-

I just wanted to let you all know how much I appreciate everything you all did for me while I was in your care. It was amazing to me to find a place where everyone seemed genuinely concerned about me & my feelings. I especially would like to thank Missy & Stacy for their unlimited patience & understanding for my low tolerance to pain, Edna for always being able to make me smile when I would have not thought it possible, & Dr. Tiller for treating me like a person with feelings, not just a patient. Before my visit, I would have never imagined that it would have been so hard to say good bye. I can not think of any thing else anyone could have done to make my stay any easier. I read the information you gave me about the clinic with the office where I had my check up (by the way, I'm doing just fine) & told them all about your clinic so they can let others know how wonderful you are. I really can't thank you enough. Take care of yourselves -

Love -

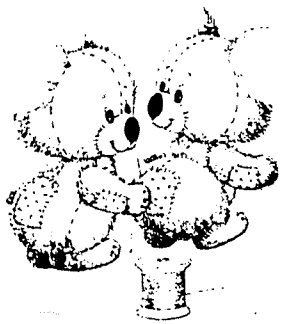
Karen

18-81

August 2

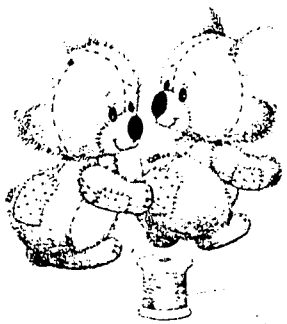
Dear Dr Zilker and Staff.

I am finding it very hard to express my true feelings and the Thanks I'm feeling on paper. I felt like I had come to the end of my rope. You all took turns holding my hand and helping me back up. I've stoped crying and hating myself for putting myself in that position. I'm now in the process of getting back in my clothes and putting my life back in the proper prospective. Next year is my senior year. Thanks to you, Now I can continue with and graduate.



After graduation I will attend College. I really believe this would not have been possible with out your help. Again, I would like to say Thank You. Although I feel these simple words do not say enough. All of you are wonderful, Special people. Never again will I find people to equal your attitudes and kindness.

Thank You,
and Best of
Love,
Laura C
Lewisville, La



84-81

I just wanted to thank everyone who contributed to my wedding and who came to support me. It was such a special day and I cannot express how much it meant to me that you were there. I will never forget how I was treated and I will never forget you wonderful, wonderful people. Thank you again, and enjoy the rest of your summer.

Love,

Dawn

The world could use

more nice people

like you!

Thanks Again

Dawn

(the Newlywed)

6-81

12-21-94

Dear Dr. Tillis,

I am writing you and your staff with sincere thanks. Everything that you have done for me was greatly appreciated. I cannot express how warm, & caring you and your staff was to me. You accomodated me to the fullest. You would always be remembered, and I hope to visit Wichita some time next year. Please I hope others send what I feel in you & thats confidence.

Love & thanks April

Dearest Dr. Tillis & staff

You're the kind of person
who does nice things
for others,
and you do them
without even giving them
a second thought.
The kindness that you've
shared with me
shows just how much
you care for me.
That's why I want to tell you
"You're terrific.
Thanks a lot."

