

**Written Testimony in Opposition of HB 516 & Support of HB 514**

February 18, 2011

Submitted by:

Caitlin Cople

President, Board of Directors, NCBI Missoula

1280 S. 3<sup>rd</sup> St. W.

Missoula, MT 59801

Dear Chairman Peterson and Members of the House Judiciary Committee:

My name is Caitlin Cople, and I live in Missoula, where I have the great privilege of serving as the president of the board of directors of the National Coalition Building Institute, one of many local groups that were instrumental in passing the Missoula Equality Ordinance. NCBI Missoula is a nonprofit organization that works across the state to train leaders of all ages and backgrounds who can end all forms of prejudice and prevent violence in their schools and communities.

NCBI runs an after school program for middle school students called Respect Club. For many kids, Respect Club is the first place they've felt safe to be themselves in school, free from bullying or peer pressure. Last winter, the kids decided they wanted to come together and hold a Diversity Day rally and parade to celebrate all the different types of people who call Missoula home. They decided to ask the mayor to proclaim Diversity Day a holiday, and began planning their event. When the kids heard about the non-discrimination ordinance, they decided they wanted to partner with the Montana Human Rights Network and allied organizations and hold Diversity Day the same day that the City Council voted on the issue.

The kids are so proud of the hard work they did to help pass the ordinance and establish a Diversity Day holiday. NCBI's Youth Programming Director Heidi Wallace asked that I share with you some quotes from them about why they believe in the Missoula Equality Ordinance and oppose efforts to dismantle it:

"Being out would make life so much easier but because there is so much prejudice and misinformation among people in my age group I find it hard to connect and interact with people on a daily basis. Having a diversity day I believe would put more information out there and educate people about why things like "that's so gay" (slang often used by everyone is if it's okay) can be truly hurtful. Not only can diversity day help the LGBTQ community but it can help anyone who has felt mistreated and over all make Missoula a more open and understanding community."

- Missoula 8<sup>th</sup> grader, Washington Middle School

"There should be a day to celebrate our differences in which nobody is judged by their sexual orientation."

- Missoula 8<sup>th</sup> grader, Washington Middle School

"I am from Respect Club. We want to bring the awareness to everyone being equal! We are rooting for a diversity day. We do not like seeing people getting fired because of who they are sexually. People should be protected no matter who they are. That's what I will do when I am an adult."

- 6<sup>th</sup> grader at C.S. Porter Middle School

"Bullying happens every day in every place. People get picked on for clothes, money, words and even worse, gender identity. Lesbians, gays, transgender and bi-gender people are living every day in fear of losing their jobs, homes or being hurt. Support Diversity Day and no one will have to be alone while experiencing this!"

- Anonymous Middle School Student

"Every day I hear the word 'gay'. It is not used in a good way though. It is a word people at my school used to discriminate against others. 'That's so gay' should not be a common phrase that you hear. Discrimination is everywhere we look. It should not be put to the side. We should all work together as a community to become one. We should respect each other's similarities and differences for no one is the same. We all have different identities that should be celebrated and appreciated. "

- Anonymous Middle School Student

In closing, I would ask that you listen to the wisdom of Missoula's young people and protect the will of Missoulians by killing this legislation. By doing so, you'll send a message that yes, it's true, young people really can make a difference in their communities! You'll be heroes to the Missoula Respect Club kids who worked so hard on this issue and give them hope to keeping dreaming big dreams for a more just and peaceful world.

To: House Judiciary Committee

Please vote NO on HB516.

Each one of us has  
LGBT friends, neighbors  
and loved ones who need  
all of us, their community  
to protect their human rights.  
Communities should be allowed  
to remedy the unequal, sometimes  
brutal treatment that prevents  
neighbors and loved ones from  
accessing the rights they  
are constitutionally guaranteed.  
These are not special rights.  
This is a group of people who  
is mistreated. All mistreatment  
deserve equal protection under  
the law, and all communities  
should be allowed to decide  
locally when an ordinance,  
resolution or policy is needed  
providing this protection when  
our state laws do not.

As a lifelong Montanan,  
new married and working  
for the state as a provider  
of educational services,  
I feel strongly that a vote  
for this bill is a vote against  
a future that holds hope  
for all Montanans.

Please vote against  
HB 516 (Hansen).

Thank you.

Teresa Velthuis

502 W. Main

Helena MT 59601

**Frequently Asked Questions**  
**Proposed Missoula Anti-Discrimination Ordinance**  
**4/12/2010**

1. **Why does Missoula need the proposed ordinance if federal and state laws already have anti-discrimination protections?**
  - a. State and federal anti-discrimination protections do not include protections for sexual orientation and gender identity or expression. The proposed ordinance would extend anti-discrimination protections to lesbian, gay, bisexual, and transgender people. Twenty-one states, the District of Columbia, and at least 129 cities and counties have taken similar action.
2. **Will the proposed ordinance give preferential treatment to lesbian, gay, bisexual, and transgender individuals?**
  - a. No. The proposed ordinance will prohibit discriminating against individuals because of their sexual orientations and gender identities or expressions. The proposed ordinance will create a mechanism for redress if individuals feel that they have been discriminated against based on their sexual orientations and/or gender identities or expressions. Individuals will be able to make complaints and engage in a process of fact-finding that would prove or disprove an individual's claim of discrimination.
3. **What does gender identity or expression mean?**
  - a. Gender identity describes how people perceive their own internal sense of maleness or femaleness. Gender expression is the physical manifestation of one's gender identity, usually expressed through clothing, mannerisms, and chosen names.
4. **Does the proposed ordinance force churches to engage in activities that are contrary to their religious doctrine or beliefs?**
  - a. No. The proposed ordinance does not have any effect on the Constitutionally protected exercise of religion. Churches and other religious institutions will be exempt from this ordinance when engaging in the practice of their religion or in activities that are for a religious purpose.
5. **Does the proposed ordinance address "gender confused?"**
  - a. No.
6. **What does transgender mean?**
  - a. Transgender is when a person's self-identified gender is different from the gender assigned at birth.
7. **Does the proposed ordinance change access to public restrooms?**
  - a. No. The ordinance prohibits discrimination in public accommodations. This means that if people feel they are denied access to public restrooms based on their sexual orientations and/or gender identities or expressions, they could make complaints and engage in a process of fact-finding that would prove or disprove their claims of discrimination.
8. **Does this ordinance prohibit gender-segregated public restrooms?**

- a. No. The proposed ordinance does not require any changes to gender-segregated public restrooms. This ordinance does require that individuals are permitted to access restrooms or locker rooms in accordance with their gender identity, rather than their assigned sex at birth. And, just as non-transgender individuals are entitled to use a restroom appropriate to their gender identity without having to provide documentation or respond to invasive requests, transgender individuals must also be allowed to use a gender-identity appropriate restroom without being harassed.
- 9. Does the proposed ordinance change access to locker rooms?**
- a. No. The ordinance prohibits discrimination in public accommodations. This means if someone feels that he or she is denied access to a public locker room based on sexual orientation and/or gender identity or expression, he or she could make a complaint and engage in a process of fact-finding that would prove or disprove the individual's claim of discrimination.
- 10. Does the proposed ordinance force public schools to change their policies around restrooms and locker rooms?**
- a. No. The Montana Code Annotated at MCA 7-1-111 (3) expressly denies local governments the power to regulate on matters relating to or affecting public schools. The proposed ordinance will have no effect on Missoula public schools.
- 11. Does the proposed ordinance give individuals the right to engage in criminal activities in public restrooms or locker rooms?**
- a. No. The proposed ordinance does not change criminal laws (local, state, or federal). Nothing in the proposed ordinance permits or requires access to any place of public accommodation for the purpose or intent of engaging in criminal conduct.
- 12. Do I currently have the right to refuse to rent to someone if I don't approve of something about them?**
- a. Only in a narrow set of circumstances. Landlords are engaging in the public marketplace and in doing so are subject to both state and federal anti-discrimination laws. While landlords retain the right to make reasonable requirements with respect to references and credit, they may not make rental decisions based on actual or perceived race, religion, sex, marital or familial status, color, national origin, ancestry, creed, physical or mental disability, or age. The proposed ordinance adds sexual orientation and gender identity or expression to the list of groups protected. Additionally, according to the Montana Code Annotated, the rental of sleeping rooms in a private residence designed as a single dwelling unit in which the owner also resides may rent to whomever they choose, provided that the owner rents no more than three sleeping rooms within the residence.

*Drafted by Missoula City Council members Stacy Rye and Dave Strohmaier with advice from City Attorney Jim Nugent and Niki Zupanic, ACLU of Montana Public Policy Director.*

Dear Vice-chairman Kerns:

I am Christina Hayden, and I live in Butte.

Please let Montanans exercise their freedom to choose whether their legislature ought to be free from the tyranny of the Montana Supreme Court, free to protect women from a “privacy” that renders them vulnerable to abortion, especially coerced abortion (64% report being pressured by others – see unchoice.com). The Montana Supreme Court has demonstrated a greater interest in protecting a “right to privacy” in order to protect abortion, than in the pregnant women who have abortions. “Imposing” a “right to privacy” on a woman so that she will be “free” to choose, denies the way women solve their problems. Isolating a woman, alienates her from her family, relationships, or community, those most willing to support her.

I've heard said that a man will go into his cave, and may invoke a “right to privacy” until he comes out, with his problem solved. The “right to privacy” was first invoked in U.S. Supreme Court decision *Griswold vs. Connecticut* in 1965 by an all man court. When women experience stress, we typically will reach out to communicate, talking out our problems in a community or relationship of support where we can be heard. This would especially be the case when we experience distress and lost control of our situation and our lives with an unintended pregnancy (we have been taught to control our lives with birth control). A woman who is pressured, manipulated, coerced or forced to have sex, may, when she becomes pregnant, be vulnerable to being pressured, manipulated, coerced or forced to have an abortion. A teenager on birth control may be especially vulnerable.

A woman is especially unstable emotionally in early pregnancy, when her female hormones are rebalancing for the pregnancy, and vulnerable to greater instability without relational support. This is especially true also, during a young woman's teenage years. This makes pregnant women, especially teenage pregnant women, vulnerable to the influence of others. During a condition of life particular to women when they are particularly vulnerable, requiring particular legal protection.

Someone gets paid when a woman has a abortion, and somebody pays for a woman's abortion. Montanans who want to protect women from abortion, or do not want to participate in abortion, ought not to be forced to pay for what is most often a traumatizing experience for women (65% report trauma after their abortions – see [afterabortion.com](http://afterabortion.com)). Taxes ought to be used to defend the common good, not the private “good” of profit making entities that exploit vulnerable pregnant women.

My “right to privacy” prevented those I asked to help me, from giving the support I needed to defend my freedom to choose to remain pregnant under pressure to abort. Because of coercion (see my testimony on HB 455), I was deeply traumatized. I certainly do not want my taxes to pay for traumatizing women. My fellow Montanans may not want to either. Let them decide.

Montanans may not want or need a “right to privacy” to protect abortion from regulation as long as abortion is legal. Women have not been able to protect themselves from abortion.

PLEASE VOTE YES ON HB 574

Sincerely:



Christina Pfarr Hayden

2601 Princeton  
Butte, MT 59701

Mr. Chair, Committee members  
name - Cardwell  
Civil Rts. attorney

Opposition to HB 516

If exclusive remedy, than  
Equal Protection demands that  
CT's job to ferret out  
HB 514  
be passed

\* Liberty and Justice for all . . .

This is the promise of America. It is our birthright and our legacy.

Thus, as Americans we have an obligation to make that promise a reality for *all* Americans, not just those with whom we agree. As Montanans, we have a long history of doing just that.

In April, 2010 Missoula passed an amendment to its anti-discrimination ordinance to make it unlawful to discriminate in the areas of employment, housing or public accommodation on the basis of sexual orientation or gender identification. The Helena Independent Record conducted a poll then, whether Helena would support similar legislation. 60% of respondents indicated that they would support such a law.

Both this poll and the historic ordinance are reflections of Montanan's sense of justice and equality. A 1982 article in Montana Magazine recognizes that for more than 120 years, Montana has been known for its "progressiveness and the Western Spirit of Liberty." The 1972 Constitutional Convention recognized this as well by producing one of the more progressive state constitutions in the country, explicitly enacting a right of privacy. Because this right is a fundamental (explicitly stated) constitutional right, Montana's Supreme Court recognizes it as "heightened."

~~It is not a point precedent in 1889 MT passed its first anti-disc. law~~  
In 1889, Legislative Councilman, Walter M. Bickford from Missoula introduced Montana's first anti-discrimination law to the Legislative Council. "Council Bill No. 4 amended the law to read that individuals otherwise qualified should be allowed to practice as attorneys without regard to sex . . ." The change in the law allowed Montana's first woman lawyer, Ella Knowles to take the bar exam and practice law. "In the house, Samuel Murray, a Missoula Lawyer, took the position that passage of the bill was an issue larger than the ambitions of one Helena woman. To him the question was one of justice, of a step forward or backward."

said it was a

as MT mag. called it

\* In light of Montana's legacy of progressiveness and "Western Spirit of Liberty" HB 516 begs the question, why? How does it advance the cause of liberty and justice for all? From a legal standpoint, because HB 516 denies a class of people their fundamental constitutional rights, and basic human rights - what is the legitimate government interest to be served by this law?

To pass constitutional muster, such a law must bear a rational relationship to a legitimate governmental purpose. *Romer v. Evans*, 517 U.S. 620, 116 S.Ct. 1620, 134 L.Ed.2d 855 (1996).

\* The U.S. Supreme Court has resoundingly stated that a similar law with a "bare desire to harm a politically unpopular group cannot constitute a legitimate governmental interest" *Id.* at 635. This is exactly what HB 516 will do if passed into law. It is thus, unconstitutional. It advances no legitimate governmental purpose and thwarts the cause of liberty and justice for all.

\* Again, I ask ~~Why?~~ Are we moving forward or backward, and do we really want Montana, in desperate need of commerce and jobs to be known as a backwards state? How do we advance the cause of liberty and justice for all? By voting in opposition to HB 516.

Mr. Chair

Comm. Members

BE of Council

Civil Rts. attorney

Here seeking liberty justice for All

Pro

Dear Chairman Petersen, Vice-chairmen Kerns and Sands, and members of the House Judiciary Committee:

I am Christina Hayden. I live in Butte. I am the second oldest of 12 children. When I was a little girl, I would sit on my mommy's lap and feel them kicking while I played with my brothers and sisters before they were born. My daddy let me use his stethoscope to find their tiny hearts beating. I studied my father's obstetric textbooks, to learn all I could about pregnancy and babies in the womb. I saw my mother's heart break when she lost 2 of us in miscarriage. I attended my first home birth when my dad helped my mom deliver my youngest sister.

In my college years, my best girlfriend had sex with 2 men, and became pregnant. She was terrified of telling her boyfriend. I begged her to let me have her baby. She had an abortion, that deeply traumatized both of us. She started drinking heavily, then just disappeared. In 2 weeks I was pregnant. I told my daddy and he took care of me until I gave her up for adoption. I was terrified of single motherhood and wanted my baby to have a mommy and a daddy.

I wanted to be a wife and mother. At my wedding, I heard him vow to accept children as a gift from God and I vowed until death. Two months later, he told me he did not want the responsibilities of fatherhood, and that I had to have an abortion. I begged him to let me give the baby up for adoption. He refused. In desperation, I turned to all his friends and my own sister for help. They told me it was my private choice, that I should do what he wanted, that I would be relieved after it was over. No one would help me. At the family planning clinic in Bozeman, they told him that "it" was a blob of tissue. His parent's had his sister aborted. He said it was legal, so there was nothing wrong with it. I felt totally abandoned.

I became extremely distressed, and violent, hitting him and screaming, "I won't kill my baby for you". I was too ashamed to tell my dad, and I was terrified of being divorced. I went numb and passive, and decided to do anything to save my marriage. I knew my baby would survive death and that he and God would forgive me someday.

I wanted my husband to get some knitting needles and do it himself. I hated him for paying a doctor to do his dirty work. On the table I broke down and wept uncontrollably. After he started the abortion, Dr. Fox asked me if I wanted him to stop. I cried out, "No, no, no"! I couldn't say yes to an abortion I didn't want. The abortionist told me I was 11 weeks pregnant. On the way home, I wanted to turn around and get my baby, so I could bury him. My husband said that was morbid and refused.

I got an infection (lacerated cervix) I treated myself, because I don't trust doctors. I was pregnant within 3 months, and had a traumatic miscarriage at 11 weeks. When I tried to find my baby, my husband flushed the toilet. In my next 2 pregnancies, I endured excruciating pain from a rigid, scarred cervix, hemorrhaged due to damage to my uterus, and relived the trauma of my abortion during the births. I considered suicide several times, suffered periodic depression, and regularly experienced extreme anxiety attacks and nightmares for many years. I birthed our next 9 babies at home, because I don't trust doctors.

I was terrified that my children would be rejected, abandoned, taken away from me, or die, causing me to over-protect and over-discipline. When expressing any grief over my lost babies, I was told it was all my fault, because I had consented to the abortion. In spite of severe and traumatizing sexual dysfunction, I continuously re-committed to my marriage, for which I had sacrificed my own child. Communication was always extremely difficult, with periodic violence, and completely broke down after 12 years of professional help from priests, psychologists, a sex therapist, psychotherapist, and psychiatrist in the first 18 years of marriage. Six years later, he wanted another woman. I witnessed my children being told that I gave a baby up for adoption because I didn't want her, that I had an abortion because I didn't want him, and that I was divorcing because I didn't want them. After his divorce was final, I had to leave my home without my children, from whom I am completely alienated to this day. I fear retaliation for giving this testimony.

