P U B L I C H E A R I N G

before

COMMISSION ON SEX DISCRIMINATION

IN THE STATUTES

"To discover whether there are incidents or common practices that encourage sex discrimination in the health field and in the delivery of health care"

June 20, 1990
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF COMMISSION PRESENT:

Assemblyman Neil M. Cohen, Vice Chair
Senator Donald T. DiFrancesco
Viola E. Van Jones, Ph.D.
Roberta Francis

ALSO PRESENT:

Ariel B. Perelmuter, Esq.
Assistant Director for Research

Joan Sampieri, Research Associate

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State of New Jersey

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NOTICE OF PUBLIC HEARING

The Commission on Sex Discrimination in the Statutes will hold public hearings on Wednesday, June 20, 1990 at 10:00 a.m. in Room 341 of the State House Annex and on Tuesday, June 26, 1990 at 12:00 noon in Room 334 of the State House Annex.

The purpose of these public hearings is to discover whether there are incidents or common practices that encourage sex discrimination in the health field and in the delivery of health care. The Commission is mandated to examine the laws of New Jersey and to suggest revisions to the statutes that will correct discriminatory language or application.

The hearings are expected to focus on the following areas:

Access to health care
AIDS
Detection and treatment of domestic violence by health care professionals
Differences in the way men and women are treated as patients
Drug treatment programs
Fetal protection policies in employment
Hospital and laboratory practices
Insurance-rates, denials, COBRA terminations
Medical education
Medical/Clinical research
Mental health care and treatment
Nursing practice and education
Previention and treatment of fetal alcohol syndrome
Prenatal, pregnancy, and childbirth services and practices
Prosecution for child abuse/neglect during pregnancy
Video display terminal workers and other possibly hazardous employment conditions

These topics do not preclude other relevant testimony, and your testimony does not have to be limited to one category.

Anyone wishing to testify should contact Jodi Danis, Research Intern at the Commission at (609)633-7098.

Anyone wishing to submit written testimony to the Commission is requested to bring 10 copies to the hearing or to mail it to the Commission office by July 3, 1990.

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SENATOR DONALD T. DiFRANCESCO (Acting Chairman): If I could have your attention for a couple of minutes-- My name is Don DiFrancesco. I'm a State Senator. I'm in another meeting next door on ethics in government. As a member of the Commission on Sex Discrimination in the Statutes, I wanted to at least make an opening statement on behalf of the Commission which reflects the feelings of the Commission as a whole in this area.

Health issues have been in the forefront of national attention over the past few years. Health, as most of us know, has also become a particularly important concern in New Jersey, and the Governor's Commission on Health Care Costs has been a means to address problems arising from the ever-increasing costs of obtaining health care. Sex discrimination in the health field and in the delivery of health care also presents what we believe to be an important area of study.

Women often face additional barriers in the health care system because of discriminatory practices and because of women's economic status. The increasing difficulty of obtaining adequate health insurance has taken an especially hard toll on women, and access to low-cost prenatal and pregnancy care remains a problem. Women may also not receive the same health care options and quality of care as do men. Women are often not studied in certain areas of medical research, and existing medical models often do not include the experience and needs of women.

Many witnesses have come today to testify on these important issues. The Commission on Sex Discrimination in the Statutes hopes that the information from these hearings will be considered by the Governor in his study of health care in New Jersey.

Now, we have a witness list, and the first person on the witness list is Dr. Marsha Kleinman, from the New Jersey Psychological Association. Is that person here?

M A R S H A K L E I N M A N, Ph.D.: Right here.

SENATOR DIFRANCESCO: There you are. You must have known that you were first. Do you have a prepared statement of any sort?

DR. KLEINMAN: No. I don't have a prepared statement. It's in my head.

SENATOR DiFRANCESCO: All right. It's being transcribed, as you know.

DR. KLEINMAN: Okay.

SENATOR DiFRANCESCO: But, this doesn't amplify your voice so that these people can hear, (referring to recording microphone) so if you can speak up, perhaps they can hear what you're saying as best they can, unless they want to move forward, and some don't. We can start.

DR. KLEINMAN: Great. I'm glad to be here this morning as a representative of the New Jersey Psychological Association. I'm a licensed clinical psychologist, and I would like to talk about the issue of domestic violence as a health care issue for women.

There are many issues in domestic violence that concern me with regard to psychologists. One of the concerns is that there is no current specific training required for psychologists in the area of domestic violence. It's considered rather new. It's a new area. It's a new area of interest for people.

What concerns me is that there are old beliefs and myths about women; about women as being masochistic; about women as being hysterical; a lot of pejorative terms used about women, and when battered women come in for treatment, they are often reviewed and viewed in terms which are not really appropriate.

Let me address some of the concerns with health care about battered women and go through them, and then hopefully I can elaborate. One is that battered women are often likely to

be battered during pregnancy, so that you have issues of women coming in for health care and physicians picking up on this and intervening in some way.

Two, I don't know of any studies, although I've looked to determine whether there's any correlation between any birth defects or birth anomalies and beatings that occur during pregnancy, since often the first pregnancy is the time when a woman is likely to begin being beaten, and the beatings escalate over time. There are statistics about what happens during the first, second, third pregnancies, etc.

Another concern is that when battered women-- Emergency rooms are the place where battered women are most likely to present. It's often the first place they go to. If emergency room personnel are not trained in the area of domestic violence, they often miss both the assessment and the referral and also, perhaps later, the important documentation that there has been domestic violence.

The literature on domestic violence tells us that battered women often lie about how they got their bruises and how things happened. However, if they are asked directly and someone says, "Did your husband," or, "Did so and so do this to you?" they will answer, "Yes." You will get a direct answer. So the training of the emergency room personnel is a critical issue in determining the care and also intervening in prevention, because for almost every battered woman, you're talking about children, and the issue of children concerns me a great deal as it relates to battered women. So there's an opportunity to intervene, to give information, and to do some prevention with regard to children.

