Bill as Introduced

HB 1659-FN – AS INTRODUCED

2012 SESSION

12-2014
01/09

HOUSE BILL ***1659-FN***

AN ACT relative to the women's right to know act regarding abortion information.

SPONSORS: Rep. Notter, Hills 19; Rep. Bergevin, Hills 17; Rep. K. Souza, Hills 11; Rep. Peterson, Hills 19; Rep. Katsakiores, Rock 5; Rep. Cartwright, Ches 2; Rep. C. Soucy, Hills 17; Rep. DeLemus, Straf 1; Rep. Birdsell, Rock 8; Rep. L. Jones, Straf 1; Sen. White, Dist 9; Sen. Groen, Dist 6; Sen. Luther, Dist 12

COMMITTEE: Judiciary

ANALYSIS

This bill establishes the women's right to know act.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twelve

AN ACT relative to the women's right to know act regarding abortion information.

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

1 New Chapter; Women's Right to Know Act. Amend RSA by inserting after chapter 132-A the following new chapter:

CHAPTER 132-B

WOMEN'S RIGHT TO KNOW ACT

132-B:1 Title. This act shall be known as the "Women's Right to Know Act."

132-B:2 Legislative Findings and Purposes.

I. The general court finds that:

(a) It is essential to the psychological and physical well-being of a woman considering an abortion that she receive complete and accurate information on abortion and its alternatives.

(b) The knowledgeable exercise of a woman's decision to have an abortion depends on the extent to which she receives sufficient information to make an informed choice between 2 alternatives: giving birth or having an abortion.

(c) Adequate and legitimate informed consent includes information which "relates to the consequences to the fetus." *Planned Parenthood v. Casey*, 505 U.S. 833, 882-883 (1992).

(d) Many abortions are performed in clinics devoted solely to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion, before or after the procedure. They do not return to the facility for post-surgical care. In most instances, the woman's only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive counseling concerning her decision.

(e) The decision to abort "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 (1976).

(f) "The medical, emotional, and psychological consequences of an abortion are serious and can be lasting...." *H.L. v. Matheson*, 450 U.S. 398, 411 (1981).

(g) Abortion facilities or providers often offer only limited or impersonal counseling opportunities.

(h) Many abortion facilities or providers hire untrained and unprofessional "counselors" to provide pre-abortion counseling, but whose primary goal is actually to "sell" or promote abortion services.

II. Based on the findings in paragraph I, the purposes of this chapter is to:

(a) Ensure that every woman considering an abortion receives complete information on abortion and its alternatives and that every woman submitting to an abortion does so only after giving her voluntary and fully-informed consent to the abortion procedure.

(b) Protect unborn children from a woman's uninformed decision to have an abortion.

(c) Reduce "the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed." *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992).

(d) Adopt the construction of the term "medical emergency" accepted by the U.S. Supreme Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

132-B:3 Definitions. In this chapter:

I. "Abortion" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(a) Save the life or preserve the health of an unborn child;

(b) Remove a dead unborn child caused by spontaneous abortion; or

(c) Remove an ectopic pregnancy.

II. "Complication" means any adverse physical or psychological condition arising from the performance of an abortion, which includes but is not limited to: uterine perforation, cervical perforation, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, adverse reactions to anesthesia and other drugs; any psychological or emotional complications such as depression, anxiety, and sleeping disorders; and any other "adverse event" as defined by the Food and Drug Administration (FDA) criteria provided in the Medwatch Reporting System. The department may further define "complication."

III. "Conception" means the fusion of a human spermatozoon with a human ovum.

IV. "Department" means the department of health and human services.

V. "Facility" or "medical facility" means any public or private hospital, clinic, center, medical school, medical training institution, health care facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

VI. "First trimester" means the first 12 weeks of gestation.

VII. "Gestational age" means the time that has elapsed since the first day of the woman's last menstrual period.

VIII. "Hospital" means a facility licensed under RSA 151.

IX. "Medical emergency" means that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

X. "Physician" means any person licensed under RSA 329. The term includes medical doctors and doctors of osteopathy.

XI. "Pregnant" or "pregnancy" means that female reproductive condition of having an unborn child in the woman's uterus.

XII. "Qualified person" means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse, or physician.

XIII. "Unborn child" means the offspring of human beings from conception until birth.

XIV. "Viability" means the state of fetal development when, in the judgment of the physician based on the particular facts of the case before him or her and in light of the most advanced medical technology and information available to him or her, there is a reasonable likelihood of sustained survival of the unborn child outside the body of his or her mother, with or without artificial support.

132-B:4 Informed Consent Requirement. No abortion shall be performed or induced without the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if:

I. At least 24 hours before the abortion, the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, of the following:

(a) The name of the physician who will perform the abortion;

(b) Medically-accurate information that a reasonable patient would consider material to the decision of whether or not to undergo the abortion, including (1) a description of the proposed abortion method; (2) the immediate and long-term medical risks associated with the proposed abortion method including, but not limited to, the risks of infection, hemorrhage, cervical or uterine perforation, danger to subsequent pregnancies, and increased risk of breast cancer; and (3) alternatives to the abortion;

(c) The probable gestational age of the unborn child at the time the abortion is to be performed;

(d) The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed;

(e) The medical risks associated with carrying her child to term; and

(f) Any need for anti-Rh immune globulin therapy if she is Rh negative, the likely consequences of refusing such therapy, and the cost of the therapy.

II. At least 24 hours before the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person has informed the woman, orally and in person, that:

(a) Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials and informational DVD given to her and described in RSA 132-B:5.

(b) The printed materials and informational DVD in RSA 132-B:5 describe the unborn child and list agencies that offer alternatives to abortion.

(c) The father of the unborn child is liable to assist in the support of this child, even in instances where he has offered to pay for the abortion. In the case of rape or incest, this information may be omitted.

(d) She is free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally-funded benefits to which she might otherwise be entitled.

(e) The information contained in the printed materials and informational DVD given to her under RSA 132-B:5, are also available on a state-maintained website.

III. The information required in paragraphs I and II is provided to the woman individually and in a private room to protect her privacy, to maintain the confidentiality of her decision, and to ensure that the information focuses on her individual circumstances and that she has an adequate opportunity to ask questions.

IV. At least 24 hours before the abortion, the woman is given a copy of the printed materials and permitted to view or given a copy of the informational DVD described in RSA 132-B:5. If the woman is unable to read the materials, they shall be read to her. If the woman asks questions concerning any of the information or materials, answers shall be provided to her in a language she can understand.

V. Prior to the abortion, the woman certifies in writing on a checklist form provided or approved by the department that the information required to be provided under RSA 132-B:5 has been provided. All physicians who perform abortions shall report the total number of certifications received monthly to the department. The department shall make the number of certifications received available to the public on an annual basis.

VI. Except in the case of a medical emergency, the physician who is to perform the abortion shall receive and sign a copy of the written certification prescribed in paragraph V of this section prior to performing the abortion. The physician shall retain a copy of the checklist certification form in the woman's medical record.

VII. In the event of a medical emergency requiring an immediate termination of pregnancy, the physician who performed the abortion shall clearly certify in writing the nature of the medical emergency and the circumstances which necessitated the waiving of the informed consent requirements of this chapter. This certification shall be signed by the physician who performed the

emergency abortion, and shall be permanently filed in both the records of the physician performing the abortion and the records of the facility where the abortion takes place.

VIII. A physician shall not require or obtain payment for a service provided to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the 24-hour reflection period required in this section.

132-B:5 Publication of Materials.

I. The department shall cause to be published printed materials and an informational DVD in English and Spanish and other appropriate language within 90 days after this chapter becomes law. The department shall develop and maintain a secure Internet website, which may be part of an existing website, to provide the information described in this section. No information regarding persons using the website shall be collected or maintained. The department shall monitor the website on a weekly basis to prevent and correct tampering.

II. On an annual basis, the department shall review and update, if necessary, the following easily comprehensible printed materials and informational DVD:

(a) Geographically indexed materials that inform the woman of 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.

(1) The materials shall include a comprehensive list of the agencies, a description of the services they offer, and the telephone numbers and addresses of the agencies, and shall inform the woman about available medical assistance benefits for prenatal care, childbirth, and neonatal care.

(2) The department shall ensure that the materials described in this section are comprehensive and do not directly or indirectly promote, exclude, or discourage the use of any agency or service described in this section. The materials shall also contain a toll-free, 24-hour-a-day telephone number which may be called to obtain information about the agencies in the locality of the caller and of the services they offer.

(3) The materials shall state that it is unlawful for any individual to coerce a woman to undergo an abortion and that if a minor is denied financial support by the minor's parents, guardian, or custodian due to the minor's refusal to have an abortion performed, the minor shall be deemed emancipated for the purposes of eligibility for public-assistance benefits, except that such benefits may not be used to obtain an abortion. The materials shall also state that any physician who performs an abortion upon a woman without her informed consent may be liable to her for damages in a civil action at law and that the law permits adoptive parents to pay costs of prenatal care, childbirth, and neonatal care. The materials shall also include the following statement:

"There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The state of New Hampshire strongly urges you to contact one or

more of these agencies before making a final decision about abortion. The law requires that your physician or his or her agent give you the opportunity to call agencies like these before you undergo an abortion."

(b) Materials that include information on the support obligations of the father of a child who is born alive, including but not limited to the father's legal duty to support his child, which may include child support payments and health insurance, and the fact that paternity may be established by the father's signature on a birth certificate, by a statement of paternity, or by court action. The printed material shall also state that more information concerning establishment of paternity and child support services and enforcement may be obtained by calling state or county public assistance agencies.

(c) Materials that inform the pregnant woman of the probable anatomical and physiological characteristics of the unborn child at 2 week gestational increments from fertilization to full term, including color photographs of the developing unborn child at 2 week gestational increments. The descriptions shall include information about brain and heart functions, the presence of external members and internal organs during the applicable stages of development, and any relevant information on the possibility of the unborn child's survival. If a photograph is not available, a picture must contain the dimensions of the unborn child and must be realistic. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages.

(d) Materials which contain objective information describing the various surgical and drug induced methods of abortion, as well as the immediate and long-term medical risks commonly associated with each abortion method including, but not limited to, the risks of infection, hemorrhage, cervical or uterine perforation or rupture, danger to subsequent pregnancies, increased risk of breast cancer, the possible adverse psychological effects associated with an abortion, and the medical risks associated with carrying a child to term.

(e) Materials that inform the pregnant woman that there is a direct link between abortion and breast cancer. It is scientifically undisputed that full-term pregnancy reduces a woman's lifetime risk of breast cancer. It is also undisputed that the earlier a woman has a first full-term pregnancy, the lower her risk of breast cancer becomes, because following a full-term pregnancy the breast tissue exposed to estrogen through the menstrual cycle is more mature and cancer resistant. In fact, for each year that a woman's first full-term pregnancy is delayed, her risk of breast cancer rises 3.5 percent. The theory that there is a direct link between abortion and breast cancer builds upon this undisputed foundation. During the first and second trimesters of pregnancy the breasts develop merely by duplicating immature tissues. Once a woman passes the thirty-second week of pregnancy (third trimester), the immature cells develop into mature cancer resistant cells. When an abortion ends a normal pregnancy, the woman is left with more immature breast tissue than she had before she was pregnant. In short, the amount of immature breast tissue is increased

and this tissue is exposed to significantly greater amounts of estrogen—a known cause of breast cancer. Women facing an abortion decision have a right to know that such medical data exists. At the very least, women must be informed that it is undisputed that pregnancy provides a protective effect against the later development of breast cancer.

(f) A uniform resource locator (URL) for the state-maintained website where the materials described in this section can be found.

(g) A checklist certification form to be used by the physician or a qualified person under RSA 132-B:4, V, which will list all the items of information which are to be given to the woman by a physician or the agent under this chapter.

(h) The materials shall be printed in a typeface large enough to be clearly legible.

(i) The department shall produce a standardized DVD that may be used statewide, presenting the information described in this section. In preparing the DVD, the department may summarize and make reference to the printed comprehensive list of geographically indexed names and services described in subparagraph II(a). The DVD shall, in addition to the information described in this section, show an ultrasound of the heartbeat of an unborn child at 4 to 5 weeks gestational age, at 6 to 8 weeks gestational age, and each month thereafter, until viability. That information shall be presented in an objective, unbiased manner designed to convey only accurate scientific information.

(j) The materials required under this section and the DVD described in subparagraph (h) shall be available at no cost from the department upon request and in appropriate number to any person, facility, or hospital.

132-B:6 Medical Emergencies. When a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an immediate abortion is necessary to avert her death or that a 24-hour delay will cause substantial and irreversible impairment of a major bodily function.

132-B:7 Criminal Penalties. Any person who intentionally, knowingly, or recklessly violates this chapter is guilty of a class A felony.

132-B:8 Civil Penalties.

I. In addition to any and all remedies available under the common or statutory law of this state, failure to comply with the requirements of this chapter shall:

(a) Provide a basis for a civil malpractice action for actual and punitive damages.

(b) Provide a basis for a professional disciplinary action under RSA 329.

II. No civil liability may be assessed against the female upon whom the abortion is performed.

III. When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the abortion was performed.

IV. If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

V. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney's fees in favor of the defendant against the plaintiff.

132-B:9 Reporting.

I. For the purpose of promoting maternal health and life by adding to the sum of medical and public health knowledge through the compilation of relevant data, and to promote the state's interest in protecting the unborn child, a report of each abortion performed shall be made to the department on forms prescribed by it. The reports shall be completed by the hospital or other licensed facility in which the abortion occurred, signed by the physician who performed the abortion, and transmitted to the department within 15 days after each reporting month. The report forms shall not identify the individual patient by name and shall include the following information:

(a) Identification of the physician who performed the abortion, the facility where the abortion was performed, and the referring physician, agency, or service, if any. Notwithstanding any provision of law to the contrary, the department shall ensure that the identification of any physician or other health care provider reporting under this section shall not be released or otherwise made available to the general public.

(b) The county and state in which the woman resides.

(c) The woman's age.

(d) The number of prior pregnancies and prior abortions of the woman.

(e) The probable gestational age of the unborn child.

(f) The type of procedure performed or prescribed and the date of the abortion.

(g) Preexisting medical condition or conditions of the woman which would complicate pregnancy, if any.

(h) Medical complication or complications which resulted from the abortion, if known.

(i) The length and weight of the aborted child for any abortion performed pursuant to a medical emergency as defined in RSA 132-B:6.

(j) Basis for any medical judgment that a medical emergency existed which excused the physician from compliance with any provision of this chapter.

II. When an abortion is performed during the first trimester of pregnancy, the tissue that is removed shall be subjected to a gross or microscopic examination, as needed, by the physician or a qualified person designated by the physician to determine if a pregnancy existed and was

terminated. If the examination indicates no fetal remains, that information shall immediately be made known to the physician and sent to the department within 15 days of the analysis.

III. When an abortion is performed after the first trimester of pregnancy, the physician shall certify whether or not the child was viable, and the dead unborn child and all tissue removed at the time of the abortion shall be submitted for tissue analysis to a board-eligible or certified pathologist. If the report reveals evidence of viability or live birth, the pathologist shall report such findings to the department within 15 days, and a copy of the report shall also be sent to the physician performing the abortion. The department shall prescribe a form on which pathologists may report any evidence of live birth, viability, or absence of pregnancy.

IV. Every facility in which an abortion is performed within this state during any quarter year shall file with the department a report showing the total number of abortions performed within the hospital or other facility during that quarter year. This report shall also show the total abortions performed in each trimester of pregnancy. These reports shall be submitted on a form prescribed by the department that will enable a facility to indicate whether or not it is receiving any state-appropriated funds. The reports shall be available for public inspection and copying only if the facility receives state-appropriated funds within the 12-calendar-month period immediately preceding the filing of the report. If the facility indicates on the form that it is not receiving state-appropriated funds, the department shall regard that facility's report as confidential unless it receives other evidence that causes it to conclude that the facility receives state-appropriated funds.

V. After 30 days public notice following the effective date of this chapter, the department shall require that all reports of maternal deaths occurring within the state arising from pregnancy, childbirth, or intentional abortion state the cause of death, the duration of the woman's pregnancy, when her death occurred, and whether or not the woman was under the care of a physician during her pregnancy prior to her death. The department shall issue any necessary regulations to assure that information is reported, and conduct its own investigation, if necessary, to ascertain such data. Known incidents of maternal mortality of nonresident women arising from induced abortion performed in this state shall be included in the report as incidents of maternal mortality arising from induced abortions. Incidents of maternal mortality arising from continued pregnancy or childbirth and occurring after induced abortion has been attempted but not completed, including deaths occurring after induced abortion has been attempted but not completed as a result of ectopic pregnancy, shall be included as incidents of maternal mortality arising from induced abortion.

VI. Every physician who is called upon to provide medical care or treatment to a woman who is in need of medical care because of a complication or complications resulting, in the good faith judgment of the physician, from having undergone an abortion or attempted abortion, shall prepare a report. The report shall be filed with the department within 30 days of the date of the physician's first examination of the woman. The report shall be on forms prescribed by the department. The

forms shall contain the following information, as received, and such other information except the name of the patient, as the department may from time to time require:

(a) Age of the patient.

(b) Number of pregnancies patient may have had prior to the abortion.

(c) Number and type of abortions patient may have had prior to this abortion.

(d) Name and address of the facility where the abortion was performed.

(e) Gestational age of the unborn child at the time of the abortion, if known.

(f) Type of abortion performed, if known.

(g) Nature of complication or complications.

(h) Medical treatment given.

(i) The nature and extent, if known, of any permanent condition caused by the complication.

VII. Reports filed pursuant to paragraphs I or VI shall not be deemed public records and shall remain confidential, except that disclosure may be made to law enforcement officials upon an order of a court after application showing good cause. The court may condition disclosure of the information upon any appropriate safeguards it may impose.

VIII. The department shall prepare a comprehensive annual statistical report for the general court based upon the data gathered from reports under paragraphs I and VI. The statistical report shall not lead to the disclosure of the identity of any physician or person filing a report under those paragraphs, nor of any patient about whom a report is filed. The statistical report shall be available for public inspection and copying.

IX. Original copies of all reports filed under paragraphs I, IV, and VI shall be available to the board of medicine for use in the performance of its official duties.

X. The following penalties shall attach to any failure to comply with the requirements of this section:

(a) Any person required under this section to file a report, keep any records, or supply any information, who willfully fails to file such report, keep such records, or supply such information at the time or times required by law or regulation, is guilty of "unprofessional conduct," and his or her license for the practice of medicine and surgery shall be subject to suspension or revocation in accordance with procedures provided under RSA 329.

(b) Any person who willfully delivers or discloses to the department any report, record, or information known by him or her to be false is guilty of a class B misdemeanor.

(c) Any person who willfully discloses any information obtained from reports filed pursuant to paragraph I or VI, other than that disclosure authorized under paragraph VII, or as otherwise authorized by law, is guilty of a class B misdemeanor.

(d) Intentional, knowing, reckless, or negligent failure of the physician to examine an unborn child or tissue remains or submit an unborn child or tissue remains to a pathologist as

required by paragraph II or III, or intentional, knowing, or reckless failure of the pathologist to report any evidence of live birth or viability to the department in the manner and within the time prescribed in paragraph III is a class A misdemeanor.

(e) In addition to the above penalties, any person, organization, or facility who willfully violates any of the provisions of this section requiring reporting shall upon conviction:

(1) For the first time, have his, her, or its license suspended for a period of 6 months.

(2) For a second time, have his, her, or its license suspended for a period of one year.

(3) For the third time, have his, her, or its license revoked.

XI.(a) The department shall create the forms required by this chapter within 60 days after the effective date of this chapter and shall cause to be published, within 90 days after the effective date of this chapter, the printed materials described in this chapter.

(b) No provision of this chapter requiring the reporting of information on forms published by the department, or requiring the distribution of printed materials published by the department pursuant to this chapter, shall be applicable until 10 days after the requisite forms are first created and printed materials are first published by the department or until the effective date of this chapter, whichever is later.

132-B:10 Construction. Nothing in this chapter shall be construed as creating or recognizing a right to abortion. It is not the intention of this law to make lawful an abortion that is currently unlawful.

132-B:11 Right of Intervention. The general court, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this chapter in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this chapter is challenged.

132-B:12 Severability. If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

2 Effective Date. This act shall take effect January 1, 2013.

LBAO
12-2014
12/28/11

HB 1659-FN - FISCAL NOTE

AN ACT relative to the women's right to know act regarding abortion information.

FISCAL IMPACT:

The Judicial Branch, Judicial Council, New Hampshire Association of Counties, and the Departments of Justice, Corrections, and Health and Human Services state this bill will increase state and county expenditures by interminable amounts in FY 2013 and in each year thereafter. There will be no fiscal impact on state, county, or local revenue, or local expenditures.