Because I consented to an abortion I didn't want, because I knew my baby, because I wanted my baby, because I was coerced by my own husband, because I knew it was wrong (I am Catholic), I am amongst those most likely to experience severe "post-abortion traumatic stress disorder". I recently went to a nurse practitioner for a pap smear, and found myself still reliving the trauma of my abortion, 30 years ago. Because of my abortion, I am a divorced single mother of 9 living children who are deprived of their mother and an intact family. I want my babies. I want my family.

Thanks to the Rachel's Vineyard Post-abortion Healing Retreat, I understand the circumstances of my abortion, my responsibility, and that of those involved. I forgive them. If I could, I would seek the civil remedy provided for in HB 544, for justice sake.

Please protect us from unwanted abortions, because we are vulnerable when we are pregnant, because we are women.

PLEASE VOTE YES ON HB 544

Representative Peterson and members of the House Judiciary Committee:

The state of Montana is a champion of States' rights. In fact, we believe in the concept so strongly that HB382 and HB321 are both proposing to nullify federal law. If we truly believe in states not all being uniform in laws and regulations and allowing people of the several states to differ in the way they govern themselves, why must we force uniformity upon the divisions of our state? If the people of the local government of Missoula wish to pass an ordinance protecting a small portion of the population from discrimination in a few select areas, why should we revoke their right with HB516? The people of Choteau, Havre and Shelby are free to pass laws of their own if they so choose and it is a stretch to say a law affecting only Missoula will affect them. Will this lead to the state regulating if communities have the choice to have mandatory recycling, or sidewalk clearing after a snowfall? No, such things are left up to the purview of local governments as different locations and different people want different laws. I strongly urge the House Judiciary committee to protect community rights and table this bill indefinitely.

Sean Schilke  
Missoula

**Written Testimony in Opposition of HB 516 + Support of HB 514**  
February 18, 2011

Submitted by:  
Caitlin Copple  
Montana Regional Development Organizer  
Pride Foundation  
P.O. Box 7456  
Missoula, MT 59807

Dear Chairman Peterson and Members of the House Judiciary Committee:

My name is Caitlin Copple and I live in Missoula with my partner, Katherine Beckley. I'm the Montana Regional Organizer for Pride Foundation, a community foundation that makes grants and awards scholarships to advance LGBT equality in Montana and other states in the Pacific Northwest. I volunteered on the steering committee that helped pass the Missoula non-discrimination ordinance last spring. Both Katherine and I testified before the City Council in support of this sorely needed legislation.

I thought about restating the many reasons why Missoula needs this ordinance, and why it's needed in other cities around our great state. However, we've already done that, and I encourage you to watch the MCAT recording of that long and historic City Council meeting on April 12<sup>th</sup>. The people of Missoula and our elected representatives heard our stories of discrimination and overwhelmingly passed the ordinance because the need was so obvious.

But apparently it's not so obvious to some of you committee members, particularly if you've never experienced being fired from your job because you are gay (or Jewish, or Indian, or black, or disabled). Maybe you've never been beaten up for being perceived as being in the wrong bathroom because you are a woman with short hair who chooses not to wear make-up and heels. Maybe the link between the political and the personal is still foggy for you, but I'm hear to tell you that there is an undeniable connection between discriminatory legislation and rejection by your family, your church, and your community for being queer.

But today, instead of dwelling on the need for our ordinance and the problem of discrimination, I want to talk to you about what means to me to live Missoula now that I have some basic rights under the law. I want to attempt to express to you what it means to me to have seen an entire town come together. Missoulians from all walks of life came together last spring to stick up for people like me and my friends, just as we are coming together here today to defend our values and our ordinance.

On April 12<sup>th</sup>, more than 800 people came together, many if not most of them our heterosexual allies. We came together to celebrate Diversity Day and honor all the groups who add vibrance to Misoula, and then we marched to the City Council Chambers and show support for LGBT Missoulians by passing the first ever non-discrimination ordinance in the state.

As LGBT Montanans, we are a minority and lack basic rights at the state level. But Missoulians believed that we could come together and have some basic rights – around housing, hiring and firing, and public accommodations – through a city ordinance. It sent a message that regardless of your sexual orientation, gender identity, or expression, you belong in Missoula, Montana.

You belong. I belong. My relationship belongs.

And isn't that what we all want? To be part of a community as equals and to believe in each other's right to live a life with peace, justice, freedom and dignity? In Missoula, we are a bit closer to that ideal because of this ordinance. Please don't take that away from us.

Don't undo the will of Missoulians and tell my friends and me that we do not belong in our own city.

I hope that you will join me in opposing HB 516 and upholding the right of Missoulians and other cities to publicly and legally value members of the LGBT community by passing inclusive non-discrimination ordinances.

Mr. Chairman and members of the Committee, my name is Heather Granbois and I am here representing myself.

Growing up in Wolf Point MT, being homosexual was not an option. Forming an impenetrable barrier around my heart was the only way to protect ~~it~~ from the oppressive nature of the majority. I didn't even come out to myself until I was 21 and living in the much more tolerant city of Missoula, MT.

Coming out opened the floodgates of my consciousness and I could finally take a breath as a free human being. I say human being because that is what we all are. We cannot be defined simply by race, creed or sexuality; only by character.

If we would all choose to go beyond our own conceptual barriers, we would start to recognize the divine light that is humanity.

That is what we should be holding up high, embracing with loving arms, and an open ~~heart~~ mind. Not hateful words, actions or intolerance.

I urge a do not pass on house

bill 516 and a Do pass on  
house bill 514.  
I thank you Mr. Chairman and  
the Committee for your time.

My name is Daniel Viehland and I am the Chairman of Montana Equality Now.

I am here because of family values. Family values like acceptance, respect, and love. These are values deeply rooted in both my own experience and my Christian faith.

As a man with Tourette syndrome, ~~and a person with a physical disability~~, I know what it is like to be treated differently because of who I am. I know the damage that can do, how hopeless and angry it can make you feel. But, unlike the LGBT community in Montana, I know that it feels like to have equal protection under the law. That is why I work for equality, to ensure my LGBT friends and neighbors have the same opportunities I have had, and they cannot be fired from their jobs or tossed from their homes for an essential part of their being.

I am also here because I am a Christian. The church I grew up in, Saint Francis United Methodist, was deeply focused on the idea of love. We were taught that everyone is equal in the eyes of God. We were taught not to judge, and we were taught that love is the greatest gift that God ever bestowed on humankind. Our church has many LGBT members including lay clergy. These Christians are some of the kindest, most beautiful people I have ever known. Many of them are deeply called by their creator to serve. They are truly children of God.

Anyone who has ever grown up in a church community knows that the term "church family" is no understatement. These wonderful men and women are my family, the people who support each other through baptisms and funerals, through marriages and tragedy. And everyday these people live knowing that, at any moment, they can be evicted from their homes or fired from their jobs because of who God has created them to love. It hurts me, as I'm sure it would hurt any of you, to have my family harmed because of who they are.

The fact is, the discrimination the LGBT community faces falls solidly against the lessons I learned in Sunday school. I was taught that Jesus said the greatest commandment was to love your neighbor.

As a Christian, I refuse to be silent. I refuse to bear false witness. I refuse to deny the basic holiness of my LGBT brothers and sisters. I refuse to deny the beauty of their love and the light in their souls. These people, these incredible people, are my family, and I refuse to believe that God hates my family.

There is nothing godly about discrimination. Discrimination is not human, it is not American, and it is most certainly not Christian.

Discrimination continues to effect the people I love, and I will work for equality as long as it takes. I would encourage the legislators here today to look at our testimony

Since I came to college here in Montana I have met some amazing LGBT people. I have seen how the lack of protections effects them, from workplace harassment to terror over the possibility of losing their job. I ask this legislature not to step backwards, but to step forwards, and stand up for equality. ~~Please~~ *I ask this*  
*legislature*  
*Please*



**Women's Health After Abortion: The Medical and Psychological Evidence  
By Elizabeth Ring – Cassidy and Ian Gentles**

**The Impact of Abortion on Subsequent Pregnancies**

**Cervical damage and premature birth**

Obstetrics and Gynecology 1993 July; 82 (1): 88-91 p. 91

Zhou W, Sorensen HT, Olsen J, Induced Abortion and Subsequent Pregnancy Duration. Obstetrics and Gynecology 1999 Dec.; 94 (6): 948-53

Molin A. Risk of damage to the cervix by dilation for first trimester induced abortion by suction aspiration. Gynecologic and Obstetric Investigation 1993; 35 (3): 152-4

Journal of Reproductive Medicine 1989 August; 34 (8): 525-30 Radiological appearance of the upper cervical canal in women with history of premature delivery 11. Relationship to clinical presentation and to tests of cervical compliance.

Lumley J. The association between prior spontaneous abortion, prior induced abortion and preterm birth in first singleton births. Prenatal and Neonatal Medicine 1998; 3:21-24

**Placenta Previa**

Taylor VM, Kramer MD, Vaughan TL, Peacock S.: Placenta previa in relation to induced and spontaneous abortion: a population – based study. Obstetrics and Gynecology 1993 July; 82 (1): 88-91; p.91

**Cerebral Palsy**

Martin JA, Hamilton BE, Ventura SJ, Menacker F, Park MM, Sutton PD: Births: Final Data for 2001. National Vital Statistics Reports 2002 December 18; 51 (2)

**Ectopic Pregnancy**

Goldner TE, Lawson HW, Xia Z, Atrash HK. Surveillance for ectopic pregnancy—United States, 1970-1989. Morbidity and Mortality Weekly Report, Centers for Disease Control Surveillance Summary 1993 December; 42(ss-6): 73-85

## Top 10 Reasons Abortion is the Un-Choice

A pattern of injustices dressed up as “choice” ...

1. **The rhetoric of choice hides the reality of coercion.**
2. **Abortion is often someone else’s “choice.” 64% of American women who have had abortions felt pressured by others.<sup>1</sup>**
3. **Pressure is significant. Her “choices” may involve loss of home, family or essential support, or abuse that can escalate to violence.<sup>2</sup> Homicide is the leading killer of pregnant women.<sup>3</sup>**
4. **Coercion can take many forms, including undisclosed, misleading or false information about fetal development and alternatives.<sup>4</sup>**
5. **Even though the majority felt rushed and uncertain, 67% received no counseling; 79% were not told about alternatives.<sup>1</sup>**
6. **Abortion is often a woman’s last choice, but her abuser’s first choice.<sup>2</sup> Teens face an especially high risk for coercion.<sup>5</sup>**
7. **Many Americans who pushed family or friends to abort were also deceived – by experts, authorities or even pastors – about fetal development, alternatives and risks.<sup>4,6</sup>**
8. **The overall death rate of women rises 3.5 times after an abortion.<sup>7</sup> Suicide rates are 6 times higher after an abortion.<sup>8</sup>**
9. **65% report symptoms of Post-Traumatic Stress Disorder they attribute to their abortions.<sup>1</sup>**
10. **“We were maiming at least one woman a month.” – Carol Everett, former abortion clinic operator**

**It wasn’t safe. It wasn’t fair. It wasn’t about “choice.”**

**Learn more about abortion’s injustice and injury to women: [TheUnChoice.com](http://TheUnChoice.com)**

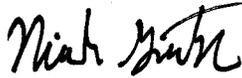
### Citations

1. 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.
2. See the special report, *Forced Abortion in America* at [www.theunchoice.com/Coerced.htm](http://www.theunchoice.com/Coerced.htm).
3. I.L. Horton and D. Cheng, “Enhanced Surveillance for Pregnancy-Associated Mortality-Maryland, 1993-1998,” *JAMA* 285(11): 1455-1459 (2001); J. Mcfarlane et. al., “Abuse During Pregnancy and Femicide: Urgent Implications for Women’s Health,” *Obstetrics & Gynecology* 100: 27-36 (2002).
4. Melinda Tankard-Reist, *Giving Sorrow Words* (Springfield, IL: Acorn Books, 2007).
5. Sobie & Reardon, “A Generation at Risk: How Pro-Abortionists Manipulate Vulnerable Teens,” *The Post-Abortion Review*, Vol. 8, No. 1, Jan-Mar. 2000.
6. Carol Everett with Jack Shaw, *Blood Money* (Sisters, OR: Multnomah Books, 1992). See also Pamela Zekman and Pamela Warwick, “The Abortion Profiteers,” *Chicago Sun Times* special reprint, Dec. 3, 1978 (originally published Nov. 12, 1978), p. 2-3, 33.
7. M Gissler et. al., “Pregnancy Associated Deaths in Finland 1987-1994 — definition problems and benefits of record linkage,” *Acta Obstetrica et Gynecologica Scandinavica* 76:651-657, 1997. See also, 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.
8. M. Gissler et. al., “Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000,” *European J. Public Health* 15(5):459-63, 2005; and M. Gissler, et. al., “Methods for identifying pregnancy-associated deaths: population-based data from Finland 1987-2000,” *Paediatric Perinatal Epidemiology* 18(6): 44855, Nov. 2004.

Dear Mr. Chairman and Members of the Committee,

My Name is Nicole Gratch and I support Bill 514. By rejecting this bill you entitle a group of people to determine whether or not they want to accept or not accept someone in regards to housing and employment on the basis of gender identity and sexual orientation. One might argue "where does it end." That argument makes me question what it would take to recognize the discrimination we endure. The act of filling out an application should be an exciting opportunity where in many cases such as my own it has turned into a fearful process. After applying for housing with my partner last year and, putting, two female names on a one bedroom application I recognized the protection I was not receiving from the state. The one perpetrating the discrimination is protected. Please understand by denying this bill many Montana citizens are hearing that the state does not care to protect them from discrimination. We deserve to feel safe. Thank you for this opportunity and your time.

Sincerely,

A handwritten signature in black ink that reads "Nicole Gratch". The signature is written in a cursive, flowing style.

Nicole Gratch

To: Representative Ken Peterson, Judiciary Committee Chairman  
From: Cindy Weese, YWCA Missoula Executive Director  
Date: February 17, 2011  
RE: HB516

As a member of the largest and oldest women's organization in the nation, the YWCA Missoula is adamantly opposed to HB516. The YWCA is dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all. In 2010, the YWCA Missoula joined as a proud supporter the efforts to pass an anti-discrimination ordinance that offers citywide protection from discrimination for all people, including members of the lesbian, gay, bisexual and transgender community in employment, housing and public accommodations. The ordinance is rooted in principles already laid out in the Montana Constitution, which says the dignity of the human being is "inviolable."

The ordinance is not a special interests issue, it is a human rights issue. With the passage of the ordinance, the citizens of Missoula took a stand against prejudice and discrimination that corrupts our humanity, erodes our integrity, and undermines the spirit of our community.

HB516 is an attempt to dismantle the Missoula ordinance, and prevent other communities from instituting community-wide polices that prohibit discrimination in all its forms. I urge the members of the committee to support and encourage the leadership of localities that promote and protect human rights by strongly opposing HB516.

Mr. Chairman and Members of the Committee:

I used to live in the City of Missoula but recently moved to the outskirts of town, still in Missoula County. My family grew up in town, using many of the activities that are available in the city/county area. Now, the Missoula City Ordinance on discrimination changes the old standard of gender to one of uncertainty and subjectivity. I am duly concerned that female members of my family will encounter men who claim to be "gender confused" in the women's dressing rooms, locker rooms and restrooms of the various recreation facilities and businesses we frequent. Irrespective of what proponent of the measure claim, it is unnatural and creates an atmosphere conducive to actions that could easily, and justifiably, be avoided. Additionally, the voters in Missoula were disregarded in their efforts to have a voice in the determination and such a matter should have been put to a vote of the people of Missoula.

I am also concerned that a law such as this could literally force churches to hire homosexuals and people with "gender-identity" issues. It also requires churches to provide the same services to homosexuals and gender-confused people that they provide to heterosexual people. Since the churches provides services for children and marriage and youth organizations, there is a requirement to force the churches to allow cross dressers, gender-modified, and others, including homosexuals, to work with our youth Sunday school, youth ministry and, likely, even in the nursery.

We do not believe that there should be different standards like this in every community across the state. This is a serious issue concerning families, churches and businesses in general. I strongly urge you to support HB 516 and maintain a statewide standard on discrimination.

Thank you.

Brad Tschida  
10825 Mullan Rd.  
(406) 546-4349  
[btschida54@hotmail.com](mailto:btschida54@hotmail.com)

**Steve Knight, LCSW  
101 E. Broadway, Suite 613  
Missoula, MT 59802  
(406) 543-3170**

---

February 18, 2011

Chairman Peterson and members of the committee, thank you for the opportunity to speak. I am against House Bill 516. This legislation would block local governments from making their own decisions. Is this the agenda of the MT GOP? State government stepping in to tell local government what they cannot do? Is this the agenda of House District 33? Did Havre and Western Hill County feel that local governments needed to be more closely monitored?

I don't believe the people of Havre and western Hill County want their legislator to represent the radical agenda of Dallas Erickson, who has tried every tactic possible to remove this ordinance from Missoula.

Yesterday I was perusing the MT GOP website and I found this quote from Rep. Kris Hansen, the sponsor of House Bill 516. She vowed to "present good legislation, defend against bad legislation, and vote for sound bills. I will work hard. I believe in solving problems and leaving well enough alone." The city council of Missoula passed an ordinance last year that solved a problem. I ask you, as members of this committee, to follow Rep. Hansen's own words, and leave well enough alone.

February 18, 2011

Mr. Chairman and Members of the Committee,

Montana Women Vote (MWV) would like to express our opposition to HB 516.

MWV is a coalition organization that works statewide to and engage women at all levels of our democracy. As an organization that is dedicated to the rights, safety, and full participation of women throughout Montana, we strongly oppose HB 516, sponsored by Rep. Hansen.