The issue of domestic violence in psychologists: The literature also tells us that mental health professionals are often the last people to know that women they see in their office are being battered. This does not bode well for good treatment. If you do not know someone is being battered and

you do not have that context, you may see this person in treatment with their spouse or their boyfriend who may be the batterer. I would consider this inappropriate as treatment. They should not be seen together.

There are also models of therapy considered to be appropriate models. They are training on these models which I would call -- which involve a complementarity -- and that means that if a woman says she is beaten, the question would be to the person who is beating her, and to her, "Well, what did you do to provoke it?" In other words, there's some interrelationship between what happened to you and what you did to provoke it.

In the issue of domestic violence I think this is extraordinarily inappropriate, and in fact, would further serve to maintain this woman in an abusive relationship. So, the training of psychologists in the area of domestic violence is one that is dear to me.

Another issue is the issue of children and what happens to them in homes in which there is violence. When I talk about domestic violence I'm not talking about homes in which women are thrown through windows, where they're stabbed. Domestic violence can be much more benign. There could be shoving, pushing, a slap, but it's always coupled with psychological abuse and emotional abuse. It is the emotional abuse that, really, women will tell you is the most disturbing and the most devastating to them, because it wears down their self-esteem, and it helps to maintain them in these relationships. It essentially helps the abuser to gain control and to gain power.

An issue that's very dear to me at this moment is battered women and custody. I am involved with -- in fact, I am currently--

SENATOR DiFRANCESCO: What's that? Battered women in custody?

DR. KLEINMAN: In custody disputes. I was testifying this week. I'll be testifying in two weeks in another custody, with a battered woman. The statistics show that almost over 70% -- close to 80% -- of battered women lose custody of their children, not because they're bad moms.

The issue-- There is a tremendous myth in the court system. There is a myth that's going on that is very destructive and very distressing; and that is, as soon as a woman is in a divorce situation and she makes certain allegations either about sex abuse or child abuse, right away she's suspect. Unfortunately, rather than wondering why she left, and that this may be the reason she, in fact, had left the relationship, right away, it's she left and now she is trying to gain custody of her child by doing this.

I've been involved in cases where I've seen psychologists and social workers, what I would call behave extraordinarily unethically in this regard. They do evaluations, and they know nothing about domestic violence. I've seen judges make what I would consider wrong decisions. I get phone calls from women. I get phone calls from attorneys. This week I've been on the phone almost every night late in the evening with a variety of cases, with attorneys calling me, and in trying to educate the judges about domestic violence. It's already in the Legislature. I think it's the Domestic Violence Act, Title 25, which says that we recognize that there is a high correlation between spouse abuse and child abuse. But one of the problems is women often do not have the funds to hire counsel. This is a critical issue.

Sometimes the counsel they get-- They find nice attorneys, nice people who will help them, who will defer payment or who will do it for limited payment. But the same attorneys who I would consider nice, good people, are not aggressive in the courtroom, and they are not represented in these cases. Generally my experience is that men who abuse are

very good at getting themselves a very aggressive attorney, someone who is going to fight for them, and they can afford the kinds of fees that are required to go through a lengthy custody battle.

The issue of money concerns me -- well, the issue of custody concerns me a great deal, because I'm seeing women lose custody of their children when there is, essentially, no allegation against them, there is no complaint against them, and the woman has made -- has called DYFS, has taken the child to the hospital, has done all kinds of things to substantiate that there has been some child abuse. This issue needs to be looked at very, very, closely. If fact, one of the cases I'm involved in currently, this woman wrote a letter -- I think to Governor Kean, while he was still in -- asking for help because her husband is a recognized official of the State.

The issue of money comes into play in other areas. Battered women often have difficulty with housing and in supporting themselves.

Let me stop because I could talk, and I could go into depth on any one of these issues, and I would love to, but I'm trying to give you a broad overview of the kinds of issues and what is going on. There is some-- There is a lot of literature about battered women in the court system. There is literature on battered women and testing, the kind of psychological tests being used to make them -- for people to gain custody, to take custody away from them. There is literature about the statistics; there is tremendous literature. In fact, I am currently preparing some literature for the New Jersey Board of Psych Examiners to look into in developing criteria for psychologists to do custody evaluations. It's my belief that when involved in custody evaluation, someone should be able to identify if there is a likelihood of domestic violence and if there is a likelihood of

sex abuse, and then someone who is an expert in these areas-- That person should only be a qualified person who does an evaluation of those areas.

I don't know if it's appropriate for me to stop and ask you whether there's questions; whether you'd like me to explain what happens in areas of domestic violence or what battered women are like and what happens to them? But let me stop and ask you if you have questions that I can then elaborate on.

MS. SAMPIERI: I had three questions while you were talking. Considering the focus of this hearing, health issues, it seems to me you raised three pertinent points: The training of emergency room physicians, training for psychologists, and some kind of standardized evaluation concerning court ordered psychological evaluations in custody battles. I don't know where, beyond those three things, you see the Commission looking at this. There's certainly some things that you've brought to our attention, and I'm wondering if there is anything specific that you would recommend as we look at these issues?

DR. KLEINMAN: I would recommend several things. I think I would recommend that as a part of routine training -- medical training and for health care workers and facilities -- that there be specific training in the area of domestic violence; that there be: how to recognize a woman who may be battered, how to interview a woman who might be battered, how to interview the children, if necessary. It's critical. The woman needs to be interviewed alone.

In the area of psychological training, I think that psychologists who work with families, with couples, with individuals -- that covers the whole range -- need also to look into the need to be trained and the need to have awareness of the issue of domestic violence. They need to know how to assess and they need to know how to interview, again; how to

elicit this information, and they need to know the appropriate standards for treatment and the appropriate ways to interview.