METHODOLOGY:

The Judicial Branch states several sections of this bill could result in a fiscal impact the Branch:

- The Branch has no information on which to estimate how many felonies would be prosecuted against individuals who intentionally, knowingly or recklessly violate the provisions of this proposed law, but the Branch indicates the estimated cost of an average routine criminal case in the superior court will be $389.84 in FY 2013 and $401.48 in FY 2014. These amounts do not include the cost of appeals which may be taken following trial.
- A civil malpractice action brought against a person for failure to comply with the requirements of this bill law would be classified as a complex civil case in the superior court. The Branch has no information on which to estimate how many new complex civil cases will be brought, but estimates the cost of an average complex civil case in the superior court will be $633.81 in FY 2013 and $651.29 in FY 2014. These amounts do not include the cost of appeals which may be taken following trial.
- Professional disciplinary actions against physicians pursuant to proposed RSA 132-B:8 or 132-B:9, X(a) may be appealed to the Supreme Court. The Branch has no information on how many appeals may arise from the proposed bill or on whether the appeals would be declined, accepted for full appellate review, or accepted for a more limited review.
- Actions to disclose to law enforcement officials confidential reports filed pursuant to proposed RSA 132-B:9 would be considered complex equity cases in the superior court. The Branch has no information on how many such cases may arise, but estimates the

cost of an average complex equity case in superior court will be $576.05 in FY 2013 and $602.60 in FY 2014. These amounts do not consider the cost of any appeals that may be taken following trial.

- The Branch has no information on how many class B misdemeanor cases would be brought pursuant to the proposed RSA 132-B:9, X (b) and (c). The Branch estimates the cost to process an average class B misdemeanor case in the district division of the circuit court will be $43.19 in FY 2013 and $44.54 in FY 2014. These amounts do not consider the cost of any appeals of a class B misdemeanor that may be taken to the Supreme Court following trial in the district division of the circuit court.
- The Branch has no information on how many class A misdemeanors would be prosecuted pursuant to 132-B:9 X(d), but does have information on the average cost of processing these cases in the trial court. The cost to the Judicial Branch of processing an average class A misdemeanor in the district division of the circuit court is estimated to be $59.11 in FY 2013 and $61.31 in FY 2014. These amounts do not consider the cost of any appeals that may be taken following trial.

In summary, the Judicial Branch is able to identify areas of fiscal impact in this bill, but is not able provide an accurate estimate of the fiscal impact.

The Judicial Council states this bill may result in little or no fiscal impact to the Judicial Council. The Council assumes physicians may be less likely than average citizens to be eligible for indigent defense representation, but states if an individual is found to be indigent, the flat fee of $275 per misdemeanor and $756.24 per felony is charged by a public defender or contract attorney. If an assigned counsel attorney is used the fee is $60 per hour with a cap of $1,400 for a misdemeanor charge and $4,100 for a felony charge. The Council also states additional costs could be incurred if an appeal is filed. The public defender, contract attorney and assigned counsel rates for Supreme Court appeals is $2,000 per case, with many assigned counsel attorneys seeking permission to exceed the fee cap. Requests to exceed the fee cap are seldom granted. Finally, expenditures would increase if services other than counsel are requested and approved by the court during the defense of a case or during an appeal.

The New Hampshire Association of Counties states to the extent more individuals are charged, convicted, and sentenced to incarceration in a county correctional facility, the counties may have increased expenditures. The Association is unable to determine the number of individuals who might be charged, convicted or incarcerated as a result of this bill to determine an exact fiscal impact. The average annual cost to incarcerate an individual in a county correctional facility is approximately $35,000. There is no impact on county revenue.

The Department of Justice states the criminal offense created by this bill would typically be prosecuted by a county attorney's office. The Department states there would be a fiscal impact in cases when an appeal is taken to the NH Supreme Court, but is not able to predict how many cases may be appealed. In addition, violations could trigger a complaint to a medical licensing board which would impact the Civil Bureau which serves as legal counsel to the boards. The Administrative Prosecutions Unit may need to investigate and prosecute complaints filed with a licensing board for violations under this law. Finally, additional resources may be needed within the Civil Bureau to provide legal counsel to the Department of Health and Human Services to assist it in meeting its obligations described in the bill. The Department is not able to determine the fiscal impact of these potential requirements.

The Department of Corrections states it is not able to determine the fiscal impact of this bill because it does not have sufficient detail to predict the number of individuals who would be subject to this legislation. The Department of Corrections states the average annual cost of incarcerating an individual in the general prison population for the fiscal year ending June 30, 2010 was $32,492. The cost to supervise an individual by the Department's division of field services for the fiscal year ending June 30, 2010 was $659.

The Department of Health and Human Services states this bill requires to Department to publish printed informational materials and produce an informational DVD in English, Spanish, and other appropriate languages. The materials would be updated annually and available at no cost, and would include the complete and comprehensive information on abortion and the alternatives to abortion as specified in the bill including the checklist certification form used by the physician or qualified person to confirm the information has been provided to the woman. In addition, the Department must maintain a secure Internet website to provide the information and a toll free 24 hour-a-day telephone number to provide information on local agencies and services available. The Department states it will prescribe and receive the required reporting forms completed by physicians, pathologists, and the hospitals or licensed facilities in which an abortion occurs and prepare the annual statistical report to the general court. The Department assumes, in order for the program to start on January 1, 2013, a full-time Program Planner III and a part-time Executive Secretary would need to start in July 2012 gathering the information, designing the printed materials and web page, establishing the 24/7 information line and creating an Access database. The Department estimates the personnel and associated costs as follows:

	FY 2013	FY 2014	FY 2015	FY 2016
Salaries - Full-time Program Planner III and Part-time Executive Secretary	$57,567	$59,514	$62,039	$64,672
Benefits	$24,002	$26,551	$28,669	$31,045

Current Expense - Postage, telephone and office supplies	$3,000	$3,000	$3,000	$3,000
Rent	$10,763	$11,790	$12,026	$12,266
In-State Travel	$1,500	$1,500	$1,500	$1,500
Equipment - Computer and office furniture	$7,000	$0	$0	$0
24 hour information line	$3,528	$3,528	$3,528	$3,528
Total	$107,360	$105,883	$110,762	$116,011

The Department is not able to accurately determine the costs for the printed materials, the DVD, or the annual report since the volume of information and size of the publications is not known at this time.

HB 1659-FN – AS AMENDED BY THE HOUSE

14Mar2012... 0089h
28Mar2012... 1327h
28Mar2012... 1482h

2012 SESSION

12-2014
01/09

HOUSE BILL *1659-FN*

AN ACT relative to the women's right to know act regarding abortion information.

SPONSORS: Rep. Notter, Hills 19; Rep. Bergevin, Hills 17; Rep. K. Souza, Hills 11; Rep. Peterson, Hills 19; Rep. Katsakiores, Rock 5; Rep. Cartwright, Ches 2; Rep. C. Soucy, Hills 17; Rep. DeLemus, Straf 1; Rep. Birdsell, Rock 8; Rep. L. Jones, Straf 1; Sen. White, Dist 9; Sen. Groen, Dist 6; Sen. Luther, Dist 12

COMMITTEE: Judiciary

ANALYSIS

This bill establishes the women's right to know act.

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

HB 1659-FN – AS AMENDED BY THE HOUSE

14Mar2012... 0089h
28Mar2012... 1327h
28Mar2012... 1482h

12-2014
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twelve

AN ACT relative to the women's right to know act regarding abortion information.

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

1 New Chapter; Women's Right to Know Act. Amend RSA by inserting after chapter 132-A the following new chapter:

CHAPTER 132-B

WOMEN'S RIGHT TO KNOW ACT

132-B:1 Title. This act shall be known as the "Women's Right to Know Act."

132-B:2 Definitions. In this chapter:

I. "Abortion" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(a) Save the life or preserve the health of an unborn child;

(b) Remove a dead unborn child caused by spontaneous abortion; or

(c) Remove an ectopic pregnancy.

II. "Facility" or "medical facility" means any public or private hospital, clinic, center, medical school, medical training institution, health care facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

III. "Gestational age" means the time that has elapsed since the first day of the woman's last menstrual period.

IV. "Hospital" means a facility licensed under RSA 151.

V. "Medical emergency" means that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

VI. "Physician" means any person licensed under RSA 329. The term includes medical doctors and doctors of osteopathy.

VII. "Pregnant" or "pregnancy" means that female reproductive condition of having an

unborn child in the woman's uterus.

VIII. "Qualified person" means an agent of the physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse, or physician.

IX. "Unborn child" means the offspring of human beings from conception until birth.

132-B:3 Informed Consent Requirement. No abortion shall be performed or induced without the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if:

I. At least 24 hours before the abortion, the physician who is to perform the abortion or the referring physician has informed the woman, orally and in person, of the following:

(a) The name of the physician who will perform the abortion;

(b) Medically-accurate information that a reasonable patient would consider material to the decision of whether or not to undergo the abortion, including (1) a description of the proposed abortion method; (2) the immediate and long-term medical risks associated with the proposed abortion method including, but not limited to, the risks of infection, hemorrhage, cervical or uterine perforation, danger to subsequent pregnancies; and (3) alternatives to the abortion;

(c) The probable gestational age of the unborn child at the time the abortion is to be performed;

(d) The medical risks associated with carrying her child to term; and

(e) Any need for anti-Rh immune globulin therapy if she is Rh negative, the likely consequences of refusing such therapy, and the cost of the therapy.

II. At least 24 hours before the abortion, the physician who is to perform the abortion, the referring physician, or a qualified person has informed the woman, orally and in person, that she is free to withhold or withdraw her consent to the abortion at any time without affecting her right to future care or treatment and without the loss of any state or federally-funded benefits to which she might otherwise be entitled.

III. In the event of a medical emergency requiring an immediate termination of pregnancy, the physician who performed the abortion shall clearly certify in writing the nature of the medical emergency and the circumstances which necessitated the waiving of the informed consent requirements of this chapter. This certification shall be signed by the physician who performed the emergency abortion, and shall be permanently filed in both the records of the physician performing the abortion and the records of the facility where the abortion takes place.

IV. A physician shall not require or obtain payment for a service provided in relation to abortion to a patient who has inquired about an abortion or scheduled an abortion until the expiration of the 24-hour reflection period required in this section.

132-B:4 Medical Emergencies. When a medical emergency compels the performance of an abortion, the physician shall inform the woman, before the abortion if possible, of the medical

indications supporting the physician's judgment that an immediate abortion is necessary to avert her death or that a 24-hour delay will cause substantial and irreversible impairment of a major bodily function.

132-B:5 Civil Penalties.

I. In addition to any and all remedies available under the common or statutory law of this state, failure to comply with the requirements of this chapter shall:

(a) Provide a basis for a civil malpractice action for actual and punitive damages.

(b) Provide a basis for a professional disciplinary action under RSA 329.

II. No civil liability may be assessed against the female upon whom the abortion is performed.

III. When requested, the court shall allow a woman to proceed using solely her initials or a pseudonym and may close any proceedings in the case and enter other protective orders to preserve the privacy of the woman upon whom the abortion was performed.

IV. If judgment is rendered in favor of the plaintiff, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant.

V. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney's fees in favor of the defendant against the plaintiff.

132-B:6 Construction. Nothing in this chapter shall be construed as creating or recognizing a right to abortion. It is not the intention of this law to make lawful an abortion that is currently unlawful.

132-B:7 Right of Intervention. The general court, by joint resolution, may appoint one or more of its members, who sponsored or cosponsored this chapter in his or her official capacity, to intervene as a matter of right in any case in which the constitutionality of this chapter is challenged.

132-B:8 Severability. If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

2 Effective Date. This act shall take effect January 1, 2013.

LBAO
12-2014
Amended 03/15/12

HB 1659 FISCAL NOTE

AN ACT relative to the women's right to know act regarding abortion information.

FISCAL IMPACT:

The Department of Health and Human Services, Judicial Branch, Judicial Council, New Hampshire Association of Counties, and the Departments of Justice, and Corrections state this bill, **as amended by the House (Amendment #2012-0089h)**, will increase state and county expenditures by interminable amounts in FY 2013 and in each year thereafter. There will be no fiscal impact on state, county, or local revenue, or local expenditures.

METHODOLOGY:

The Department of Health and Human Services states this bill requires to Department to publish printed informational materials and produce an informational streaming video in English, Spanish, and other appropriate languages. The materials would be updated annually and available at no cost, and would include the complete and comprehensive information on abortion and the alternatives to abortion as specified in the bill including the checklist certification form used by the physician or qualified person to confirm the information has been provided to the woman. In addition, the Department must maintain a secure Internet website to provide the information and a toll free 24 hour-a-day telephone number to provide information on local agencies and services available. The Department states it will prescribe and receive the required reporting forms completed by physicians, pathologists, and the hospitals or licensed facilities in which an abortion occurs and prepare the annual statistical report to the general court. The Department assumes, in order for the program to start on January 1, 2013, a full-time Program Planner III and a part-time Executive Secretary would need to start in July 2012 gathering the information, designing the printed materials and web page, establishing the 24/7 information line and creating an Access database. The Department estimates the personnel and associated costs as follows:

	FY 2013	FY 2014	FY 2015	FY 2016
Salaries - Full-time Program Planner III and Part-time Executive Secretary	$57,567	$59,514	$62,039	$64,672
Benefits	$24,002	$26,551	$28,669	$31,045
Current Expense - Postage, telephone and office supplies	$3,000	$3,000	$3,000	$3,000
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In-State Travel	$1,500	$1,500	$1,500	$1,500

Equipment - Computer and office furniture	$7,000	$0	$0	$0
24 hour information line	$3,528	$3,528	$3,528	$3,528
Total	$107,360	$105,883	$110,762	$116,011

The Department is not able to accurately determine the costs for the printed materials, the streaming video, or the annual report since the volume of information and size of the publications is not known at this time.

The Judicial Branch states several sections of this bill could result in a fiscal impact the Branch:

- The Branch has no information on which to estimate how many felonies would be prosecuted against individuals who intentionally, knowingly or recklessly violate the provisions of this proposed law, but the Branch indicates the estimated cost of an average routine criminal case in the superior court will be $389.84 in FY 2013 and $401.48 in FY 2014. These amounts do not include the cost of appeals which may be taken following trial.
- A civil malpractice action brought against a person for failure to comply with the requirements of this bill law would be classified as a complex civil case in the superior court. The Branch has no information on which to estimate how many new complex civil cases will be brought, but estimates the cost of an average complex civil case in the superior court will be $633.81 in FY 2013 and $651.29 in FY 2014. These amounts do not include the cost of appeals which may be taken following trial.
- Professional disciplinary actions against physicians pursuant to proposed RSA 132-B:8 or 132-B:9, X(a) may be appealed to the Supreme Court. The Branch has no information on how many appeals may arise from the proposed bill or on whether the appeals would be declined, accepted for full appellate review, or accepted for a more limited review.
- Actions to disclose to law enforcement officials confidential reports filed pursuant to proposed RSA 132-B:9 would be considered complex equity cases in the superior court. The Branch has no information on how many such cases may arise, but estimates the cost of an average complex equity case in superior court will be $576.05 in FY 2013 and $602.60 in FY 2014. These amounts do not consider the cost of any appeals that may be taken following trial.
- The Branch has no information on how many class B misdemeanor cases would be brought pursuant to the proposed RSA 132-B:9, X (b) and (c). The Branch estimates the cost to process an average class B misdemeanor case in the district division of the circuit court will be $43.19 in FY 2013 and $44.54 in FY 2014. These amounts do not

consider the cost of any appeals of a class B misdemeanor that may be taken to the Supreme Court following trial in the district division of the circuit court.

- The Branch has no information on how many class A misdemeanors would be prosecuted pursuant to 132-B:9 X(d), but does have information on the average cost of processing these cases in the trial court. The cost to the Judicial Branch of processing an average class A misdemeanor in the district division of the circuit court is estimated to be $59.11 in FY 2013 and $61.31 in FY 2014. These amounts do not consider the cost of any appeals that may be taken following trial.

In summary, the Judicial Branch is able to identify areas of fiscal impact in this bill, but is not able provide an accurate estimate of the fiscal impact.

The Judicial Council states this bill may result in little or no fiscal impact to the Judicial Council. The Council assumes physicians may be less likely than average citizens to be eligible for indigent defense representation, but states if an individual is found to be indigent, the flat fee of $275 per misdemeanor and $756.24 per felony is charged by a public defender or contract attorney. If an assigned counsel attorney is used the fee is $60 per hour with a cap of $1,400 for a misdemeanor charge and $4,100 for a felony charge. The Council also states additional costs could be incurred if an appeal is filed. The public defender, contract attorney and assigned counsel rates for Supreme Court appeals is $2,000 per case, with many assigned counsel attorneys seeking permission to exceed the fee cap. Requests to exceed the fee cap are seldom granted. Finally, expenditures would increase if services other than counsel are requested and approved by the court during the defense of a case or during an appeal.

The New Hampshire Association of Counties states to the extent more individuals are charged, convicted, and sentenced to incarceration in a county correctional facility, the counties may have increased expenditures. The Association is unable to determine the number of individuals who might be charged, convicted or incarcerated as a result of this bill to determine an exact fiscal impact. The average annual cost to incarcerate an individual in a county correctional facility is approximately $35,000. There is no impact on county revenue.

The Department of Justice states the criminal offense created by this bill would typically be prosecuted by a county attorney's office. The Department states there would be a fiscal impact in cases when an appeal is taken to the NH Supreme Court, but is not able to predict how many cases may be appealed. In addition, violations could trigger a complaint to a medical licensing board which would impact the Civil Bureau which serves as legal counsel to the boards. The Administrative Prosecutions Unit may need to investigate and prosecute complaints filed with

a licensing board for violations under this law. Finally, additional resources may be needed within the Civil Bureau to provide legal counsel to the Department of Health and Human Services to assist it in meeting its obligations described in the bill. The Department is not able to determine the fiscal impact of these potential requirements.

The Department of Corrections states it is not able to determine the fiscal impact of this bill because it does not have sufficient detail to predict the number of individuals who would be subject to this legislation. The Department of Corrections states the average annual cost of incarcerating an individual in the general prison population for the fiscal year ending June 30, 2010 was $32,492. The cost to supervise an individual by the Department's division of field services for the fiscal year ending June 30, 2010 was $659.

Committee Minutes

Printed: 04/05/2012 at 11:54 am

SENATE CALENDAR NOTICE
HEALTH AND HUMAN SERVICES

Senator Jeb Bradley Chairman
Senator Tom De Blois V Chairman
Senator Molly Kelly
Senator Gary Lambert
Senator Andy Sanborn

For Use by Senate Clerk's Office ONLY
☐ Bill Status
☐ Docket
☐ Calendar
Proof: ☐ Calendar ☐ Bill Status

Date: April 5, 2012

HEARINGS

Thursday **4/12/2012**

(Name of Committee)	(Place)	(Time)
HEALTH AND HUMAN SERVICES	SH 100	1:00 PM

EXECUTIVE SESSION MAY FOLLOW

1:00 PM	HB1660-FN	relative to abortions after 20 weeks.
1:20 PM	HB1659-FN	relative to the women's right to know act regarding abortion information.
1:40 PM	HB1679-FN	(New Title) relative to partial-birth abortion.
2:00 PM	HB1680-FN	(New Title) relative to the duties of the oversight committee on health and human services.

Sponsors:

HB1660-FN

Rep. Robert Willette, Rep. Susan DeLemus, Rep. Harry Hardwick, Rep. Kris Roberts
Rep. Larry Gagne, Sen. Raymond White, Sen. Fenton Groen, Rep. J.R. Hoell

HB1659-FN

Rep. Jeanine Notter, Rep. Jerry Bergevin, Rep. Kathleen Souza, Rep. Lenette Peterson
Rep. Phyllis Katsakiores, Rep. Anne Cartwright, Rep. Connie Soucy, Rep. Susan DeLemus
Rep. Regina Birdsell, Rep. Laura Jones, Sen. Raymond White, Sen. Fenton Groen
Sen. Jim Luther

HB1679-FN

Rep. Ross Terrio

HB1680-FN

Rep. Marilinda Garcia, Rep. Lawrence Kappler, Rep. Daniel Tamburello, Rep. Kathleen Lauer-Rago
Rep. Daniel Itse, Rep. Carlos Gonzalez, Rep. Jeanine Notter

Robyn Dangora 271-4154

Sen. Jeb Bradley
Chairman

Health and Human Services Committee

Hearing Report

TO: Members of the Senate

FROM: Robyn Dangora, Legislative Aide

RE: Hearing report on HB 1659-FN – **relative to the women's right to know act regarding abortion information.**

HEARING DATE: April 12, 2012

MEMBERS OF THE COMMITTEE PRESENT: Sen. Bradley, Sen. De Blois, Sen. Kelly, Sen. Lambert, Sen. Sanborn

MEMBERS OF THE COMMITTEE ABSENT: None

Sponsor(s): Rep. Notter, Hills 19; Rep. Bergevin, Hills 17; Rep. K. Souza, Hills 11; Rep. Peterson, Hills 19; Rep. Katsakiores, Rock 5; Rep. Cartwright, Ches 2; Rep. C. Soucy, Hills 17; Rep. DeLemus, Straf 1; Rep. Birdsell, Rock 8; Rep. L. Jones, Straf 1; Sen. White, Dist 9; Sen. Groen, Dist 6; Sen. Luther, Dist 12

What the bill does: This bill establishes the women's right to know act.