Montana Women Vote supports the Missoula Non-Discrimination Ordinance because it protects people who live, work, or visit the City of Missoula from discrimination in the areas of housing, employment, and public accommodations based on their sexual orientation and gender identity or expression. Our state office is located in Missoula and the ordinance provides necessary protections to our staff, supporters, and broader community.

Discrimination based on one's sexual orientation or gender identity was very real and documented in our community. As a community were identified this problem and as a community we were able to create policies that meet our needs in Missoula. We must ensure that Missoula and other municipalities across MT maintain their same ability to create public policies that meet the needs of their people.

Furthermore, as you are aware, violence against women in our society is a real issue and one that we hope policy makers and community members continue to address. Ordinances like this one, which offer protections to individuals who experience discrimination in society, help prevent violence against lesbians and transgender women.

We respectfully urge a NO vote on HB 516.

Sincerely,

Olivia Riutta  
[olivia@montanawomenvote.org](mailto:olivia@montanawomenvote.org)  
(406) 543-3550

Written Testimony in Opposition of HB 516 and in Support of HB 514

February 18, 2011

Submitted by:

Kelly McGuire  
Volunteer, Forward Montana Foundation  
500 N. Higgins Ave Suite 107  
Missoula, MT 59802

Chairman Peterson and Members of the House Judiciary Committee:

My name is Kelly McGuire, and I live in Missoula. I am speaking on behalf of Forward Montana Foundation, where I am a volunteer. Forward Montana Foundation is a non-partisan grassroots organization that trains, mobilizes, and educates a new generation of progressive leaders for Montana.

Last spring, Forward Montana Foundation gathered 1700 signatures in support of Missoula's equality ordinance, which prohibits discrimination based on sexual orientation or gender identity.

After three months of grassroots organizing, hundreds of Missoulians stood in solidarity on April 12 to celebrate Missoula's first annual Diversity Day, in honor of the ordinance. We marched together on the City Council Chambers in a show of support for equal rights for everyone in our community.

That city council meeting drew the largest crowd in at least 30 years, according to one longtime city official. That night, after five and a half hours of testimony, our City Council passed Montana's first city ordinance to extend equal rights and protections to the LGBT community.

That day was a proud day for me and for thousands of other Missoulians. We stood up for what was right, regardless of whether we were personally impacted by the ordinance or not – because we care about everyone in our community. Countless volunteers put their time and energy into getting this ordinance passed, and the majority of Missoulians have expressed their support for the ordinance. It would be a disgrace to pass this bill and nullify an ordinance that brought our community together in such a powerful way.

Whether or not you agree with everyone's lifestyle, whether or not you think that being gay or transgendered is acceptable, we should all be able to agree that *no person deserves to be harassed, fired or evicted based on their appearance or their personal relationships*. I hope that you will join me and Forward Montana in opposing HB 516, and in supporting HB 514, which would extend these equal rights to all Montanans.

**Written Testimony in Opposition of HB 516**

February 18, 2011

Submitted by:

Melissa Fisher

915 Rollins #1

Missoula, MT 59801

Dear Chairman Peterson and Members of the House Judiciary Committee:

My name is Melissa Fisher. I was born and raised in Helena. I graduated from Capital High School in 1996. I'm a 4<sup>th</sup> generation Montanan, I come from a military family, and I've lived in Montana 23 of my 32 years. This is my home.

I slowly started "coming out" to close friends nine years ago, when I was working at The Friendship Center here in Helena. This was a slow and painful process for me, and, at that time, I didn't feel safe or comfortable being totally "out" in Helena. Because of this, in 2005, I decided to leave my beloved Montana and move to Seattle, where I knew I'd find a community more accepting of me, where I could learn to be more accepting of myself. In 2007, I graduated with honors from the University of Washington with a Master's Degree in Public Administration.

In 2010, I realized that my love for Montana is greater than my fear of , so I decided to return home. My fear of being "out" – of being who I am - kept me away from Montana for five years, but I returned because I know I belong here.

Before I moved back last fall, Missoula passed its anti-discrimination ordinance. I am tremendously grateful for, and inspired by the efforts of everyone who helped bring safety and respect to the LGBTQ community in Missoula. The ordinance was a very big part of why, when I decided to move home to Montana, I chose Missoula instead of my hometown of Helena.

Because of the anti-discrimination ordinance, Missoula is a place in Montana where I can be myself, a little bit safer, a little bit freer. When I started my new job in December, I felt safe coming out to my boss and co-workers. I didn't have to be afraid that I might lose my new job because I am queer, and I didn't have to hide who I am. And because the issue of LGBTQ equality has been discussed on such a public community forum in Missoula, I have been able to have meaningful and informed conversations with my new co-workers, friends and neighbors about what it means to be "out" in Montana, and what it means to be treated with simple, basic respect. Please don't take this away from me.

During the five years I spent in Seattle, I talked endlessly about Montana – the beauty, the mountains. And the people. I talked about how Montanans are GOOD are to one another. How Montanans RESPECT and VALUE one another. Please, don't prove me wrong – join me in opposing HB 516.

Sincerely,



Melissa Fisher

Carissa Spurzem  
802 Laurel St  
Helena, MT 59601

Chairman Peterson & Judiciary Committee members:

I am writing in opposition to HB 516. I am here as an ally of the LGBT community. I was in Missoula when the ordinance was passed and was in awe of the support and love from the community. The voice of Missoula was heard. The cities have this right now and do not need this changed. Their voices have been heard and need to be respected.

The cities in Montana must have the opportunity to protect the LGBT community and all other communities that are not covered under the Human Rights Act. Please do not take this right away from them.

Please vote no on HB 516 and keep this protection in place and allow other cities to have their say and their voices to be heard.

Thanks for your time.

Re: HB 516

Dear Members of House Judiciary Committee:

Upon hearing of this bill, I instantly became disheartened, frustrated and ultimately shocked. The passage of this ordinance in Missoula brought hope and comfort in a world where the LGBT community is so often targeted. I typically feel pretty safe in my community. However, there was one instance in which I feared for my safety and well being. It was shortly after 11pm and I had just gotten home from work. I was going to meet a few friends downtown. I only live 4 or 5 blocks from the area so I started walking. As I said previously, I usually feel pretty safe walking around by myself. I was standing on the corner of Higgins and Broadway waiting for the light to change so I could cross the street. All of a sudden a very large truck full of men drove by me and belligerently shouted at me and called me a "fucking faggot". It was the first time I truly felt fear simply for being gay. I didn't know if they were going to stop and physically attack me or not. I couldn't even look up to see what kind of truck it was. I had to get a ride home that evening. I suddenly didn't feel safe anymore. It was an awful feeling that I don't ever want to experience again. Nobody should have to.

These incidences happen all the time. The protections put forth by the ordinance in Missoula are one way we can feel just a little bit safer in our community where we simply want to live our lives in peace. Please don't take that away from us. I implore you to vote against this bill.

Thank you for your time and consideration,

Kim Leighton



February 18, 2011

Mr. Chairman, Members of the Committee:

For the record, my name is Molly Severtson (SEVERTSON), and I'm here today representing The Policy Institute, a nonprofit organization here in Helena. Our mission is to promote public policy based on economic justice, fair taxation, environmental responsibility and corporate accountability. We are a sister organization of the Montana Human Rights Network.

I rise today in solidarity with my LGBT neighbors, friends and family members in opposition to HB 516 and in support of the idea that special ordinances, resolutions and policies that are enacted in communities across our state are often necessary to protect the rights of those not covered in the Montana Human Rights Act.

It is especially offensive to me that HB 516 would retroactively repeal the Missoula Nondiscrimination Ordinance that was passed last spring as a result of the hard work of so many who are here today.

I urge a no vote on HB 516.

Thank you very much,

Molly Severtson  
Interim Director  
The Policy Institute

Feb 18, 2011

Montana House Judiciary Committee

Re: HB 514 I strongly oppose this bill.

Mr. Chair and Members of the Committee:

You cannot consider taking fundamental rights away from residents of this state without allowing the public to speak. It is unacceptable to conduct the people's business in this manner.

Sincerely,

A handwritten signature in black ink, consisting of a stylized 'A' followed by a long horizontal flourish.

Ashley Duncan

Feb 18, 2011

Montana House Judiciary Committee

Re: HB 516

*Please oppose this bill!!*

Mr. Chair and Members of the Committee:

You cannot consider taking fundamental rights away from residents of this state without allowing the public to speak. It is unacceptable to conduct the people's business in this manner.

Sincerely,

*Susan E. Duran*

2/18/2011

To All Members of the House Judiciary Committee

Montana State Legislature

Helena, MT

Honorable Representatives;

In case you haven't heard – there's a major recession in Montana and across the nation. Business are doing all they can to stay afloat. Such is my case. I am part of a small family corporation that owns a farm in Teton County and two motels in Missoula.

Missoula recently passed an "Anti-Discrimination" city ordinance which puts all business owners in a very precarious position. If we terminate an employee, who happens to decide they are "gender-confused" or if we don't hire interviewees who are cross dressers, we are liable for a lawsuit because we discriminated according to this Missoula City Ordinance.

Employers need to retain the freedom to hire whom they so desire. It is one more anti-business strategy implemented by the Missoula City Council. And it could happen anywhere in Montana, should other cities decide to pass similar ordinances.

Please vote to support HB 516. It will remove a noose from the neck of business owners.

Sincerely,

Sonya Quackenbush

6610 Linda Vista Blvd.

Missoula, MT 59803

To: Representative Ken Peterson, Judiciary Committee Chairman  
From: Cindy Weese, YWCA Missoula Executive Director  
Date: February 17, 2011  
RE: HB516

As a member of the largest and oldest women's organization in the nation, the YWCA Missoula is adamantly opposed to HB516. The YWCA is dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all. In 2010, the YWCA Missoula joined as a proud supporter the efforts to pass an anti-discrimination ordinance that offers citywide protection from discrimination for all people, including members of the lesbian, gay, bisexual and transgender community in employment, housing and public accommodations. The ordinance is rooted in principles already laid out in the Montana Constitution, which says the dignity of the human being is "inviolable."

The ordinance is not a special interests issue, it is a human rights issue. With the passage of the ordinance, the citizens of Missoula took a stand against prejudice and discrimination that corrupts our humanity, erodes our integrity, and undermines the spirit of our community.

HB516 is an attempt to dismantle the Missoula ordinance, and prevent other communities from instituting community-wide polices that prohibit discrimination in all its forms. I urge the members of the committee to support and encourage the leadership of localities that promote and protect human rights by strongly opposing HB516.

## STATEMENT OF CARSON TAYLOR IN OPPOSITION TO HB 516

I am unable to attend the House Judiciary Committee hearing on HB 516 and submit this statement instead of my testimony.

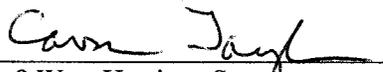
I am a City Commissioner in Bozeman, I teach at Montana State University, and I was a School Board member in Bozeman for 8 ½ years prior to beginning on the City Commission. I only speak for myself, but I have stated the above because I believe that my experience demonstrates the likelihood that I know and understand the culture of Bozeman and the will of its citizens. We are a welcoming community. Our different governmental bodies have from time to time passed resolutions condemning hate literature and acts of violence against various groups, and we have passed resolutions demonstrating acceptance and tolerance of a diverse set of people. In fact, we know that diversity in citizenship makes a better community for all.

The welcoming approach has worked for us and there are few that are not proud of our community. In 2010, our City Commission passed an Ordinance stating that we would not discriminate in our (City's) employment practices against persons on the ground of their sexual orientation. We did this because we felt that it is the right thing to do, and because we want to attract the most competent employees to our city. The right to set employment practices for city government ought to rest in the hands of each community, because each community knows what is best for itself. The State ought not to interfere in this area.

Several years ago, our school district passed a motion that stated that it is the policy of the district to not discriminate against students on the ground of sexual orientation. This policy was received with little fanfare and has made a statement which students and school employees ought to follow. Such statements of non-discrimination ought reside in the sound discretion of the local governmental bodies that wish to enact them.

From a policy perspective it should not escape the legislature that, just as Montanans resent and deny the federal government's right, or lack thereof, to interfere in the running of our state, local governments will resent unnecessary intervention from the State. If Bozeman was trying to force other local entities to adopt its philosophy of welcoming all, then the State might intervene. Of course, that is not happening. Instead and in reality the morality of some legislators is being forced on Bozeman. I urge you to let us, and other like-communities, make our own decisions. Trust that we do know what is best for us.

If the above argument does not sway you, consider the can of worms that you will open regarding veteran's who have certain employment preferences, but who are not a protected class. HB 516 clearly prevents local governments from going any further than state law regarding veterans. Further, the proposed statute will generate useless and expensive litigation as to the power of the State to intervene in the self government of local cities with a charter form of government, all at the taxpayers' expense.

  
8 West Harrison Street  
Bozeman, MT 59715

February 17, 2011

# Forced Abortion in America

## Unwanted abortions and other risks and human rights abuses

### The Un-Choice:

- 64% of women reported feeling pressured to abort.<sup>1</sup>
- 79% weren't told of available resources.<sup>1</sup>
- Pressure to abort can escalate to violence.<sup>2</sup>
- Clinics fail to screen for coercion.<sup>4</sup>
- Suicide rates 6 times higher after abortion.<sup>6</sup>
- Most felt rushed or uncertain, yet 67% weren't counseled.<sup>1</sup>
- 84% weren't sufficiently informed before abortion.<sup>1</sup>
- Homicide is the leading killer of pregnant women.<sup>3</sup>
- Women nearly 4 times more likely to die after abortion.<sup>5</sup>
- 65% of women suffer trauma symptoms after abortion.<sup>1</sup>

### Unwanted Choice: Most abortions are unwanted or coerced. Many are forced.

Most abortions are unwanted or coerced and many are forced, sometimes violently. Escalating pressure to abort can come from employers, husbands, parents, doctors, partners, profit-driven abortion businesses, landlords, friends and family, or even trusted financial, personal, school or religious guides, gatekeepers or authorities. They may be negligent in telling young or vulnerable individuals or couples about available resources. They may misrepresent information or present false information as fact. They may threaten or blackmail.

These are not idle threats. Coercion can escalate to violence. As this report shows, women who resist abortion have been beaten, tortured and killed. Some have been forcibly injected with drugs, secretly given veterinary or other abortifacient drugs to force a miscarriage. Others were the victim of hit men hired to injure or kill the baby, the mother, or both.

Sometimes, the threats involve blackmail or loss of one's home or job, or the exploitation of those facing a crisis. In one case, an employer threatened to push his pregnant employee down the stairs if she didn't agree to have an abortion. In another case, a maternity-shop retailer fired pregnant employees. In yet another, a homeless woman was denied shelter until she agreed to an abortion. Often, such pressure comes from all sides and can escalate.

### Coerced Choice ... Taken to the Clinic to Make Sure She Keeps the Appointment

A former abortion clinic security guard testified before the Massachusetts legislature that women were routinely threatened and abused by the boyfriends or husbands who took them to the clinics to make sure they underwent their scheduled abortions.<sup>7</sup> Many women are also pressured by clinic staff financially rewarded for selling abortions.<sup>8</sup>

### Forced Choice ... Threats Can Escalate to Violence or Homicide — the Leading Killer of Pregnant Women

Many pregnant women have been killed by partners trying to prevent the birth. Simply being pregnant places women at higher risk of being attacked.<sup>9</sup> Homicide is the leading cause of death among pregnant women.<sup>3</sup> Women are aware of these risks. 92% of women surveyed list domestic violence and assault as the women's issue that is of highest concern to them.<sup>10</sup>

### Uninformed Non-Choice ... "When I learned the truth, I can't tell you how betrayed I felt."

- 54% were unsure of their decision, yet 67% received no counseling beforehand.<sup>1</sup>
- 84% were inadequately counseled beforehand.<sup>1</sup> 79% not told or deceived about available resources.<sup>1</sup>
- Many were misinformed by experts about fetal development, abortion alternatives or risks.<sup>11</sup>
- Many were denied essential personal, family, societal or economic support.<sup>11</sup>

### Unsafe Choice ... Americans Concerned About Coercion and Risks; Support Research and Screening.

Nearly half of voters believe coerced abortion is common. They believe negative effects are more common than generally reported. They'll support candidates who advocate legislation holding abortionists liable for failing to screen for evidence of coercion.<sup>12</sup> Nearly 80% of abortions take place in non-hospital facilities, ill-equipped for emergency care.<sup>13</sup>

- 31% had health complications afterwards.<sup>1</sup>
- 65% higher risk of clinical depression.<sup>14</sup>
- 3.5x higher risk of death from all causes.<sup>5</sup>
- 65% suffer multiple symptoms of post-traumatic stress disorder.<sup>1</sup>
- 10% have immediate complications, some are life-threatening.<sup>15</sup>
- Suicide rates are 6 times higher if women abort vs. giving birth.<sup>6</sup>

## Learn More

Download the special report, *Forced Abortion in America*, at [www.theunchoice.com/ForcedAbortions.pdf](http://www.theunchoice.com/ForcedAbortions.pdf)