In evaluations for custody, I'm concerned with several things: One, I'm concerned with funding for lawyers. I'm really very concerned that there should be a defense fund for attorneys for battered women. I would tell you right now that that concerns me more than anything, because when battered women are in the court system with children, you are talking about millions and millions of children who are being victimized by decisions that are being made by people who do not know anything about domestic violence.

So, to have a legal defense fund, whether it was in the private sector or not, how that came to be, I think is critical.

A very critical issue is that judges need training. They're clearly uninformed and unaware, and making decisions out of, I believe, ignorance, not malice.

I think that attorneys need training. I think that attorneys often don't believe the women who come in and they don't understand, and it's not until the case has gotten so complicated that they really see what's going on, and what this man is capable of. I think attorneys need training in the area of domestic violence.

I'm not sure what else the Commission's looking into where I could be helpful to answer the last part of your question.

MS. SAMPIERI: Okay. I have one last piece of that: With your association with the New Jersey Psychological Association, how can you see this being made part of licensing?

DR. KLEINMAN: I don't think it will be made part of licensing. The licensing law is fixed and I think that the Board of Psych Examiners, which monitors and regulates licensing, is looking into the area of custody evaluations and criteria, and who does them. And they're -- the psychologists -- are currently reviewing this themselves.

MS. SAMPIERI: Okay. Thank you.

DR. VAN JONES: I would like to ask another question. I'm sorry that I'm late. I got caught in traffic.

My name is Dr. Van Jones and I'm from Rutgers University. I'm one of the Commissioners on the Commission on Sex Discrimination in the Statutes.

I wanted to get a little more explanation about the defense fund. How do you see that as a solution to the problem, and also explain the connection with the public defender's office for those who either cannot, or can ill afford to pay their attorney fees?

DR. KLEINMAN: The public defender's office only covers criminal trials. I'm involved with the public defender's office in Pennsylvania tomorrow with a battered woman who killed in self-defense, and I get involved in criminal trials of that kind. The public defender does not handle divorce and custody.

Legal Services handles, but they often-- In a case where I was involved where a woman lost custody of her five children, Legal Services did not retain me, although they contacted me, because of funding problems.

The concern is that battered women, if they lose custody, do not have money for an appeal. There's no money to get a copy of the transcript. The kind of money that these cases involve for legal costs are $50,000 or $60,000. I know people who have put time in -- myself included -- for free, when there have been children involved, and I know attorneys who have put time in for free, but an attorney, unless the attorney is independently wealthy, can't afford to take the kind of time necessary to battle one of these cases, because generally men who batter, who fight for custody, are extraordinarily devious and clever. They have good counsel, and the woman is often--

The other piece is that when a woman leaves a relationship, the battering goes on in one way or another. They may not be physically beaten, but there is ongoing harassment, and they are constantly in court. They often get frozen out with money, so that they have to stop going to court; they cannot fight back. They go pro se; many go pro se, or they give up the fight. There's no way to continue fighting. They've depleted family resources. Their homes have been mortgaged; the parents have mortgaged as much as they can. Often battered women in these relationships have no control over resources. Even if there is money, she has not had access to it; does not have a name on an account. So that without representation, she doesn't have a shot, and without good representation, she doesn't have a shot, and I'm very concerned, because we're talking about children, not just women here. It's the health care of children, because these children are-- I see grown adults in my practice who have come from these homes.

DR. VAN JONES: Okay. That's it. Thank you.

DR. KLEINMAN: Thank you.

DR. VAN JONES: Okay. We'd like to call our next two people. I understand that you're working jointly. Dr. Kathleen Ruben, and Lucile Pfleeger?

L U C I L E - H A R K N E S S P F L E E G E R: Pfleeger. (pronounces name)

DR. VAN JONES: Pfleeger, a double "e," Pfleeger.

MS. PFLEEGER: Right.

DR. VAN JONES: Okay. Welcome to the hearing. It's up to--

K A T H L E E N R U B E N, Ph.D: Lucile is going to go first.

DR. VAN JONES: Okay.

MS. PFLEEGER: We're working together, and I'm listed as being from the Family Planning Services of Cumberland,

Gloucester, and Salem Counties, which I am. We are here to talk about-- We want this Commission to help us with a State ordinance to prevent the blockade of clinics, because these blockades are preventing women from receiving health care.

I'm not going to read my first page. I simply outline why I'm interested in this and what my involvements over the years have been. I was a housing authority commissioner for 10 years and worked with low-income minority families and their health problems. Presently I'm President of the Board of PASA, the shelter for battered women for Gloucester County. The testimony we just heard is of great interest to me. I'm a member of the Board of the Family Planning Services. I just said that. I'm also, right now, today-- I co-chair, with Dr. Kathleen Ruben, the Clinic Defense for South Jersey -- for the Alice Paul-South Jersey Chapter of the National Organization for Women. I'll start with my testimony.

For several years I have volunteered on Saturday mornings to escort patients into the Cherry Hill Women's Center in Cherry Hill, New Jersey. Originally, only two or three volunteers were needed to shield the young girls and women patients from the demonstrators walking on the sidewalk in front of the clinic.

In 1985 there was an invasion of the clinic when several persons, mostly males, forced their way into the clinic. Health center employees suffered broken foot bones and broken ribs. The trespassers chained themselves to chairs and disrupted the operation of the clinic for several hours.

In November of 1987, Randall Terry and "Operation Rescue" staged a trial siege, or blockade, at the Cherry Hill Women's Center in preparation for a week-long assault on New York City clinics. It took several hours for the police to carry away the demonstrators. Since then, the Cherry Hill Women's Center has had three major "hits" by Operation Rescue.

As a result of these assaults on the Cherry Hill Women's Center and other health centers, the defenders of clinics, under the leadership of NOW, have become organized. On each Saturday morning from 20 to 50 volunteers arrive at the Cherry Hill Women's Center at 5:30 a.m. and stay at least until 10:00 a.m. to escort patients. If we have a major "hit," we alert our phone tree, and extra emergency volunteers arrive on the scene to assist. Our volunteers include teenagers and senior citizens, both male and female, who volunteer for this service.