Who supports the bill: Rep. Notter, Hills 19; Rep. K. Souza, Hills 11; Rep. DeLemus, Straf 1; Rep. Baldasaro, Rock 3; David Ross; Ellen Kolb, Cornerstone; Fmr. Rep. Harriet Cady; Kurt Wuelper, NH Right to Life; **To see the full list of those who signed in to support the bill, please see the permanent record*

Who opposes the bill: Dr. Barry Smith, NH Medical Society; Fmr. Rep. Liz Hagar, NARAL, Pro-Choice NH; Kathleen Kidder, NH Nurse Practitioners Assoc.; Linda Griebsch, Joan G. Lovering Health Center; Rep. Bouchard, Merr 11; Hilda Sokol and Margaret Powell, Seniors Defending Women's Health NH; Jen Castle and Jen Frizzelle, Planned Parenthood of Northern New England; Tori Bunk; Claire Ebel, NH Civil Liberties Union; Rep. Harding, Graf 11; Dahlia Vidunas, Concord Feminist Health Center; Linda Gerrish

Summary of testimony received:
Hearing opened at 1:35 PM, recessed at 1:38 PM, resumed at 2:39 PM and closed at 4:42 PM

Summary of Testimony Received in Support
(See committee file for all submissions)

•This was sponsored by nine women in the House and is a watered down version of legislation passed in 31 other states already, so it is not anti-woman.
•All this requires is a one-day wait period to receive and process information. Women must wait 6 weeks before having an abortion already so the fetus is developed enough for physicians to count the parts after they are aborted, so 24 hours to gain information is no added burden. Also, abortion providers do not work 7 days a week; if a woman in Manchester goes to Planned Parenthood on a Friday she has to wait until the following Thursday (their "surgical abortion day") anyways, so she can receive information and reflect during that time. When men have vasectomies they must wait and get their spouse's signature.
•There are no other procedures that people go into without being told the risks. At Planned Parenthood patients generally speak with an administrator if anyone, not a doctor. Patients have a right to discuss the procedure with a medical professional as with all other procedures.
•83% or women who have abortions suffer mental and/or physical problems after. This is an irreversible decision and women deserve the right to know all the information even if they don't think they want to know the implications. One woman who testified hemorrhaged and was not informed she could have bled to death.
•Since Roe v. Wade states have been responsible for restoring rightful pieces of legislation like parental notification other conscientious laws; this is among them.
•Abortion is the only procedure that results in the killing of another human so giving information is important. There is nothing wrong with waiting 24 hours to learn the risks of the procedure.
•It is the role of government to create reasonable rules and regulations to prevent predatory practice so this is not a violation of patient-doctor relations. Since doctors do not always perform the operation of even meet or refer patients, it is even more important to ensure patients receive information.
•The abortion providers cannot say how many abortions are done on the first day and how many women come back at another time or get counseling and choose not to return, so they have no evidence to back up the claim of a 24-hour delay being burdensome. (When asked out of the 1,000 abortions the Concord Feminist Health Center provides each year how many were performed at the first visit, Ms. Vidunas did not know)
•80% of post-abortion women say they had little or no counseling before the procedure. Countries with good and thorough informed consent laws have lower rates of abortions.

Summary of Testimony Received in Opposition
(See committee file for all submissions)
•This is discriminatory; no other procedures require a 24-hour wait period by law. It is also insulting because it assumes women do not know what it means to be pregnant or terminate a pregnancy and it assumes doctors are not following best practices. Women have the ability to look up any information they want.
•This bill does not make an exception for those who suffered rape, incest, or fetal anomaly from having to "reflect" for 24 hours.
•This bill is unfair to women in rural areas or low income women who may not be able to or afford to make a second trip. This may create a slippery slope where there are waiting periods for other procedures, further disenfranchising this group.

•We have had informed consent laws since 1977, so health care providers are already explaining the procedure and other options at the time of the visit. You cannot legislate informed consent because there is new information everyday. The Concord Feminist Health Center, for example, has 4 consent forms that lay out the risks and options and the fact that this is the patients choice. Planned Parenthood of Northern New England has a 5 page consent form.
•This bill only references physicians, not other health care professionals like nurse practitioners. If Nurse practitioners are no longer permitted to perform abortions, then this will change their scope of practice, which they oppose because it does not allow them to function at their highest level. The entire medical profession works in a team approach, so only mentioning physicians is problematic. It will also drive up costs to require physicians to be the provider of care and counseling.
•Statistically it is 10x more dangerous to carry a baby to term than to abort it. Also, NH specific studies show only 15-20% of post-abortion patients cite having depression. Some regret having abortions just as some regret taking pregnancy to term or giving children up for adoption; a 24-hour wait period will not change someone's mind. A 24-hour delay is not the same as hindsight and the government cannot prevent us from making bad decisions.
•This will slow down the ability to provide good medical care. Also, how will the reflection period work for medical (as opposed to surgical) abortions? Withhold the medication for 24 hours?
•Second-trimester abortions increase 53% in states with mandatory waiting periods according to a six-year study. This is not really a "24-hour" period; it is whenever the woman can make time to return.
•Some women who come in for an abortion are abused and have partners that steal their birth control and force them to remain at home. They may only have one opportunity to get out and receive the abortion.
•NH has the lowest rate of teen pregnancy in the U.S. and access to reproductive health is an essential part of keeping that statistic.
•The NHCLU will challenge the 24-hour waiting period in court as being contrary to the NH constitution. One such argument that will be made will cite a provision from the 1980s – A MD case regarding sobriety roadblocks was found in the U.S. Supreme Court to not be an undue burden on drivers, but in NH the next year, the NH supreme court found that in NH it is a burden and does interfere with our rights, so all roadblocks in NH must be advertised as to where they are located and when they will take place and allow for an alternate route. We believe this too will be found to be an undue burden interfering with our rights.
•the other 31 states with this legislation are not New Hampshire. We cannot compare ourselves to places like Alabama; we are the live free or die state.

Funding: See Fiscal Note

Action: Pending

rmd
[file: HB 1659-FN report]
Date: 4/13/12

Speakers

SPEAKING IN OPPOSITION
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 12, 2012 Time: 1:20 p.m. SH 100 Public Hearing on HB 1659-FN

HB 1659-FN **relative to the women's right to know act regarding abortion information.**

Name	Representing					
BARRY SMITH, MD	NH Med Society / NH ACOG	Oppose ☑	Speaking?	Yes ☑	No ☐
Liz Hager	NARAL	Oppose ☑	Speaking?	Yes ☑	No ☐
KATHLEEN KIDDER	NHNPA	Oppose ☑	Speaking?	Yes ☑	No ☐
LINDA GRIEBSCH	NGLHC	Oppose ☑	Speaking?	Yes ☑	No ☐
Barbara Maling	Self	Oppose ☐	Speaking?	Yes ☐	No ☒
Rep. Timothy Horrigan	Strafford 7	Oppose ☒	Speaking?	Yes ☐	No ☒
Rose L. Miller	myself	Oppose ☒	Speaking?	Yes ☐	No ☐
Heather Sokoe	"Seniors Defending Women's Health" NH	Oppose ☒	Speaking?	Yes ☒	No ☐
Margaret Powell	Seniors Defending Women's Health NH	Oppose ☒	Speaking?	Yes ☒	No ☐
Tori Bunk	SCIF	Oppose ☒	Speaking?	Yes ☒	No ☐
DALIA VIDUNAS	CONCORD FEMINIST HEALTH CENTER	Oppose ☒	Speaking?	Yes ☒	No ☐
X Rep. Candace Bouchard	Concord Merrimack Dist 11	Oppose ☐	Speaking?	Yes ☒	No ☐
Jennifer Frizzell and Jen Castle	Planned Parenthood of Northern New England	Oppose ☒	Speaking?	Yes ☐	No ☐

SPEAKING IN OPPOSITION
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 12, 2012 Time: 1:20 p.m. SH 100 Public Hearing on HB 1659-FN

HB 1659-FN **relative to the women's right to know act regarding abortion information.**

Name	Representing	Oppose	Speaking?	Yes	No
Claire Ebel	NHCLL	☒		☒	☐
★ Rep. Laurie Harding	Grafton 11	☒		☒	☐
~~Rep. M. Goldner~~	~~Rockingham Dist 3~~	☐		☐	☐
Rep. David Campbell	Hills 24	☒		☐	☒
Rep. Cindy Rosenwald	Hills 24	☒		☐	☒
		☐		☐	☐
Linda A Gessish	Bedford	☐		☐	☐
		☐		☐	☐
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SPEAKING IN SUPPORT
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 12, 2012 Time: 1:20 p.m. SH 100 Public Hearing on HB 1659-FN

HB 1659-FN **relative to the women's right to know act regarding abortion information.**

Name	Representing	Support	Speaking?	Yes	No
Rep. Jeanine Notter	Hills 19 - Sponsor	☒		☒	☐
* Dan Hogan	SEE	☒		☒	☒
Rep Kathleen Souza	Hills. Dist 11	☑		☐	☐
* DAVID ROSS	SEE	☑		☑	☐
† Cliff Kolb	CORNERSTONE	☒		☒	☐
† Meredith Cook	Roman Catholic Diocese of Manchester	☒		☒	☐
Rep Susan C. Dehemus	Rochester, Dist #1	☒		☒	☐
Rep Dan Itse	Rock Dist 9	☑		☐	☐
Rep AL Baldasaro	Rock - Dist 3	☒		☐	☒
Rep. Don LeBrun	Nashua Dist 26	☒		☐	☒
		☐		☐	☐
		☐		☐	☐
		☐		☐	☐
		☐		☐	☐

SPEAKING IN SUPPORT
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 12, 2012 Time: 1:20 p.m. SH 100 Public Hearing on HB 1659-FN

HB 1659-FN **relative to the women's right to know act regarding abortion information.**

Name	Representing	Support	Speaking?	Yes	No
Harriet E Cady		Support ☒	Speaking?	☒	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐
		Support ☐	Speaking?	☐	☐

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 12, 2012 Time: 1:20 p.m. SH 100 Public Hearing on HB 1659-FN

HB 1659-FN **relative to the women's right to know act regarding abortion information.**

Name	Representing	Support	Oppose
Sara Crane	NARAL Pro-Choice NH	☐	☒
Lisa Gerrish Bow NH	WOMEN / SELF	☐	☒
Sylvia Gale	self	☐	☒
Lucy Edwards Northwood	women / self	☐	☒
Mary Eastbrook Hopkinton	SELF	☐	☒
Simke Ellis	Self	☐	☒
Peggy Gilmour RN	women / self / nurse educator	☐	☒
Rep. Timothy Horrigan	Strafford 7	☐	☒
Barbara M'Elroy	self	☐	☒
Carol Groteau	self	☐	☒
Rep. Harry Hardwick	Hills. 2	☒	☐
Stella Tremblay	Auburn, Londonderry	☒	☐
Christy Bartlett	self - Council	☐	☒
Rep David Kidder	self	☐	☒

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 12, 2012 Time: 1:20 p.m. SH 100 Public Hearing on HB 1659-FN

HB 1659-FN **relative to the women's right to know act regarding abortion information.**

Name	Representing	Support	Oppose
REP. LARRY GAGNE	SELF	☒	☐
Rep Philip Munck	Strafford 2	☒	☐
Rep Anne Cartwright	Cheshire 2	☒	☐
Rep Jerry Borgeum	Self	☒	☐
Rep CARL SEIDEL	Hills 20	☒	☐
Jess Clark	America Votes	☐	☒
Josiette White	America Votes	☐	☒
Rep David Kidder	Merr 1	☐	☒
MO BAXLEY	SELF	☐	☒
Terry BARNUM	NHRTL + self	☐	☐
Rep Jason Antosz	Self	☒	☐
Theresa Clark	Respect Life Committee	☒	☐
Nancy A Normand	self + Concord Fem Health Ctr	☐	☒
		☐	☐

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 12, 2012 Time: 1:20 p.m. SH 100 Public Hearing on HB 1659-FN

HB 1659-FN **relative to the women's right to know act regarding abortion information.**

Name	Representing		
Rep. Jennifer Daly	Hillsborough 4	Support ☐	Oppose ☒
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 12, 2012 Time: 1:20 p.m. SH 100 Public Hearing on HB 1659-FN

HB 1659-FN **relative to the women's right to know act regarding abortion information.**

Name	Representing	Support	Oppose
Sen. Green	SD. 6	☑	☐
Sen. White	SD. 9	☑	☐
Rep. Barry Palmer	Hills. #26	☑	☐
Kurt Wuelper	N.H. Right to Life	☑	☐
Rep Cindy "Lee" Hogue	Hills. 25 Nashua	☑	☐
Rep Stephen Palmer	Hills 6	☑	☐
Louise Nies	NH Board of Nursing	☐	☑
Margaret M. Drye	self	☑	☐
Elaine West	Self	☑	☐
Laura Grant	Self	☑	☐
Maria Chamberlain	self	☑	☐
Kathleen Seppala	self	☑	☐
Rep Kevin Avard	Hills #20	☑	☐
Rep R.F. Welch	Hills 6	☒	☐

Testimony

Wuelper

Women, Abortion, and the Brain

by Evelyn Birge Vitz and Paul C. Vitz

September 20, 2010

Women are hard-wired for relationships—and a woman's relationship to her baby is one of the most powerful of all, whether she realizes it or not. The hard-wiring of the brain may explain many women's disturbing post-abortion feelings.

This past semester, in a course taught by one of us at New York University, the class spent considerable time reading women's stories about their abortions, focusing particularly on a website called www.afterabortion.com. This website was founded by a pro-choice woman and on it no mention of politics, religion, or morality is allowed. The website contains thousands of women's stories about their abortions—and about their post-abortion feelings. And **many of these women are in acute pain; some are almost totally incapacitated**. One writes in a post: "I am not coping at all; I feel as though the top of my head is going to fly off." Another says: "I am just grieving like crazy!" A third: "I don't understand why I am not getting better, but worse all the time! I am so depressed!" (Stories on this website are protected by copyright, and it is not permitted to quote directly from them. Quotations provided here are therefore faithful rewordings.)

Many of these women cannot go outside for fear of "triggers"—the sight or sound of things that will bring back the abortion experience and cause panic attacks. Triggers include the sound of a vacuum cleaner (many abortions are done by the vacuuming out of the fetus from the uterus) or the music that was playing at the abortion clinic while the abortion was being performed. The sight of pregnant women, or maternity clothes, or babies, or toddlers, or school-children, or of the place (even the neighborhood or town) where the abortion took place can all serve as triggers. Other triggers are anniversaries of all kinds, especially of the abortion and of the EBD (expected birth date), and, in particular, Mother's Day.

What is particularly striking is that most of the women who have these powerful emotional reactions to their abortion are stunned by them. They were not opposed to abortion; many were actively pro-choice. They were blind-sided by their own reaction. One woman lamented—and thousands of others echo her mystified anguish—"If this was the right decision, why do I feel so terrible?"

Research indicates that there are various psychological or political factors that may contribute to this disconnect between the anticipated and the actual emotional outcome. Since this disturbing phenomenon is so widespread, and found among women from varied backgrounds and different parts of the world, it seems likely that the brain itself—in particular, the nature of women's brains—may shed some particularly useful light on this unexpected negative emotional reaction.

Women's brains are, of course, in many fundamental ways the same as men's. Men and women think and reason in similar ways. But recent research shows that there are some significant differences in the brain and brain-related psychology of the two sexes. And a few of these differences can make a very large difference with regard to decision-making and its emotional consequences.

The part of the brain that processes emotion, generally called the limbic system, of women functions differently than that of men. Women experience emotions largely in relation to other people: what moves women most is relationships. Females are more personal and interpersonal than men. (Differences show up as early as a day after an infant's birth: newborn baby girls look at faces relatively more than boys, who focus more on moving robotic figures.) There is wide consensus among scientists and researchers on this fundamental issue.

Recent research has also studied the ways in which males and females cope with stress. Whereas men's behavior under stress is generally characterized by what is called "fight or flight," women respond to stress by turning toward nurturing behavior, nicknamed "tend and befriend."

Men's and women's brains also work differently in handling memory and memories. Men are more apt to recall facts of all kinds, on the one hand, and a global picture of events, on the other. By contrast, women remember people (for example, faces), details of all kinds, and emotion-laden narratives—and they may return to them obsessively.

Women are more vulnerable to depression and anxiety than men, perhaps because they have a lower level of serotonin, an important neurotransmitter. In addition, women are twice as likely as men to suffer from post-traumatic stress disorders. Men suffer more than women from other mental pathologies, such as autism, dyslexia, and Narcissistic Personality Disorder; the two sexes suffer about equally from yet other mental problems, such as bi-polarity.

What do these differences add up to, practically speaking? Let's walk quickly through an unplanned pregnancy and abortion. A woman may reason her way to the decision to terminate the unwanted pregnancy. Her abortion decision may seem, and may indeed be, rational in terms of her long-term goals and interests, and her chosen values. But afterwards, a woman may experience several powerful reactions, which are rooted in the structures and basic chemistry of her brain.

- A woman may discover, emotionally, that she has (now, *had)* a far more powerful relationship with the fetus than she had thought. This may be particularly true if the relationship with her partner (in the interests of which she may have decided to have the abortion) should deteriorate after the abortion.

- When responding to the stress of the abortion, she may well be drawn to nurturing, to "tending and befriending" behavior: this is, we saw, characteristic of women. But one of the key persons she might have tended and befriended—her unborn child—she has just terminated. She therefore has no ready outlet to cope with this significant stress.

- Add to this already toxic mix the very power of the memories involved in most unwanted pregnancies and abortion experiences, such as the nausea or other physical symptoms, often exacerbated by hormonal instability and mood swings; the anxiety over the unwanted pregnancy; the drama of the pregnancy test; often, the difficulty of making the decision, then the waiting before the abortion can take place; perhaps protesters in front of the clinic; the abortion clinic waiting room, crowded perhaps with other emotional women and men; the abortion itself—the doctors and nurses, the stirrups, the vacuum or other machinery—then the recovery room; the pain and bleeding afterward. All these dramatic experiences are likely to provide her with indelible memories. A woman may return to them and relive them over and over.

- And to cap it off, as a woman she is more vulnerable to depression and anxiety, and to post-traumatic stress disorders.

Thus, though a woman can decide rationally to have an abortion, afterwards the other shoe may drop—and it may drop very hard indeed. **For the thousands of women** on www.afterabortion.com and similar websites, **a terrible and shocking reaction sets in after their abortion.** Many women have discovered that somewhere down in their psyche—deep in their limbic system—they were *already* in a living relationship with the fetus, their "baby" (though they may have *thought* they thought it was just a random clump of cells). **Often what lasts is** not the relief or the power of the logical arguments: these may prove very short-lived. It is, rather, **the failed, betrayed relationship between the woman and her fetus—now, in her mind, her dead baby—that has staying power.**

Many of these women feel "haunted" (their word) by their lost child. They cry: "I miss my baby!" "It has been three years, and I still think of my baby girl every single day!" "I want my twins back!" The babies they ******, they now desperately want to love, to hold. (Those asterisks represent one of the words—"killed"—that are so painful and triggering that their use is prohibited on www.afterabortion.com.) A good many women on the website have named the aborted baby, which appears to promote healing.

For some women, this surprising and terrifying shift from cool logic to hot maternal feelings may be the result of particular experiences: seeing the fetal heartbeat on a sonogram, or watching a pair of twins move; or, in a medical abortion at home, recognizing that what fell into the toilet bowl was not (as they had thought it would be) undifferentiated tissue but, rather, "a tiny, pale-gray baby," and then agonizing over the dilemma of what to do with it (flush it down the toilet? bury it—and where?).

Sometimes, however, the shift cannot be explained by any one particular memory. Their reaction seems more profound and inexplicable than that—more hard-wired. Women care about relationships—and a woman's relationship to her baby is one of the most powerful of all.

If we look at all this in evolutionary terms, we cannot be surprised. Human mothers (unlike the females of most other species) produce few offspring. For infants to survive, they must be very carefully tended and protected, over many years. Historically, culturally, the investment of women in their young has been tremendous. Billions of mothers have lavished their time, energy, and attention—their love—on their children. And what is the reward, the reinforcement for all this maternal time and effort? What does the mother get out of it? Whatever it is, it must be a reliable, immediate, and strong reinforcement. Otherwise, infant mortality—always high in the human and primate past—would have led to our extinction. Thus, we should not be surprised that human mothers are richly rewarded—by their own feelings, their own brain responses, their own chemistry—for good mothering, and that they are emotionally punished, internally, for failure.

What to do for these wounded women? **Afterabortion.com** provides an impressive virtual support system: women from around the world send hugs, visualized as "(((hugs!!)))", and loving messages of support, understanding, and affirmation to each other. Thus, women from around the world "tend and befriend" these suffering women. After a while, many who were previously beside themselves with grief write in to say that they are now feeling better; they are healing; they have stopped hating themselves; they feel once again that they have a future. This valuable sisterhood is supplemented, for many women, by psychotherapy of some form.