## Citations

1. 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).
2. See the [www.theunchoice.com](http://www.theunchoice.com) for further information and cases.
3. I.L. Horton and D. Cheng, "Enhanced Surveillance for Pregnancy-Associated Mortality-Maryland, 1993-1998," *JAMA* 285(11): 1455-1459 (2001); see also J. McFarlane et. al., "Abuse During Pregnancy and Femicide: Urgent Implications for Women's Health," *Obstetrics & Gynecology* 100: 27-36 (2002).
4. See [stopforcedabortions.com](http://stopforcedabortions.com).
5. M Gissler et. al., "Pregnancy Associated Deaths in Finland 1987-1994 -- definition problems and benefits of record linkage," *Acta Obstetrica et Gynecologica Scandinavica* 76:651-657, (1997). 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. DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women," *Southern Medical Journal* 95(8):834-41, (2002).
6. M Gissler et. al., "Pregnancy Associated Deaths in Finland 1987-1994 -- definition problems and benefits of record linkage," *Acta Obstetrica et Gynecologica Scandinavica* 76:651-657 (1997); and M. Gissler, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European J. Public Health* 15(5):459-63 (2005).
7. Brian McQuarrie, "Guard, clinic at odds at abortion hearing," *Boston Globe*, April 16, 1999.
8. Carol Everett with Jack Shaw, *Blood Money* (Sisters, OR: Multnomah Books, 1992). See also Pamela Zekman and Pamela Warwick, "The Abortion Profiteers," *Chicago Sun Times* special reprint, Dec. 3, 1978 (originally published Nov. 12, 1978), p. 2-3, 33.
9. Julie A. Gazmararian et al., "The Relationship Between Pregnancy Intendedness and Physical Violence in Mothers of Newborns," *Obstetrics & Gynecology*, 85:1031 (1995); Hortensia Amaro et al., "Violence During Pregnancy and Substance Use," *American Journal of Public Health*, 80: 575 (1990); and J. McFarlane et al., "Abuse During Pregnancy and Femicide: Urgent Implications for Women's Health," *Obstetrics & Gynecology*, 100: 27, 27-36 (2002).
10. "Is Your Mother's Feminism Dead? New Agenda for Women Revealed in Landmark Two-Year Study," press release from the Center for the Advancement of Women ([www.advancewomen.org](http://www.advancewomen.org)), June 24, 2003; and Steve Ertelt, "Pro-Abortion Poll Shows Majority of Women Are Pro-Life," *LifeNews.com* ([www.lifenews.com/nat13.html](http://www.lifenews.com/nat13.html)), June 25, 2003.
11. See Theresa Burke, *Forbidden Grief: The Unspoken Pain of Abortion* (Springfield, IL: Acorn Books, 2000) and [www.theunchoice.com](http://www.theunchoice.com).
12. "National Opinion Survey of 600 Adults Regarding Attitudes Toward a Pro-Woman/Pro-Life Agenda," proprietary poll commissioned by the Elliot Institute, conducted in Dec. 2002.
13. D. Reardon, *Abortion Malpractice* (Denton, TX: Life Dynamics, 1993)
14. JR Cogle, DC Reardon & PK Coleman, "Depression Associated With Abortion and Childbirth: A Long-Term Analysis of the NLSY Cohort," *Medical Science Monitor* 9(4):CR105-112, 2003.
15. Frank, et.al., "Induced Abortion Operations and Their Early Sequelae," *Journal of the Royal College of General Practitioners* 35(73):175-180, April 1985; Grimes and Cates, "Abortion: Methods and Complications", in *Human Reproduction*, 2nd ed., 796-813; M.A. Freedman, "Comparison of complication rates in first trimester abortions performed by physician assistants and physicians," *Am. J. Public Health* 76(5):550-554, 1986).

## Recent Research

### Abortion's Harm to Women

---

- 1. 62% Higher Risk of Death from All Causes, 2.5 Times Higher Risk of Suicide**

Compared to women who give birth, women who abort have an elevated risk of death from all causes, which persists for at least eight years. Higher risk of death from suicide and accidents were most prominent. Projected on the national population, this effect may contribute to 2,000 - 5,000 more deaths among women each year.<sup>1</sup>

Southern Medical Journal, 2002
- 2. 3.5 Times Higher Death Rates from Suicide, Accidents, Homicides (Suicide 6 Times Higher)**

Researchers examining deaths among the entire population of women in Finland found that those who had abortions had a 3.5 times higher death rate from suicide, accidents, or homicides in the following year. Suicide rates among aborting women were six times higher compared to women who gave birth and two times higher compared to women who miscarried.<sup>2</sup>

European Journal of Public Health, 2005
- 3. Abortion Deaths Underreported on Death Certificates**

A study of medical records in Finland found that 94 % of maternal deaths associated with abortion are not identifiable from death certificates alone. The researchers found that linking death certificates to medical records showed that the death rate associated with abortion is three times higher than that associated with childbirth.<sup>3</sup>

Paediatric Perinatal Epidemiology, 2004
- 4. 65% Suffered Trauma, 31% Had Health Complications**

In this study comparing American and Russian women who had experienced abortion, 65% of American women studied experienced multiple symptoms of post-traumatic stress disorder (PTSD), which they attributed to their abortions. Slightly over 14% reported all the symptoms necessary for a clinical diagnosis of abortion induced-PTSD, and 84% said they did not receive adequate counseling. 31% had health complications afterwards.<sup>4</sup>

Medical Science Monitor, 2004
- 5. 64% Involve Coercion, 84% Not Fully Informed**

In the above study comparing American and Russian women who had experienced abortion, 64% of American women reported that they felt pressured by others to abort. 84% said they did not receive adequate counseling.<sup>5</sup>

Medical Science Monitor, 2004
- 6. Abortion Linked to Wide Range of Mental Health Disorders**

A survey of 5,877 women found that women who had abortions were at higher risk for various mental health disorders. Researchers studied 15 different mental health problems, including anxiety disorders (panic disorder, panic attacks, agoraphobia, post-traumatic stress disorder), mood disorders (bipolar disorder, mania, major depression) and substance abuse disorders. Abortion made a significant contribution for 12 out of the 15 disorders studied.<sup>6</sup>

Journal of Psychiatric Research, 2008
- 7. 30% Higher Risk of Mental Health Problems After Abortion; Abortion Offers No Benefits**

An ongoing survey of women in New Zealand found that women were 30 percent more likely to experience substance abuse, suicidal thoughts, anxiety disorders and major depression after abortion than after other pregnancy outcomes. No increase in mental health risks was found among women who continued an unplanned pregnancy, and the researchers said there was no evidence abortion offered any mental health benefits to women.<sup>7</sup>

British Journal of Psychiatry, 2008

continued ▶

8. **Higher Rates of Depression, Substance Abuse, Suicidal Behavior After Abortion**

In a New Zealand study, women who had abortions subsequently experienced higher rates of substance abuse, anxiety disorders, and suicidal behavior than women who had not had abortions, even after controlling for pre-existing conditions. Approximately 42% of women with a history of abortion had experienced major depression in the last four years (nearly double the rate of women who had not been pregnant and 35% higher than those who carried to term).<sup>8</sup>

**Journal of Child Psychology and Psychiatry, 2006**
9. **Significantly Higher Risk of Clinical Depression**

Compared to women who carry their first unintended pregnancies to term, women who abort their first pregnancies are at significantly higher risk of clinical depression as measured an average of eight years after their first pregnancies.<sup>9</sup>

**British Medical Journal, 2002**
10. **65% Higher Risk of Clinical Depression**

Analysis of a federally funded longitudinal study of American women revealed that, compared to women who gave birth, women who aborted were 65% more likely to be at risk of long-term clinical depression after controlling for age, race, education, marital status, history of divorce, income, and prior psychiatric state.<sup>10</sup>

**Medical Science Monitor, 2003**
11. **30% Higher Risk of Generalized Anxiety Disorder**

Researchers compared women who had no prior history of anxiety and who had experienced a first, unintended pregnancy. Women who aborted 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.<sup>11</sup>

**Journal of Anxiety Disorders, 2005**
12. **Five Times Higher Risk of Substance Abuse**

Women who abort are five times more likely to report subsequent drug or alcohol abuse than women who deliver.<sup>12</sup>

**American Journal of Drug and Alcohol Abuse, 2000**
13. **Unintended First Pregnancies: Increased Substance Abuse if Women Abort**

Among women who had unintended first pregnancies, those who had abortions were more likely to report, an average of four years later, more frequent and recent use of alcohol, marijuana, and cocaine than women who gave birth. This is the first study to compare substance abuse rates among women who had unintended pregnancies.<sup>13</sup>

**American Journal of Drug and Alcohol Abuse, 2004**
14. **Nearly Twice as Likely to Be Treated for Sleep Disorders, Which Are Often Trauma-Related**

In a record based study of nearly 57,000 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. Aborting women were nearly twice as likely to be treated for sleep disorders in the first 180 days after the pregnancy ended compared to delivering women. Numerous studies have shown that trauma victims will often experience sleep difficulties.<sup>14</sup>

**Sleep, 2006**
15. **Records-Based Study Indicates More Outpatient Psychiatric Care**

Analysis of California Medicaid records shows that women who have abortions subsequently require significantly more treatments for psychiatric illness through outpatient care.<sup>15</sup>

**American Journal of Orthopsychiatry, 2002**
16. **160% More Likely to be Hospitalized for Psychiatric Treatment**

A review of the medical records of 56,741 California Medicaid patients revealed that women who had abortions were 160% more likely than delivering women to be hospitalized for psychiatric treatment in the first 90 days following abortion or delivery. Psychiatric treatment rates remained significantly higher for at least four years.<sup>16</sup>

**Canadian Medical Association Journal, 2003**

17. **Abortion Increases Risk of Domestic Violence, Relationship Problems for Both Women and Men**  
Compared to those with no history of abortion, both women and men who had an abortion with their current partner were more likely to report domestic violence, arguing about children and feeling that their lives would be better if the relationship ended. Women who had an abortion with their current partner reported more arguments about money and relatives, and were more likely to experience sexual dysfunction after abortion with a current or previous partner. Men reported more problems with jealousy and drug use after abortion with a current or previous partner.<sup>17</sup>  
Public Health, 2009
18. **Father's Role Significant in Deciding Pregnancy Outcome; Abortion Linked to Later Problems**  
A survey of low-income women who had a previous child found that women who felt they could not rely on their partner to help in caring for the child were more likely to have an abortion. Women who had an abortion were more likely to report subsequent violence by their partner and to report heavy alcohol abuse (three times more likely) and cigarette smoking (twice as likely).<sup>18</sup>  
International Journal of Mental Health & Addiction, 2008
19. **Screening for Known Risk Factors Would Dramatically Reduce Abortions**  
This study is an analysis of 63 medical studies that identify risk factors that predict negative psychological reactions to abortion. The review concludes that the number of women suffering from negative emotional reactions to abortion could be dramatically reduced if abortion clinics screened women for these risk factors.<sup>19</sup>  
The Journal of Contemporary Health Law and Policy, 2004
20. **Subsequent Children Are Negatively Affected**  
The children of women who had abortions have less supportive home environments and more behavioral problems than children of women without a history of abortion. This finding supports the view that abortion may negatively affect bonding with subsequent children, disturb mothering skills, and otherwise impact a woman's psychological stability.<sup>20</sup>  
Journal of Child Psychology and Psychiatry, 2002
21. **Drug Abuse During Subsequent Pregnancies Five Times More Likely**  
Among women delivering their first pregnancy, women with a history of abortion are five times more likely to use illicit drugs and two times more likely to use alcohol *during* their pregnancies. This substance use places their unborn children at risk of birth defects, low birth weight, and death.<sup>21</sup>  
American Journal of Obstetrics and Gynecology, Dec. 2002
22. **Increased Smoking and Drug Abuse During Subsequent Pregnancies**  
A study of women who had just given birth found that compared to women who had experienced other types of pregnancy loss or had never had an abortion, women who had previously had an abortion are more likely to smoke, drink alcohol, or use marijuana, cocaine, or other illegal drugs during pregnancy.<sup>22</sup>  
British Journal of Health Psychology, 2005
23. **95% Want To Be Fully Informed of All Statistically Associated Risks**  
Women considering elective surgery, such as abortion, consider all information about physical or psychological risks to be very relevant to their decisions. 95% of patients wished to be informed of all risks statistically associated with a procedure, even if the causal connection between the procedure and risk has not been fully proven.<sup>23</sup>  
Journal of Medical Ethics, 2006
24. **Teens Have More Mental Health Problems After Abortion, Even With Unplanned Pregnancies**  
A nationally representative study found that teen girls who abort unintended pregnancies are five times more likely to seek subsequent help for psychological and emotional problems compared to their peers who carry unintended pregnancies to term. Teens who aborted were also three times more likely to report having trouble sleeping and nine times more likely to report subsequent marijuana use.<sup>24</sup>  
Journal of Youth & Adolescence, 2006

## 25. Abortion Increases Risk of Later Miscarriage by 60%

Researchers in the U.K. surveyed women ages 18 to 55 about their reproductive histories, life-styles and relationships and found that women who had a previous abortion had a 60% higher risk of miscarriage during a later pregnancy.<sup>25</sup>

BJOG: An International Journal of Obstetrics & Gynecology, 2006

The Elliot Institute was involved in many of the studies listed above. For more information, visit [www.TheUnChoice.com](http://www.TheUnChoice.com).

### Citations

1. 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.
2. M. Gissler et. al., "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European J. Public Health* 15(5):459-63, 2005.
3. M. Gissler, et. al., "Methods for identifying pregnancy-associated deaths: population-based data from Finland 1987-2000," *Paediatric Perinatal Epidemiology* 18(6): 448-55, Nov. 2004.
4. 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.
5. Ibid.
6. PK Coleman et. al., "Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of abortion in the national comorbidity survey," *Journal of Psychiatric Research* doi:10.1016/j.psychires.2008.10.009, 2008.
7. DM Fergusson et. al., "Abortion and mental health disorders: evidence from a 30-year longitudinal study," *The British Journal of Psychiatry*, 193: 444-451, 2008.
8. DM Fergusson, et. al., "Abortion in young women and subsequent mental health," *Journal of Child Psychology and Psychiatry* 47(1):16-24, 2006.
9. DC Reardon, JR Cogle, "Depression and Unintended Pregnancy in the National Longitudinal Survey of Youth: A Cohort Study," *British Medical Journal* 324:151-2, 2002.
10. JR Cogle, DC Reardon & PK Coleman, "Depression Associated With Abortion and Childbirth: A Long-Term Analysis of the NLSY Cohort," *Medical Science Monitor* 9(4):CR105-112, 2003.
11. JR Cogle, DC Reardon, PK Coleman, "Generalized Anxiety Following Unintended Pregnancies Resolved Through Childbirth and Abortion: A Cohort Study of the 1995 National Survey of Family Growth," *Journal of Anxiety Disorders* 19:137-142, 2005.
12. DC Reardon, PG Ney, "Abortion and Subsequent Substance Abuse," *American Journal of Drug and Alcohol Abuse* 26(1):61-75, 2000.
13. D.C. Reardon, P.K. Coleman, and J.R. Cogle, "Substance use associated with unintended pregnancy outcomes in the National Longitudinal Survey of Youth," *American Journal of Drug and Alcohol Abuse* 26(1):369-383, 2004.
14. DC Reardon and PK Coleman, "Relative Treatment Rates for Sleep Disorders and Sleep Disturbances Following Abortion and Childbirth: A Prospective Record Based-Study," *Sleep* 29(1):105-106, 2006.
15. PK Coleman et. al., "State-Funded Abortions Versus Deliveries: A Comparison of Outpatient Mental Health Claims Over Four Years," *American Journal of Orthopsychiatry* 72(1):141-152, 2002.
16. DC Reardon et. al., "Psychiatric Admissions of Low-Income Women Following Abortions and Childbirth," *Canadian Medical Association Journal* 168(10), 2003.
17. P.K. Coleman, V.M. Rue, C.T. Coyle, "Induced abortion and intimate relationship quality in the Chicago Health and Social Life Survey," *Public Health* (2009), doi:10.1016/j.puhe.2009.01.005.
18. PK Coleman et. al., "Predictors and Correlates of Abortion in the Fragile Families and Well-Being Study: Paternal Behavior, Substance Abuse and Partner Violence," *International Journal of Mental Health and Addiction*, DOI 10.1007/s11469-008-9188-7, 2008.
19. DC Reardon, "The Duty to Screen: Clinical, Legal, and Ethical Implications of Predictive Risk Factors of Post-Abortion Maladjustment," *The Journal of Contemporary Health Law and Policy* 20(2):33-114, Spring 2004.
20. PK Coleman, DC Reardon, & JR Cogle, "The Quality of the Caregiving Environment and Child Developmental Outcomes Associated with Maternal History of Abortion Using the NLSY Data," *Journal of Child Psychology and Psychiatry* 43(6):743-57, 2002.
21. PK Coleman et. al., "A History of Induced Abortion in Relation to Substance Abuse During Subsequent Pregnancies Carried to Term," *American Journal of Obstetrics and Gynecology* 167:3-8, Dec. 2002.
22. PK Coleman, DC Reardon, JR Cogle, "Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy," *British Journal of Health Psychology* 10, 255-268, 2005.
23. PK Coleman, DC Reardon, MB Lee, "Women's preferences for information and complication seriousness ratings related to elective medical procedures," *Journal of Medical Ethics*, 32:435-438, 2006.
24. PK Coleman, "Resolution of Unwanted Pregnancy During Adolescence Through Abortion Versus Childbirth: Individual and Family Predictors and Psychological Consequences," *Journal of Youth and Adolescence* (2006).
25. N. Maconochie, P. Doyle, S. Prior, R. Simmons, "Risk factors for first trimester miscarriage—results from a UK-population-based case-control study," *BJOG: An International Journal of Obstetrics & Gynaecology*, Dec 2006. Abstract available at [www.blackwell-synergy.com](http://www.blackwell-synergy.com).