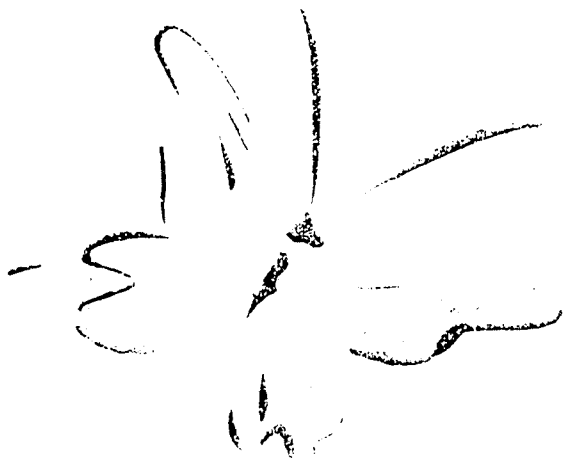
April & Devon

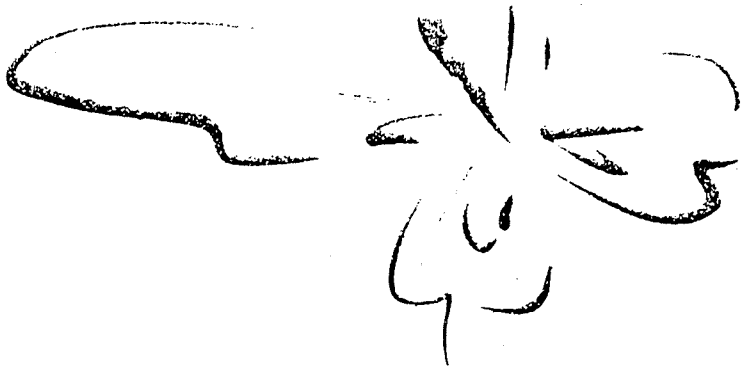
12-21-94

5-81

December 24th, 1959

It's nice knowing people
with such thoughtful ways
Who bring so much pleasure
to so many days
And think of such pleasant
and kind things to do--
It's nice knowing people
as special as you!





Thanks So Much
To Each and
Every One of You

Mr. Miller & Staff -

Want you very much for the opportunity to have had Carol Anne. I know I will get a lot of pleasure from the pictures, but you and your staff overlooked what has helped me a great deal. After I said the last day, "I'll be going through this again." But I'm glad you were [illegible]

December 18, 1992

Dear Dr. Tiller and the staff,

How have you been? It has already been one week since we left your clinic. I don't know how to thank you. We very much appreciated your warmhearted, sympathetic, and quick treatment. I now feel as if it was not myself who was worrying about so many things. Thank you very much.

Looking back on the pregnancy, it was very tough. In October, I was told that I had twins but that there was almost no chance to have both babies in a healthy condition. It kept me awake at night again and again. I was examined once or twice a week at hospitals, but nothing good ever came of it. Although I hoped something better might happen at least to one of the twins, some fatal failure was finally detected. It was the 24th week and too late in Michigan to get the medical treatment that you kindly did for me. As soon as we were informed of your clinic from our doctors here and decided to see you, I prayed that I could come to your clinic safely. Since I was told that babies may have to be delivered even in the 24th week and, if so, the abnormality may last for their entire lives, I could not be relieved until I safely arrived at Wichita airport and came to see you. When I visited your office, all of you treated me warmly and with great consideration. The security staff also helped me to feel relieved. The slogan, "Attitude is Everything" shown on your badges, was an encouragement, too. I did not expect you to offer me such a nice gentleman, Dr. Chang, for translation service. What a wonderful consideration for us, foreigners! His translations really relieved me very much.

You did well and your decision was right. You should have a delightful future." These words Dr. Tiller gave us and smiles and sympathy your nurses and staff offered us encouraged me and my husband to try to make our future bright and be full of delight. Thank you very much.

We thought that there was no hope for us to have a joyful Christmas anymore. However, thanks to your help, we can enjoy and celebrate Christmas with our two-year-old daughter.

May happiness be with you and your families. Please take care of yourself, too. Thank you very much. I wish you a Merry Christmas and a Happy New Year!

We support your practice!

Sincerely yours,

[redacted]