The leaders of the blockades are always men. Women participate, but they are given orders which they must follow. Most of the leaders of both the blockades and the regular Saturday morning picketing are clergy.

For instance, two fundamentalist preachers routinely bring their youth groups -- preteens and teens -- to the Cherry Hill Women's Center on Saturday mornings to harass and annoy women, an early lesson in sexism. They risk the lives of these children as they purposely send them across the driveway as patients are making left turns, across two lanes of traffic, into the driveway of the Women's Center. I predict a terrible accident will happen because of this tactic.

These clergy have been highly incensed when I have reminded them that clergy are one of the top four categories of men who beat their wives, and that their harassing of women patients expresses a need for them to dominate and control women.

Catholic clergy and laypersons loudly recite their rosaries and vociferously accuse both patients and defenders of being "Agents of Satan."

Women's Health Centers provide routine gynecological health care which includes pelvic examinations, PAP tests, breast examinations, sexually transmitted diseases testing, contraceptive services, pregnancy testing, counseling services,

and laboratory services, as well as first and second trimester abortion procedures under local or general anesthesia.

Young girls and women seeking these gynecological services must enter the clinic while being assaulted by ugly posters and barraged by men with bullhorns who harangue and harass them.

Women scheduled for abortions have been required to fast and are frequently feeling weak and queasy. On the days when the clinic is under siege women are forced to wait outside in their automobiles, sometimes for several hours, for the police to clear the blockade. Some become distraught, and staff and volunteers attempt to comfort them.

Some women are in the second day of a two-day process, laminaria, and must receive attention immediately or they can suffer severe adverse effects. On the days the clinic is blockaded these women must be sent immediately to another facility several miles away, in Pennsylvania.

In August of 1989, while giving instructions to one of these women, a trespasser who was harassing the patient, reported to the police that I had "touched" her. A policeman threatened to arrest me even though I was wearing a clinic escort sign and was assisting patients at the request of the Cherry Hill Women's Center. The trespasser was violating the law by being on the property.

During the April 29, 1989 blockade attempt, our clinic escorts were able to hold the door and were able to assist all patients in reaching the door even though the trespassers pushed, shoved, and kicked the patients, our volunteers, and the police -- all of us. During the invasion I was knocked to the ground, and later, when I was crushed against the door, I felt panic and understood how it was possible for those soccer fans to be killed. Some patients were thoroughly terrorized.

I left the Cherry Hill Women's Center at 11:00 a.m., called the New Jersey State Police to report that the situation

at the Cherry Hill Women's Center was out of control, and asked for their assistance. We had previously had a conference concerning the clinic blockades with a representative of the State Police, at their request. I was told later that State Police are not allowed to provide assistance unless requested to do so by the municipality.

We request this Commission to investigate the possibility of revising this regulation. We question why, when blockades occur, one municipality should be expected to assume the expenses of the police, courts, and jails, when Women's Health Centers serve women in all municipalities in all counties in large regions of our State? There are only a few of these health centers.

Presently, there is no uniform law enforcement of existing ordinances against blockades. Women are discouraged by officials from filing complaints. They are told that the chances of successful prosecution are slim. I feel that a State ordinance is needed which would require police to arrest those who invade clinic property, before they have the opportunity to "seize" the door, and would require courts to levy and enforce strong penalties.

We request this Commission to investigate the possibility of drafting an ordinance which would require Operation Rescue to notify the police as to the location of their proposed blockade, as was required by the police during their assaults in New York City. Much time, expertise, and resources are wasted by the police and the volunteers who defend the clinics because of having to be constantly ready to respond to a blockade or siege.

We request this Commission to investigate the possibility of drafting State regulations which would prevent the harassment of Women's Health Center employees off the site and would prevent the targeted picketing of their homes.

Well, there's a little section in here about crisis pregnancy centers, and the fact they can advertise free pregnancy testing, and yet legal medical centers are not allowed to. But since we're talking about the blockades, I'll skip that for the moment.

In summation, I feel that the blockading of Women's Health Centers, thus denying women access to legal health care, is discrimination against women. The First Amendment does not grant the right to be violent or intimidating in expressing one's opinions.

Women are not offered equal access to medical facilities and basic health care. Poor women are denied medical care which is available for affluent women.

In addition to opposing abortion, most of those, especially the males, who lay siege to women's health centers, also oppose birth control and sterilization. Yet, they do not harass or prevent men from obtaining vasectomies nor intimidate them when they seek routine urological health care.

There is no segment of our society, other than women, which is denied access to health care and/or harassed while seeking health care which is their right.

Thank you.

DR. RUBEN: We'll hold the questions until after I'm finished. This is the same topic.

My name is Dr. Kathleen Ruben, and I'm co-coordinator with Lucile of the South Jersey Clinic Defense Task Force.

My testimony concerns the need for a State law which would guarantee women the right of equal access to medical care. A modified version of a Maryland statute which I have attached to my testimony. It would carry a mandatory fine of $500 for the first offense, $1000 for the second offense, and/or a term of imprisonment of up to 90 days for obstructing a person's passage to or from a medical facility. Passage of this law would be the first step in redressing the damaging

effects of discriminatory municipal law enforcement that has commonly been the response to violent demonstrations at New Jersey health care facilities that offer abortion services.

There are many complex reasons for this discrimination. Local officials may argue that protesters are protected under the First Amendment. Anti-choice protesters who demonstrate at the clinics are, according to this argument, simply exercising the right of free speech as guaranteed by the Constitution, and must therefore be allowed to do so. This seems reasonable until one actually visits a clinic when it is under siege by Operation Rescue. The violent nature of the demonstration becomes obvious. Two hundred individuals, mostly men, trespass on clinic property, blockade the door, and assault escorts, patients, staff, and physicians.