## Psychological Risks Traumatic Aftereffects of Abortion

---

### Suicide

- **6 times higher suicide rate.** Two national records-based studies from Finland revealed that aborting women were 6 times more likely to commit suicide in the following year than were delivering women.<sup>1</sup>
- **Up to 60% have suicidal thoughts.** According to a recent study in a major scientific journal, 31% had thoughts of suicide after abortion. 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.<sup>2</sup>
- **154% higher risk of suicide.** Another study of more than 173,000 American women who had abortions or carried to term found that, during the eight years after the pregnancy ended, women who aborted had a 154% higher risk of suicide than women who carried to term.<sup>3</sup>
- **Higher suicide risks for teens.** Teen girls are 6 times more likely to attempt suicide if they have had an abortion in the last six months than girls who have not had an abortion, and 2-4 times more likely to commit suicide after abortion compared to adult women.<sup>4</sup>

### Depression

- **65% higher risk of clinical depression.** A longitudinal study of American women revealed that those who aborted were 65% more likely to be at risk of long-term clinical depression after controlling for age, race, education, marital status, history of divorce, income, and prior psychiatric state.<sup>5</sup>
- **Depression risk remained high, even when pregnancies were unplanned.** Among a national sample of women with unintended first pregnancies, aborting women were at significantly higher risk of long-term clinical depression compared to delivering women.<sup>6</sup>

### Trauma

- **65% report symptoms of post-traumatic stress disorder.** In a study of U.S. and Russian women who had abortions, 65% of U.S. women 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, and 25% said they did not receive adequate counseling. 64% said they felt pressured by others to abort.<sup>7</sup>
- **60% said they felt "part of me died."** In the above study, 60% of American women reported that they felt "part of me died" after their abortions.<sup>7</sup>
- **Twice as likely to be hospitalized.** Compared to women who deliver, women who abort are more than twice as likely to be subsequently hospitalized for psychiatric illness within six months.<sup>8</sup>
- **More outpatient psychiatric care.** Analysis of California Medicaid records shows that women who have abortions subsequently require significantly more treatments for psychiatric illness through outpatient care.<sup>9</sup>
- **Multiple disorders and regrets.** A study of post-abortion patients only 8 weeks after their abortions found that 44% reported nervous disorders, 36% experienced sleep disturbances, 31% had regrets about their decision, and 11% had been prescribed psychotropic medicine by their family doctor.<sup>10</sup>
- **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.<sup>11</sup>

continued ►

- **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.<sup>12</sup>
- **Disorders not pre-existing.** In a New Zealand study, 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.<sup>13</sup>

#### Eating disorders & substance abuse

- **39% had eating disorders.** In a survey of women with post-abortion problems, 39% reported subsequent eating disorders.<sup>14</sup>
- **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.<sup>15</sup>
- **Substance abuse during subsequent pregnancies.** Among women giving birth for the first time, women with a history of abortion are five times more likely to use drugs, twice as likely to use alcohol, and ten times more likely to use marijuana *during* their pregnancy, compared to women who have not had an abortion.<sup>16</sup>
- **Alcohol abuse linked to other problems.** Alcohol abuse after abortion has been linked to violent behavior, divorce or separation, auto accidents, and job loss.<sup>17</sup>

#### Coercion, guilt, repressed grief

- **Coerced to violate their beliefs, values and conscience.** The "decision" to abort is often based on the demands or threats of others — even when it violates the woman's own moral beliefs and desire to keep the baby.<sup>18</sup> This is a known risk factor for psychological complications after abortion.<sup>19</sup>
- **64% of abortions involve coercion.** A recent study of women who had abortions found that 64% of American women reported that they felt pressured by others to abort.<sup>7</sup>
- **Common negative reactions.** In a survey of women reporting post-abortion problems, 80% experienced guilt, 83% regret, 79% loss, 62% anger and 70% depression.<sup>2</sup>
- **Forbidden grief.** After abortion, societal expectation, personal shame and public and professional denial result in repressed grief, causing serious problems including clinical depression, eating disorders, self-destructive lifestyles and suicide.<sup>20</sup>

#### Divorce and chronic relationship problems

- **Women with a history of abortion are significantly more likely to subsequently have shorter relationships and more divorces.** This may be due to lowered self-esteem, greater distrust of males, sexual dysfunction, substance abuse, and increased levels of depression, anxiety, and volatile anger.<sup>21</sup>
- **More poverty and single parenthood after repeat abortions.** Women who have more than one abortion (nearly half of those seeking abortions each year)<sup>22</sup> are more likely to become single parents and to require public assistance.<sup>23</sup>
- **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.<sup>23</sup>

#### Not counseled before or after the abortion, many wanted alternatives

In a study of American and Russian women who experienced abortion:

- 67% of American women reported that they received no counseling beforehand

- 84% reported they received inadequate counseling beforehand
- 79% were not counseled about alternatives
- 54% were not sure about their decision at the time.<sup>7</sup>

### Unresolved trauma and child abuse

- **144 % more likely to abuse their children.** One study found that women with a history of induced abortion were 144% more likely to physically abuse their children than women who had not had an abortion.<sup>24</sup>
- **Child abuse linked to unresolved trauma.** Abortion is linked with increased violent behavior, alcohol and drug abuse, replacement pregnancies, depression, and poor maternal bonding with later children. These factors are closely associated with child abuse and would appear to confirm a link between unresolved post-abortion trauma and subsequent child abuse.<sup>25</sup>

### Repeat abortions, self-punishment and risk factors

- **48% of aborting women have had a previous abortion.**<sup>22</sup> Women who have had an abortion are 4 times more likely to abort a current pregnancy than those with no prior abortion history.<sup>21</sup> This may reflect aspects of self-punishment.<sup>26</sup>
- **Studies have identified factors that put women at risk for negative reactions to abortion,** including feeling pressured into unwanted abortions, 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. An analysis of 63 medical studies that identify risk factors concluded that the number of women suffering from negative emotional reactions could be dramatically reduced if abortion clinics screened women for these risk factors.<sup>19</sup>

To learn more, see **Forbidden Grief: The Unspoken Pain of Abortion.** To order, call: **Acorn Books: 1-888-412-2676.**

### Citations for *Psychological Risks of Abortion* Fact Sheet

1. Gissler, Hemminki & Lonnqvist, "Suicides after pregnancy in Finland, 1987-94: register linkage study," *British Journal of Medicine* 313:1431-4, 1996; and M. Gissler, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European J. Public Health* 15(5):459-63, 2005.
2. D. Reardon, *Aborted Women, Silent No More* (Springfield, IL: Acorn Books, 2002).
3. 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.
4. B. Garfinkel, et al., "Stress, Depression and Suicide: A Study of Adolescents in Minnesota," *Responding to High Risk Youth* (University of Minnesota: Minnesota Extension Service, 1986); M. Gissler, et. al., "Suicides After Pregnancy in Finland: 1987-94: register linkage study," *British Medical Journal*, 313: 1431-1434, 1996; and N. Campbell, et. al., "Abortion in Adolescence," *Adolescence*, 23:813-823, 1988. See the "Teen Abortion Risks" Fact Sheet at [www.theunchoice.com/resources.htm](http://www.theunchoice.com/resources.htm) for more information.
5. JR Cogle, DC Reardon & PK Coleman, "Depression Associated With Abortion and Childbirth: A Long-Term Analysis of the NLSY Cohort," *Medical Science Monitor* 9(4):CR105-112, 2003.
6. DC Reardon, JR Cogle, "Depression and unintended pregnancy in the National Longitudinal Study of Youth: a cohort study," *British Medical Journal* 324:151-2, 2002.
7. 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.
8. DC Reardon et. al., "Psychiatric admissions of low-income women following abortions and childbirth," *Canadian Medical Association Journal* 168(10): May 13, 2003.
9. PK Coleman et. al., "State-Funded Abortions Versus Deliveries: A Comparison of Outpatient Mental Health Claims Over Four Years," *American*

*Journal of Orthopsychiatry* 72(1):141-152, 2002.

10. Ashton, "The Psychosocial Outcome of Induced Abortion", *British Journal of Ob & Gyn.* 87:1115-1122, 1980.
11. JR Cogle, DC Reardon, PK Coleman, "Generalized Anxiety Following Unintended Pregnancies Resolved Through Childbirth and Abortion: A Cohort Study of the 1995 National Survey of Family Growth," *Journal of Anxiety Disorders* 19:137-142 (2005).
12. DC Reardon and PK Coleman, "Relative Treatment Rates for Sleep Disorders and Sleep Disturbances Following Abortion and Childbirth: A Prospective Record Based-Study," *Sleep* 29(1):105-106, 2006.
13. DM Fergusson et. al., "Abortion in young women and subsequent mental health," *Journal of Child Psychology and Psychiatry* 47(1): 16-24, 2006.
14. T. Burke with D. Reardon, *Forbidden Grief: The Unspoken Pain of Abortion* (Springfield, IL: Acorn Books, 2002) 189, 293
15. DC Reardon, PG Ney, "Abortion and Subsequent Substance Abuse," *American Journal of Drug and Alcohol Abuse* 26(1):61-75, 2000.
16. PK Coleman et. al., "A history of induced abortion in relation to substance abuse during subsequent pregnancies carried to term," *American Journal of Obstetrics and Gynecology* 167:3-8, Dec. 2002.
17. Benedict, et al., "Maternal Perinatal Risk Factors and Child Abuse," *Child Abuse and Neglect* 9:217-224, 1985; P.G. Ney, "Relationship between Abortion and Child Abuse," *Canadian Journal of Psychiatry*, 24:610-620, 1979; Shepard, et al., "Contraceptive Practice and Repeat Induced Abortion: An Epidemiological Investigation," *J. Biosocial Science* 11:289-302, 1979; M. Bracken, "First and Repeated Abortions: A Study of Decision-Making and Delay," *J. Biosocial Science* 7:473-491, 1975; S. Henshaw, "The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients," *Family Planning Perspectives*, 20(4):158-168, 1988; D. Sherman, et al., "The Abortion Experience in Private Practice," *Women and Loss: Psychobiological Perspectives*, ed. W.F. Finn, et al., (New York: Praeger Publishers, 1985) 98-107; E.M. Belsey, et al., "Predictive Factors in Emotional Response to Abortion: King's Termination Study - IV," *Social Science and Medicine* 11:71-82, 1977; E. Freeman, et al., "Emotional Distress Patterns Among Women Having First or Repeat Abortions," *Obstetrics and Gynecology* 55(5):630-636, 1980; C. Berger, et al., "Repeat Abortion: Is it a Problem?" *Family Planning Perspectives* 16(2):70-75 (1984).
18. George Skelton, "Many in Survey Who Had Abortion Cite Guilt Feelings," *Los Angeles Times*, March 19, 1989, p. 28 (question 76). See also Mary K. Zimmerman, *Passage Through Abortion* (New York, Praeger Publishers, 1977).
19. David C. Reardon, "The Duty to Screen: Clinical, Legal, and Ethical Implications of Predictive Risk Factors of Post-Abortion Maladjustment," *The Journal of Contemporary Health Law and Policy* 20(2):33-114, Spring 2004.
20. For more on this topic, see T. Burke, *Forbidden Grief: The Unspoken Pain of Abortion* (Springfield, IL: Acorn Books, 2002).
21. Shepard, et al., "Contraceptive Practice and Repeat Induced Abortion: An Epidemiological Investigation," *J. Biosocial Science* 11:289-302, 1979; M. Bracken, "First and Repeated Abortions: A Study of Decision-Making and Delay," *J. Biosocial Science* 7:473-491, 1975; S. Henshaw, "The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients," *Family Planning Perspectives*, 20(4):158-168, 1988; D. Sherman, et al., "The Abortion Experience in Private Practice," *Women and Loss: Psychobiological Perspectives*, ed. W.F. Finn, et al., (New York: Praeger Publishers, 1985) 98-107; E.M. Belsey, et al., "Predictive Factors in Emotional Response to Abortion: King's Termination Study - IV," *Social Science and Medicine* 11:71-82, 1977; E. Freeman, et al., "Emotional Distress Patterns Among Women Having First or Repeat Abortions," *Obstetrics and Gynecology* 55(5):630-636, 1980; C. Berger, et al., "Repeat Abortion: Is it a Problem?" *Family Planning Perspectives* 16(2):70-75 (1984).
22. "Facts in Brief: Induced Abortion," The Alan Guttmacher Institute ([www.agi-usa.org](http://www.agi-usa.org)), 2002.
23. Speckhard, *Psycho-social Stress Following Abortion*, (Kansas City, MO: Sheed & Ward, 1987); and Belsey, et al., "Predictive Factors in Emotional Response to Abortion: King's Termination Study - IV," *Social Science & Medicine* 11:71-82, 1977. See also P.K. Coleman, V.M. Rue, C.T. Coyle, "Induced abortion and intimate relationship quality in the Chicago Health and Social Life Survey," *Public Health* (2009), doi:10.1016/j.puhe.2009.01.005.
24. Priscilla K. Coleman, et. al., "Associations between voluntary and involuntary forms of perinatal loss and child maltreatment among low-income mothers," *Acta Paediatrica* 94, 2005.
25. Benedict, et al., "Maternal Perinatal Risk Factors and Child Abuse," *Child Abuse and Neglect* 9:217-224, 1985; P.G. Ney, "Relationship between Abortion and Child Abuse," *Canadian Journal of Psychiatry*, 24:610-620, 1979. See also Reardon, *Aborted Women, Silent No More* (Springfield, IL: Acorn Books, 2002) 129-30, which describes a case of woman who beat her three year old son to death shortly after an abortion which triggered a "psychotic episode" of grief, guilt, and misplaced anger.
26. Leach, "The Repeat Abortion Patient," *Family Planning Perspectives* 9(1):37-39, 1977; S. Fischer, "Reflection on Repeated Abortions: The meanings and motivations," *Journal of Social Work Practice* 2(2):70-87, 1986; B. Howe, et al., "Repeat Abortion, Blaming the Victims," *Am. J. of Public Health* 69(12):1242-1246, 1979.21. David C. Reardon, "The Duty to Screen: Clinical, Legal, and Ethical Implications of Predictive Risk Factors of Post-Abortion Maladjustment," *The Journal of Contemporary Health Law and Policy* 20(2):33-114, Spring 2004.3. 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.

# Teen Abortion Risks Fact Sheet

*"Parents are faced with a shell of a person and have no idea where they lost their child."*

—Terri, who had a secret abortion as a teen

## Suicide attempts 6 times more likely

- Teenagers are 6 times more likely to attempt suicide if they have had an abortion in the last six months than are teens who have not had an abortion,<sup>1</sup> and four times more likely to commit suicide than adults who abort.<sup>2</sup> A history of abortion is likely to be associated with adolescent suicidal thinking.<sup>1</sup> Overall, women who have abortions have a 6 times higher rate of suicide compared to women who carry to term.<sup>3</sup>
- Teens who abort are more likely to develop psychological problems,<sup>4</sup> and are nearly three times more likely to be admitted to mental health hospitals than teens in general.<sup>5</sup>
- About 40% of teen abortions take place with no parental involvement,<sup>6</sup> leaving parents in the dark about subsequent emotional or physical problems and putting them at risk for further injury and death.<sup>7</sup>
- Teens are 5 times more likely to seek subsequent help for psychological and emotional problems compared to their peers who carry "unwanted pregnancies" to term.<sup>8</sup>
- Teens are 3 times more likely to report subsequent trouble sleeping, and nine times more likely to report subsequent marijuana use after abortion.<sup>8</sup>
- Among studies comparing abortion vs. carrying to term, worse outcomes are associated with abortion, even when the pregnancy is unplanned.<sup>8</sup>
- Teens are more likely to abort because of pressure from their parents or partner.<sup>9</sup> In one study, 64% of women who had undergone an abortion reported that they felt pressured by others to abort.<sup>10</sup>
- Teens are more likely to report being misinformed in pre-abortion counseling.<sup>11</sup>

## Acute Pain. Infertility. Risk of Death.

- **Acute pain.** Teens report more severe pain during the abortion procedure than do adult women.<sup>12</sup>
- **Lacerations up to twice as likely.** Teens are up to twice as likely to experience dangerous cervical lacerations during abortion compared to older women.<sup>13</sup>
- **Infertility and life-threatening complications.** Studies have found that teens are at higher risk for post-abortion infections such as pelvic inflammatory disease (PID) and endometritis.<sup>14</sup> These infections increase their risk of infertility, hysterectomy, ectopic pregnancy, and other serious complications.<sup>15</sup>
- **Higher breast cancer risk.** An early full-term birth reduces breast cancer risk by as much as 1/3, while abortion of a first pregnancy carries a 30- to 50% increased risk of breast cancer.<sup>16</sup> More than 90% of those who abort at 17 or younger have not had a previous full-term pregnancy, compared to 78% of patients age 18-19 and 49% of abortion patients overall.<sup>17</sup>
- **Teens are more likely to have riskier late-term abortions.** According to the CDC, approximately 30% of abortions among teens take place at 13 weeks gestation or greater, compared to only 12% among women in general.<sup>18</sup> Late-term abortions are associated with more severe psychological problems,<sup>19</sup> higher risk of physical complications,<sup>20</sup> and problems in later pregnancies.<sup>21</sup>

## Grief, trauma and self-destructive outcomes

- Teens who abort are twice as likely as their peers to abuse alcohol, marijuana, or cocaine.<sup>22</sup>

continued ►

- \* **Teens have greater difficulty coping** after abortion,<sup>23</sup> leading to problems such as suicide, psychological problems, substance abuse, and difficulty in relationships.
- **Negative effects on relationships and parenting.** Teens who report "being particularly fond of children" do not do as well psychologically after an abortion.<sup>24</sup> Teens who have abortions often have later problems regarding sexuality and parenting.<sup>25</sup>
- **A lonely, traumatic experience.** The abortion procedure itself is considered by many teens to be stressful and associated with feelings of guilt, depression, and a sense of isolation.<sup>26</sup>
- **A nightmare that doesn't end.** Teens are more likely to report severe nightmares and to score higher on scales measuring antisocial traits, paranoia, drug abuse, and psychotic delusions than are older abortion patients.<sup>27</sup>
- **Four times higher risk of repeat abortion.** Teens who abort are likely to become pregnant again within the next few years.<sup>28</sup> Among pregnant teens, those who had had an abortion were at least 4 times more likely to abort.<sup>29</sup>