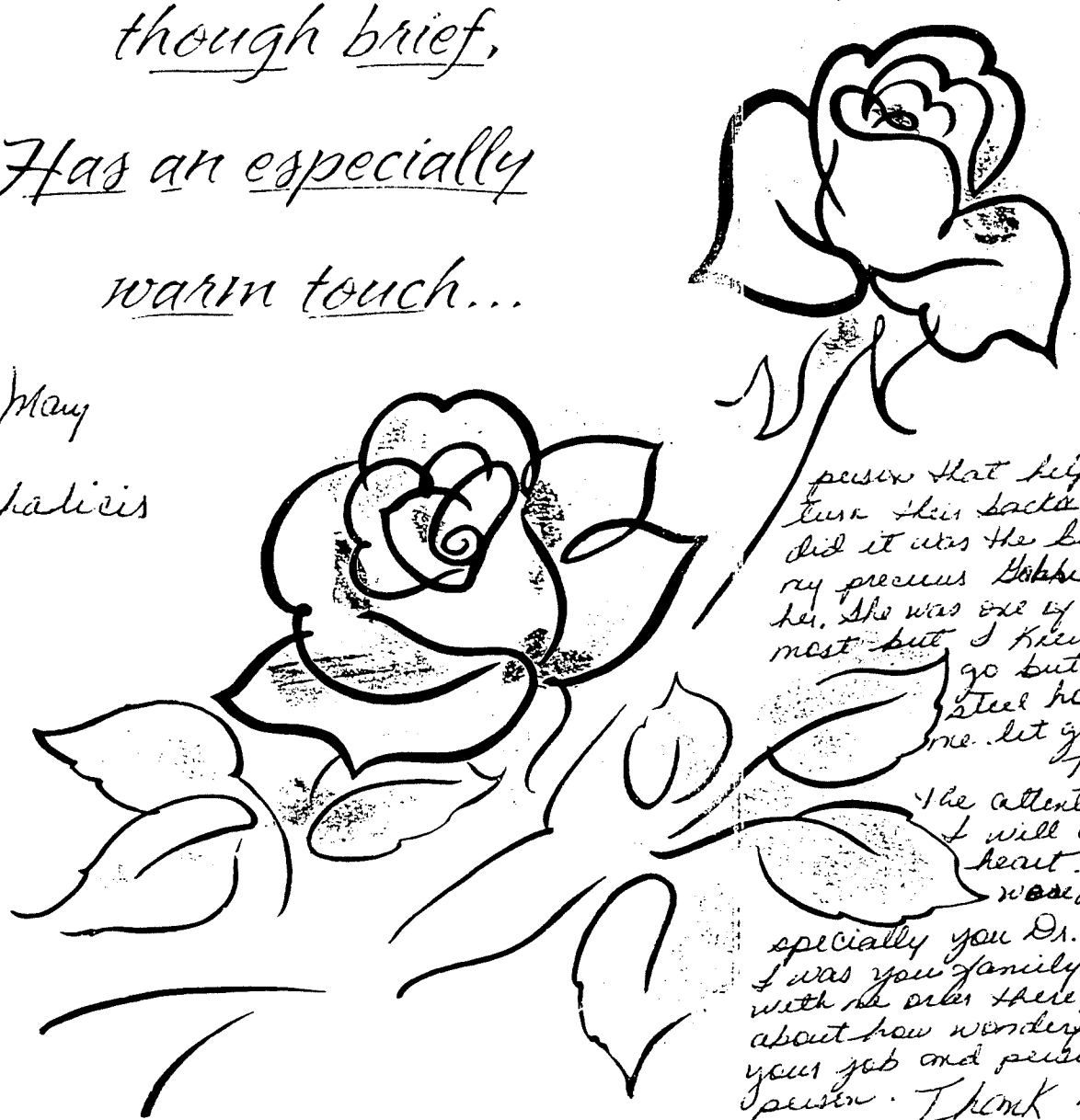
This message,

though brief,

Has an especially

warm touch...

Gabriela May
1/18/96
Hydrocephalicis



1/31/96

Dear Dr. George Tilley:

Right now it been 2 weeks after the procedure, sometimes I think it was a bad dream, but then I realize that everyth was true. I will always remember you as the person that helped me when everybody had their backs on me. I know that what we did it was the best thing for all of us, and for my precious Gabriela May. I will never forget her. She was one of the things that I wanted the most but I knew that somehow I had to let go but I didn't know how, and I'm still holding one but God is helping me let go day by day.

For it comes

from the heart—

"Thank you all

very much!"