But **can't we work to *prevent* at least some women from having to experience this painful surprise? One important change would surely be for the medical and psychological professions, and the university health centers, to be more honest about the psychological impact of abortion on substantial numbers of women.** Is it not like the fine print on prescriptions?: "This medication may cause internal bleeding, or blindness, or [other grave side-effects]."

Some women appear to have no regrets whatever after abortion: see www.Imnotsorry.net. Some experience modest sadness. But for many women, their abortion turns out to have been a nightmare from which they cannot wake up. Some awaken each morning to *that*. Women and those who advise them need to be more aware of this risk, and why it occurs. Human beings—and women in particular—are not just cortex, not just what used to be called "gray cells." Women need to be told the truth. They need to be prepared for what may be the consequences of this major life decision.

This is what informed choice means.

Evelyn Birge Vitz is Professor of French and Affiliated Professor of Comparative Literature at New York University. Paul C. Vitz is Professor Emeritus of Psychology at New York University and Senior Scholar at the Institute for the Psychological Sciences.

LifeSiteNews.com

Friday November 12, 2010

Britain Needs Informed Consent Laws to Lower Abortion Rates: Pro-Abortion MP

By Hilary White

LONDON, November 12, 2010 (LifeSiteNews.com) – Britain's abortion rate could be lowered with the adoption of laws requiring women to be given full information as to the effects of abortion, a British MP said earlier this month. Nadine Dorries, the MP for Mid Bedfordshire, believes abortion should remain legal, but has campaigned consistently for more restrictions.

Nadine Dorries, MP for Mid Bedfordshire.

Dorries said in a debate in the House of Commons on November 2 that in Germany, France, Belgium, Finland, informed consent laws have made the "abortion procedure a far kinder one" for women.

"All those countries with good informed consent legislation had significantly lower than average daily abortion rates than the countries that do not have such informed consent legislation. Although a causal link is impossible to prove, these figures suggest that informed consent legislation might prove a good way of reducing Britain's abortion figures."

Britain's abortion rate, one of the highest in Europe, slowed slightly last year, but still came close to 200,000, or approximately 572 per day.

"A woman has an assumed right to choose," Dorries said. "However, she apparently has no right whatever to any information on which to make that choice."

For any minor surgery, she continued, doctors are required to explain it to patients in detail. They are required to discuss possible pain, the dangers of general anaesthetic and post-operative progress is checked in follow-up appointments. "A woman who has an abortion has none of that."

"Before the woman received the procedure, she might have felt coerced, pressurized or bullied into the abortion. To her, it might have been a life or the beginning of a life - depending on her perspective. She might have had a seed of doubt, but once she was on the conveyor belt to the clinic, she might have felt helpless and unable to step off."

"Abortion in this country is an industry from which a small number of organisations and individuals make vast amounts of money. No sensible person would condone this."

Anne Milton, a minister with the Department of Health, responded for the Government, saying that reducing the abortion rate is "an absolute priority" for the coalition government and that "advances" had been made to ensure women have "safe, legal abortions."

Milton said that a White Paper report is scheduled to be issued later this year which will set out the Government's position in more detail, and promised that the results of a review of the evidence surrounding mental health consequences of abortion will be published next year.

In the same debate, Andrew Selous, MP for South West Bedfordshire, pointed out that the cost of "counseling" for abortion is only covered by the public health service if the abortion goes ahead. The woman pays herself if she decides to allow her child to live.

Moreover, Dorries said, that only "minimal" counseling is available from NHS hospitals and private abortion facilities, and that in those places, there is a natural "conflict of interest." If a woman is not interested in aborting her child, "no alternative counseling is provided to negate that option."

Dorries decried the laxity of the existing restrictions that require the consent of two physicians. "Abortion clinics freely admit that consent forms pile up in their offices, waiting for the second signature, long after the event has taken place."

But Andrew Stephenson, head of the pro-life group Abort 67, told LifeSiteNews.com that if he had Dorries in front of him, he would ask her, "Why do you want to restrict abortion? If abortion isn't killing a small human being, then why have any restriction on it?"

Stephenson, with colleague Catherine Sloane, recently made headlines when they were arrested for showing large graphic images of abortion outside the Marie Stopes private abortion facility in Brighton as part of the Genocide Awareness Project movement.

He said, "You've got to ask yourself why. If there's nothing wrong with abortion, then you can support it without any restriction. So why does Dorries want greater restrictions but not to outlaw it? But if it's true that abortion kills an innocent human being, how can she support it?"

Stephenson and Sloane speak to women at Britain's abortion facilities, and say that their experiences show that "girls don't know the facts about abortion."

"That's perfectly true. Women have told us that they've been told by doctors that their baby was just a 'mass of tissue' like a kidney bean. So clearly something needs to be done, these women need more information."

But there is a question of bias and motive, he said. "Whether I trust those people who would kill these women's babies to give them genuinely accurate information is another question."

"You've got to ask whether someone who is willing to kill a baby would give the sort of information required to help a woman make an informed decision."

The work of Abort 67, which includes a website featuring graphic images and videos of abortions and aborted children, is to inform women of the grisly reality of what abortion really does to a child.

The women going into abortion facilities, Stephenson said, are often "in no fit state" to make such decisions. "They're often being dragged by their friends or families or boyfriends or husbands, and are not capable of understanding what is happening."

Instead, Stephenson said, "Society as a whole needs a fuller information on this. We need to reach those who are pressuring girls to abort before the situation arises."

The group aims to do something "much more broad" than giving information to "a girl sitting in a doctor's surgery hearing a few stats and facts."

"We do know that when girls see the reality of abortion up front, they change their minds. I would agree that in our experience that's been the case many times." This shows the need for a nation wide information campaign. "We need to see girls in schools being properly informed about what abortion is, before they get to the stage when they're having to make this decision.

"If we're serious about reducing abortion numbers, we need to be educating men and women from an early age about the truth of abortion. Only when the truth is known everywhere will we decrease those numbers."

"We've seen it on a small scale and we know it would work on the larger scale."

URL: http://www.lifesitenews.com/ldn/2010/nov/10111203.html

SOUZA

From Suicide to Conversion: Recovering From an Abortion

by Jewels Green | Washington, DC | LifeNews.com | 12/19/11 5:57 PM

Email

After trying to kill myself to escape the overwhelming guilt after my abortion, I emerged from my month spent in an adolescent psychiatric unit with an incongruous newly-found zeal for abortion rights.

Within weeks of my discharge from the psych unit, I found myself on a bus to Washington, D.C. to march for abortion rights and soon after I began volunteering as an escort for a first-trimester abortion clinic. An advanced degree in psychology isn't necessary to see that I was plainly trying to assuage my guilt (and protect my delicate and damaged psyche) by assuming the precise opposite of what I truly believed. Freud called this reaction formation, one of many coping strategies he dubbed defense mechanisms. I certainly took reaction formation to the extreme by espousing the most diametrically opposed position of my innermost heart when I accepted the offer of a job at an abortion clinic.

I completely bought the bill of goods I was sold: that abortion was somehow linked to women's equality, that giving birth and making an adoption plan for an unwanted child (rather than killing it by abortion) was somehow unduly burdensome for a pregnant mother, and that countless women would die if abortion was illegal. (Naturally, I no longer believe any of that propaganda.) Combine all of this with my unconscious overwhelming need to repress/transform my personal feelings about *my* abortion—and my longing for *my* lost child—and it created the perfect recipe for a die-hard abortion rights advocate.

We all truly believed we were offering women an innocuous, much-needed, and unfairly-maligned "medical" service. Although violence was not common, every publicized incident—but especially the murders, as well as the non-violent invasion, occupation, and blockade of the clinic where I worked—steeled our resolve in our self-righteous insistence that abortion remain safe and legal. Not surprisingly, it is easy to discount the opinions of people you think are trying to kill you.

As strange as it may sound now, my years spent working at the clinic were some of the best of my life. The camaraderie at work created a family-like atmosphere—it was a nearly all-female workplace (with the exception of a few of the doctors)—and as a very young woman (I worked there from age 18 – 23) I found this inspiring.

Then I started having nightmares—nightmares that were no longer only about my lost baby—but about all of the babies killed by abortion where I worked every day, all of the babies killed by abortion everywhere. My sleep was haunted by tiny limbless phantom babies... But even then, my desire to survive in a world without my child—because I'd killed him—warped my mind into believing that if all of these strong, capable women I worked with thought abortion was OK, I must be able to believe that too. So I pushed down the unpleasantness—muzzled my pesky conscience—and I kept going back to work, day after day. It wasn't

until many years and innumerable nightmares later that I finally opened my eyes to the brutal and barbaric truth: abortion is murder.

A cold day a year ago, I found myself contemplating the bizarre and unnatural process of in-vitro fertilization and surrogacy. After learning of a surrogate mother who accepted payment of her surrogacy contract in full to abort the innocent baby with Down syndrome she was carrying for an infertile couple, something finally (finally!) clicked in my mind—pregnancy was now a commercial transaction: the little helpless human a commodity to be conceived, sold, bought, and disposed of at will—how gruesome and indefensible and reprehensible—and I had been a part of that "industry" for years.

My conversion to the pro-life worldview could never have happened without the courageous public testimony of Abby Johnson, the former Planned Parenthood Director who experienced a profound change of heart after watching an ultrasound-guided abortion, best described in her amazing book, Unplanned. Her courage and strength in the face of overwhelming opposition from her former employer (and former friends and co-workers) inspired the confidence I needed to fully change my mind and support the inherent right-to-life of all human beings from conception to natural death.

Within weeks of self-identifying as pro-life I began donating my time, talents, and treasure to the cause: I joined Feminists for Life, the Susan B. Anthony List, and Pennsylvanians for Human Life. Then I sought out my local chapter of 40 Days for Life and attended my first vigil outside of the hospital where my third son was born, and where abortions are performed. Next I began speaking to local church leaders about helping to support Amnion Crisis Pregnancy Centers. Taking these steps to help support the pro-life movement, and to foster the changing of hearts and minds, has been a transformative experience for which I am grateful. But I still miss my baby, and no amount of dollars I donate will make that pain go away.

LifeNews Note: This is Part Three of a series on post-abortion recovery. See part one at I Tried to Take My Life to Erase the Pain of My Abortion and part two at Recovering From a Suicide Attempt After Abortion Depression. Jewels Green is a post-abortive mother of three who worked in an abortion clinic before becoming pro-life. Watch for the next installment in this series of post-abortion pain and recovery, "Abortion Hurts, Part 2: The Psychiatric Hospital" coming soon. Green writes for the Live Action blog and this column is reprinted with permission.

SOURCE

Psychological Risks
Traumatic Aftereffects of Abortion

Suicide

- **6 times higher suicide rate.** Aborting women were six-seven times more likely to commit suicide in the following year than were delivering women.[1] A study of women for up to eight years after the preganncy ended found a 2.5 times higher suicide rate after abortion than after giving birth.[2]
- **Up to 60% have suicidal thoughts.** In a study in a major scientific journal, 31% of women had thoughts of suicide after undergoing an abortion.[3] In another survey, approximately 60% of women with post-abortion problems reported suicidal thoughts, with 28% attempting suicide and half of those attempting suicide two or more times.[4]

Depression

- **65% higher risk of clinical depression.** Women who aborted were 65% more likely than delivering women to be at risk of long-term clinical depression after controlling for age, race, education, marital status, income, and prior psychiatric state.[5]
- **Depression risk remained high, even when pregnancies were unplanned.** Among women with unintended first pregnancies, aborting women were at significantly higher risk of long-term clinical depression compared to delivering women.[6]

Trauma

- **65% report symptoms of post-traumatic stress disorder.** 65% of U.S. women who had abortions experienced multiple symptoms of PTSD, which they attributed to their abortions. Slightly over 14% reported all the symptoms necessary for a clinical diagnosis of abortion-induced PTSD.[3]
- **60% said they felt "part of me died."** In the above study, 60% reported that they felt "part of me died" after their abortions.[3]
- **More psychiatric treatment.** Compared to women who deliver, women who abort are more than twice as likely to be subsequently hospitalized for psychiatric illness within six months.[7] Analysis of California Medicaid records shows that women who have abortions subsequently require significantly more treatments for psychiatric illness through outpatient care.[8]
- **Multiple disorders and regrets.** In a study eight weeks after abortion, 36% of women experienced sleep disturbances, 31% had regrets about the abortion, and 11% had been prescribed psychotropic medicine by their family doctor.[9]
- **Generalized anxiety disorder.** Among women with no previous history of anxiety, women who aborted a first, unplanned pregnancy were 30% more likely to subsequently report all the symptoms associated with a diagnosis for generalized anxiety disorder, compared to women who carried to term.[10]
- **Sleep disorders.** In a study of women with no known history of sleep disorders, women were more likely to be treated for sleep disorders after having an abortion compared to giving birth (nearly twice as likely in the first 180 days afterwards). Numerous studies have shown that trauma victims often experience sleep difficulties.[11]
- **Disorders not pre-existing.** A New Zealand study found that women had higher rates of suicidal behavior, depression, anxiety, substance abuse, and other disorders after abortion. The study found that these were not pre-existing problems.[12]

Eating disorders & substance abuse

- **39% had eating disorders.** In a survey of women with post-abortion problems, 39% reported subsequent eating disorders.[13]
- **Five-fold higher risk of drug and alcohol abuse.** Excluding women with a prior history of substance abuse, those who abort their first pregnancy are 5 times more likely to report subsequent drug and alcohol abuse vs. those who give birth.[14]

continued ▸

Divorce and chronic relationship problems

- Women with a history of abortion are significantly more likely to subsequently have shorter relationships and more divorces.[15]
- **More poverty and single parenthood after repeat abortions.** Women who have more than one abortion (nearly half of those seeking abortions each year[16]) are more likely to become single parents and to require public assistance.[17]
- **30-50% of post-abortive women report experiencing sexual dysfunctions** such as promiscuity, loss of pleasure from intercourse, increased pain, and aversion to sex and/or men.[18]
- **Studies have identified factors that put women at risk for negative reactions to abortion,** including feeling pressured to abort, lack of support, being more religious, prior emotional or psychological problems, adolescence, being unsure of her decision, and receiving little or no counseling prior to abortion.[19]

To find out more, including pregnancy help and post-abortion resources, visit TheUnChoice.com

Citations

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2. DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women," *Southern Medical Journal* 95(8):834-41, Aug. 2002.

3. VM Rue et. al., "Induced abortion and traumatic stress: A preliminary comparison of American and Russian women," *Medical Science Monitor* 10(10): SR5-16, 2004.

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SOV22A

Physical Risks
Life-Threatening Risks of Abortion

Higher death risk, 6 times higher suicide rate

Compared to pregnant women who had their babies, pregnant women who aborted were ...

- **3.5 times more likely to die in the following year**
- **6 times more likely to die of suicide**
- **4 times more likely to die of injuries related to accidents**[1]
- **1.6 times more likely to die of natural causes**
- **14 times more likely to die from homicide**

Another study found that, compared to women who gave birth, women who had abortions had a 62% higher risk of death from all causes for at least *eight* years after their pregnancies. Deaths from suicides and accidents were most prominent, with deaths from suicides being 2.5 times higher.[2]

Causes of death within a week — The leading causes of abortion-related maternal deaths within a week of abortion are hemorrhage, infection, embolism, anesthesia complications, and undiagnosed ectopic pregnancies.[3]

Cancer — Significantly increased risk of breast cancer, cervical cancer, and lung cancer (probably due to heavier smoking patterns after abortion).[4]

Immediate complications — About 10% suffer immediate complications; one-fifth of which are life-threatening,[5] These risks include hemorrhage, cervical injury, perforation of the uterus, infection, embolism, chronic pain, and anesthesia complications.

31% suffer health complications— A recent study published in a major medical journal found that 31% of American women surveyed who had undergone abortions had health complications.[6]

80%-180% increase in doctor visits — Based on health care sought before and after abortion. On average, there is an 80% increase in doctor visits and a 180% increase in doctor visits for psychosocial reasons after abortion.[7]

Self-destructive lifestyles, spiraling health problems — Increased risk of promiscuity, smoking, drug abuse, and eating disorders, which all put the woman at increased risk for other health problems.[8]

Infertility and life-threatening reproductive risks

Abortion can damage reproductive organs and cause long-term and sometimes permanent problems that can put future pregnancies at risk. Women who have abortions are more likely to experience ectopic pregnancies, infertility, hysterectomies, stillbirths, miscarriages, and premature births than women who have not had abortions.[9]

Reproductive complications and problems with subsequent deliveries

Pelvic Inflammatory Disease — Abortion puts women at risk of pelvic inflammatory disease (PID), a major direct cause of infertility. PID also increases risk of ectopic pregnancies. Studies have found that approximately one-fourth of women who have chlamydia at the time of their abortion and 5% of women who don't have chlamydia will develop PID within four weeks afterwards.[10]

Placenta Previa — After abortion, there is a seven- to 15-fold increase in placenta previa in subsequent pregnancies, a life-threatening condition for the mother and baby that increases the risk of birth defects, stillbirth, and excessive bleeding during labor.[11]

Ectopic Pregnancy — Post-abortive women have a significantly increased risk of subsequent ectopic pregnancies,[12] which are life threatening and may result in reduced fertility.

Endometritis, a Major Cause of Death — Abortion can result in for endometritis, which can lead to hospitalization and infertility problems. It is a major cause of maternal death during pregnancy.[13]

Women who abort twice as likely to have pre-term or post-term deliveries.[14] Women who had one, two, or more previous

continued ▸

induced abortions are, respectively, 1.89, 2.66, or 2.03 times more likely to have a subsequent pre-term delivery, compared to women who carry to term. Pre-term delivery increases the risk of neonatal death and handicaps. Women who had one, two, or more induced abortions are, respectively, 1.89, 2.61, and 2.23 times more likely to have a post-term delivery (over 42 weeks).

Death or disability of newborns in later pregnancies — Cervical and uterine damage may increase the risk of premature delivery, complications of labor, and abnormal development of the placenta in later pregnancies.[15] These complications are the leading causes of disabilities among newborns.

To find out more, including pregnancy and post-abortion resources, visit TheUnChoice.com

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Sorza

Key Facts — Abortion's Impact
Coercion, Trauma, Grief, Injury, Death

Most abortions are coerced or unwanted, based on insufficent information

64% involve coercion. A study published in a major international medical journal found that 64% of American women who had abortions felt pressured by others.[1] Coercion can include loss of home, job or family, and even violent assault.[2]

Up to 83% wanted to have the baby. In a survey of women who sought help after abortion, 83% said they would have carried to term if they had received support from the baby's father, their family, or other important people in their lives.[3]

In 95% of cases, men play a central role in the decision to abort according to a survey of women at abortion clinics.[4]

Husbands and boyfriends threaten women at the clinic. A former abortion clinic security guard testified before the Massachusetts legislature that women were routinely threatened and abused by the husbands and boyfriends who took them to the clinics to make sure they had abortions.[5]

Dangerous consequences if she resists. Coercion can escalate to violence and even murder.[2] Homicide is the leading killer of pregnant women.[6] The "Forced Abortion in America" report includes examples of molesters posing as fathers to procure cover-up abortions and women being fired, beaten, shot, stabbed, tortured or killed for refusing to abort.[2]

Not given enough information.

- 67% said they received no counseling beforehand.
- 84% reported they received inadequate counseling beforehand.
- 54% were not sure about their decision at the time, yet 79% were not counseled about alternatives.[1]

Rushed into abortion. Many women may be making hasty, ill-considered decisions for abortion, according to journal articles by the National Abortion Federation.[7] One in five women served by their clinics are philosophically and morally opposed to abortion.[8] A recent study found that 52% needed more time to make their decision.[1]

Deception and sales tactics. Many who sought answers and help, instead encountered pressure from "counselors" trained to sell abortions in profit-driven clinics.[9] In a survey of women experiencing problems after abortion:

- 66% said counselor's advice was very biased
- 60% were uncertain of their decision
- 44% hoped to find an alternative
- 71% felt their questions were ignored or trivialized.[3]

After Abortion

Health complications

- 31% suffered health complications.[1]
- About 10% suffer immediate complications; of which one-fifth are life-threatening. Hemorrhage, endotoxic shock andanesthesia complications are among the many potential problems.[12]
- Women also risk infertility or problems with future pregnancies, such as ectopic pregnancies, labor complications, miscarriages, stillbirths or premature births, the leading cause of birth defects.[13]

Trauma and suicide

- 65% suffer multiple symptoms of post-traumatic stress disorder.[1]
- 62% increased risk of death from all causes, including suicide.[10]
- Suicide rates are 6 times higher if women abort vs. giving birth.[11]
- 60% of women who had abortions said they felt that "part of me died."[1]

continued ▸

Increased awareness and declining abortion rates

Majority of women oppose abortion on demand. A poll by the Center for the Advancement of Women, which supports abortion, shows more than half of American women oppose abortion on demand. Legal abortion was the next to last priority for women.[14]

Abortion rates steadily dropping. There has been a slow steady drop in abortion rates over the last 15 years, in part because of raised awareness that abortion is not a "quick and easy" solution.[15] 77% of Americans now realize that abortion takes a life, including one-third of those who describe themselves as strongly pro-choice.[16]

Few regret keeping unintended babies. Studies of women who sought but did not have abortions show that few, if any, later regret their decision or suffer psychological problems from having an unintended child.[17]

Even in hard cases, women don't want abortion ...