## Citations

1. Garfinkel et al., "Stress, Depression and Suicide: A Study of Adolescents in Minnesota," *Responding to High Risk Youth* (U. of Minnesota: Minnesota Extension Service, 1986)
2. Gissler et al., "Suicides After Pregnancy in Finland: 1987-94: register linkage study," *British Medical Journal*, 313: 1431-1434, 1996; Campbell, et al., "Abortion in Adolescence," *Adolescence*, 23:813-823, 1988.
3. Gissler, op. cit.; Gissler, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European J. Public Health* 15(5):459-63, 2005. See also 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.
4. Franz and Reardon, "Differential Impact of Abortion on adolescents and adults," *Adolescence*, 27 (105), 172, 1992.
5. Somers, "Risk of Admission to Psychiatric Institutions Among Danish Women Who Experienced Induced Abortion: An Analysis Based on National Report Linkage" (Ph.D. Dissertation, Los Angeles: University of California, 1979, Dissertation Abstracts International, Public Health 2621-B, Order No. 7926066)
6. "Teenage Pregnancy: Overall Trends and State-by-State Information," Report by the Alan Guttmacher Institute, Washington, DC, www.agi.org.
7. For more information, see www.unchoice.info.
8. Coleman, "Resolution of Unwanted Pregnancy During Adolescence Through Abortion Versus Childbirth: Individual and Family Predictors and Psychological Consequences," *Journal of Youth and Adolescence* (2006).
9. Barglow and Weinstein, "Therapeutic Abortion During Adolescence: Psychiatric Observations," *Journal of Youth and Adolescence*, 2(4):33, 1973.
10. Rue et al., "Induced abortion and traumatic stress: A preliminary comparison of American and Russian women," *Medical Science Monitor* 10(10): SR5-16, 2004.
11. Franz and Reardon, "Differential Impact of Abortion on adolescents and adults," *Adolescence*, 27 (105), 172, 1992.
12. Belanger, et al., "Pain of First Trimester Abortion: A Study of Psychosocial and Medical Predictors," *Pain*, 36:339; Smith, et al., "Pain of first-trimester abortion: Its quantification and relationships with other variables," *American Journal Obstetrics & Gynecology*, 133:489, 1979.
13. Burkman, et al., "Morbidity Risk Among Young Adolescents Undergoing Elective Abortion," *Contraception*, 30(2):99, 1984; Schulz, et al., "Measures to Prevent Cervical Injury During Suction Curettage Abortion," *The Lancet*, 1182-1184, May 28, 1993 .
14. Burkman, et al., "Culture and treatment results in endometritis following elective abortion," *American J. Obstet. & Gynecol.*, 128:556, 1997; Avonts and Piot, "Genital infections in women undergoing induced abortion," *European J. Obstet. & Gynecol. & Reproductive Biology*, 20:53, 1985; Cates, "Teenagers and Sexual Risk-Taking: The Best of Times and the Worst of Times," *Journal of Adolescent Health*, 12:84, 1991.
15. "Teenage Pregnancy: Overall Trends and State-by-State Information," Report by the Alan Guttmacher Institute, Washington, DC, www.agi.org.
16. Brind et al., "Induced abortion as an independent risk factor for breast cancer: a comprehensive review and analysis," *J. Epidemiology & Community Health*, 50:481, 1996.
17. Kochanck, "Induced Terminations of Pregnancy, Reporting States 1988," *Monthly Vital Statistics Report*, 39(12): Suppl. 1-32, April 30, 1991.
18. Strahan, "Differential Adverse Impact on Teenagers Who Undergo Induced Abortion," *Association for Interdisciplinary Research Bulletin*, 15(1):3, March/April 2000.
19. Strahan, "Psycho-Social Aspects of Late-Term Abortions," *Assoc. For Interdisciplinary Research Bulletin*, 14(4):1, 2000.
20. Burkman, *American J. Obstet. & Gynecol.* op. cit; Lurie and Shoham, "Induced Midtrimester Abortion and Future Fertility: Where Are We Today?" *International J. of Fertility*, 40(6):311, 1995.
21. Atrash and Hogue, "The effect of pregnancy termination on future reproduction," *Baillieres Clinic Obstet. & Gynecol.*, 4(2):391, 1990; Rooney, "Is Cerebral Palsy Ever a Choice?" *The Post-Abortion Review*, 8(4):4-5, Oct.-Dec. 2000.
22. Amaro, et al., "Drug use among adolescent mothers: profile of risk," *Pediatrics*, 84, 1989, 144-150.
23. Horowitz, "Adolescent Mourning Reactions to Infant and Fetal Loss," *Soc. Casework*, 59:551, 1978.
24. Smith, "A follow-up study of women who request abortion," *American Journal of Orthopsychiatry*, 1973, 43: 574-585.
25. Zakus and Wilday, "Adolescent Abortion Option." *Social Work in Health Care*, 12, 1987, 77-91.
26. Biro, et al., "Acute and Long-Term Consequences of Adolescents Who Choose Abortions," *Pediatric Annals*, 15(10):667-672, 1986.
27. Campbell, et al., "Abortion in Adolescence," *Adolescence*, 23:813-823, 1988.
28. Wheeler, "Adolescent Pregnancy Loss," in Woods, Jr. Woods (eds.), *Loss During Pregnancy or the Newborn Period* (1997); Cvejic et al., "Follow-up of 50 adolescent girls 2 years after abortion," *Canadian Medical Assoc. Journal*, 116:44, 1997.
29. Joyce, "The Social and Economic Correlates of Pregnancy Resolution Among Adolescents in New York by Race and Ethnicity: A Multivariate Analysis," *American J. of Public Health*, 78(6):626, 1988.

# Negligent Screening Act – HB 544

## The Problem

- ◆ Many abortion providers have compromised the standard of care for counseling and screening of patients in order to reduce costs and maximize profits.
- ◆ In hundreds of cases each day, known risk factors for physical and psychological complications are not being detected because simple questions are not being asked.
- ◆ Women are suffering from *avoidable* physical and psychological complications that may have been *prevented or minimized if the proper pre-abortion screening standards had been employed.*
- ◆ Without adequate screening for risk factors it is impossible for abortion providers to give accurate information about risks to women based on their individual risk profile.

## What the Negligent Screening Act Does

- ◆ It removes legal obstacles which typically make it difficult or impossible for women to hold her abortion provider liable for avoidable injuries which are a result of negligent pre-abortion screening and counseling.
- ◆ It clarifies in statute the duty of physicians to screen for risk factors which place women at higher risk of physical or negative complications of abortion.
- ◆ It restores the accountability of physicians for making informed medical recommendations based on each woman's individual risk profile.
- ◆ It better protects women from undergoing coerced abortions, which is a major risk factor for severe post-abortion psychological problems.
- ◆ It better protects women from illegal abortions and/or marketing of self-abortion kits.

## What the Negligent Screening Act Does NOT Do

- ◆ It does not impose any requirements on abortion providers that are contrary to the standard of care for screening which applies to any other medical procedures.
- ◆ It does not impose any burdens on women seeking abortions.
- ◆ It does not *ban* any abortions, even in those cases where a woman may be at higher risk of one or more adverse reactions. The final decision remains with the woman and her doctor—but it will be a more informed decision
- ◆ It does not affect any other medical procedures.

- ◆ It does not require any enforcement by the State. The provisions of the bill defining negligent screening are enforced solely by the injured women through civil remedies.

## The Benefits

- ◆ It will reduce the number of women who undergo *unwanted* abortions, sparing them the grief, guilt, depression, and trauma that often follow an unwanted abortion.
- ◆ It will reduce the number of abortion related physical and/or psychological injuries suffered by women.
- ◆ It will reduce abortion rates and better *enable women who don't want abortions* to welcome an unplanned child into their lives.
- ◆ This statute will correct a loophole in the law that shields abortion providers from proper liability when they neglect to provide reasonable medical advice, which can only be done after proper screening of the individual patient's needs and risk factors.
- ◆ It will reverse the decline in the standard of care in abortion clinics.

## Protecting Women's Right to Redress For Negligent Abortion Screening & Counseling Is Constitutional

- ◆ "[T]he abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available." *Roe v Wade* 410 U.S. 113, 166 (1973).
- ◆ "The medical, emotional, and psychological consequences of abortion are serious and can be lasting... An adequate medical and psychological case history is important to the physician." *H.L. v Matheson* 450 U.S. 398, 411 (1980).
- ◆ "It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know.... Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends....and if some procedures have different risks than others, it does not follow that the State is altogether barred from imposing reasonable regulations." *Gonzales v. Carhart*, 550 U.S. (2007).

# FACTS UNDERLYING THE NEED FOR PRE-ABORTION SCREENING AND HB1236

Induced Abortion Entails Inherent Risks.....	1
Some Women Are at Greater Risk of Adverse Reactions .....	7
Because the Factors Involved in a Woman’s Decision Regarding Abortion Are Complex, Adequate Screening and Counseling is Essential to Protect the Validity of the Women’s Consent and to Protect Her Health.....	9
Physicians Have a Legal and Ethical Obligation to Protect the Rights and Well-being of Women Considering an Abortion .....	10
The Standard of Care Widely Used by Abortion Providers in Practice Is Not Always Adequate to Protect the Health Needs of Women .....	12
Clarifying the Appropriate Standard of Care in Statute with Appropriate Civil Remedies for Injured Women Is the Most Practical Means of Protecting the Rights of Women Without Infringing on Their Reproductive Rights.....	14
The Prevailing Low Standard of Care Discourages Competent Physicians From Providing Better Counseling Services and Safer Reproductive Health Care .....	15
Providing Right to Redress Against Non-physicians Who Perform Illegal Abortions or Encourage Self-abortions Is an Important Means of Protecting Women’s Health .....	18

## **Induced Abortion Entails Inherent Risks**

1. Compared to women who give birth, women who abort have an elevated risk of death, with the risk of death associated with abortion approximately 3 times greater than the risk associated with childbirth.<sup>1</sup> The elevated risk of death associated with abortion persists for at least eight years.<sup>2</sup> Most prominent is the higher risk of death from suicide and accidents (which may be proxy for unrecognized suicides or risk taking behavior) though deaths from natural causes are also elevated. Projected on the national population, this effect of an elevated mortality rate after an abortion may contribute to 2,000 - 7,000 more deaths among women each year.<sup>3</sup>

<sup>1</sup> Gissler M, Berg C, Bouvier-Colle MH, Buekens P. Pregnancy-associated mortality after birth, spontaneous abortion or induced abortion in Finland, 1987-2000. *Am J Ob Gyn* 2004; 190:422-427. Gissler M, Kauppila R, Merilainen J, Toukoma H, Hemminki E. Pregnancy-associated deaths in Finland 1987-1994--definition problems and benefits of record linkage. *Acta Obstet Gynecol Scand* 1997; 76(7):651-7. Gissler M, Berg C, Bouvier-Colle MH, Buekens P. Methods for identifying pregnancy-associated deaths: population-based data from Finland 1987-2000. *Paediatr Perinat Epidemiol*. 2004 Nov;18(6):448-55.

<sup>2</sup> Reardon DC, Ney PG, Scheuren FJ,, Cogle JR, Coleman, PK, Strahan T. Deaths associated with pregnancy outcome: a record linkage study of low income women. *Southern Medical Journal*. 95(8):834-841, August 2002.

<sup>3</sup> Reardon DC, Strahan TW, Thorp JM, Shuping MW. Deaths associated with abortion compared to childbirth: a review of new and old data and the medical and legal implications. *The Journal of Contemporary Health Law & Policy* 2004; 20(2):279-327.

2. Women who have abortions have twice the risk of complications in subsequent pregnancy leading to pre- or post-term delivery.<sup>4</sup> Premature delivery is a leading cause of neonatal death and developmental disabilities. The average hospital charge from delivery to discharge for a premature birth is \$58,000, compared to \$4,300 for a full-term birth.
3. A recent analysis of health care costs found that 31.5% of preterm births are attributable to a history of induced abortion and that the initial neonatal hospital costs for treating preterm births until release from the hospital **cost the nation over \$1.2 billion per year.**<sup>5</sup> (With 1.2 million abortions per year, this translates to additional health care costs of about \$1000 per abortion.) Moreover, this cost estimate does not include additional costs associated with follow-up care or with lifetime treatment costs associated with cerebral palsy (1096 cases per year) which are attributable to the excess premature births resulting from latent abortion sequelae.
4. Pelvic Inflammatory Disease (PID) is a life-threatening disease that can increase a woman's risk of future infertility problems and ectopic pregnancies. Studies have found that 23% of women who have a Chlamydia infection at the time of their abortion and 5% of women who don't have Chlamydia will develop PID within four weeks after having the abortion. Approximately one-fourth of women seeking abortions have Chlamydia infections.<sup>6</sup>
5. Women with a history of abortion are at increased risk for endometriosis, especially teenagers who are 2.5 times more likely to acquire endometritis following abortion than are women age 20-29.<sup>7</sup>
6. A history of abortion is significantly associated with an increased risk of breast cancer, cervical cancer, and lung cancer (probably due to heavier smoking patterns after abortion).<sup>8</sup>

---

<sup>4</sup> Ancel PV, Lelong N, Papiernik E, Saurel-Cubizolles MJ, Kaminski M. History of induced abortion as a risk factor for preterm birth in European countries: results of EUROPOP survey. *Human Repro* 2004; 19(3): 734-740. Zhou, Weijin, et al., "Induced Abortion and Subsequent Pregnancy Duration," *Obstetrics & Gynecology* 94(6):948-953 (Dec. 1999); Lieberman E., et al. Risk factors accounting for racial differences in the rate of premature birth. *New England J. Medicine*, 317:743-748 (1987).

<sup>5</sup> Calhoun B, Shadigian E, Rooney B. Cost consequences of induced abortion as an attributable risk for preterm birth and its impact on informed consent. *Journal of Reproductive Medicine* Oct. 2007

<sup>6</sup> Radberg, et al., "Chlamydia Trachomatis in Relation to Infections Following First Trimester Abortions," *Acta Obstetrica Gynaecologica* (Supp. 93), 54:478, 1980; L. Westergaard, "Significance of Cervical Chlamydia Trachomatis Infection in Post-abortion Pelvic Inflammatory Disease," *Obstetrics and Gynecology* 60(3):322-325, 1982; M. Chacko, et al., "Chlamydia Trachomatis Infection in Sexually Active Adolescents: Prevalence and Risk Factors," *Pediatrics* 73(6), 1984; M. Barbacci, et al., "Post-Abortal Endometritis and Isolation of Chlamydia Trachomatis," *Obstetrics and Gynecology* 68(5):668-690, 1986; S. Duthrie, et al., "Morbidity After Termination of Pregnancy in First-Trimester," *Genitourinary Medicine* 63(3):182-187, 1987.

<sup>7</sup> Burkman, et al., "Morbidity Risk Among Young Adolescents Undergoing Elective Abortion" *Contraception* 30:99-105, 1984; "Post-Abortal Endometritis and Isolation of Chlamydia Trachomatis," *Obstetrics and Gynecology* 68(5):668- 690, 1986)

<sup>8</sup> H.L. Howe, et al., "Early Abortion and Breast Cancer Risk Among Women Under Age 40," *International Journal of Epidemiology* 18(2):300-304, 1989; L.I. Remennick, "Induced Abortion as A Cancer Risk Factor: A Review of Epidemiological Evidence," *Journal of EpidemiologicalCommunity Health* 1990; M.C. Pike, "Oral Contraceptive Use and Early Abortion as Risk Factors for Breast Cancer in Young Women," *British Journal of Cancer* 43:72, 1981; M-G, Le, et al., "Oral Contraceptive Use and Breast or Cervical Cancer: Preliminary Results of a French Case-Control Study, *Hormones and Sexual Factors in Human Cancer Etiology* ed. JP Wolff, et al., (New York, Excerpta Medica, 1984) 139-147; F. Parazzini, et al., "Reproductive Factors and the Risk of Invasive and Intraepithelial Cervical Neoplasia," *British Journal of Cancer* 59:805-809, 1989; H.L. Stewart, et al., "Epidemiology of Cancers of the Uterine Cervix and Corpus, Breast and Ovary in Israel and New York City," *Journal of the National Cancer*

27. Many researchers have found that women who choose abortion in violation of their consciences are significantly more prone to suffer severe psychological distress following an abortion.<sup>37</sup>
28. The National Abortion Federation, which represents abortion providers, reports that one in five women served by their clinics are choosing abortion despite being philosophically and morally opposed to it and are therefore at a higher risk of adverse emotional reactions.<sup>38</sup> Other research indicates that up to 70 percent of women seeking abortion may be morally opposed to it.<sup>39</sup>
29. Researchers who support abortion have found, using just five screening criteria, that 68 percent of the 326 women seeking an abortion had risk factors for a negative psychiatric outcome that should have been used to refer the patients for more extensive counseling. Of this high risk group, 72 percent actually did develop negative post-abortion reactions during the three-month follow-up period. "From a clinician's point of view," the researchers concluded, "this result can be viewed as erring on the right side, for a [pre-abortion screening] system that tends to select more women for counseling than is actually necessary is preferable to the reverse."<sup>40</sup> Despite this finding and recommendation, even these few screening criteria are not used by all abortion providers.
30. There are many cases in which women who would prefer to keep their pregnancies feel pressured by boyfriends, relatives, or by other individuals or circumstances, to undergo unwanted abortions that they subsequently regret. These coercive pressures may be subtle or overt. Women who submit to an unwanted abortion as the result of coercive pressures are significantly more likely to suffer severe psychological maladjustments following the abortion.<sup>41</sup>
31. In some cases where women are feeling pressured to submit to an unwanted abortion, abortion providers have failed to assist the woman in finding relief from these coercive

---

<sup>37</sup>Baker A, et. al., "Informed Consent, Counseling, and Patient Preparation," A Clinician's Guide to Medical and Surgical Abortion, ed. Maureen Paul, et. al., (New York: Churchill Livingstone, 1999) 29. Rue VM, Coleman PK, Rue JJ, Reardon DC. Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. *Med Sci Monit*, 2004 10(10): SR5-16.