Thank you and your staff for the attention that you all gave me. I will always keep you all in my heart because the way you all were with me and treated me, and especially you Dr. Tilley that made me feel like I was your family. My mother-in-law that was with me over there, she can just stop talking about how wonderful you. God bless you for your job and personality, you are a really nice person. Thank You Once Again! Nilza

...It is more blessed
to give than to receive.

ACTS 20:35

Warren & Pam

It's through people like you
that God's blessings
are known,
And I'm grateful to you
for the kindness
you've shown.

P.S. Thanks to you all
for your moral support
as well as your spiritual
support. Special Thanks to
you Dr. Tiller for your guidance
and to you Tracy for kindness &
to you Edna for your devotion &
perseverance to Dana for concern.
Thanks again everyone.

18-54

55-81

Nov 27, 1992

Dear Dr. Tiller,

this is just a little note to say thank you. It's a little word that expresses the appreciation for your care, attention, thoughtfulness, and of course, the good care of your staff. I'm doing fine and feel great, thanks to you.

Sincerely Doris

If "thank-you's"
could be flowers,
I would send
a bright bouquet

To show
that I'm more thankful
than mere words
could ever say!

18-96

Dr. Tiller, Dr. Harris, and their wonderful nurses –

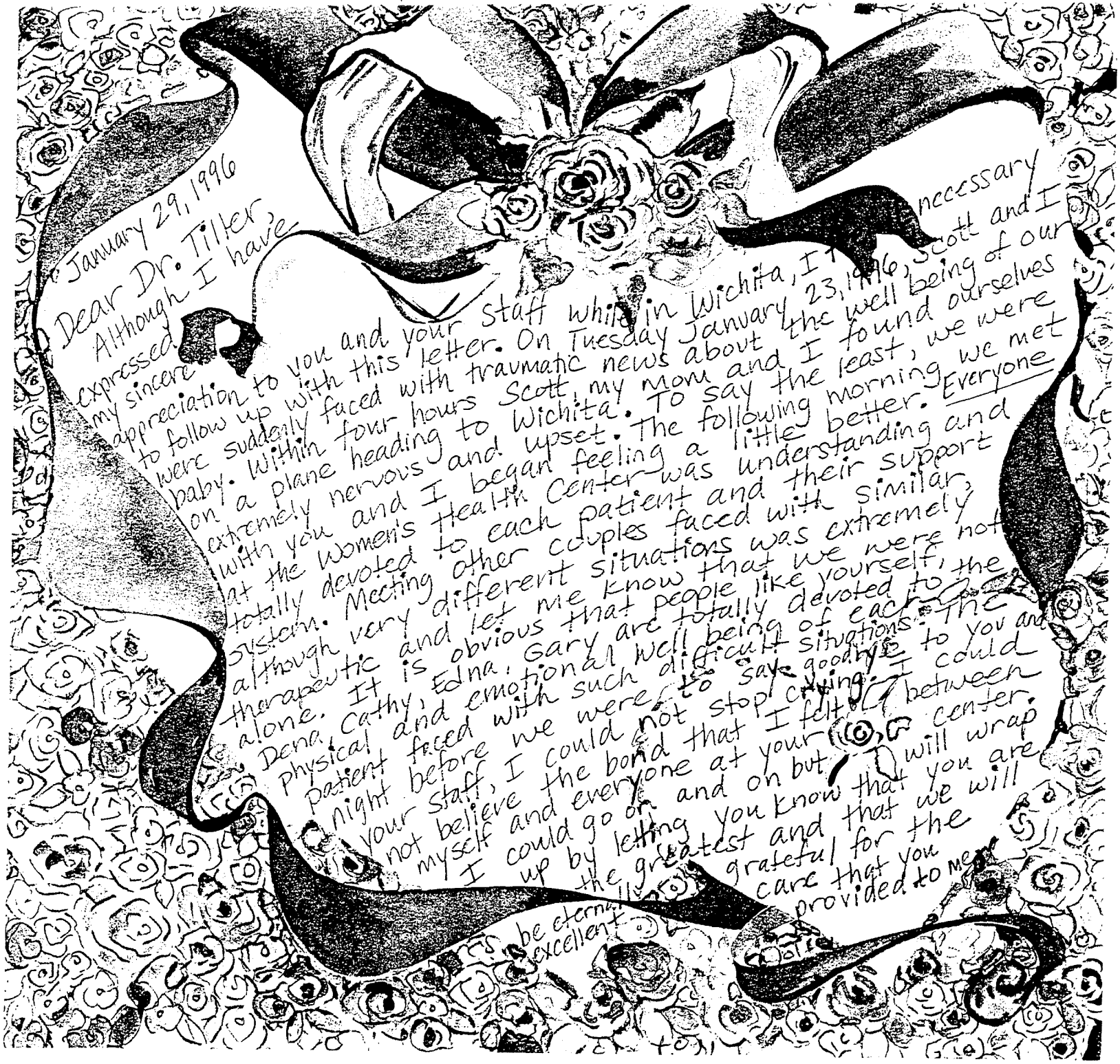
I just wanted to take this minute to tell you all thanks for all you did for me. U really appreciate your sincere, kind, caring, and loving attitude that you had towards me. It made everything so much more comfortable and alot easier on my part. Thanks for being there when U needed you most. U really appreciate everything.