Victims say it only intensifies the trauma. In a survey of women who became pregnant through rape or incest, many only aborted because they felt pressured to do so and said abortion only increased their grief and trauma.

- 70% had their babies, and none regretted their decision.
- 78% of those who aborted had regrets and said that abortion was the wrong solution.[18]

Petition for Hearings. An Ad Hoc Committee of Women Pregnant by Sexual Assault has put together a Petition to Congress and State Legislators to request hearings on this issue. (For a copy of the petition, see the "Hard Cases Booklet" at www.theunchoice.com/resources.htm).

Americans want more research into abortion's impact on women. The majority of voters surveyed believe government-funded research on women's emotional reactions to abortion should be a high priority.[15]

Assembly-line medicine

Impersonal clinics. More than 80% of all abortions are done in non-hospital facilities, at clinics devoted solely to providing abortions and contraceptive services. Most abortions are done by a stranger who has no relationship with the patient, either before or after the procedure. Often women do not return for post-surgical care.[19]

Low standard of care. The standard of care is often poor. Some abortionists move from state to state to avoid investigations and patient complaints.[20]

Failure to screen for known risk factors. (Screening would eliminate 70% or more of all abortions.)
Most abortionists don't screen for risk factors or determine whether abortion will benefit their patients. Proper screening would *eliminate 70% or more of all abortions.*[21]

Profit-driven clinics, high-pressure "counseling." Many abortion "counselors" are not licensed counselors. Some are trained to "sell" abortions and ease women's concerns so they will be more likely to abort, thus increasing clinic profits.[9]

The journey toward healing

In the U.S., over 50 million women and men have lost a child to abortion. Many are realizing they are not alone and finding that hope and healing are possible. Experts estimate that post-abortion healing programs have already served as many as 20 million women and others impacted by abortion. Learn more at www.utheunchoice.com/healing.htm.

***More information** on unwanted abortions and abortion risks can be found in the special report, "Forced Abortion in America," and in our Research Booklet. Both can be downloaded for free at www.theunchoice.com/resources.htm. For current news and updates on abortion research and risks, see www.theunchoice.com/news.htm.*

Source

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Rep Souza

Normal Breast Physiology

The Reasons Hormonal Contraceptives and Induced Abortion Increase Breast-Cancer Risk

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Abstract

A woman gains protection from breast cancer by completing a full-term pregnancy. In utero, *her offspring produce hormones that mature 85 percent of the mother's breast tissue into cancer-resistant breast tissue. If the pregnancy ends through an induced abortion or a premature birth before thirty-two weeks, the mother's breasts will have only partially matured, retaining even more cancer-susceptible breast tissue than when the pregnancy began. This increased amount of immature breast tissue will leave the mother with more sites for cancer initiation, thereby increasing her risk of breast cancer. Hormonal contraceptives increase breast-cancer risk by their proliferative effect on breast tissue and their direct carcinogenic effects on DNA. Hormonal contraceptives include estrogen-progestin combination drugs prescribed in any manner of delivery: orally, transdermally, vaginally, or intrauterine. This article provides the detailed physiology and data that elucidate the mechanisms through which induced abortion and hormonal contraceptives increase breast-cancer risk.*

Since 1957, a large number of epidemiological studies have suggested a link between induced abortion and breast cancer,[1] with other studies indi-

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Wuelper

Reproductive Breast Cancer Risks and Breast Lobule Maturation

Who is the single most important person protecting this woman from breast cancer?

BREAST CANCER Prevention INSTITUTE

Her baby!

Long before birth, her baby's chemical signals began the process of breast growth and maturation that make breastfeeding possible. And it is only through a full-term pregnancy and lactation that a woman acquires her greatest protection against breast cancer.

Reproductive breast cancer risks and breast lobule maturation

Breast maturity is closely correlated with known reproductive risk factors for breast cancer. The breast is not fully developed at birth. At full development, the breast is comprised of 15- 25 lobes or segments which are in turn comprised of lobules. Lobules in turn are composed of breast cells.

There are 4 types of lobules whose structural differences appear under the microscope.

These lobules represent different stages of development and maturity of breast tissue.

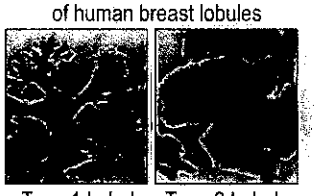
Type 1, 2 & 3 lobules are differentiated by the *average number of ductules per lobular unit*:

Type 1 has *11*; Type 2 has *47*; Type 3 has *80*.

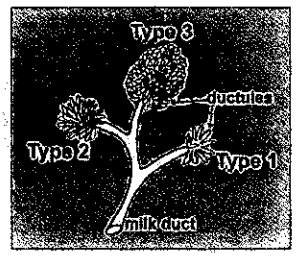
Type 4 lobules are fully matured and contain colostrum or milk.

Type 1 lobules mature into Type 2 lobules under the cyclic influence of the female hormones, estrogen and progesterone, during menstrual cycles. Type 2 lobules only become fully mature into Type 3 then Type 4 lobules under the influence of the hormonal changes of a full-term pregnancy. A major influence in this final stage of maturation into Type 4 lobules is human placental lactogen (hPL) which sharply rises during the last few months of pregnancy. Human chorionic gonadotropin (hCG, which stimulates the ovaries to produce estrogen and progesterone within a few days after conception) and prolactin also play a major role in maturation. HCG and hPL are made in the mother's womb during pregnancy. HCG also stimulates the ovary to produce inhibin, a cancer suppressing hormone, increasing protection of the mother even more.

Actual photomicrographs of human breast lobules

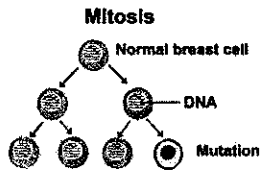


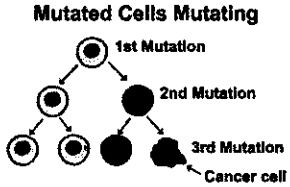
Type 1 Lobule Type 3 Lobule



These 4 types of lobules are also metabolically different and have different breast cancer potential.

Type 1 & 2 lobules have more estrogen and progesterone receptors than Type 3 which cause them to grow through mitosis (cell division) when estrogen and progesterone levels are elevated. Mitosis requires replication of DNA (genes) and therefore can result in mutations.





Mutated cells also undergo mitosis. Multiple mutations can cause cancer cells to form. Cells of Type 1 & 2 lobules also multiply faster than Type 3 resulting in more chances for mutations to occur. This growth (proliferation) under estrogen and progesterone stimulation explains the cancer causing properties of estrogen/ progestin combination drugs.

Type 1 lobules are where **ductal cancers** start. These account for at least 85% of all breast cancers.

Type 2 lobules are where **lobular cancers** start. These account for about 12% of all breast cancers.

Type 3 lobules are cancer resistant when they are the result of the regression of **Type 4 lobules** after birth and weaning.

Type 4 lobules are cancer resistant.

The breast maturation process through a normal full-term pregnancy

At birth, after the mother's hormones dissipate, a small amount of breast tissue lies dormant under the infant's nipple & areola.

At puberty, when the ovaries produce cyclic elevations of the female sex steroid hormones, estrogen and progesterone, the breast enlarges. However, only Type 1 and 2 lobules are formed, which are where ductal and lobular cancers start respectively. Most of the breast tissue is stroma (tissue surrounding the lobules). The lobules account for about 10% of the breast tissue.

After puberty, there is a reduction in stroma and lobules account for 30% of the breast tissue: 75% are Type 1 and 25% are Type 2 lobules with a few Type 3.

The "susceptibility window," the period between puberty and a full-term pregnancy, is the time the breast is most susceptible to forming cancer; i.e., when the woman's breast is composed primarily of Type 1 and 2 lobules.

After conception, the baby secretes hCG, stimulating the ovaries to produce the pregnancy hormones estrogen and progesterone, which cause the breast to start to enlarge by making **greater numbers of lobules**. This causes the mother's breast to feel sore and tender.

By the end of the 1st trimester, during the maturation of Type 1 lobules into Type 2, the actual **numbers of these lobules will increase** while the surrounding tissue (stroma) decreases. The breast now has **more places for cancers to start.**

By mid 2nd trimester, the breast has **doubled in volume** and has continued to mature rapidly under the influence of placental lactogen. The breast is now 70% Type 4 cancer resistant lobules and 30% immature cancer susceptible lobules.

By the end of the 3rd trimester, 85% of the breast is fully matured to Type 4 lobules and only 15% remain immature cancer susceptible lobules, leaving **fewer places for cancer to start.**

At delivery, the mother's breasts are now **predominantly Type 4 lobules**. They are fully mature and resistant to carcinogens, resulting in **lower long-term risk of breast cancer for the mother**.

While breastfeeding, the mother's menstrual cycles may stop or become anovulatory, further reducing her risk.

After weaning, Type 4 lobules regress to Type 3 and the breasts get smaller again. However, there is evidence of **permanent changes in the genes** of these Type 3 lobules which confer **life-long cancer resistance** even after menopause when they further regress to Type 1.

These facts of the breast maturation process account for the following known facts about breast cancer risk:

A woman who has a full-term pregnancy decreases her breast cancer risk. A woman who is childless has increased breast cancer risk.

The timing of pregnancy in the course of a woman's reproductive life is crucial to breast cancer risk.

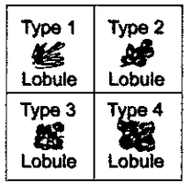
The longer a woman waits before having her first child, the higher her risk because she has a longer "susceptibility window."

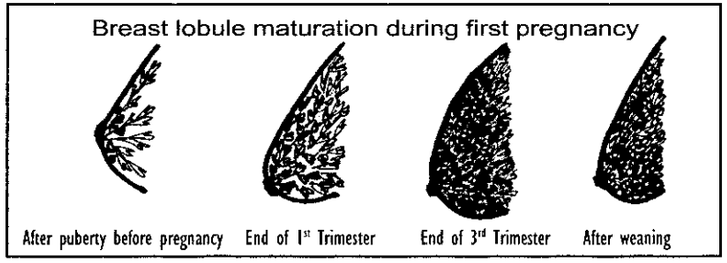
For example, a woman who gives birth at 18 has a 50-75% lower risk of breast cancer than a woman who waits until she is 30.

Each additional birth results in a further 10% risk reduction. Breast feeding reduces risk in proportion to the cumulative length of lactation.

Women who have breast cancer despite prior full-term childbirth, have a higher percentage of Type 1 lobules than women who give birth and do not develop cancer. This is possibly due to a defect in maturation.

Scientists have been unsuccessful to date in their attempt to create an hormonal "cocktail" to protect childless women from breast cancer.





Illustrations of pregnancy outcomes and their effect on breast cancer

***Before and After...*First full-term pregnancy (FFTP):**

Full-term births cause near complete maturation of the breast to Type 4 lobules therefore **lowering breast cancer risk.** A pregnancy ending between 32 and 36 weeks has about 90% of the protective effect of a full-term pregnancy of 40 weeks. If the first full-term pregnancy occurs late in the woman's reproductive life, her risk is transiently elevated in the first few years post partum. This is due to mutated cells that may have formed during a long "susceptibility window," which then may become cancerous. Cancer cells already present at conception may grow faster under the stimulation of the elevated pregnancy hormones estrogen and progesterone.

***Before and After...*Spontaneous abortion (miscarriage) in the 1st Trimester:**

Approximately 23% of all conceptions end in a spontaneous abortion by 11 weeks in the 1st trimester. This is when the fetus and placenta must make enough hormones to sustain the pregnancy. **In most pregnancies which miscarry during the 1st trimester, pregnancy hormones are lower than in a normal pregnancy, due to either a fetal or ovarian abnormality.** Therefore, the breasts may have never grown more Type 1 & 2 lobules (places where cancers start) in response to the pregnancy or at least very few. This is why women who miscarry will often remark they never "felt" pregnant before the miscarriage. Their breasts were never sore from growing and they were never nauseous from higher than normal hormone levels. **Thus the vast majority of spontaneous abortions (miscarriages) in the 1st trimester do not increase breast cancer risk.**

***Before and After...*Induced abortion in the 1st Trimester:**

Induced abortion of a **normal pregnancy** during which there has been breast growth results in increased risk of breast cancer in the mother. The later in pregnancy an abortion is done, the higher the risk of breast cancer as the more Type 1 and 2 lobules will have formed. **Induced abortion leaves a woman with more places for breast cancer to start.** If an induced abortion is done on a pregnancy which would have spontaneously aborted by 11 weeks, there would be **no** increase in risk. There is some data to suggest that the sooner a woman delivers and nurses a child after having had a prior induced abortion, the smaller the risk increase from the abortion.

Other pregnancy outcomes and breast cancer risk

Premature delivery before 32 weeks:

Premature delivery before 32 weeks is known to more than double breast cancer risk because it leaves the breast with **more places for cancers to start**. The risk is proportional to gestational length. The pregnancy hormone levels are usually normal so the breast changes are those of a normal pregnancy. The effect of premature delivery is the same as in an induced abortion as they differ only in whether the fetus is delivered alive or not. The premature delivery may be caused by multiple gestations (twins, triplets or more with assisted reproduction pregnancies), an incompetent cervix, an induced abortion, or physician-induced labor for fetal abnormalities such as anencephaly.

Spontaneous abortion (miscarriage) in the 2nd Trimester:

The effect would probably be the same as a premature delivery in the second trimester and increase risk. Most 2nd trimester spontaneous abortions occur because of a physical and not hormonal abnormality. For example, there is fetal demise or the mother sustained an injury.

Induced abortion in the 2nd Trimester:

The effect would be the same as a premature delivery before 32 weeks and a spontaneous abortion in the 2nd Trimester. There would be increased risk because there are **more places for cancers to start.** There are data to show there is a 3% increase in breast cancer risk for each week of gestation before the abortion.

Stillbirth:

The death of an infant near or at delivery would not change that full-term pregnancy's protective effect on the breast. There would have been normal maturation of the breast to Type 4 cancer resistant lobules.

Ectopic Pregnancy:

This is the result of an embryo which grows outside of the womb (uterus); e.g. in the mother's Fallopian tube. Its effect on breast cancer risk would most likely be small or minimal as the pregnancy usually ruptures or causes a medical emergency very early on in the pregnancy. There is too little data to be certain of any small risk elevation.

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13. Behrman R, et al. Preterm birth: Causes, Consequences and Prevention. Institute of Medicine 2006 page 519 Appendix B, Table 5

BREAST CANCER Prevention INSTITUTE

The **Breast Cancer Prevention Institute** is a research and educational 501(c)(3) public charity with headquarters at
9 Vassar Street, Poughkeepsie, NY 12601 USA
Phone: 1-86 NO CANCER (1-866-622-6237)
www.bcpinstitute.org

DeLemus

HB 1659

Abortion Question:
How early can I get an abortion?

Q: Is there is a waiting period before you can get an abortion? Do you have to be pregnant a few weeks or can it just be days after you find out you are pregnant?

Clinics and doctors vary on how soon you can get a first-trimester abortion - usually it's 5 to 6 weeks after your last menstrual period (LMP).

The Abortion Pill is an option as soon as pregnancy can be determined by ultrasound (sonogram). This webpage compares the two types of early abortion.

These websites describe the state laws in various states regarding waiting periods and other local regulations:

- Who Decides State Profiles
  http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/
- Mapping Our Rights
  http://www.mappingourrights.org/
- Around the World
  http://reproductiverights.org/en/our-regions

back to questions

WHEN DOES A BABY DEVELOP A HEARTBEAT?

Sep 2, 2010 | By Rose Welton

Photo Credit pregnant women belly image by Slobodan Vasic from Fotolia.com

The human heart is an intricate organ. Its right side receives blood flowing from the body and pumps it to the lungs to receive oxygen, while the left side receives the oxygen-rich blood from the lungs and pumps it into the

body. Your unborn baby's heart begins its careful formation in early pregnancy, and starts to beat soon after. In a healthy pregnancy, his heartbeat will continue to strengthen.

WEEK 5

According to Medline Plus, your baby's heart begins to develop in the fifth week of pregnancy, along with her brain and spinal cord. This stage of development occurs shortly after her implantation into the uterus, and her blood cells have already begun to multiply for different functions.

WEEK 6

By week six of pregnancy, your baby's heart is pumping blood. His heartbeat may be visible on a vaginal ultrasound as small blinking light, and will have a regular rhythm sometime between weeks six and seven. If a vaginal ultrasound during the sixth week does not reveal a fetal heartbeat, your doctor may schedule you for an ultrasound in three to seven days to check the baby's heart development.

WEEK 7

By the seventh week of your pregnancy, American Pregnancy Association states that your baby's heartbeat will be assessed by your doctor to determine the health of the pregnancy. Once a heartbeat is definitively detected, the chance of the pregnancy continuing is 70 to 90 percent. A healthy heartbeat during this stage is 90 to 110 beats per minute. If your baby is five millimeters or longer and has no heartbeat, a miscarriage may be determined. If she is less than five millimeters long, your doctor may look for a heartbeat in a few days.

WEEK 8 AND BEYOND

At the eight week of pregnancy, your baby's heart, which began as a singular tubal structure, is increasing in length. It develops to include a wall separating two chambers and valves that keep blood moving throughout the chambers. By week nine of pregnancy, a normal heartbeat is between 140 and 170 beats per minute. A doctor may be able to hear your baby's heartbeat with a fetal Doppler around week 13 and a stethoscope around week 22 of pregnancy.

DEVELOPMENT FACTORS

Keep in mind that the development of an unborn baby varies according to the mother's health and calculation of ovulation. Your baby may also develop a heart defect, especially if he is exposed to alcohol, drugs or industrial chemicals through the mother's body in early pregnancy. These abnormalities may only become apparent after birth, when the baby's heart takes over the placenta's job of oxygen exchange in his body.

REFERENCES

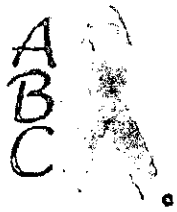
Medline Plus: Fetal Development
American Pregnancy Association: Concerns Regarding Early Fetal Development
Kids Health: If Your Child Has a Heart Defect
MayoClinic.com: Fetal Development: The First Trimester
Article reviewed by MER Last updated on: Sep 2, 2010

RELATED SEARCHES:

Baby Gender Myths, Pregnancy Baby Gender, 3D Baby Ultrasound, Baby Gender Calculator, Baby Birth Calculator

MUST SEE: PHOTO GALLERIES

In 1986, government scientists wrote a letter to the British journal Lancet and acknowledged that abortion is a cause of breast cancer. They wrote, "Induced abortion before first term pregnancy increases the risk of breast cancer." (Lancet, 2/22/86, p. 436)



Women were never told about their findings.

HB 1659

As of 2006, eight medical organizations recognize that abortion raises a woman's risk for breast cancer, independently of the risk of delaying the birth of a first child (a secondary effect that all experts already acknowledge). An additional medical organization, the Association of American Physicians and Surgeons, issued a statement in 2003 calling on doctors to inform patients about a "highly plausible" relationship between abortion and breast cancer. General counsel for that medical group wrote an article for its journal warning doctors that three women (two Americans, one Australian) successfully sued their abortion providers for neglecting to disclose the risks of breast cancer and emotional harm, although none of the women had developed the disease. Click here for more.

[Click here to enter the site]

Medical Groups Recognizing Link

A list of medical organizations recognizing a link between abortion and breast cancer is provided below. Telling women their abortions are related to increased breast cancer risk is clearly not good for cancer fundraising businesses, the abortion industry and the pharmaceutical industry. Medical groups whose doctors do not perform abortions or refer women for abortions will be among the first to recognize that abortion raises a woman's breast cancer risk.

National Physicians Center for Family Resources
P.O. Box 59692
Birmingham, AL 35259
205/870-0234
www.physicianscenter.org

The National Physicians Center for Family Resources offers a CD intended for parents and health educators which cites "increased breast cancer risk" as a "long-term complication of abortion" and offers a biological explanation for the abortion-breast cancer link. The CD is entitled, "Prescriptions for Parents: A Physicians' Guide to Adolescence and Sex."

Catholic Medical Association
2020 Pennsylvania Ave. NW, #864
Washington, DC 20006
Tel: 1-877-CATHDOC (877-228-4362)
www.cathmed.org

"Whereas epidemiological evidence of an association between abortion and breast cancer has existed for almost a half century,

"Whereas 29 our ot 38 worldwide epidemiological studies show an increased risk of breat cancer of approximately 30% among women who have had an abortion,

"Whereas all women undergoing abortion are entitled to full informed consent as to all risks including long term risks,

"Therefore be it resolved that the Catholic Medical Association endorses the passage of state legislation to require abortionists to inform all women of their future increased vulnerability to breast cancer."