<sup>38</sup>Woo, J., "Abortion Doctor's Patients Broaden Suits," *Wall Street Journal*, Oct 28, 1994, B12:1.

<sup>39</sup>Zimmerman, M.K. *Passages Through Abortion* (New York: Praeger Publishers, 1977) 69; see also Los Angeles Times Poll, March 19, 1989, question 76. Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. Rue VM, Coleman PK, Rue JJ, Reardon DC. *Med Sci Monit*, 2004 10(10): SR5-16.

<sup>40</sup>Belsey, E.M., et al., "Predictive Factors in Emotional Response to Abortion: King's Termination Study - IV," *Soc. Sci. & Med.*, 11:71-82 (1977).

<sup>41</sup>Council on Scientific Affairs, American Medical Association, "Induced Termination of Pregnancy Before and After *Roe v Wade*: Trends in Mortality and Morbidity of Women," *JAMA*, 268(22):3231-3239 (1992).; Miller, W.B., "An Empirical Study of the Psychological Antecedents and Consequences of Induced Abortion," *Journal of Social Issues*, 48(3):67-93 (1992); Zimmerman, M., *Passage Through Abortion* (New York: Praeger Publishers, 1977); Vaughan, H.P., *Canonical Variates of Post Abortion Syndrome* (Portsmouth, NH: Institute for Pregnancy Loss, 1990).

pressures to avoid an unwanted abortion.<sup>42</sup> In at least a few cases, abortion providers have participated in this coercion resulting in harm to women.<sup>43</sup>

32. One study has found that that 44% of women having abortions experienced doubts about a decision to abort upon confirmation of their pregnancies, while 30% continued to have doubts on the day of their abortions.<sup>44</sup> Another study found approximately 64% felt pressured to choose abortion by others, over half felt they needed more time for the decision, over a third felt emotionally close to the aborted child, and at least half felt they were violating their moral beliefs in having an abortion. Only 11% believed their pre-abortion counseling was adequate.<sup>45</sup>

***Because the Factors Involved in a Woman's Decision Regarding Abortion Are Complex, Adequate Screening and Counseling is Essential to Protect the Validity of the Women's Consent and to Protect Her Health***

33. Research conducted at abortion clinics has also found that most women seeking abortion have little or no prior knowledge about the abortion procedure, its risks, or fetal development.<sup>46</sup>
34. Some women seek abortions in great haste and under emotional stress. Many have stated that they made poor decisions in violation of their conscience and maternal desires because they did not adequately think through alternative ways of coping with their crisis situations.<sup>47</sup>
35. Journal articles by National Abortion Federation officials verify that many women in a crisis pregnancy situation may be making hasty, ill considered, dysfunctional decisions for abortion.<sup>48</sup> Because the woman is in a crisis situation, it is incumbent on the health care provider to bring a "cool head" to the situation in order to help the patient explore alternatives she may not have considered, to identify and explain her individual risk factors, and to arrive at a medical recommendation independently.
36. Some women report having had abortions, which they now regret, because they were unaware of alternatives or resources that were available that would have empowered them

---

<sup>42</sup>David C. Reardon, "Who Was Most Guilty?", *The Post-Abortion Review* 4(2-3) Spring & Summer 1996.

<sup>43</sup>Doris Kalasky, "Accomplices in Incest" *The Post-Abortion Review* 2(1) Winter 1993; Mark Crutcher, *Lime 5*, (Denton, TX:: Life Dynamics, 1996) 77-78.

<sup>44</sup>Husfeldt C, Hansen SK, Lyngberg A, Noddebo M, Pettersson B. Ambivalence among women applying for abortion. *Acta Obstetrica et Gynecologica Scandinavica*, 1995; 74, 813-817.

<sup>45</sup>Rue VM, Coleman PK, Rue JJ, Reardon DC. Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. *Med Sci Monit*, 2004 10(10): SR5-16.  
[http://www.medscimonit.com/pub/vol\\_10/no\\_10/4923.pdf](http://www.medscimonit.com/pub/vol_10/no_10/4923.pdf)

<sup>46</sup>Zimmerman, *Passage Through Abortion*, (New York: Praeger Publishers, 1977) 139.

<sup>47</sup>David C. Reardon, *Aborted Women - Silent No More* (Chicago, IL: Loyola University Press, 1987) 9-15.

<sup>48</sup>Landy, "Abortion Counseling - A New Component of Medical Care," *Clinics in Obs/Gyn*, 13(1):33-41 (1986).

to carry their pregnancies to term.<sup>49</sup> Researchers have found that 30 to 60 percent of women seeking abortion express some desire to keep the child.<sup>50</sup>

37. Women who initially sought an abortion and then change their minds have shown that few, if any, later regret their decision to carry to term or suffer negative psychological consequences from giving birth to an unintended child.<sup>51</sup>
38. Most abortion providers do not screen women for all the known risk factors statistically associated with adverse physical and psychological reactions. As a result, most women considering an abortion have not been informed of the risks that are particularly associated to women matching their unique physical and psychological profile.<sup>52</sup>
39. Post-procedural adjustment to an induced abortion is complicated by sexual, familial, and moral dimensions. Conversely, if unresolved emotional issues exist prior to an abortion, adjustment and recovery are complicated and the risk of serious emotional sequelae is heightened.<sup>53</sup>
40. "It cannot be questioned that psychological well-being is a facet of health. . . . In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed." *Planned Parenthood v. Casey* 120 L Ed 2d 674 at 718.

### ***Physicians Have a Legal and Ethical Obligation to Protect the Rights and Well-being of Women Considering an Abortion***

41. Abortion is one of many options used by physicians to treat a crisis pregnancy. Other tools, such as a referral for financial aid, legal counseling, or marital counseling, may sometimes better serve a woman's needs by helping to alleviate a crisis situation, allowing her to carry a wanted pregnancy to term, or otherwise better preserve a woman's health or serve her socioeconomic needs.
42. "The abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician." *Roe v Wade*, [hereinafter *Roe*] 410 U.S. 113, 166 (1973). "The attending physician, in consultation with his patient, is free to determine, without regulation by the State, that in his medical judgment, the patient's pregnancy should be terminated." *Roe* at 163.

---

<sup>49</sup>David C. Reardon, *Aborted Women - Silent No More* (Chicago, IL: Loyola University Press, 1987) 333-335.

<sup>50</sup>Zimmerman MK, *Passage Through Abortion* (New York: Praeger Publishers, 1977), also Reardon DC, *Aborted Women-Silent No More*, (Chicago: Loyola University Press, 1987) and Francke LB, *The Ambivalence of Abortion* (New York: Random House, 1978).

<sup>51</sup>Söderberg, H. (1998) Urban women applying for induced abortion: Studies of epidemiology, attitudes and emotional reactions. 1998. Dissertation. Departments of Obstetrics and Gynecology and Community Medicine, Lund University, Malmö, Sweden.

<sup>52</sup>David C. Reardon, *Aborted Women - Silent No More* (Chicago, IL: Loyola University Press, 1987) 14-15, 335.

<sup>53</sup>Philip G. Ney, *Deeply Damaged* (Vancouver, BC: Pioneer Publishing, 1997).

43. It is clear, both in the law<sup>54</sup> and in standard medical ethics,<sup>55</sup> that patients are not allowed to prescribe their own abortion. While a woman may initiate a request for an abortion, it is the attending physician who is responsible for determining if an abortion is actually recommended and likely to be beneficial, given each woman's individual needs and risks.
44. At least some abortion providers perform abortions on request without forming an adequate medical basis to justify recommending abortion as the best form of care compared with other alternatives for managing a crisis pregnancy.
45. In forming a medical recommendation, the physician is obligated to develop this opinion "in light of all factors - physical, emotional, psychological, and the woman's age - relevant to the well being of the patient." *Planned Parenthood v Danforth* 428 U.S. 51, 67 (1975). And in all cases, the weighing of all the factors should operate "for the benefit, not the disadvantage, of the pregnant woman." *Doe v. Bolton* 410 U.S. 179 (1973) at 192.
46. It is essential to the psychological and physical well-being of a woman considering an abortion that she receives complete and accurate information on her alternatives. This is especially so since "abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life." *Harris v. McRaie*, 448 U.S. 297, 325 (1980).
47. A patient has the right to be fully informed of the basis for a physician's recommendation to abort, and of the risks attendant to abortion, and of alternative forms of care. "The decision to abort, indeed, 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." [emphasis added] *Danforth*, at 67. Furthermore, provision of this information is necessary to "insure that the pregnant woman retains control over the discretion of her consulting physician." *ibid*, at 66.
48. A study of women's desires to be informed of risks relative to elective procedures found that 95 percent of patients wished to be informed of all the risks of a procedure and 69 percent wanted to be informed of all alternative treatments, not just the alternatives preferred by their doctor, and that the desire for full disclosure is generally even higher when the elective procedure being considered is abortion. Moreover, in their ranking of the seriousness of complications, women ranked mental health complications as "very serious" and only slightly below the risk of death or heart disease.<sup>56</sup>
49. The standards for screening and provision of information which should be required by state statute should not be less than that of the following recommendation of medical authorities: "It is essential for the gravida [pregnant woman] to be *fully informed* about alternative resources and options and about the safety and risks of the procedure. Psychosocial

---

<sup>54</sup>Roe at 153.

<sup>55</sup>American College of Obstetricians and Gynecologists: Committee on Professional Standards, *Standard for Obstetric-Gynecological Services* (1981). Also, ACOG Executive Board, *Statement of Policy - Further Ethical Considerations in Induced Abortion*, (Washington, DC: ACOG, 1977), p2: "In responding to the patient's expressed wish for termination of her pregnancy, there may be a tendency for the physician to act solely as a technician. Such action denies the physician's traditional role as a counselor and advisor. Physicians have an ethical responsibility to assure quality counseling is provided by them or others."

<sup>56</sup> PK Coleman, DC Reardon, MB Lee, "Women's preferences for information and complication seriousness ratings related to elective medical procedures," *Journal of Medical Ethics*, 32:435-438 (2006).

assessment and counseling are done at the very first visit [see section on psychosocial assessment]. In addition to the medical history, an *in-depth* social history including relationships with others, attitudes about abortion, and support systems *must be obtained* at this time...No decision should be made by the gravida *in haste, under duress, or without adequate time and information*. Special attention should be given to feelings of ambivalence, guilt, anger, shame, sadness, and sense of loss.... Patients requesting abortion *must also be screened* to uncover any serious medical or psychiatric conditions."<sup>57</sup> [Italics added]

### ***The Standard of Care Widely Used by Abortion Providers in Practice Is Not Always Adequate to Protect the Health Needs of Women***

50. At least some abortion providers neglect to develop an adequate psychosocial profile of the woman seeking an abortion, or fail to identify and note known risk factors that would place the woman at greater risk of experiencing adverse physical or psychological sequelae after an abortion, both of which are necessary to making an informed recommendation.<sup>58</sup>
51. Some abortion providers have admitted a lack of expertise in providing counseling regarding all aspects of the abortion decision that might be relevant to women considering an abortion.<sup>59</sup>
52. Some abortion providers hire unlicensed "counselors" with no formal medical or psychological training. In some cases, the persons employed as "abortion counselors" are primarily trained to ease a woman's concerns and fears to encourage a decision to abort with the purpose of selling abortion services.<sup>60</sup>
53. In a retrospective survey of 252 women who experienced post-abortion sequelae, 66 percent of the woman said their counselors advice was very "biased" toward choosing abortion. In addition, 40 to 60 percent of the women described themselves as not certain of their decision prior to counseling, of whom 44 percent were actively hoping to find an option, other than abortion, during their counseling sessions. Only 5 percent report that they were encouraged to ask questions, while 52 to 71 percent felt their questions were inadequately answered, sidestepped, or trivialized. In all, over 90 percent said they were not given enough information to make an informed decision. Over 80 percent said that it was very likely that they would have chosen differently if they had not been so strongly encouraged to abort by others, including their abortion counselor.<sup>61</sup>

---

<sup>57</sup>Friedman, E., ed., *Obstetrical Decision Making, Second Edition* (Philadelphia: B.C. Decker Inc., 1987), especially Borton, "Induced Abortion" p. 44 and Stewart, "Psychosocial Assessment" p. 30.

<sup>58</sup>Carol Everett, *Blood Money* (Sisters, OR: Multnomah Publishers, 1992) and Pamela Zekman and Pamela Warrick, "The Abortion Profiteers," *Chicago Sun-Times*, special reprint 3 December 1978 (original publication 12 November, 1978).

<sup>59</sup>"Complaint for Injunctive Relief and Declaratory Judgment," Presidential Woman's Center, et al., v State of Florida et al, Circuit Court of the 15<sup>th</sup> Judicial Circuit, Palm Beach, FL CL-97-5796AG, page 22.

<sup>60</sup>Carol Everett, *Blood Money* (Sisters, OR: Multnomah Publishers, 1992) and Pamela Zekman and Pamela Warrick, "The Abortion Profiteers," *Chicago Sun-Times*, special reprint 3 December 1978 (original publication 12 November, 1978).

<sup>61</sup>Reardon, *Aborted Women*, 15-19. See also Rue VM, Coleman PK, Rue JJ, Reardon DC. Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. *Med Sci Monit*, 2004 10(10): SR5-16.

54. At least some abortion practitioners withhold information about risks or alternatives that if provided might alter the woman's decision and result in her refusal to undergo the recommended abortion. Sometimes this information is withheld to reduce the woman's stress prior to the abortion, but this omission may result in greater distress, or even psychological illness, following the abortion.<sup>62</sup>
55. Women are ill served by those abortion providers who would patronizingly protect them from evidence of risks that they have a right and need to consider. "As the patient must bear the expense, pain and suffering of any injury from medical treatment, his right to know all material facts pertaining to the proposed treatment cannot be dependent upon the self-imposed standards of the medical profession." *Cooper v. Roberts*, 220 Pa. Super Ct. 260,267,286 A.2d 647, 650 (1971). "True consent to what happens to oneself is the exercise of a *choice*, and that entails an opportunity to evaluate knowledgeably the *options available* and the *risks* attendant upon each." *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) at 780. "What is at stake is the woman's right to make the ultimate decision, not a right to be insulated from all others in doing so." *Casey*, at 715
56. The recommendation for abortion by some doctors is influenced by financial interests, racial bigotry, or population control ideology that may be at odds with the individual woman's own best interests.<sup>63</sup>
57. Some abortion providers encourage clients to make a decision quickly and without adequate counseling necessary to alleviate stress that may result in an ill-considered decision that will later be regretted.<sup>64</sup>
58. At least a few abortion providers encourage women to believe that abortion is the only way to solve their crisis when in fact financial, legal, and social resources are available which might help them to resolve their social, economic, or familial problems and thereby transform their untimely pregnancy into a wanted pregnancy.<sup>65</sup>
59. More than 80% of all 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. Often, women 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.

<sup>62</sup>Statistical analysis demonstrates that patient dissatisfaction with abortion counseling is a highly significant predictor ( $p < .0001$ ) of severe psychological reactions after an abortion. "Differential Impact of Abortion on Adolescents and Adults," Wanda Franz and David Reardon, *Adolescence*, 1992.

<sup>63</sup>"Doctor's Abortion Business Is Lucrative", *San Diego Union*, Oct. 12., 1980 B1:1. Carol Everett, *Blood Money* (Sisters, OR: Multnomah Publishers, 1992); David C. Reardon, *Making Abortion Rare: A Healing Strategy for a Divided Nation* (Springfield, IL: Acorn Books, 1996) 77-79; Reardon DC. The duty to screen: clinical, legal and ethical implications of predictive risk factors of post-abortion maladjustment. *J Contemp Health Law Policy*. 2003 Winter;20(1):33-114

<sup>64</sup> Carol Everett, *Blood Money* (Sisters, OR: Multnomah Publishers, 1992); David C. Reardon, *Aborted Women - Silent No More* (Chicago, IL: Loyola University Press, 1987) 232-271.

<sup>65</sup>Ibid.

60. Abortion providers, particularly in urban settings, complain of intense competition for customers. As described in a recent front page article in the *New York Times*, the subsidized abortion services of Planned Parenthood, which runs 147 abortion clinics in the U.S., has left for-profit clinics with little choice but to hire low-paid, poorly educated workers "to do everything but the actual surgery."<sup>66</sup> Their survival as businesses rests on high volume and low costs. Because of this competitive cost-cutting pressure, while all other medical costs have soared nearly 500 percent in the last twenty-five years, the cost of abortion has hardly changed at all.
61. Some abortion providers admit they simply don't have time for individual counseling. "Most of us abortion providers don't have time. Well at least at our clinic, we don't specifically counsel every woman. I liked that--today's term--'consult with women' as a part of getting them--as a part of the decision of making the abortion rather than counseling. So I used to be really pro-counseling but now I'm really changing my thinking in term--in that term."<sup>67</sup> At the same conference another participant discussed the financial pressure on clinics to do "enough abortions" to be profitable: "And that we really are running a business and it was very difficult--and it still is very difficult for me when I say 'Oh my God, we didn't do enough abortions today! Aahh!' You know, we're not gonna make our budget." ... Cause when I tell my friends, they go, "What?! You didn't do enough abortions? That's disgusting!" But that is the bottom line with us, isn't it?"<sup>68</sup>
62. Financial pressures not only discourage investment of the time and staff necessary to do proper individualized screening and counseling, but they may also foster a desire to "sell" this elective surgery to every customer who walks in the door.<sup>69</sup> In this regard, screening and counseling for risk factors, might actually serve to reduce a clinic's clientele and jeopardize their ability to survive as a business enterprise precisely because the proper identification of risks might cause some women to change their minds or even compel the counselor to recommend against abortion.
63. Some abortion practitioners, many with a history of incompetency, move from state to state.<sup>70</sup>

***Clarifying the Appropriate Standard of Care in Statute with Appropriate Civil Remedies for Injured Women Is the Most Practical Means of Protecting the Rights of Women Without Infringing on Their Reproductive Rights***

64. Some abortion facilities or providers neglect to carry adequate insurance coverage to protect the interests of patients who may be injured because of their abortions.