Enjoy your goodies!

With love, Lindsay

It's just a little message,
But in it you will find
A great big "thanks" for being
So thoughtful and so kind!

Thanks again
with lots of love,
Lindsay M.


January 29, 1996
Dear Dr. Tiller,
Although I have
expressed my sincere
appreciation to you and your staff while in Wichita, I feel necessary
to follow up with this letter. On Tuesday January 23, 1996, Scott and I
were suddenly faced with traumatic news about the well being of our
baby. Within four hours Scott, my Mom and I found ourselves
on a plane heading to Wichita. To say the least, we were
extremely nervous and upset. The following morning we met
with you and I began feeling a little better. Everyone
at the Women's Health Center was understanding and
totally devoted to each patient and their support
system. Meeting other couples faced with similar
although very different situations was extremely
therapeutic and let me know that we were not
alone. It is obvious that people like yourself, the
Physical and emotional well being of each patient
Dena, Cathy, Edna, Gary are totally devoted to
night before we were to say goodbye to you and
your staff, I could not stop crying. I could
not believe the bond that I felt between
myself and everyone at your center.
I could go on and on but I will wrap
up by letting you know that you are
the greatest and that we will
be eternally grateful for the
excellent care that you
provided to me.

Your honesty and compassion will live with us always. I left a piece of my heart at 5107 E. Kellogg. Your wife and three daughters have an awful lot to be proud of!

We Love You!

Ellen and Scott

Once again, thanks to everyone at the Women's Health Center for providing excellent care to me and everyone else that is a patient of the center!

N. Wales, PA
19454

95-81

Gina Ann

Washington, D.C. 20011

2 December, 1992

Dr. George Tiller & Staff
Women's Health Care Services
5107 E. Kellogg Blvd.
Wichita, Kansas

Dear Dr. Tiller & Staff,

I am writing to thank you all so much for all the love & support that you all gave me, when I was there in June of this year. You all made what was possibly the most traumatic event of my life a lot more bearable. I will always be grateful to you all. Along with being grateful to you, what I am most grateful for is the existence of such a facility as yours.

After realizing that I could not obtain the medical help that I needed near my home, I was at a loss for what to do and felt extremely depressed and like my life was over. However, when I heard of your clinic, it gave me one last chance at avoiding a potentially detrimental situation. That hope was increased, by your personal call to me (Dr. Tiller) at the wee hours of the morning; assuring me that you could & would help me. To say that I slept better that night was an understatement. Along with the fear I had about the abortion, was the embarrassment that I suffered because I did not realize until such a late date that I was pregnant. I had been so sick, and through so much emotional turmoil (surviving a prior abusive relationship) that I was totally unaware of my physical situation. However, upon my arrival at your clinic, I was not made to feel stupid or ridiculous by your staff. They were all like mothers or sisters to me.