Resolution Approved 10/15/03

American Association of Pro-Life Obstetricians and Gynecologists
844 South Washington, Suite 1600
Holland, MI 49423
616-546-2639
www.aaplog.org

AAPLOG has posted a position statement about the ABC link on its website.

Breast Cancer Prevention Institute
9 Vassar St.
Poughkeepsie, NY 12601
845/452-0797
www.bcpinstitute.org

The Polycarp Research Institute

2232 Second Avenue
Altoona, PA 16602
www.polycarp.org

Ehtics and Medics
6399 Drexel Road
Philadelphia, PA 19151
www.ethicsandmedics.com

MaterCare International
8 Riverview Avenue
St. John's, Newfoundland
Canada A1C 2S5
Phone: 709-579-6472
Fax: 709- 579-6501
E-Mail: info@matercare.org

Statement Concerning the Link between Induced Abortion and Breast Cancer, R. L. Walley. FRCSC., FRCOG., MPH Executive Director and Honourary Research Professor of Obstetrics and Gynaecology

"MaterCare International an international group of Obstetricians and Gynaecologists was presented with the evidence of the link between abortion and breast cancer at its international conference in Rome in October 2004 by Dr Joel Brind's research group. The medical explanation and the epidemiological evidence convinced our group that there is a significant increase in breast cancer risk after induced abortion, especially before the first full term pregnancy. This evidence has been denied by the U.S. National Cancer Institute (NCI) and other researchers. Recently ten studies have been published in an attempt to discredit Brind's conclusion.

"In turn Brind has examined these ten studies and in a peer reviewed paper published in the Journal of American Physicians and Surgeons (Vol 10, No 4, Winter 2005, <http://www.jpands.org>) he has shown that they have serious methodological weaknesses and flaws and therefore do not invalidate the conclusion that there is a increased risk of breast cancer.

"Women have a basic right to know of this increased risk of breast cancer and it is unacceptable that the information should be denied to them by the medical and cancer research establishments. MaterCare International as an organisation of women's health specialists recognies its responsibilities in this matter and will do all it can to publish this evidence."

Breast Care Center-EAMC
G/F OPD Bldg East Avenue Medical Center, East Avenue,
Quezon City, Philippines
Phone: (632)-928-0611 loc 578
E-mail: pfbci_bcc@yahoo.com
http://www.abortionbreastcancer.com/news/Santos/index.htm

Medical Groups Supporting Disclosure of Research

Association of American Physicians and Surgeons
1601 N. Tucson Blvd., Suite 9
Tucson, AZ 85716-3450
520-323-3110

"The Association of American Physicians and Surgeons believes that patients have the right to give or withhold fully informed consent before undergoing medical treatment. This includes

notification of potential adverse effects. While there is a difference of medical opinion concerning the abortion breast cancer link, there is a considerable volume of evidence supporting this link, which is, moreover, highly plausible. We believe that a reasonable person would want to be informed of the existence of this evidence before making her decision."

Jane Orient, MD
Executive Director
October 27, 2003

Read Mrs. Malec's article, "The Abortion-Breast Cancer Link: How Politics Trumped Science and Informed Consent," in the Journal of American Physicians and Surgeons: www.jpands.org/vol8no2/malec.pdf

Medical Groups in Need of Political Courage

Royal College of Obstetricians and Gynecologists

American Medical Association
- A spokesman for the AMA told World Net Daily that its group "doesn't have a policy at all" on whether its doctors should inform women about the abortion-breast cancer research. [John Dougherty, "Can doctors be sued over abortion? Those who don't inform patients of breast cancer link could be targets,"
World Net Daily March 27, 2002.
Available at: http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=26970
Visited October 8, 2003.

American College of Obstetricians and Gynecologists

American Society of Breast Surgeons

Miami Breast Cancer Conference

All Cancer Groups
http://www.abortionbreastcancer.com/newsletter102202.htm
http://www.abortionbreastcancer.com/050902.htm

Vidurea

CONSENT TO SURGICAL ABORTION

The Concord Feminist Health Center (CFHC) will perform an abortion procedure only with your informed consent. Please take your time reading the entire form. We will be happy to answer any questions that you have about the form or the abortion procedure. After you have read this form, if you wish to consent to the performance of an abortion and you agree with the contents of the form, please sign and date the form in the space provided below.

I hereby certify that the staff of the CFHC has explained to me the nature of the abortion procedure. I understand that the abortion will be performed by a physician, that I will be given a local anesthetic and that CFHC will dispose of any tissue that may be removed during the course of the procedure. I agree that the following have been explained: A) the probable consequences of the procedure, in particular the termination of my pregnancy, B) routine post-operative consequences, and C) the risks, including: 1) infection; 2) bleeding; 3) perforation of the uterus; 4) an incomplete abortion; 5) continuing pregnancy; 6) adverse drug reaction; 7) adverse emotional reaction; 8) loss of child-bearing capacity; 9) death. I understand that, following the abortion, CFHC staff will be available 24 hours a day for emergency telephone consultation, should I have questions about any post-operative consequence. I have been given an opportunity to ask questions and all of my questions, including any about abortion alternatives, have been answered to my full satisfaction. My decision to have an abortion is strictly a personal decision, voluntarily arrived at, without any attempt at persuasion or influence on the part of the Center.

Consent: I, the undersigned, hereby consent to, request and authorize the performance of an abortion on me using a local anesthetic, by a physician associated with CFHC, and the disposal of any tissue that may be removed during the course of the procedure. Because at times CFHC serves as a training facility, I understand that under the direction and supervision of my attending physician, trainees such as interns, residents, nurses, or other students may perform or observe some of the health care services I receive.

If conditions arise during the course of the abortion calling for procedures in addition to or different from those consented to above, I also consent to, request, and authorize the physician to perform any procedure and administer any medication that she or he deems necessary to treat such unforeseen conditions.

Release: In consideration of CFHC's performance of an abortion at my request, I hereby release CFHC, its employees and medical staff from any and all liability for adhering to my request for an abortion to be performed on me.

Financial Disclosure: I understand and agree that neither Concord Feminist Health Center (CFHC) nor their physicians assume responsibility for expenses that may be incurred should any complication develop as a consequence of the abortion or related treatment. I understand that CFHC staff are available 24 hours a day for emergency telephone consultation. If complications requiring treatment arise, CFHC will make every effort to provide that treatment at CFHC during regular clinician hours at no additional charge. I understand that it may be necessary to be seen elsewhere at my own expense.

Signature of patient / legal guardian	Date	Witness	Date

Revised 01/12

State of New Hampshire
House of Representatives

REP. LAURIE HARDING

Executive Departments and Administration

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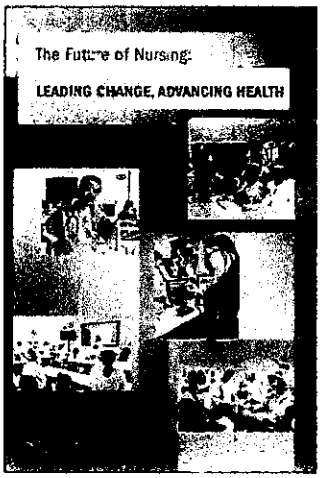
The Future of Nursing
Focus on Scope of Practice



Transforming the health care system to meet the demand for safe, quality, and affordable care will require a fundamental rethinking of the roles of many health care professionals, including nurses. The 2010 Affordable Care Act represents the broadest health care overhaul since the 1965 creation of the Medicare and Medicaid programs, but nurses are unable to fully participate in the resulting evolution of the U.S. health care system. This is true for nurses at all levels, whether they practice in schools or community and public health centers or actue care settings. A variety of historical, cultural, regulatory, and policy barriers limit nurses' ability to contribute to widespread and meaningful change.

In 2008, the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing.

As part of its report, *The Future of Nursing: Leading Change, Advancing Health*, the committee considered the obstacles all nurses encounter as they take on new roles in the transformation of health care in the United States. While challenges face nurses at all levels, the committee took particular note of the legal barriers in many states that prohibit advance practice registered nurses (APRNs) from practicing to their full education and training. The committee determined that such constraints will have to be lifted in order for nurses to assume the responsibilities they can and should be taking during this time of great need.

While challenges face nurses at all levels, the committee took particular note of the legal barriers in many states that prohibit advance practice registered nurses (APRNs) from practicing to their full education and training.

The Changing Health Care System

In the 21st century, the health challenges facing the nation have shifted dramatically. The health care system is in the midst of great change as care providers discover new ways to provide patient-centered care; to deliver more primary care as opposed to specialty care; and to deliver more care in the community rather than the acute care setting. Nurses are well poised to meet these needs by virtue of their numbers, scientific knowledge, and adaptive capacity, and health care organizations would benefit from taking advantage of the contributions nurses can make.

As the health care system has expanded over the past 40 years, the education and roles of APRNs, in particular, have evolved in such a way that nurses now enter the workplace qualified to provide more services than had been the case previously. Yet while APRNs are educated and trained to do more, some physicians challenge expanding scopes of practice for nurses. The committee stresses that physicians are highly trained and skilled providers and that some services clearly should be provided by physicians, who have received more extensive and specialized education and training than APRNs. However, given the great need for more affordable health care, nurses should be playing a larger role in the health care system, both in delivering care and in decision making about care.

The committee argues that APRNs are not acting as physician extenders or substitutes. They work throughout the entirety of health care, from health promotion and disease prevention to early diagnosis to prevent or limit disability. APRNs sometimes provide services that many people associate with physicians, such as assessing patient conditions or ordering and evaluating tests, but they also incorporate a range of services from other disciplines, including social work, nutrition, and physical therapy.

Inconsistent State Regulations

State regulations often restrict the ability of nurses to provide care legally. State legislation regarding the legal scopes of practice for nurses—which defines the activities that a qualified nurse may perform—vary widely. Some state legislation is very detailed, while in other states, there are vague provisions that are open to interpretation. Some states have kept pace with the evolution of the health care system by changing their scope-of-practice regulations to allow nurse practitioners (NP) and certified nurse midwives, for example, to see patients and prescribe medications without a physician's supervision or collaboration. Most states, however, have not made these changes. As a result, what NPs and, more broadly, APRNs are able to do after graduation varies widely across the country for reasons that are not related to their ability, education, or training, but rather to the political decisions of the state in which they work.

Both educational and national certification standards—which most, if not all, states recognize—support broader practice by APRNs. No studies suggest that APRNs are less able than physicians to deliver care that is safe, effective, and efficient or that care is better in states with more restrictive scope of practice regulations for APRNs. In fact, evidence shows that nurses provide quality care to patients, including preventing medication errors, reducing or eliminating infections, and easing the transition patients make from hospital to home. Yet most states continue to restrict the practice of APRNs. However, various stakeholders are working to develop ways to eliminate variations in scope of practice regulations across states. In 2008, several nursing organizations came together and developed a consensus model for standardizing the regulation of APRNs, including education, accreditation, certification, and licensure. This model will help encourage the development of consistent regulations that recognize the competence of APRNs across states.

The trend over the past 20 years has been a growing receptivity on the part of state legislatures to expanded scopes of practice for nurses. Quite simply, there are not enough primary care physicians to care for today's aging population, and the patient load will dramatically increase as more individuals gain insurance coverage.

Current laws in many states are hampering the ability of APRNs to contribute to innovative health care delivery solutions. Some NPs, for example, have left primary care to work as specialists in hospital settings. Others have left NP practice altogether to work as staff RNs. State regulations have limited the expansion of retail clinics, where NPs provide a limited set of primary care services directly to patients. Depending on the state, restrictions on an APRN's scope of practice may limit or prohibit the authority to prescribe medications, admit patients to hospitals, assess patient conditions, and order and evaluate tests, thereby restricting access to care.

The trend over the past 20 years has been a growing receptivity on the part of state legislatures to expanded scopes of practice for nurses. Quite simply, there are not enough primary care physicians to care for today's aging population, and the patient load will dramatically increase as more individuals gain insurance coverage. The experience of states that have led these changes offers important reassurance to physicians who continue to believe that patient care may be adversely affected or that expanded nursing practice autonomy threatens the professional and economic roles of physicians. States with broader nursing scopes of practice have experienced no deterioration of patient care.

The Federal Government's Role in Reform

The federal government has a compelling interest in the regulatory environment for health care professions because of its responsibility to patients covered by federal programs including Medicare, Medicaid, the Veterans Administration, and the Bureau of Indian Affairs. Equally important is the responsibility to all American taxpayers who fund the care provided under these programs to ensure that their tax dollars are spent efficiently.

Congress, the Federal Trade Commission, the Office of Personnel Management, and the Centers for Medicare and Medicaid Services each have specific authority over or responsibility for decisions that either could or must be made at the federal level to be consistent with state efforts to remove scope-of-practice barriers. While no single actor or agency can independently make a sweeping change to eliminate current barriers, the various state and federal entities can each make relevant decisions that together can lead to needed improvements.

Because one of the greatest barriers to nurses' capacity to transform the health care system is the patchwork of state regulations, the committee finds that the federal government is particularly well situated to enact effective reform of the practice of APRNs by disseminating best practices from across the country and creating incentives for their adoption.

Conclusion

Now is the time to eliminate the outdated regulations and organizational and cultural barriers that limit the ability of nurses to practice to the full extent of their education, training, and competence. The U.S. is transforming its health care system to provide quality care leading to improved health outcomes, and nurses can and should play a significant role. The current conflicts between what APRNs can do based on their education and training and what they may do according to state and federal regulations must be resolved so that they are better able to provide seamless, affordable, and quality care. Scope-of-practice regulations in all states should reflect the full extent not only of nurses but of each profession's education and training. Elimination of barriers for all professions with a focus on collaborative teamwork will maximize and improve care throughout the health care system.

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HB 1659

ROSS

AMERICAN LIFE LEAGUE

The Obama Planned Parenthood Nexus

Alliances have always been at the heart of political campaigns. For example, prior to the 1980 election of Ronald Reagan many so-called conservative organizations worked together because they had a common goal of electing a man they believed best represented the values upon which America was founded.

Throughout this nation's history, special interest groups have worked for the election of individuals they felt best represented their interests. Today nothing has changed, but the values have dramatically shifted. This is perhaps best evidenced by the latest Planned Parenthood/Obama video in which the president gives his wholehearted support to the work of what we know is one of the most evil organizations ever to exist in America. Let there be no mistake about what I have just said here. I know that "evil" is a loaded word these days, but I also know what evil is and what it means.

Let's examine why evil is the proper word to define not only the Planned Parenthood notion of freedom, but also what Obama thinks about it. In "A Message to Planned Parenthood Supporters from President Obama," the president makes it clear that he is not only supportive of the deceit Planned Parenthood perpetuates, but that he is part of the game. Why else would he tell the viewer that the "greatness" of Planned Parenthood resides in its work to protect women from cancer and to protect a woman's right to "choose when to start a family"?

Nice sentiments? Well, that depends on how much you know about the actual facts. For example, Planned Parenthood does not do mammograms, but refers its patients to other locations. So when it comes to protecting women from cancer, the claim that Planned Parenthood is devoted to this goal is, at the very least, questionable.

If indeed it really were the case that Planned Parenthood cared about cancer prevention, the organization would never prescribe or provide the birth control pill or abortion. After all, many experts agree that both birth control and abortion are tied to increased rates of cancer. But facts like these do not play well within the Obama Planned Parenthood Nexus.

However, there is a far more sinister principle that exists in the bowels of this evil connection, and that is that sexual license trumps all that is good and holy about sexual relations and the fruits of the marital act (i.e., babies)! Planned Parenthood's perspective on this has always been that the only babies worth acknowledging are the ones expectant mothers "want." Planned Parenthood is all about not being a parent unless you "want" to be a parent. This is why PP's birth control and abortion business is so lucrative.

As the chief architects of today's sexually permissive culture, Planned Parenthood rejects the fact that welcoming and acknowledging the child because he is one of us from his biological beginning is right and good. Obama is trading on that very same precept, counting on it and doing all he can to advance those who share his despicable disdain for the dignity of the human person—particularly the preborn individual.

Obama suggests that the best way to protect women's health is to support Planned Parenthood. He commits himself to the same agenda and does so without batting an eye. For them it can be said that truth is fiction and fiction is truth and they like it that way.

It reminds me of a quote from C.S. Lewis' *The Screwtape Letters*: "It is funny how mortals always picture us as putting things into their minds: In reality our best work is done by keeping things out."

That's the Nexus at work.

National Cancer Institute

FactSheet

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health

Abortion, Miscarriage, and Breast Cancer Risk

Introduction

A woman's hormone levels normally change throughout her life for a variety of reasons, and these hormonal changes can lead to changes in her breasts. Many such hormonal changes occur during pregnancy, changes that may influence a woman's chances of developing breast cancer later in life. As a result, over several decades a considerable amount of research has been and continues to be conducted to determine whether having an induced abortion, or a miscarriage (also known as spontaneous abortion), influences a woman's chances of developing breast cancer later in life.

Current Knowledge

In February 2003, the National Cancer Institute (NCI) convened a workshop of over 100 of the world's leading experts who study pregnancy and breast cancer risk. Workshop participants reviewed existing population-based, clinical, and animal studies on the relationship between pregnancy and breast cancer risk, including studies of induced and spontaneous abortions. They concluded that having an abortion or miscarriage does not increase a woman's subsequent risk of developing breast cancer. A summary of their findings, titled *Summary Report: Early Reproductive Events and Breast Cancer Workshop,* can be found at http://www.cancer.gov/cancertopics/ere-workshop-report.

NCI regularly reviews and analyzes the scientific literature on many topics, including various risk factors for breast cancer. Considering the body of literature that has been published since 2003, when NCI held this extensive workshop on early reproductive events and cancer, the evidence overall still does not support early termination of pregnancy as a cause of breast cancer. To view regular updates on this topic, please go to http://www.cancer.gov/cancertopics/pdq/prevention/breast/HealthProfessional/page2#Section_280.

Background

The relationship between induced and spontaneous abortion and breast cancer risk has been the subject of extensive research beginning in the late 1950s. Until the mid-1990s, the evidence was inconsistent. Findings from some studies suggested there was no increase in risk of breast cancer among women who had had an abortion, while findings from other studies suggested there was an increased risk. Most of these studies, however, were flawed in a number of ways that can lead to unreliable results. Only a small number of women were included in many of these studies, and for most, the data were collected only after breast cancer had been diagnosed, and women's histories of miscarriage and abortion were based on their "self-report" rather than on their medical records. Since then, better-designed studies have been conducted. These newer studies examined large numbers of women, collected data before breast cancer was found, and gathered medical history information from medical records rather than simply from self-reports, thereby generating more reliable findings. The newer studies consistently showed no association between induced and spontaneous abortions and breast cancer risk.

Ongoing Research Supported by the National Cancer Institute

Basic, clinical, and population research will continue to be supported to investigate the relationship and the mechanisms of how hormones in general and during pregnancy influence the development of breast cancer.

Important Information About Breast Cancer Risk Factors

At present, the factors known to increase a woman's chances of developing breast cancer include age (a woman's chances of getting breast cancer increase as she gets older), a family history of breast cancer, an early age at first menstrual period, a late age at menopause, a late age at the time of birth of her first full-term baby, and certain breast conditions. Obesity is also a risk factor for breast cancer in postmenopausal women. More information about breast cancer risk factors is found in NCI's publication *What You Need To Know About™ Breast Cancer.*

Important Information About Identifying Breast Cancer

NCI recommends that, beginning in their 40s, women receive mammography screening every year or two. Women who have a higher than average risk of breast cancer (for example, women with a family history of breast cancer) should seek expert medical advice about whether they should be screened before age 40, and how frequently they should be screened.

# # #

Munsen

This testimony concerns the recently-passed HB 1659, the so-called Women's Right to Know Act, which is now under consideration by you, the Senate. I want to strongly urge you to defeat this bill, whose provisions are unnecessary, unduly burdensome , and discriminatory toward women seeking an abortion.

I have been a health worker and counselor at Concord Feminist Health Center for 34 years. I have a master's degree in counseling, and have trained dozens of health workers over the years to provide counseling to women regarding their reproductive health choices, including decision-making regarding untimely pregnancies. At my workplace, empowering women through sharing accurate information has been at the heart of our mission for nearly four decades. Our goal is to help women make wise and informed choices that will best meet their own needs. It is not, as alleged in the introduction to HB 1659, to "sell abortion." We are in complete agreement that any person who is to have a medical procedure should receive "medically accurate information" beforehand so that she - or he - can make an informed decision. Informed consent is a basic principle of modern medical ethics, consumer protection and patient care. Any reputable medical practice takes for granted that patients must be informed of the risks and benefits of procedures they are to undergo.