In light of this activity, the Supreme Court has indicated that the blocking of a clinic door is not a protected form of free speech. It upheld an injunction against this behavior that is in force in Georgia, and let a similar injunction stand in New York. The New York case calls for fines of $100,000 for each offender and authorized collection through liens on income and bank accounts. It found that the blocking of clinic doors was not an acceptable form of communication in a democratic society, and that the civil rights of women were definitely being violated. The Court compared these women's rights to those of blacks who attempted to gain access to segregated establishments in the early days of the civil rights movement. Federal marshals, in those cases, were assigned to escort blacks into these buildings because of the volatile nature of the situation at that time.

These volatile conditions affect all New Jersey women now who are seeking gynecological or abortion services at local women's health care facilities. I have had firsthand experience with the violence that has been focused on women who attempt to enter these clinics. As Coordinator of the Clinic

Defense Task Force, I have helped to organize teams of escorts to help women at the clinics. I have also conducted training sessions for teams in other parts of New Jersey and have spoken with clinic administrators throughout New Jersey. The story is pretty much the same; one or two groups of individuals travel from clinic to clinic and continue to disrupt service.

It doesn't matter whether or not the woman is young or old, whether she's the doctor or the patient, whether she is there as a volunteer to help the clients, or whether she is just walking her dog. If she's in the vicinity of that clinic, she is a target for violence, harassment, and verbal abuse. We can't even imagine this happening to men on a routine basis. If priests or bishops were knocked down every time they tried to enter their church, we'd see quite a different response. Because the women involved are often most likely young and usually without money or influence, it's easy for people to see them as victims.

The impact on these women is devastating. One woman who was nine months pregnant was recently surrounded by anti-choice individuals who tried to keep her from entering her private doctor's office in Willingboro for vital prenatal care. They asked her repeatedly not to kill her baby. She and her mother almost turned back. During other Operation Rescue attacks, individuals who are there to provide safe passage for clients are often pushed against clinic doors.

Lucile went into what else happens there at the clinics. It's in my testimony; I won't repeat it, but I have been there in the crush. I have been ribbed. People have poked me in the ribs; they have tried to strangle me. I have seen patients knocked to the ground. I will be passing around pictures where the administrator of the Cherry Hill Women's Center was grabbed by the hair and thrown to the ground. I could go on, but the violence there-- The doctors are attacked, and it's not a peaceful demonstration. There's no way that it can be described as a peaceful demonstration.

One woman, in particular, I will never forget. She was out in front of the clinic when it was very hot, and she was sitting there waiting to get in because she had had a laminaria in place and she had to get into the center. She couldn't go home. She couldn't go anywhere else. She was forced to stay there.

She was out in the parking lot for over five hours with these individuals harassing her. She was afraid to go to the bathroom. She didn't have anything to eat or drink because she had to wait for her procedure, and when I finally went to her and tried to help her and took her to the bathroom, she told me that her friend had drank bleach because she wanted to abort so badly. I said, "Don't worry about it; you will get in. You don't have to make that decision."

But we're talking about women who are desperate. They're not just there to get their teeth pulled. They're there for operations that are necessary. They have searched their souls, and they have decided that they are going to go through with it.

And in the case of people who have laminaria inserted, they must have attention, or they risk infection and possibly death.

It is vital that women have access to local clinics for routine gynecological services, prenatal care, and abortion services. Ninety-seven percent of all abortions are performed in local nonprofit and private clinics. Without these clinics, women would not have access to safe and legal abortion, irrespective of the laws safeguarding that right in principle, because they would not be able to afford hospital procedures.

Only 13% of all abortions are performed in hospitals, in part because of the high cost of $1000 to $1600 per procedure. This low percentage also reflects the fact that most abortions are not required to be performed in a hospital because they're performed before 15 weeks gestation; 95.8% are

performed before 15 weeks gestation. While hospitals may accept Medicaid patients, only four clinics are able to do so because of the special licensing requirements. They have been repeatedly attacked by Operation Rescue. The ultimate goal is not to just harass the patients, but to close the clinics permanently, and if the clinics are closed, there's no place to go.

Recently the U.S. Supreme Court determined that Operation Rescue was actually involved in a conspiracy to close these clinics, and found that the clinic which brought the case to the Court -- which was the Northeast Women's Center in Philadelphia -- was entitled to triple damages under the Racketeer Influenced and Corrupt Organizations Act. However, most Operation Rescue members have already transferred their assets and make it impossible to recover legal fees, which were in this case in excess of $150,000. This is the way that Operation Rescue wears down the individual clinic owners by involving them in lengthy and costly lawsuits, by harassing staff and physicians at their homes, at the clinics, and even in public restaurants; making normal life seem impossible for those involved.

In addition, demonstrations create noise, traffic hazards, and unsafe conditions for those who live in the neighborhood. Even though most individuals in the community support the clinic involved, they still yearn for peace and tranquillity. This actually has instigated a ground swell of support for laws such as the one I am urgently asking you to support and to introduce in the Legislature.

Local officials have also expressed frustration over this continued disruption in the communities. They are looking for help, really. Each time that the Cherry Hill Women's Center is attacked by Operation Rescue, it costs over $6000 in costs that are primarily police overtime pay. The perception is that this money and effort is largely wasted because nothing

is being done to deter the behavior and change the situation. It has led to a reduction in the police intervention in some communities. They simply can't afford to continue to send police out in these numbers every time the clinic is hit.

Police complain that they literally break their backs and risk injuries to themselves time and time again and nothing ever happens to the individuals who break the law. Their cases take years to be heard, and when they finally are heard, the offenders get another warning and yet another token penalty, a token fine. This high cost of police intervention and the low police incentive due to uneven judicial enforcement may account for insufficient police protection at some New Jersey clinics.