Since I was there in June, my life has been going well. I returned to my job at the U.S. Coast Guard as an attorney. My boyfriend & I are still together (not the one I had the abusive relationship with) and planning for a future together. My mother & I are also a lot closer than we had ever been. I know that this experience was difficult for her, but I know it was your staff that helped her cope.

This experience has made me aware of how lucky I was both to find you and to be able to afford to travel to your clinic. I am very aware that many other women do not have that luxury. Although I was pro-choice, prior to my abortion, I now understand in a very

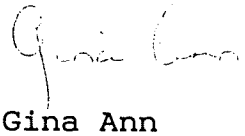
18-59

real way what an important right this is, and that it must be protected at all costs. To further this effort, I have volunteered at a local Planned Parenthood office, talking to young women about the importance of making the right choices and decisions in their lives, and how those decisions will effect the rest of their lives. I also plan on performing some volunteer work for NARAL; using my legal skills to preserve the right of choice for all women in this country. I have also forwarded your brochures and cards to both my ob/gyn as well as to other clinics in the Washington area.

Finally, I want to let you know that physically I am fine. I took all of the medication that was prescribed for me there, and saw my doctor as instructed. She assures me that I am fine. I am currently using both birth control pills and condoms for protection. I am still suffering from Graves disease, and will probably have to have my thyroid destroyed to cure me; the medication that I had been on for the past two years, has ceased to work.

Thank you all, once again and keep doing the great work that you all do.

Sincerely,



Gina Ann

P.S. Please feel free to place my letter in you clinic, for public view, but I would appreciate it if you would black out my name and address. Thanks

18-60

1

1-9-81

Tuesday, September 27

To all at Womens Health Care Service,

I just had to write and thank you so very very much for helping me last week. I had reached a point in my life where I could not even think clearly. I was so scared and confused. Each of you made my abortion much, much easier to come to terms with. I will never, and I mean never forget the wonderful care I received at your clinic! What all of you do is so incredibly amazing to me. At your clinic you give and give because you see a need. I never thought I would be where I was, but when I was I could not have asked for

KATHRYN

a better place. I truly admire each and everyone of you, from Dr. Tiller to Kathy to Elana to Rhonda, everyone. I hope all is going well for you - no more bomb threats and the picketers are not driving you too crazy!! Thank you all again -

♡ Katie

Dear Dr. Tillu & Staff,

Well I know you all get letters everyday, but Everyone really appreciates what you all do. I thought it was the end of the world until I came to the clinic. Everyone was great and made me feel better. I had a little problem with my I.D. but thanks to Tracy she got through that. It was right before Christmas and I was really depressed but I felt 100% better because of all of you. Thank you all for so much. I've made new friends not just a doctor and some nurses. Thank you all. Merry Christmas and Happy New Year. My started out great with new hopes & dreams all because of you. You very special people. Don't forget to give yourselves a lot of credit.

Jill

18-63

A very special
"Thank you"
That's as warm as it can be
For as nice
a group of people
As this world will ever see!

Thanks for everything!
Sherrie
family

Thank you all very much for everything you all did while I was in your office. After talking to Dr Liles I knew that what I was doing was the right thing to do. I want to thank each and every one of the Staff; they were all wonderful to me & my family. They were very understanding and comforting to us. Once again, thank you all very very much. We never forget you all.

18-64

STATE OF KANSAS

NANCEY HARRINGTON
SENATOR TWENTY-SIXTH DISTRICT
9811 SOUTH 183RD WEST
CLEARWATER, KANSAS 67026
(316) 584-3267

STATE CAPITOL
ROOM 143-N
TOPEKA, KANSAS 66612-1504
(913) 296-7367

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
EDUCATION
PUBLIC HEALTH AND WELFARE
TRANSPORTATION

Testimony before the Senate Public Health and Welfare Committee
Proponent for HB 2938
by Senator Nancey Harrington
March 13, 1996

Thank you Chairman Praeger, and members of the Committee.

It is my desire for the committee to understand the merits of H.B. 2938.