A thorough informed consent process has always been an integral – and required - part of an abortion visit at CFHC, beginning with the very first contact from a woman requesting an appointment, when any question she has is gladly answered, any concern addressed. She is told about the different abortion methods and what happens during the visit. By the time she makes this contact, she has usually already done some research, talked to significant people in her life, and concluded that she wants an abortion; but if she expresses uncertainty, or needs more information, she is offered a free options counseling session at CFHC or a referral to counseling in her community, as well as to internet and talkline resources, to help her come to a decision in which she can be confident. For adoption or parenting support, we often refer to Child and Family Services.

If she does set up an appointment, information about the abortion process, including an explanation of

the risks, is sent to her via mail or email; or if she prefers to access this information online, it is posted on our website. She therefore has time to review and weigh this information before her appointment, and we let her know she may call at any time with questions.

On the day of her visit, after lab work and an ultrasound, she has an information session that includes a detailed review of the abortion method, its risks, and its potential aftereffects. Because it is important to us to know that she is clear in her decision and ready to go ahead, she is asked to share how she came to her decision and how sure she is feeling about it, and whether she has considered all her options. Once all her questions have been answered, she is asked to sign a consent form. If she is conflicted, or says that she is being pressured, the abortion may be deferred and she may be asked to take more time to consider her options and clarify her decision, with the assistance of a counseling referral and other resources as needed.

This consent process is carried out by trained, experienced, professional health care workers who treat every woman with the greatest of compassion and consideration for what she feels to be in her best interest, be it abortion, adoption, or parenthood. Our counseling is informed by decades of experience working in the field of reproductive health, working closely with our physicians and nurse practitioners, staying abreast of current standards through research and review of the latest developments in abortion and contraceptive care, attending conferences and workshops, and through our membership in our professional organizations: the National Abortion Federation (NAF), the Abortion Care Network (ACN), and the Feminist Abortion Network (FAN). We subscribe to the clinical standards promulgated and updated annually by NAF, including those relating to informed consent. I am proud to say that at our last NAF site visit, our services were characterized as "exceptional."

It should be very clear that informed consent goes to the heart of our belief that women are entitled to any and all information that they need in order to make sound decisions about their bodies and their health care. What I take issue with is the government specifying who is to provide that information. This bill requires the physician who will perform the abortion, or the "referring physician," to personally

counsel the woman in order to obtain informed consent. It is important for you to know that although many physicians and other medical providers, counselors, therapists, school nurses, etc. refer to us because of our outstanding reputation, most women who come to CFHC for abortion services do not have a "referring physician." And if they do, that physician may never have done an abortion and may know virtually nothing about it (doctors are not required to learn about abortion in medical school), and therefore be poorly qualified or unwilling to provide the kind of information needed for informed consent. In some cases women are uncomfortable talking to their physician because they are not sure whether he or she will be understanding and supportive. Sadly, some are not.

So why can't "the physician who is to perform the abortion" conduct the information session 24 hours prior to the abortion? This requires an understanding of the logistics of the clinic-based abortion. It is well known that abortion providers are few and far between in this country. Most of the relatively few physicians who provide abortions do so in a clinic setting, where they generally work on a very limited basis. They are principled individuals who take time out of their own busy practices to provide a service they deeply believe in, because they know that their skills are badly needed by women who face an unwanted pregnancy. Because of this, the physician who performs the abortion will not be at the clinic 24 hours before the procedure is to be performed. His or her own office may be located many miles from the clinic. It is unfair and unrealistic to ask women to travel potentially a long distance on one day to the physician for the informed consent discussion, assuming it will even be feasible for the physician to provide this service in his or her office; and 24 hours later, to travel again to get to the clinic for her abortion.

Contrary to the assumptions in this bill, women who seek abortion services in New Hampshire are already being served with excellence and professionalism by clinic staff. My dictionary defines a profession as "a calling that requires specialized knowledge." Counselors at CFHC are indeed caring and knowledgeable professionals, fully capable of carrying out the informed consent process. We have been doing this for decades. We do have specialized knowledge. We are experts in our field. And we are devoted to our calling, which is to help, support, and empower other women who are struggling

with reproductive health care issues. There is no need to change a process that has worked very well for New Hampshire women for nearly forty years. This provision is unnecessary.

This brings me to my second issue with this bill. I find it highly objectionable that the government would single out abortion, a safe, legal, and constitutionally-protected procedure, from other medical procedures for a mandatory 24 hour waiting period after receiving the information required for informed consent; while a woman who chooses to have a child is not subjected to any kind of mandatory counseling or "reflection," despite the fact that it is far more life-changing and medically risky than abortion. As I stated earlier, by the time a woman calls requesting an abortion appointment she is almost always sure of her decision, and she generally has already acquired much of the information she needs in order to make that decision. Some are sure from the outset and do not need to engage in a long decision-making process; but often, days or weeks of deliberation, discussion and research have taken place between the time she finds out she is pregnant and the time she calls for an appointment. She may have talked it over repeatedly with her partner, parents, friends, physician, counselor, clergy person, and others; made lists of pros and cons; gathered information by visiting our website and other websites that provide information about abortion; had an exam or ultrasound from her own doctor; even visited a crisis pregnancy center. The very reason she is calling is that she knows she does not want or cannot support a child at this time in her life. While a formal consent process is necessary and helpful to resolve any remaining questions, she does not then need an additional 24 hours imposed upon her for "reflection," as if she were a criminal needing rehabilitation or a sinner needing to contemplate her sin.

Besides being gratuitously insulting to their intelligence, the added burdens that this requirement will impose on women and their support people will be very onerous for some. It means two appointments instead of one, traveling what for some will be long distances not once but twice; and a prolongation of what is undoubtedly a very stressful time for her. It may mean taking extra time off from work, possibly threatening her income or even her job, or if she is in school, two days away from classes; and arranging child care and transportation for two separate visits. The support person she has chosen may face

similar challenges, and may as a result be unable to accompany her. Additionally, the added time involved may push some women beyond the gestational limit that would qualify them for an abortion at their chosen facility, resulting in even further delay and difficulty.

These kinds of barriers are burdensome at best and insurmountable at worst. I would hate to think, but cannot help but suspect, that this is exactly what the sponsors of this bill have in mind – to create barriers that will cause some women to give up in defeat and continue their pregnancies by default. I hope I am wrong, because this would amount to parenthood by state coercion, which would be an unconscionable intrusion upon personal choice and family life.

And so I urge you to vote no on this bill for these reasons:

1. It is unnecessary, since abortion providers in New Hampshire are already doing an outstanding job of making sure women's needs for both accurate information and emotional support are met, and are ensuring informed consent.
2. It imposes unwarranted and onerous burdens on women and their loved ones.
3. It is discriminatory in singling out abortion – a legal, safe, constitutionally protected medical procedure needed and accessed only by women - from other medical procedures by placing upon it special barriers and requirements.

Thank you for your consideration.

Jane Hunter Munson, M. Ed

Following are some of the resources we make available to women and their loved ones:

Free telephone counseling for pregnancy, abortion, parenting, adoption
www.faithaloud.org
www.yourbackline.org
www.exhale.org

Information about pregnancy options
www.pregnancyoptions.org
www.MomDadIMpregnant.com (for teens – how to talk to your parents; for parents, how to talk to your teen)
www.abortioncarenetwork.org
www.prochoice.org

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Concord Feminist Health Center

Quality ~ Compassion ~ Respect - Since 1974

April 12, 2012
Health and Human Services Committee
Testimony on HB 1659

Thank you for reading the following testimony. My name is Dalia Vidunas. I am the Executive Director of the Concord Feminist Health Center. I am here to let you know that I am against HB1659, known as the "women's right to know act", but in essence is a "make abortions as difficult as possible to obtain" bill.

As written, this insidious bill impedes a woman's access to a legal medical procedure. It does this through a variety of ways:

- This bill requires that only a physician can perform the procedure. It will take away the rights of Nurse Practitioners who have been deemed qualified to do these procedures to continue to do them even though the NH Medical Society and Licensing Board states they are qualified.

- This bill makes the assumption that women, as consumers of services, as the entity typically responsible for making health care decisions for the children they bear, ARE NOT responsible enough to make health care decisions for themselves. By imposing a 24 hour waiting period, you are putting up yet another barrier for women to get the health care they need – especially for those who are the working poor and/or live in rural areas. The 24 hour waiting period will result in making women take another day off from work and potentially losing her job, spending more money on someone to watch her children instead of feeding them, trying to come up with money for transportation/gas.

  Also, by requiring specific doctors to the counseling for this procedure – a procedure that is done without anesthesia, without narcotics, using over the counter pain relievers such as Advil/ibuprofen - a woman's access is severely impeded due to scheduling nightmares between the doctor's time when a woman can get time off from work and arrange day care.

- This bill makes the assumption that we, as health care professionals, do not treat our clients professionally and give them honest, accurate information. It does not allow the doctor, a medical professional, to determine who is best qualified in their practice to inform and educate their own patient. At the Concord Feminist Health Center, our health care professionals receive specific training to deal with these issues. By requiring someone like a licensed therapist to educate patients, you will be driving up medical costs tremendously. It makes the assumption that the only qualified people to educate a woman has to have a Master's degree or be a medical professional. And yet at CFHC, an extensive informed consent process has always been an

integral part of an abortion visit, and is in fact a non-negotiable requirement for any woman seeking that service from us.

I would like to give you some statistics about the women who chose abortion:

According to the CDC:

- 89.6 % of all abortions are women age 20 and over
- The only age group that has seen an increase in the percentage of abortions since 1996 is for women over the age of 40.
- 58.6% of women having abortions have given birth.

The CDC further documents that risks for abortion complications are lowest at the earlier gestation stage. Putting up barriers for women to obtain an abortion will only decrease patient safety. Currently surgical abortion is one of the safest types of medical procedures. Complications from having a first-trimester aspiration abortion are considerably less frequent and less serious than those associated with giving birth.

Abortion is "legal" in this country, but it is far from being available, accessible, or affordable.

I am honored to be part of an organization that provides necessary medical care to women who need it. We know there are centuries more to this story. We know that for centuries women have chosen abortion when they feel they cannot have a *baby.* We know that most women choosing abortion are mothers struggling to house and feed their current children. We know that women choose abortion because their health depends on it. We know that women choose abortion because working wages and child care options are often impossible. We know that women choose abortion because of unsupportive and/or abusive partners. We know that women choose abortion responsibly. We know that women choose abortion, because naturally and instinctually, they have always been the bearers of life. We know that women are the only ones who can truly know when it is time to bring new life into the world.

Please vote this bill inexpedient to legislate. Thank you for your attention.

Dalia Vidunas, MSW

DIOCESE OF MANCHESTER
Secretariat for Administration and Community Affairs

April 12, 2012

Senator Jeb Bradley
Senate Health and Human Services Committee
107 North Main Street – Room 102
Concord, New Hampshire 03301

Re: HB 1659 (Women's Right to Know Act Regarding Abortion Information)

Dear Senator Bradley and Members of the Senate Health and Human Services Committee:

> Life is the first good received from God and is fundamental to all others; to guarantee the right to life for all and in an equal manner for all is the duty upon which the future of humanity depends.

Pope Benedict XVI, Address to General Association of Pontifical Academy for Life, 2007.

As the Director of the Office of Public Policy of the Roman Catholic Diocese of Manchester, and on behalf of Bishop Peter Libasci, I want to register our support for **HB 1659**. This legislation establishes a woman's right to know regarding abortion, and thus, it will protect and advance life and human dignity on two fronts: the life of the unborn child and the life and well-being of the woman who might undergo an abortion.

To some large degree, the abortion industry relies on the obscuring of the fundamental and indisputable fact that abortion kills a human being. The massive loss of life which is attendant to abortion in this country, however, is compounded by the impacts on the women who become involved with the abortion industry. It is sheer folly to operate as if abortion has little in the way of consequences.

If we as Americans must at least for the present, live with a legal system which permits abortions to occur, we have a right to demand that for the good of the unborn child and the good of the mother, the full impact of abortion be known. It is manifestly not in the best interests of a woman to undergo this life-changing medical procedure without being fully informed of the true consequences of that procedure and potential alternatives.

Pope John Paul II said in his encyclical letter *The Gospel of Life:*

> A society lacks solid foundations when on the one hand it asserts values such as the dignity of the person, justice and peace, but then, on the other hand, radically acts to the contrary by allowing or tolerating a variety of ways in which a human life is devalued and violated, especially where it is weak or marginalized.

DIOCESE OF MANCHESTER
Secretariat for Administration and Community Affairs

We urge you to stand up for the dignity of every human life, and vote that **HB 1659** ought to pass. Thank you for your consideration of our testimony and for your service to the people of New Hampshire.

Sincerely,

Meredith Cook

Meredith P. Cook, Esq.
Director, Office of Public Policy

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Kolb

Cornerstone
RESEARCH - ACTION - COMPASSION

TO: Senate Health and Human Services Committee
FROM: Ellen Kolb, VP Government Affairs & Advocacy, Cornerstone Action
Phone 321-2703, email ekolb@nhcornerstone.org
RE: HB 1659, Women's Right to Know

Cornerstone Action is a non-profit, non-partisan public policy agency representing over 6,000 New Hampshire residents. We strongly support HB 1659 and we thank the 13 co-sponsors who proposed it. They have brought forward a bill that reflects full respect for the decades of U.S. Supreme Court decisions now in effect regarding informed consent for abortion. As recently as 2007 (*Gonzales v. Carhart*), the court wrote that the state "has an interest in ensuring that so grave a choice is well-informed."

Informed consent is essential to good health care, and "choice" in its absence is an empty slogan. In order for a woman to be in control of her own health, we believe she is entitled to information about any procedure she is considering, without the coercion that comes from a demand for immediate action and payment. The 24-hour reflection period is a reasonable provision to help ensure that a pregnant woman or adolescent has time to review and ask questions about the information regarding her pregnancy and the proposed abortion procedure.

This information, under the terms of the bill, includes a right to know 24 hours in advance who will be performing the abortion. There can be no patient-provider relationship if the patient doesn't have a clue who the provider might be. A woman wanting to look up publicly-available information about the provider is stymied if that provider is anonymous.

There is a medical emergency exception in the bill, protecting a woman whose life is threatened by the continuation of her pregnancy, so the 24 hours would not apply for such women. As for women without a medical emergency, we wonder how they are treated now, especially in light of potential transportation problems faced by women in rural areas. Are abortion-minded women diagnosed with pregnancy and provided with an abortion in one visit? Is that standard practice? Do abortion providers in the state work seven days a week? It's my understanding that surgical abortions are done at PPNNE's Manchester facility one day a week (Thursday), although I defer to PPNNE's representatives if they provide correction to that. If an abortion-minded woman comes in on Friday, gets some sort of counseling and then decides she wants an abortion (in the absence of a medical emergency), what does such a provider do? Is it standard practice to provide transportation for a woman to another abortion provider, if the 24 hour wait is so burdensome? Or is it standard practice to schedule the abortion for the following Thursday? If that is currently the case, then the 24-hour period imposed by this bill is neither a burden nor an interposition by the state in a patient-provider relationship.

While the text of this bill appears to conform to Supreme Court decisions, we are pleased to see a severability clause which would prevent a court from overturning the entire law if a deficiency is found in one part of it. A challenge in our view would be a waste of the plaintiffs' time and money, however. This bill is a thoughtful assertion of the primacy of women's health over non-medical considerations. We hope this HB 1659 receives your prompt approval.

Grebsh

Joan G. Lovering
Health Center
Dedicated to choice & sexual health

April 12, 2012
Senate Health and Human Service Committee
Testimony on HB 1659

This bill raises several issues of concern. I will address the main points.

I. Doctors are being asked to give information to their patients that is not supported by scientific research, which means violating their Hippocratic Oath. If this bill passes and doctors do not give out this false information, they will be prosecuted and face losing their license to practice, a civil suit and a possible jail sentence. The language used in this bill is based on ideology and not scientific fact, some of the statements are open to interpretation, some are misleading and taken out of context and some are just plain false.

II. This bill requires a doctor to spend up to 45 minutes with a woman explaining the procedure and does not allow the doctor's office to bill for that time. If the woman returns for an abortion, the doctor may or may not recover those costs. If the woman does not return for a procedure, the doctor receives no compensation for his/her time and expertise.

III. The underlying assumption on which this bill is based is that women are incapable of making their own decisions. This is an antiquated idea that has no place in our time. We have seen women who chair important committees in the legislature, women speakers of the NH House and the US Congress, President of the NH Senate, Women Governors, US Senators, CEO's of large companies and on and on. Women make responsible decisions and every day. The cartoon image of woman as a dither headed, incompetent and brainless being with no moral compass is outdated and just plain bigoted. The parallel assumption made in this bill is that a woman has not given the matter of her pregnancy one thought prior to calling a clinic or the doctor's office. She hasn't done any research or talked with anyone close to her. She needs 24 more hours to think about her decision, in addition to the time she has already spent. The truth is that woman do their own research, talk to important people in their lives, including sometimes clergy, and consider all the options before they make an appointment. Sometimes they may call for information or to make an appointment for options counseling prior to making an abortion appointment, but they always are thinking about their decision.

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www.joangloveringhealthcenter.org

IV. Making this a two day procedure, where the woman has to appear in person, is very hard on women who have jobs with no paid time off or women who have to arrange childcare. It increases the burden with no definable benefit.

V. Clinics offer fully informed consents that are gone over thoroughly and completely prior to any procedure. It might interest you to know that informed consent, which is now standard procedure for every medical person in the land, came out of the women's health movement of the sixties and seventies. That's right. Women demanded informed consent and now they get it with every abortion and with every other medical procedure. This bill is going backward with that positive outcome by asking for misinformed consent.

VI. Crisis Pregnancy Centers do not have any of the restrictions named in this bill. They do not have "professional counselors". Some don't even have a doctor associated with them. This bill sets different standards for clinics based on their ideological leaning and not on the services they provide.

VII. This bill contradicts and overlaps HB 1680, which is a bill to deal with statistics collected for the state. This will lead to confusion, duplication and bad information. In addition there are penalties attached to keeping these records and 2 different laws governing the collection and filing. If someone is criminally liable for completing a task, confusion should be eliminated or reduced as much as possible.

In conclusion, this bill violates the right of an individual to make their own decisions and seek the medical care they require. It violates a doctor's right to practice medicine in a way that complies with his medical oath, with threat of criminal and civil prosecution. It violates a doctor's right to practice medicine in a way that allows him or her to run the office in a patient centered and efficient way.

For all these reasons and many others brought forth by other parties, please vote this bill inexpedient to legislate. This bill has no place in "Live Free or Die" New Hampshire. Thank you for your attention.

Linda Griebsch

Testimony by Kurt Wuelper
President of New Hampshire Right to Life
Senate Health and Human Services Committee
HB 1659 April 12, 2012

I'm here in support of HB 1659 for two reasons:

1. Abortion kills over a thousand NH babies each year, and it has major negative consequences for women's health, even for their very lives.
2. Both sides of the abortion debate agree we should lower the number of abortions. Informed Consent laws have proven successful in this area in several countries and many states, without restricting a woman's 'right' to an abortion.

In terms of the negative health effects for women, attached to this are three fact sheets documenting the wide range of major medical and psychological consequences for women, including the source studies citations. *Key Facts-Abortions Impact* talks to the deadly long term effects of abortion and the client's reported need for additional counseling. *Physical Risks* spells out the wide range of complications from the abortion procedure per se, and *Psychological Risks* explains the incidence of various disorders [Suicide, Depression, eating disorders, etc.] associated with having an abortion.

In the interest of time, I'll just mention a few of those, but remember, they are all from well documented, peer reviewed, research:

- Pregnancy-associated **deaths** are actually **two to four times higher for aborting women**
- Immediate medical risks include infection and damage to reproductive organs
- Women may become Sterile
- Women may have difficulty carrying future pregnancy to term-more miscarriages-more premature births. More premature births, more disabled children.
- Women may have substantially increased risk of Breast Cancer
- Women have nearly double the risk of mental health difficulties [depression, etc.]
- Women having multiple abortions have multiplied risks

One finding critical for your consideration in terms of HB 1659 is that over 80 percent of post-abortive women report getting little or no counseling prior to their abortions. HB 1659 is a corrective for that.

Women have the right to know these risks, just as they do for any other medical procedure.

Many times, even pro-abortion women, suffer from long term psychological effects for decades [for testimonies see www.afterabortion.org]. Risk factors for many of these effects are well documented. It has been estimated that, using good medical standards and good pre-abortion counseling, that up to 60 percent of all abortions would be medically contraindicated. As the providers who testify how many women they counsel to NOT have abortion because of these known risk factors.

Lastly on the medical front, during House testimony on this bill, a man testified that for him to get a vasectomy, he needed the written permission of his wife and that permission could not be granbted in one visit. They had to go home and reflect upon their decision and return another day before the procedure could be approved. We all recognize the serious nature of male sterilization, but shouldn't a woman take similar time to reflect upon an almost universally voluntary procedure that might leave her sterile as well?