However, a more insidious explanation of both the lack of adequate police protection and the lack of judicial involvement -- the follow-through from the judges -- can also be explained in terms of bias, personal prejudice. People tend to view this issue as an ideological one rather than one concerned with the maintenance of law and order for the common good. The escorts, clinic staff, and patients are seen as forming one army or team, and the Operation Rescue trespassers are seen as forming the opposing team. These two armies are using the local clinic, according to this view, as a battleground where the battle over whether it is "right" or "wrong" to have an abortion will be fought. That leaves the police, the judges, and the town council members to base their action on their own personal bias and beliefs on the abortion issue, and the issue, really, of equal rights for women, and they simply root for the team of their choice. Since the clinic becomes a war zone, the normal laws that apply are suspended.

Individuals who are assaulted during this time are actually told not to bother to file charges. I know this from personal experience. Operation Rescue members routinely file fake countercharges against the people who have filed assault

charges, and the judge who hears both of them apparently can't determine who is telling the truth, so they throw the case out of court. This happens time and again.

I had a situation where I was knocked over and thrown to the ground. It happened to be in Philadelphia, but this happens all over New Jersey. Police told me, "Don't bother to file because nothing is going to happen."

So, if there is no assault law enforced, and people aren't removing them because of the trespass law, well then, it is a lawless zone. You are protected by no laws there. We have to have something that comes from the State.

Operation Rescue members are permitted, are allowed, to trespass on clinic property, as I pointed out, for several hours at some clinics, before police action is taken. So the current laws on the books which prohibit trespass and assault leave enough to the discretion of local police and officials to render them inadequate to mandate nondiscriminatory law enforcement in communities with women's health care facilities. Even though some progress has been made in communities such as Cherry Hill which has passed an ordinance which prohibits blocking access to and egress from a health care facility, and in other communities where injunctions have been obtained, enforcement is still uneven and inadequate.

In Cherry Hill police protection has increased somewhat, and offenders have been given relatively serious fines with the risk of a suspended driver's license or a jail term for nonpayment. Under the ordinance, police can take direct action to remove individuals who block clinic doors without a complaint filed by clinic personnel. This is very important. Police file the charges; they testify in court. This saves the clinic time and legal fees. They do not have to continuously pursue the endless court cases that come out of these actions.

However, offenders in Cherry Hill have yet to be sentenced under the new ordinance, apparently because of the description of medical health facility and its applicability to clinics and private doctors' offices such as the Cherry Hill Women's Center and other doctors' offices in New Jersey. This has become yet another excuse to continually debate the issue, even in Cherry Hill where the law was passed, and continues to postpone the enforcement of the ordinance and the passing out of these fines that are supposedly going to deter the behavior.

The changes in Cherry Hill are the result of extensive lobbying, which is a continuing process. It requires an incredible amount of energy and perseverance. Even if it were possible for Lucile and I to mount a campaign in every community, it would take years to accomplish what would be accomplished by your group pushing for the enactment of a State law which we are proposing.

Local response changes with the change in personnel and policy, and since personal bias plays such a prominent role in this area, the solution to this problem must not be left to local officials or ordinances. These ordinances do not bring the full range of legal remedies to bear in the case, and I'm told that the judge in Cherry Hill is hesitant to use the ordinance because he may not be able to suspend their driver's licenses, or whatever you can do with State ordinances, nor can council members, police, or judges be expected to continually safeguard the civil rights of women at the clinics, especially since the personnel does change and their views continue to change with them.

In conclusion, inadequate police protection and inconsistent judicial enforcement have denied women equal protection under the law. These practices are discriminatory insofar as they fail to protect the civil rights of women who attempt to gain access to the medical facility of their choice. I am a woman among many who has been injured while

trying to gain access to the Cherry Hill Women's Center and other centers for myself as an escort, as well as for the patient who I may be escorting at that time.

I feel that the State of New Jersey has the obligation to protect women like myself who may find themselves at a local women's health care facility for whatever reason. Women should be able to stand in front of any private business in New Jersey without fear of bodily harm. And yet it is a frightening experience to stand in front of a clinic before dawn, perhaps knowing that anti-choice demonstrators are converging on the clinic and that they will soon be attacking. The worse part of it is knowing that there may be periods of time during the siege when no laws are in force to protect you, and no police officer is there who would care to.

We desperately need this law to remove the legal immunity now enjoyed by Operation Rescue members in various communities, and to provide impetus to local governments to clear protesters from private clinic property with all due speed, to arrest and charge all individuals who have trespassed, and to make sure that individuals who have impeded access to the clinic, or assaulted women, have been prosecuted to the fullest extent of the law.

Thank you. Oh. And I have pictures here which I have Xeroxed and attached to your information. I need to have these two back, and this one the Commission members can keep. You will see that in the top picture that I would like to pass around initially, the administrator of the clinic is being harassed and she was thrown to the ground while she was telling the individuals that they were trespassing. She is required to do this by the police department.

Essentially individuals block the clinic door, and they assault the individuals who are in the clinic vicinity.

If you have any questions now, we'd be happy to answer them.

DR. VAN JONES: Do you have any other recommendations other than the law that you have just passed -- I think it was attached to your testimony -- about the Maryland, you know, about the regulation, the state regulation? Any other recommendations for the Commission?

DR. RUBEN: Well, Lucile had mentioned that if there was some way of involving the State Police in monitoring this-- The municipalities definitely need help in enforcement, and for some reason they're unwilling -- they're unable to move along in this area. And also, if there were a requirement that the individuals notify the police department ahead of time-- I mean, you can have as many laws as you like, but the enforcement is the important part of it. If the Commission took an active role in even making it known that the State of New Jersey wanted to see that clinics were kept open, that would be an incredible impetus in itself. It's all part of creating an atmosphere where people realize that we want to see these places kept open.

MS. PFLEEGER: The State Police contacted me personally because I write letters to the editor, and so we met at the Cherry Hill Women's Center. The cochair at the time, Vickie Gibson, who has been involved in this a long time, and the reason for talking to us was to-- He is supposed to prevent violence, and so he wanted to know if we are going to be violent. I said, "We don't plan anything. All we do is react. We're just there to protect the clinics."