The purpose of the Act is to ensure a woman, seeking an abortion, full awareness of the physical and emotional risks of choosing an abortion. To supply all information on possible alternatives, that if an alternative choice is made, the father would be held responsible for financial support. Ensuring all risks are known, and information provided for possible alternatives, is the only way to ensure a fully informed consent to an abortion.

This bill in no way limits a woman's access, or hinders her ability to choose an abortion.

The legislation is patterned after present Pennsylvania law, which was upheld constitutionally by the Supreme Court.

The bill also addresses the possible link between breast cancer and induced abortion. Advocates of abortion resist investigation into the abortion breast cancer link.

There have been nine studies on induced abortion and breast cancer in American women, seven of which have shown an increased risk.

On October 29, 1994, the LA Times story titled "Induced Abortion

Links Breast Cancer Risk" reports:

> "An induced abortion raises a woman's risk of developing breast cancer by age 45 at least 50%, and by 3 times that if she is under 18 when the abortion occurs, according to a large new study by Seattle epidemiologist, Dr. Louise Brinton of the National Cancer Institute. "The Seattle study is a very definite step in the right direction. I think it raises concerns about the risk of induced abortions, but it does not resolve the issue."

According to a Time magazine article dated November 7, 1994:

> Some reporters highlight every possible flaw in the Seattle study, prompting epidemiologist Janet Daling of the Fred Hutchinson Cancer Research Center to defend her team's work. She pointed out that the investigation followed 1,800 women over a 7 year period, making it one of the largest studies ever to examine the relationship between abortion and cancer. "I am absolutely appalled that politics is entering into the science of this study," the researcher complained. "No one is getting any of the correct information out to the public," Daling said.

One in eight women will get breast cancer, 46,000 die yearly. I ask that the same consideration given women who are placed on HRT (Hormone Replacement Therapy) apply to women when considering an abortion. The Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, and U.S. Preventative Services Task Force recommend that all women understand the risks and benefits of HRT, and participate with their physicians in making an informed decision. In deciding whether to begin preventative HRT, a woman and her physician should consider the woman's risk factors for breast cancer (including family history). The studies linking breast cancer to HRT (Hormone Replacement Therapy) have been inconclusive, yet women are warned of the possible risk.

Statements made that the link between breast cancer and abortion is creating an issue that does not exist, that scientific research has been misrepresented, is equivalent to a person who sees a glass of water as

half empty, versus another who sees it as half full. I ask the Committee's support of HB 2938, and ensure women the right to make a well informed health care choice.

ABSTRACT

Background: Some studies have indicated that certain events of reproductive life, including incomplete pregnancies, may increase a woman's risk of breast cancer. Since the early 1970s, the abortion rate in China has been rising, due in part to a ~~concerned~~ concerted effort to limit population growth. Although the incidence of breast cancer is low compared to western populations, the incidence of breast cancer has increased in reproductive-age women from 1970 to 1989.

Purpose: We conducted a case-control study of breast cancer in women younger than 45 years of age to investigate the relationship of induced abortion to subsequent breast cancer risk.

Methods: Using the cancer registries from nine hospitals in Harbin City and Qiqihar City, People's Republic of China, we identified all women newly-diagnosed with breast cancer during October, 1990 to December 1992. From each one we sought an in-person interview about their reproductive history. For each of the interviewed cases we identified two age-matched neighbors as controls; they were interviewed in a similar manner. The study was restricted to women who were parous. Analyses were conducted using conditional logistic regression.

Results: The women with breast cancer (n = 232) were more likely to have had an abortion (60.8%) than the control women (42.3%). The risk of breast cancer in those women who had experienced an induced abortion adjusted for the matching variables, education, and age at first birth, was 2.9 times greater than that of other women (95% CI = 1.4 - 4.4). The risk was

somewhat higher among women diagnosed with breast cancer at age 35 years or less (RR = 4.5, 95% CI = 1.9 - 10.7) compared to the older women (RR = 2.4, 95% CI = 1.5 - 3.9).

Conclusion: This study in a population at low risk for breast cancer supports the hypothesis that induced abortion may increase a woman's risk of breast cancer.