<sup>66</sup> Gina Kolata, As Abortion Rate Decreases, Clinics Compete for Patients, N. Y. TIMES, Dec. 30, 2000, at A13.

<sup>67</sup> Claudia, WomenCare Clinic in San Diego, Transcript from the National Abortion Federation, Sixteenth Annual Meeting, April 12-15, 1992, San Diego, CA.

<sup>68</sup> Cheryl Schrepf, National Abortion Federation, Sixteenth Annual Meeting, Apr. 12-15, 1992, San Diego, CA.

<sup>69</sup> Zeckman & Warrick. Abortion Profiteers (special reprint), CHICAGO SUN-TIMES, Dec. 3, 1978 (original publication Nov. 12, 1978).

<sup>70</sup> Mark Crutcher, *Lime 5*, (Denton, TX.: Life Dynamics, 1996).

65. Some injured abortion patients have been unable to recover damages in civil action for lack of adequate insurance coverage to cover their claims.
66. According to the *New York Times*, "a \$300 abortion in 1972 would cost \$2,251 today."<sup>71</sup> One of the major ways the cost of abortion has been kept low is by minimizing the costs of screening and counseling individual women.
67. Some complications associated with abortion may only become clear several years, or even decades, after the abortion.<sup>72</sup>
68. Some injured abortion patients have suffered psychological injuries that prevent them from seeking recovery of damages in a civil action, or cooperating effectively with counsel, before their recovery from their psychological disabilities. Because these injured women may be unable to cooperate in an action for recovery before the expiration of the normal statute of limitations, some injured patients have been denied legal representation or standing.
69. Without a clear statutory provision allowing women to recover damages for delayed reactions to abortion, women are often denied just compensation for their injuries. Obstacles, such as this, in the way of injured patients recovering damages for abortion related injuries, have artificially reduced the abortion provider's liability and undermined the financial motivations which normally work to ensure that physicians employ a high standard of care. Eliminating barriers to proper liability will encourage a higher standard of care and thereby will reduce the occurrence of abortion related injuries and, conversely, increase the likelihood that the psychosocial benefits sought by their patients will actually be achieved.

### ***The Prevailing Low Standard of Care Discourages Competent Physicians From Providing Better Counseling Services and Safer Reproductive Health Care***

70. While every licensed physician is allowed by law to perform abortions, and most have a favorable view of abortion, only a small number of physicians currently perform abortions, often in facility dedicated primarily to abortion services. According to Ronald Fitzsimmons, executive director of the National Coalition of Abortion Providers, he gets calls from doctors who want to perform abortions but he cannot help them because "There are places in this country where there are more doctors who perform abortions looking for work than we can handle."<sup>73</sup>

<sup>71</sup> Gina Kolata, As Abortion Rate Decreases, Clinics Compete for Patients, N. Y. TIMES, Dec. 30, 2000, at A13.

<sup>72</sup> Major B, Cozzarelli C, Cooper ML, Zubek J, Richards C, Wilhite M, Gramzow RH. Psychological responses of women after first-trimester abortion. *Arch Gen Psychiatry*. 2000 Aug; 57(8): 777-84; Miller WB, Pasta DJ, Dean CL. Testing a model of the psychological consequences of abortion. In LJ Beckman and SM Harvey (eds.), *The new civil war: The psychology, culture, and politics of abortion*. Washington DC: American Psychological Association; 1998; 235-67; Reardon DC, Cogle JR, Rue VM, Shuping MW, Coleman PK, Ney PG. Psychiatric admissions of low income women following abortion and childbirth. *Can Med Assoc J*. 2003; 168(10):1253-7.

<sup>73</sup> Gina Kolata, "As Abortion Rate Decreases, Clinics Compete for Patients" *New York Times*, Dec 30, 2000, p1.

71. According to a front page investigative report from the New York Times tough competition has resulted in cost cutting measures that involve the use of untrained staff and variations from recommended procedures.<sup>74</sup>

“...unlike other areas of medicine, where prices have surged over the years, competition among abortion clinics has kept prices so low that an abortion in many cities costs less now than it did 25 years ago, without even adjusting for the nearly 500 percent inflation in medical services. If abortion had kept up with inflation in medical services, a \$300 abortion in 1972 would cost \$2,251 today....

“The fees are not set by the cost of the services but by the cost of the competition,” said Dr. Warren Hern, owner of the Boulder Abortion Clinic in Colorado. And, he said, “the competition for patients is absolutely ruthless.

“Ms. Allen and Ms. Miller [owners of an Arizona abortion clinic] still have to watch every penny. Like other clinics, the owners save money by training a low-paid staff to do everything but the actual surgery, from drawing blood to doing lab tests. Most of the time, no patients are scheduled and the staff cleans and does paper work. But when the doctor comes, a parade of patients is ready for the procedure, which takes just two or three minutes in the first trimester of pregnancy...

“Now, clinics are grappling with the mifepristone dilemma. Owners feel they have to offer the recently approved abortion pill, formerly known as RU-486, because women are asking for it and seem to expect it. But its price -- \$270 for three pills -- will be a problem. Many owners say that if they charge what it costs to provide the three pills plus the three office visits, the lab work, and the counseling, they will lose customers to competitors who say they will keep the price much lower.

“Some have found creative solutions. Ms. Chelian said she is considering offering women just one pill instead of three and to have them sign a form saying they understand that one pill is not the approved dose but that studies have shown that one pill is effective. Then she can charge them just \$80 more than for a surgical abortion.

“Carmen Franco, who owns six clinics in Detroit, said she expects to charge women \$450 for a mifepristone abortion with the full three-pill dose. It is less than her costs. But, she said, by making it available, she expects to draw patients to the clinic where they can see the full range of options she provides. ‘We probably will use it as a loss leader,’ she said.”

72. The specialization of abortion services has led to competitive marketing practices that emphasize high volume and low cost. The cost cutting measures have often involved compromises in the standard of care necessary to safe guard women’s health and have led to charges that many freestanding abortion clinics operate on an “assembly line” basis. In many cases, the time set aside for counseling women is extremely limited. This is especially disturbing since the irrevocable decision to abort is very complex one, often made in highly emotional situations with great ambivalence, and includes many risks. Furthermore, in many cases, this very limited screening and counseling that is provided is

---

<sup>74</sup>Gina Kolata, “As Abortion Rate Decreases, Clinics Compete for Patients” *New York Times*, Dec 30, 2000, p1.

undertaken by employees who lack any professional accreditation as medical or psychological counselors.

73. The cost-cutting measures employed by “assembly line” abortion clinics have reduced costs to a point that it is difficult for other physicians who would employ a higher standard of care to provide abortions at a comparable cost. Many physicians who would otherwise be willing to perform abortions simply cannot afford to provide abortion services at a competitive rate without making similar sacrifices in the standard of care they believe would be most appropriate.

“Dr. Hern used to have plenty of patients for first-trimester abortions at his clinic in Boulder, where he was charging \$375. Then, a Planned Parenthood clinic opened in nearby Fort Collins, charging less than \$300. Subsidized by the nonprofit Planned Parenthood Foundation, the clinic was able to keep its fees lower than Dr. Hern could even contemplate.

“Within a month after that clinic opened, my patient numbers dropped by 25 percent,” Dr. Hern said.

Independent abortion providers say Planned Parenthood clinics can easily undercut them. “I would sort of compare them to Wal-Mart coming in and taking over from all the mom and pops’,” said Dr. William West, who works at an abortion clinic in Dallas.”<sup>75</sup>

74. To the degree that the higher standards of care that will result from this statute may increase the cost of abortion, more physicians will be able to provide abortion services at a reasonable profit without endangering their patient’s health.
75. Reports of aberrant and unethical behavior on the part of some abortion providers, and the fact many doctors who perform abortions do so in an “assembly line fashion,” have contributed to negative perceptions about abortion providers within the medical community and in society at large.<sup>76</sup> This perception may discourage many doctors who favor abortion from actually providing abortion services.
76. Defining a higher standard of care through statute will help to reduce the perception, both within and outside the medical community, that the quality of health care provided by doctors who perform abortions is “second rate.”
77. Appropriate screening and counseling of women are necessary to protect their health and to determine if a recommended abortion is indeed likely to be more beneficial than harmful to them. It is the considered opinion of this committee that any increased costs associated with providing this necessary level of care are appropriate and necessary for the protection of women. Therefore, it is in the legitimate interests of the state to clarify the standards for screening, counseling, and disclosure by statute in order to ensure that the standard of care does not decline because of cost cutting pressures.

---

<sup>75</sup>Gina Kolata, “As Abortion Rate Decreases, Clinics Compete for Patients” *New York Times*, Dec 30, 2000, p1.

<sup>76</sup> Mark Crutcher, *Lime 5*, (Denton, TX:: Life Dynamics, 1996) 177-178.

## **Providing Right to Redress Against Non-physicians Who Perform Illegal Abortions or Encourage Self-abortions Is an Important Means of Protecting Women's Health**

78. Abortions performed by persons other than a licensed physician are dangerous and have many times the risk of causing death and other serious physical and psychological injury.
79. Women who attempt or complete a self-abortion are at a much greater risk of suffering serious physical and emotional complications, including death, as compared to women who receive abortions from a licensed physician under safe conditions with appropriate screening and counseling. Persons or organizations which dispense medical advice regarding self-abortion techniques are exploiting the fears of women in crisis, encourage the false belief that a self-induced abortion can be safe, and thereby deter women from seeking appropriate medical care from a licensed physician who can ensure that women receive adequate pre-abortion risk evaluation, counseling, and post-operative care.
80. Providing a means for women to hold non-physicians who perform illegal abortions or provide information or materials with the intent of encouraging or aiding a woman in inducing a self-abortion liable for endangerment of the woman's health and for actual injuries suffered is an important deterrent against such activity and will safeguard women's health by better ensuring that women seeking abortion will be counseled and treated by licensed physicians.

## **LEGISLATIVE PURPOSES**

Based on the findings described above, HB1236 is intended to achieve the following purposes:

1. To 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*, 112 S.Ct. 2791, 2823, (1992).
2. To clarify the standard of care for screening and counseling of women seeking abortion so as to better ensure that physicians recommending and performing abortions have carefully evaluated and informed each woman of the risks that are most likely to be associated with a person matching her physical and psychosocial profile.
3. To better ensure that women who have abortions do so only after giving their voluntary and fully informed consent and to better ensure that a woman's agreement to a recommendation to abort is not the result of coercion or external pressures that are in conflict with her own personal moral beliefs or desires to give birth to her unborn child.
4. To better protect women from individuals or circumstances that would pressure them into a violation of their conscience.
5. To make information about the risks and alternatives to abortion more readily available to physicians and the public.

6. To better ensure that physicians providing abortion have malpractice insurance that is sufficient to protect the interests of women who may be injured from malpractice.
7. To preserve the rights of women who may have suffered from an emotional or psychological disability that prevents them from being able to seek recovery or cooperate with counsel to bring a civil action within a reasonable time limit after they have recovered from their emotional or psychological injuries.
8. To discourage and prevent illegal abortions.

# Negligent Screening Act – HB1236

## -- Talking Points --

### The Problem

- ◆ Many abortion providers have compromised the standard of care for counseling and screening of patients in order to reduce costs and maximize profits.
- ◆ In hundreds of cases each day, known risk factors for physical and psychological complications are not being detected because simple questions are not being asked.
- ◆ Women are suffering from *avoidable* physical and psychological complications that may have been *prevented or minimized if the proper pre-abortion screening standards had been employed.*
- ◆ Without adequate screening for risk factors it is impossible for abortion providers to give accurate information about risks to women based on their individual risk profile.

### What the Negligent Screening Act Does

- ◆ It removes legal obstacles which typically make it difficult or impossible for women to hold her abortion provider liable for avoidable injuries which are a result of negligent pre-abortion screening and counseling.
- ◆ It clarifies in statute the duty of physicians to screen for risk factors which place women at higher risk of physical or negative complications of abortion.
- ◆ It restores the accountability of physicians for making informed medical recommendations based on each woman's individual risk profile.
- ◆ It better protects women from undergoing coerced abortions, which is a major risk factor for severe post-abortion psychological problems.
- ◆ It strengthens the Women's Right to Know Law by ensuring that women are given not only the general information about abortion risks, but also the specific information most relevant to individual women according to their own unique risk factors.
- ◆ It better protects women from illegal abortions and/or marketing of self-abortion kits.

### What the Negligent Screening Act Does NOT Do

- ◆ It does not impose any requirements on abortion providers that are contrary to the standard of care for screening which applies to any other medical procedures.
- ◆ It does not impose any burdens on women seeking abortions.
- ◆ It does not *ban* any abortions, even in those cases where a woman may be at higher risk of one or more adverse reactions. The final decision remains with the woman

- ◆ It does not affect any other medical procedures.

### The Benefits

- ◆ It will reduce abortion rates, particularly among the 64% of women who report feeling pressured by others to consent to an unwanted abortion.
- ◆ It will reduce abortion rates among the subset of women who are at highest risk of suffering complications from the abortion who might prefer to seek other options after receiving proper, individualized screening and counseling.
- ◆ It will reduce the number of abortion related physical and/or psychological injuries suffered by women.
- ◆ It will reverse the decline in the standard of care in abortion clinics.
- ◆ It will *immediately* protect women from negligent screening because (a) it provides no basis for abortion providers to obtain a federal injunction as affirmed in *Okpalobi v Foster*, 244 F\_3d 405 (5th Cir\_2001) because it erects no threats of criminal penalties or loss of license, and (b) even in the event an injunction is obtained, the statute is tolled until all legal challenges are settled.

### Protecting Women's Right to Redress For Negligent Abortion Screening & Counseling Is Constitutional

- ◆ "[T]he abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available." *Roe v Wade* 410 U.S. 113, 166
- ◆ "The medical, emotional, and psychological consequences of abortion are serious and can be lasting; this is particularly so when the patient is immature. An adequate medical and psychological case history is important to the physician." *H.L. v Matheson* 450 U.S. 398, 411 (1980).
- ◆ "It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know.... Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends....and if some procedures have different risks than others, it does not follow that the State is altogether barred from imposing reasonable regulations." *Gonzales v. Carhart*, 550 U.S. (2007).

# STOP FORCED ABORTION



About Us

The Initiative

FAQ's

## What the *Protection from Coerced and Unsafe Abortions Act* Does – and Doesn't – Do

Forced Abortions in America

Our Initiative

What it Does

Questions and Answers

About Us

Donate



News

Join Us

How You Can Help

### The Problem

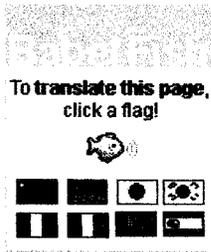
- ◆ In hundreds of cases each day, pregnant women are being pressured, coerced, or even forced into *unwanted abortions*. Often this pressure may even include acts of **violence** against these women.
- ◆ Most abortion providers have **abandoned any effort to screen** for coercion and other risks in order to reduce costs and maximize profits.
- ◆ Women are suffering from **avoidable physical and psychological complications** that may have been prevented or minimized if the proper pre-abortion screening standards had been met.
- ◆ Without adequate screening for coercion and other risk factors it is impossible for abortion providers to give their patients an informed medical recommendation which will best address a patient's individual needs and risks.

### What the Women's Health Protection Act Does

- ◆ It clarifies in statute the duty of physicians to screen for statistically proven risk factors which identify women at higher risk of physical or negative complications of abortion.
- ◆ It clarifies the duty of abortion providers to ask whether a patient is feeling pressured into the abortion. This gives the woman and the doctor the opportunity to openly discuss any pressures she faces to submit to an unwanted abortion and to consider alternatives, if appropriate, such as group counseling for the patient and those pressuring her.
- ◆ It restores the accountability of physicians for making informed medical recommendations based on each women's unique profile of risks, wants, and needs.

### What the Women's Health Protection Act Does NOT Do

- ◆ It does not impose any burdens on women seeking abortions.
- ◆ It does not ban any abortions nor does it make any abortions illegal, even in those cases where a woman may face elements of coercion or may be at higher risk of one or more adverse reactions.



- ◆ It does not impose any requirements on abortion providers that are contrary to the standard of care for screening that applies to other medical procedures.
- ◆ It does not require any enforcement by the State. The provisions of the bill defining negligent screening are enforced solely by injured women through civil remedies.

### The Benefits

- ◆ It will reduce the number of women who undergo unwanted abortions, sparing them the grief, guilt, depression, and trauma that often follow an unwanted abortion.
- ◆ It will reduce abortion rates and better enable women who don't want abortions to welcome an unplanned child into their lives.
- ◆ This statute will correct a loophole in the law that shields abortion providers from proper liability when they neglect to provide reasonable medical advice, which can only be done after proper screening of the individual patient's needs and risk factors.
- ◆ It will reduce the number of abortion related physical and/or psychological injuries suffered by women. This is achieved by creating an incentive for abortion providers to improve substandard pre- and post-abortion counseling programs so that they properly address the pre-abortion risk factors and post-abortion reactions that effect many of their patients.
- ◆ It will reverse the **decline in the standard of care** in abortion clinics.

This public education effort is sponsored by the Stop Forced Abortions Alliance. copyright 2007-2008 Stop Forced Abortions Alliance