So that day when I left and called them, I understand that they did come down and they cruised past, but the regulations are that they are not allowed to -- unless invited by the municipality -- come in there and join in in protecting. You know, the police were there that day. My husband is not a very well person, and he was there sort of standing in the back line. He was just horrified to see the way those demonstrators were beating on the police. They were

beating on us. We were taking the young women over the top of the hood of a car and down in to get them into the door. I mean, it was a real battle that day, and here they were shoving and pushing the police. There should be some rule that they can call other municipalities or the police. I mean, the policemen I talked to indicated that they're willing to come help, but the law needs to allow them to come help.

DR. RUBEN: Well, if you take it one step further, during the early -- as I said before -- civil rights movement, they had Federal marshals who assisted individuals in getting individuals into buildings, and I don't think it's so farfetched that we assign someone from the State to go and monitor what's happening at the clinics. And, if necessary, assign individuals to help these patients get into the centers.

You see, I didn't know whether that was possible under the State law, to get people to come to the centers. It may well be, I don't know. I didn't put that in my testimony but that would be a good--

MS. PFLEEGER: I don't know whether I stated it adequately, but you know, we were making a list of the places where there is free pregnancy testing. There's only a few, you know; there are only a few of these clinics throughout the State. Family Planning does-- There's only one Family Planning facility where abortions are done. So, you know, Cherry Hill serves all of South Jersey. There is one in Atlantic City, but people come from all over, long distances, and yet the Cherry Hill police have to handle this. What we're trying to say here today is, we think it's a State function, that that municipality shouldn't have to bear the brunt of all that defense.

DR. RUBEN: Nor will they. I mean, they, you know, need a little help in handling whatever they can handle.

MS. PFLEEGER: Yeah, well, Kathy's-- We've been, you know, we've been to the Cherry Hill Council meetings time and

again, and of course, the other side comes and we propose an ordinance-- You see, they were picketing the Director's home, and terrorized her teenage daughter who happened to be there alone, and that ended up a tie. So there is no ordinance that prevents them from going and picketing her house. They see her on the street and they say, "We're going to come get you."

DR. RUBEN: They followed her several times.

MS. PFLEEGER: So, anyway, we go to the Council meetings and they did pass this last ordinance, but now we're finding it's not being very effective. I have in front of me the proposed one, the Senate bill, you know, nationally, that's pending. It's Senate No. 2321. This would propose that it would be-- They'd be guilty of a Class "E" Federal felony, punishable by a sentence of up to three years and a fine of up to $250,000, in addition to restitution for any damages to property or bodily injury sustained by a victim.

Now, that's pending. What we're saying is that we would like to see the State of New Jersey pass one.

DR. RUBEN: Well, the only reason I didn't mention the Federal -- the one in Federal committee -- is because, judging from the atmosphere with the Federal government, with President Bush's vetoes of the various bills that come past, I think that that probably is not going to get very far. But, I think in the State of New Jersey, there's a chance that we might be able to do something, at least for the women in New Jersey.

MS. PFLEEGER: You know, I get up at 4:15 in the morning and I have to drive up from Glassboro to Cherry Hill, and it's wonderful to see, sometimes five, six, seven, ten police cars out there in the street, you know, right out in the middle of this huge highway. They stay around and then when they're changing shifts, sometimes there are 10 or 12 cars, and then we stand there anxiously, you know. Here we are, old people, and we know that we have to get to that door and hook our elbows if they show up. Then the police cars start fading

away as they've changed the shifts, and then they will come back later on and they will park across, and-- But, they don't get out of their cars. We handle trying to keep the driveway clear, and so forth, so we're not saying that Cherry Hill does not give us any cooperation. They give us cooperation, but it's a lot to be asked of a municipality and a police department.

DR. VAN JONES: Are there any questions?

MS. SAMPIERI: I don't have any, thank you.

MS. PERELMUTER: I just have one brief question, and that is: Do you have any idea what kind of effect the law has had in Maryland; what responses they've had; how it's worked out?

DR. RUBEN: No. Unfortunately I don't have access to that information. I have one person who is a law student who has been helping me, but I really don't have access to that information.

MS. PERELMUTER: Thank you.

DR. VAN JONES: Okay, thank you.

MS. PFLEEGER: Thank you.

DR. RUBEN: Thank you. Has everyone seen the photos? (no response)

DR. VAN JONES: Our next two speakers are Joan Bertin, from the Women's Rights Project of the American Civil Liberties Union, and then we have Jeanne Stellman, Associate Professor from Columbia University. I understand that the two of you are going to talk to us.

J O A N B E R T I N, ESQ.: We're going to switch the order, though. Dr. Stellman is going to go first.

DR. VAN JONES: Okay, fine.

J E A N N E S T E L L M A N, Ph.D.: Basically what I'm going to do is spend a few minutes talking about some of the background, technical and scientific issues that relate to

aspects of sex discrimination and public health in the statutes, and then Joan, who is the lawyer, will speak about the policy aspects of this.

You don't actually need a professor to come down and tell you that women are different biologically than men; we all know that. The issue is: Do the biological differences that we know about, in particular with respect to toxic chemicals and to arduous environments and in the workplace-- Does that biological difference require different treatment, particularly in the workplace?

First, let me go back and say that, in fact, I think you do need to relook at the question as to whether it's significant; whether it is an interesting question to think about whether women are different from men biologically. It's very easy to make that statement, but in fact, when you say women and men, for almost every biological function and every medical function, you are really talking about a distribution of traits. There is a distribution-- The simplest example is height. But, there is generally a normal distribution of traits, and by and large for most of these traits the differences within the sex are greater than the differences between the sexes. That was very much the basis for saying, "Well, you just can't make generalizations about who can lift what and who can work in which kind of strenuous environment."