Testimony by Kurt Wuelper
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Now, in terms of reducing abortions, everyone agrees that abortions should be minimized. You remember the mantra of the pro-aborts: "Safe, legal and rare"? One would expect that we all could agree to measures that both enhance safety and reduce frequency of abortion. HB 1659 is just such a measure.

In Germany, France, Belgium, Finland, and many of our sister states [upheld by the US Supreme Court], Informed Consent laws have done precisely that. Every place with informed consent legislation has lower abortion rates than those without them.

Nothing in HB 1659 prevents any woman from having an abortion. Abortion is, however, an industry from which a small number of organizations and individuals make tons of money. You'll be hearing from some of those in opposition to this bill. Last week, in consideration of HB 228, we talked about the choice of health care organizations to perform elective abortions. Planned Parenthood, in particular, remains adamant that they would sacrifice all other health care to women on the altar of performing abortions. I suggest you ask opponents of HB 1659, just why it is so important to them that women not be informed, that women not be assured the protection against poor decision making that men are given.

HB 1659 is a powerful tool to reduce the number of babies killed by abortion without interfering with any woman's rights. I urge you to enthusiastically support HB 1659.

Key Facts — Abortion's Impact
Coercion, Trauma, Grief, Injury, Death

Most abortions are coerced or unwanted, based on insufficent information

64% involve coercion. A study published in a major international medical journal found that 64% of American women who had abortions felt pressured by others.[1] Coercion can include loss of home, job or family, and even violent assault.[2]

Up to 83% wanted to have the baby. In a survey of women who sought help after abortion, 83% said they would have carried to term if they had received support from the baby's father, their family, or other important people in their lives.[3]

In 95% of cases, men play a central role in the decision to abort according to a survey of women at abortion clinics.[4]

Husbands and boyfriends threaten women at the clinic. A former abortion clinic security guard testified before the Massachusetts legislature that women were routinely threatened and abused by the husbands and boyfriends who took them to the clinics to make sure they had abortions.[5]

Dangerous consequences if she resists. Coercion can escalate to violence and even murder.[2] Homicide is the leading killer of pregnant women.[6] The "Forced Abortion in America" report includes examples of molesters posing as fathers to procure cover-up abortions and women being fired, beaten, shot, stabbed, tortured or killed for refusing to abort.[2]

Not given enough information.

- 67% said they received no counseling beforehand.
- 84% reported they received inadequate counseling beforehand.
- 54% were not sure about their decision at the time, yet 79% were not counseled about alternatives.[1]

Rushed into abortion. Many women may be making hasty, ill-considered decisions for abortion, according to journal articles by the National Abortion Federation.[7] One in five women served by their clinics are philosophically and morally opposed to abortion.[8] A recent study found that 52% needed more time to make their decision.[1]

Deception and sales tactics. Many who sought answers and help, instead encountered pressure from "counselors" trained to sell abortions in profit-driven clinics.[9] In a survey of women experiencing problems after abortion:

- 66% said counselor's advice was very biased
- 60% were uncertain of their decision
- 44% hoped to find an alternative
- 71% felt their questions were ignored or trivialized.[3]

After Abortion

Health complications

- 31% suffered health complications.[1]
- About 10% suffer immediate complications; of which one-fifth are life-threatening. Hemorrhage, endotoxic shock andanesthesia complications are among the many potential problems.[12]
- Women also risk infertility or problems with future pregnancies, such as ectopic pregnancies, labor complications, miscarriages, stillbirths or premature births, the leading cause of birth defects.[13]

Trauma and suicide

- 65% suffer multiple symptoms of post-traumatic stress disorder.[1]
- 62% increased risk of death from all causes, including suicide.[10]
- Suicide rates are 6 times higher if women abort vs. giving birth.[11]
- 60% of women who had abortions said they felt that "part of me died."[1]

continued ▸

Increased awareness and declining abortion rates

Majority of women oppose abortion on demand. A poll by the Center for the Advancement of Women, which supports abortion, shows more than half of American women oppose abortion on demand. Legal abortion was the next to last priority for women.[14]

Abortion rates steadily dropping. There has been a slow steady drop in abortion rates over the last 15 years, in part because of raised awareness that abortion is not a "quick and easy" solution.[15] 77% of Americans now realize that abortion takes a life, including one-third of those who describe themselves as strongly pro-choice.[16]

Few regret keeping unintended babies. Studies of women who sought but did not have abortions show that few, if any, later regret their decision or suffer psychological problems from having an unintended child.[17]

Even in hard cases, women don't want abortion ...

Victims say it only intensifies the trauma. In a survey of women who became pregnant through rape or incest, many only aborted because they felt pressured to do so and said abortion only increased their grief and trauma.

- 70% had their babies, and none regretted their decision.
- 78% of those who aborted had regrets and said that abortion was the wrong solution.[18]

Petition for Hearings. An Ad Hoc Committee of Women Pregnant by Sexual Assault has put together a Petition to Congress and State Legislators to request hearings on this issue. (For a copy of the petition, see the "Hard Cases Booklet" at www.theunchoice.com/resources.htm).

Americans want more research into abortion's impact on women. The majority of voters surveyed believe government-funded research on women's emotional reactions to abortion should be a high priority.[15]

Assembly-line medicine

Impersonal clinics. More than 80% of all abortions are done in non-hospital facilities, at clinics devoted solely to providing abortions and contraceptive services. Most abortions are done by a stranger who has no relationship with the patient, either before or after the procedure. Often women do not return for post-surgical care.[19]

Low standard of care. The standard of care is often poor. Some abortionists move from state to state to avoid investigations and patient complaints.[20]

Failure to screen for known risk factors. (Screening would eliminate 70% or more of all abortions.) Most abortionists don't screen for risk factors or determine whether abortion will benefit their patients. Proper screening would *eliminate 70% or more of all abortions.*[21]

Profit-driven clinics, high-pressure "counseling." Many abortion "counselors" are not licensed counselors. Some are trained to "sell" abortions and ease women's concerns so they will be more likely to abort, thus increasing clinic profits.[9]

The journey toward healing

In the U.S., over 50 million women and men have lost a child to abortion. Many are realizing they are not alone and finding that hope and healing are possible. Experts estimate that post-abortion healing programs have already served as many as 20 million women and others impacted by abortion. Learn more at www.utheunchoice.com/healing.htm.

More information *on unwanted abortions and abortion risks can be found in the special report, "Forced Abortion in America," and in our Research Booklet. Both can be downloaded for free at www.theunchoice.com/resources.htm. For current news and updates on abortion research and risks, see www.theunchoice.com/news.htm.*

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Physical Risks
Life-Threatening Risks of Abortion

Higher death risk, 6 times higher suicide rate

Compared to pregnant women who had their babies, pregnant women who aborted were ...

- **3.5 times more likely to die in the following year**
- **6 times more likely to die of suicide**
- **4 times more likely to die of injuries related to accidents**[1]
- **1.6 times more likely to die of natural causes**
- **14 times more likely to die from homicide**

Another study found that, compared to women who gave birth, women who had abortions had a 62% higher risk of death from all causes for at least *eight* years after their pregnancies. Deaths from suicides and accidents were most prominent, with deaths from suicides being 2.5 times higher.[2]

Causes of death within a week — The leading causes of abortion-related maternal deaths within a week of abortion are hemorrhage, infection, embolism, anesthesia complications, and undiagnosed ectopic pregnancies.[3]

Cancer — Significantly increased risk of breast cancer, cervical cancer, and lung cancer (probably due to heavier smoking patterns after abortion).[4]

Immediate complications — About 10% suffer immediate complications; one-fifth of which are life-threatening,[5] These risks include hemorrhage, cervical injury, perforation of the uterus, infection, embolism, chronic pain, and anesthesia complications.

31% suffer health complications— A recent study published in a major medical journal found that 31% of American women surveyed who had undergone abortions had health complications.[6]

80%-180% increase in doctor visits — Based on health care sought before and after abortion. On average, there is an 80% increase in doctor visits and a 180% increase in doctor visits for psychosocial reasons after abortion.[7]

Self-destructive lifestyles, spiraling health problems — Increased risk of promiscuity, smoking, drug abuse, and eating disorders, which all put the woman at increased risk for other health problems.[8]

Infertility and life-threatening reproductive risks

Abortion can damage reproductive organs and cause long-term and sometimes permanent problems that can put future pregnancies at risk. Women who have abortions are more likely to experience ectopic pregnancies, infertility, hysterectomies, stillbirths, miscarriages, and premature births than women who have not had abortions.[9]

Reproductive complications and problems with subsequent deliveries

Pelvic Inflammatory Disease — Abortion puts women at risk of pelvic inflammatory disease (PID), a major direct cause of infertility. PID also increases risk of ectopic pregnancies. Studies have found that approximately one-fourth of women who have chlamydia at the time of their abortion and 5% of women who don't have chlamydia will develop PID within four weeks afterwards.[10]

Placenta Previa — After abortion, there is a seven- to 15-fold increase in placenta previa in subsequent pregnancies, a life-threatening condition for the mother and baby that increases the risk of birth defects, stillbirth, and excessive bleeding during labor.[11]

Ectopic Pregnancy — Post-abortive women have a significantly increased risk of subsequent ectopic pregnancies,[12] which are life threatening and may result in reduced fertility.

Endometritis, a Major Cause of Death — Abortion can result in for endometritis, which can lead to hospitalization and infertility problems. It is a major cause of maternal death during pregnancy.[13]

Women who abort twice as likely to have pre-term or post-term deliveries.[14] Women who had one, two, or more previous

continued ▸

induced abortions are, respectively, 1.89, 2.66, or 2.03 times more likely to have a subsequent pre-term delivery, compared to women who carry to term. Pre-term delivery increases the risk of neonatal death and handicaps. Women who had one, two, or more induced abortions are, respectively, 1.89, 2.61, and 2.23 times more likely to have a post-term delivery (over 42 weeks).

Death or disability of newborns in later pregnancies — Cervical and uterine damage may increase the risk of premature delivery, complications of labor, and abnormal development of the placenta in later pregnancies.[15] These complications are the leading causes of disabilities among newborns.

To find out more, including pregnancy and post-abortion resources, visit TheUnChoice.com

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Psychological Risks
Traumatic Aftereffects of Abortion

Suicide

- **6 times higher suicide rate.** Aborting women were six-seven times more likely to commit suicide in the following year than were delivering women.[1] A study of women for up to eight years after the pregnancy ended found a 2.5 times higher suicide rate after abortion than after giving birth.[2]
- **Up to 60% have suicidal thoughts.** In a study in a major scientific journal, 31% of women had thoughts of suicide after undergoing an abortion.[3] In another survey, approximately 60% of women with post-abortion problems reported suicidal thoughts, with 28% attempting suicide and half of those attempting suicide two or more times.[4]

Depression

- **65% higher risk of clinical depression.** Women who aborted were 65% more likely than delivering women to be at risk of long-term clinical depression after controlling for age, race, education, marital status, income, and prior psychiatric state.[5]
- **Depression risk remained high, even when pregnancies were unplanned.** Among women with unintended first pregnancies, aborting women were at significantly higher risk of long-term clinical depression compared to delivering women.[6]

Trauma

- **65% report symptoms of post-traumatic stress disorder.** 65% of U.S. women who had abortions experienced multiple symptoms of PTSD, which they attributed to their abortions. Slightly over 14% reported all the symptoms necessary for a clinical diagnosis of abortion-induced PTSD.[3]
- **60% said they felt "part of me died."** In the above study, 60% reported that they felt "part of me died" after their abortions.[3]
- **More psychiatric treatment.** Compared to women who deliver, women who abort are more than twice as likely to be subsequently hospitalized for psychiatric illness within six months.[7] Analysis of California Medicaid records shows that women who have abortions subsequently require significantly more treatments for psychiatric illness through outpatient care.[8]
- **Multiple disorders and regrets.** In a study eight weeks after abortion, 36% of women experienced sleep disturbances, 31% had regrets about the abortion, and 11% had been prescribed psychotropic medicine by their family doctor.[9]
- **Generalized anxiety disorder.** Among women with no previous history of anxiety, women who aborted a first, unplanned pregnancy were 30% more likely to subsequently report all the symptoms associated with a diagnosis for generalized anxiety disorder, compared to women who carried to term.[10]
- **Sleep disorders.** In a study of women with no known history of sleep disorders, women were more likely to be treated for sleep disorders after having an abortion compared to giving birth (nearly twice as likely in the first 180 days afterwards). Numerous studies have shown that trauma victims often experience sleep difficulties.[11]
- **Disorders not pre-existing.** A New Zealand study found that women had higher rates of suicidal behavior, depression, anxiety, substance abuse, and other disorders after abortion. The study found that these were not pre-existing problems.[12]

Eating disorders & substance abuse

- **39% had eating disorders.** In a survey of women with post-abortion problems, 39% reported subsequent eating disorders.[13]
- **Five-fold higher risk of drug and alcohol abuse.** Excluding women with a prior history of substance abuse, those who abort their first pregnancy are 5 times more likely to report subsequent drug and alcohol abuse vs. those who give birth.[14]

continued ▸

Divorce and chronic relationship problems

- **Women with a history of abortion are significantly more likely to subsequently have shorter relationships and more divorces.**[15]
- **More poverty and single parenthood after repeat abortions.** Women who have more than one abortion (nearly half of those seeking abortions each year[16]) are more likely to become single parents and to require public assistance.[17]
- **30-50% of post-abortive women report experiencing sexual dysfunctions** such as promiscuity, loss of pleasure from intercourse, increased pain, and aversion to sex and/or men.[18]
- **Studies have identified factors that put women at risk for negative reactions to abortion,** including feeling pressured to abort, lack of support, being more religious, prior emotional or psychological problems, adolescence, being unsure of her decision, and receiving little or no counseling prior to abortion.[19]

To find out more, including pregnancy help and post-abortion resources, visit TheUnChoice.com

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HB 1659, relative to the women's right to know act regarding abortion information

Hearing: **April 12, 2012**

Committee: **Senate Health and Human Services**

Position: **OPPOSE**

Mr. Chairman and members of the committee, my name is Kathleen Kidder, although I prefer to be called Kitty, and I am an Advanced Practice Registered Nurse (APRN). I own a practice in New London, NH, providing primary care services to about 3000 patients. I am representing the New Hampshire Nurse Practitioner Association, having served as a previous president of the association, and I am here to share my concerns with you about HB 1659.

In New Hampshire Advanced Practice Nurses provide healthcare services, safely, to thousands of citizens. They provide quality care with quality outcomes in a fiscally responsible manner. The safety record among Advanced Practice Nurses is exemplary. This bill serves to the limit the Scope of Practice, thus reducing access to care at a time when women are most healthy.

In 2006 the Board of Nursing reviewed the educational preparation for APRN's prepared to provide surgical abortions and deemed it appropriate thus allowing for it in Scope of Practice. In the six years since, there have been no complaints received by the Board of Nursing concerning these issues. There is, therefore, no need to limit access of care by establishing the "physician-only" language included in this bill.

Thank you for your time. I am happy to answer any questions. I wish to let you know that Denise Nies, Executive Director of the BON is in the room and would be available to answer questions, also.

Please let me know if I can be of further assistance.

Kathleen M. Kidder, MSN, FNP-BC, APRN

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Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: 4/20/12

THE COMMITTEE ON Health and Human Services

to which was referred House Bill 1659-FN

AN ACT relative to the women's right to know act regarding abortion information.

Having considered the same, the committee recommends that the Bill:

IS INEXPEDIENT TO LEGISLATE

BY A VOTE OF: 3-2

Senator Molly Kelly
For the Committee

Robyn Dangora 271-4154

New Hampshire General Court - Bill Status System

Docket of HB1659

Docket Abbreviations

Bill Title: relative to the women's right to know act regarding abortion information.

Official Docket of **HB1659**:

Date	Body	Description
12/29/2011	H	**Introduced** 1/4/2012 and Referred to Judiciary; **HJ 7**, PG.363
1/18/2012	H	Public Hearing: 1/24/2012 11:30 AM LOB 208
1/18/2012	H	Subcommittee Work Session: 1/26/2012 1:32 PM LOB 202
2/15/2012	H	==CANCELLED== Executive Session: 2/21/2012 10:30 AM LOB 208
2/22/2012	H	Executive Session: 2/23/2012 9:00 AM LOB 208
2/23/2012	H	Majority Committee Report: Ought to Pass with Amendment #0089h for Mar 7 (Vote 13-4; RC); **HC 19**, PG.1130-1131
2/23/2012	H	Proposed Majority Committee Amendment **#2012-0089h**; **HC 19**, PG.1183-1185
2/23/2012	H	Minority Committee Report: Inexpedient to Legislate; **HC 19**, PG.1130-1131
3/14/2012	H	Special Order to Next Order of Business: Without Objection; **HJ 24**, PG.1467
3/14/2012	H	Amendment #0089h Adopted, DIV 185-116; **HJ 24**, PG.1469
3/14/2012	H	**Ought to Pass with Amendment** #0089h: MA **RC** 189-151; **HJ 24**, PG.1469-1471
3/14/2012	H	Reconsideration (Rep Notter): MF VV; **HJ 24**, PG.1474
3/15/2012	H	Reconsider Third Reading Motion of March 14 (Reps Jasper and Norelli): MA VV; **HJ 26**, PG.1615
3/15/2012	H	Divide Third Reading Motion to Remove HB1659 (Reps Jasper and Norelli): Speaker Ordered; **HJ 26**, PG.1615
3/15/2012	H	Remaining Bills to Third Reading (Reps Jasper and Norelli): MA VV; **HJ 26**, PG.1615
3/15/2012	H	HB1659 Referred to Criminal Justice and Public Safety: Without Objection; **HJ 26**, PG.1615
3/15/2012	H	Public Hearing: 3/20/2012 10:30 AM LOB 204 ===Executive Session To Follow==
3/21/2012	H	Majority Committee Report: Ought to Pass with Amendment #1327h for Mar 28 (Vote 8-7; RC); **HC 25**, PG.1507-1508
3/21/2012	H	Proposed Majority Committee Amendment **#2012-1327h**; **HC 25**, PG.1594
3/21/2012	H	Minority Committee Report: Inexpedient to Legislate; **HC 25**, PG.1507-1508
3/28/2012	H	Amendment #1327h: AA DIV 210-106; **HJ 30**, PG.1759-1760
3/28/2012	H	Floor Amendment **#2012-1458h**(NT) (Rep S.Keans): Ruled Non-Germane By Speaker; **HJ 30**, PG.1760-1761
3/28/2012	H	Ought to Pass with Amendment #1327h: MF **RC** 164-181; **HJ 30**, PG.1759-1763
3/28/2012	H	Inexpedient to Legislate (Rep Shurtleff): MF **RC** 170-179; **HJ 30**,

		PG.1763-1765
3/28/2012	H	Ought to Pass (Rep Bettencourt); **HJ 30**, PG.1765
3/28/2012	H	Laid On The Table (Rep Shurtleff): MA **RC** 190-161; **HJ 30**, PG.1765-1767
3/28/2012	H	Remove from the Table (Rep K.Souza): MA DIV 165-162; **HJ 30**, PG.1834
3/28/2012	H	Special Order to First Order of Business on Mar 29 (Rep Rowe): MF DIV 93-237; **HJ 30**, PG.1835
3/28/2012	H	Floor Amendment **#2012-1482h** (Rep Simmons): AA DIV 178-152; **HJ 30**, PG.1834-1835
3/28/2012	H	**Ought to Pass with Amendment** #1482h: MA **RC** 185-138; **HJ 30**, PG.1835-1837
3/28/2012	H	Reconsideration (Rep Simmons): MF DIV 106-194; **HJ 30**, PG.1841
3/28/2012	S	Introduced and Referred to Health and Human Services
4/5/2012	S	Hearing: 4/12/12, Room 100, SH, 1:20 p.m.; **SC14**
4/20/2012	S	Committee Report: Inexpedient to Legislate, 4/25/12; **SC16A**
4/25/2012	S	Inexpedient to Legislate, **RC** 12Y-11N, MA === BILL KILLED ===

NH House	NH Senate

Other Referrals

COMMITTEE REPORT FILE INVENTORY

HB 1691-FN ORIGINAL REFERRAL _____ RE-REFERRAL

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE AIDE AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

✓ DOCKET (Submit only the latest docket found in Bill Status)

✓ COMMITTEE REPORT

___ CALENDAR NOTICE

✓ HEARING REPORT

✓ HANDOUTS FROM THE PUBLIC HEARING

✓ PREPARED TESTIMONY AND OTHER SUBMISSIONS

✓ SIGN-UP SHEET(S)

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

___ - AMENDMENT # _____ ___ - AMENDMENT # _____

___ - AMENDMENT # _____ ___ - AMENDMENT # _____

ALL AVAILABLE VERSIONS OF THE BILL:

✓ AS INTRODUCED ✓ AS AMENDED BY THE HOUSE

N/A FINAL VERSION N/A AS AMENDED BY THE SENATE

___ OTHER (Anything else deemed important but not listed above, such as amended fiscal notes): _____

DATE DELIVERED TO SENATE CLERK 5/31/12 _____

BY COMMITTEE AIDE

Revised 2011