It is unquestionably true that women are childbearers, and men are not. But, it is also unquestionably true that there are two very important points with respect to women and childbearing that are all too often overlooked. The first very important point is that, although women are capable of being childbearers, women are not always childbearers. Women are not perpetually pregnant until proven otherwise, and in fact, in modern day America, pregnancy planning is an integral part of the life of certainly every working women, and on the average, women in the working classes, the middle classes and on up, have fewer than two children each.

In order to achieve having fewer than two children each, you must control your pregnancies, and birth control and pregnancy control are the modus vivendi in American society. Women, while they are capable of being childbearers, are not perpetual childbearers, and pregnancy is not a contagious disease. We are perfectly capable of controlling our own procreation.

The second very important point that is all too often overlooked in the issue of women as childbearers, particularly in the workplace, and particularly with regard to restraint from different activities, is that women are not alone in procreation. It takes a man and a woman to create a child. It is unbelievable, but you do need a professor to come down and tell you that. I have now testified in many hearings to the fact that men and women both participate in the child-creating process. Yet, despite that fact, our society does not require, for example, the testing of drugs for male reproductive effects. Our FDA rules still only require testing for effects during pregnancy. There are-- Joan is going to talk to you soon about many instances in which impact on the males in different environments is completely overlooked.

We have a genuine dearth of knowledge about male reproductive effects. We don't have an overwhelmingly great amount of knowledge about female reproductive effects, but we are burdened by a great deal of male mythology, I think the most serious of which is the concept of some kind of super sperm in which there is a selection process that only the swiftest and most fit sperm is the one that actually gets to fertilize the egg. We know that this is not true.

We know two things: That sperm are exquisitely sensitive and spermatogenesis is exquisitively sensitive to many environmental hazards, and that for some environmental hazards for which a great deal of experimental data is

available, like for ionizing radiation, spermatogenesis is about 10 times more sensitive in males than it is in females to damage from radiation.

We have learned within the last few years -- I believe it was actually some experimental work done by a drug company in New Jersey -- that the actual fertilization of the egg appears to be controlled by the ova and not the sperm. It is not the sperm selecting -- conquering the ovum -- as we actually see illustrations of in textbooks, but in fact, there seems to be some kind of genetic control within the outer core of the ovum which actually turns on a mechanism within the sperm and allows it to penetrate the outer layer of the ova and fertilize the egg. So, the very concept which has allowed us to picture women as vulnerable and men as invulnerable in various environments is not based on real biological fact.

There is also the fact that women are born-- When a baby female is born she has between 300,000 and 400,000 egg-producing follicles. By the time she gets to be 40 that's down to about 25,000, and over the course of a lifetime the average woman only produces about 400 mature eggs. There is a selection process going on there. We don't know what that is, but the same arguments that can be raised for saying why men can be exposed to environmental hazards, because of selection, because of regeneration, those same arguments can, in fact, be made about the female. I don't know whether they are legitimate arguments in either case, but there are, easily, parallels.

We are burdened in setting rules and setting statutes with a lack of knowledge, and that lack of knowledge persists. There was just a GAO report that shows that National Institutes of Health studies still routinely exclude females from studying the effects for various risk factors and various environments for women. They orient toward males. These are generally for

chronic diseases, heart disease, where we associate males with being at greater risk. So, women are routinely left out of these studies.

Similarly for reproductive hazards, males are left out, and you will have study after study after study that look at the effects of environmental factors on females as if we were a nation of hermaphrodites, a nation where Immaculate Conception was the rule of the day. So, we have these two areas of great unknown, and there are many important questions.

We know that mutagens can affect sperm. We know that sperm can become distorted, that men can lose functional ability. We don't know, however, whether funny looking sperm make funny looking babies. We don't have these critical answers. We don't really understand the maternal embryonic environment. We have many, many, rules proposed, for example, about lead, and Joan will talk about some of these, but we don't even understand the dynamic of transference between maternal environment and the fetal environment and the embryonic environment with regard to lead.

We have very great difficulties separating out low-dose effects and high-dose effects. For things like infertility, about 80% of all causes of infertility are not known, rather than known. There is a concept of attributable risk, which is, how much of an effect that we perceive can we associate with a particular cause? My husband did a study at the American Cancer Society on attributable risk in breast cancer in which they took the known risk factors: whether your mother had breast cancer, your aunt had breast cancer, diet, the different proposed risk factors, and looked prospectively among their breast cancer cases, and those known risk factors could only account for less than 70% of the breast cancer that was there.

So, by and large, we have large areas of unknown and the question is: "Well, what do we do in that case?" I think

Joan will spend some time talking about the fact that we develop two kinds of policies: We develop a policy for workers, for nonfertile women, for areas in our society where we as a society have said risk is acceptable, and where there is a dearth of data in those areas, we allow the exposures to continue. But when we come to potential fetuses and potential embryos, then we develop a "no risk at any cost" attitude, overlooking completely the unreality, the lack of reality of taking such a position. For example, if we are to say women shall not be in such and such an environment, what is the price that is being paid? What is the result of the stress of losing your job, for example? What is the result of being in a weaker economic position, of being without health care benefits? Those are all costs that have profound public health effects and individual health effects which are not in general weighed in the calculation.

We're also burdened with an awful lot of bad science. We have study after study in which people's pet ideas about what one ought to do, translate into papers. I edit the journal, "Women in Health," and it is always possible to get something published, someplace. We reject about 90% of the submissions that we receive for the journal, and they always end up being published someplace. Somebody will always publish. Once you get your act together to write a paper, you can find a home for it. We have a study, for example, in looking at the early effects of alcohol on outcome, and a study that says that drinking as little as one drink a day affects the motor neuron behavior of infants. Well, it turned out in this particular study that it made a difference which of the electroencephalograph technicians observed the infants. So, in their list of variables they actually have the EEG technician as one of the predictors. What of the biological model? You can drink if you go to this technician because then your kid's going to be normal, but you can't drink if you go to that technician because then, effects are going to be observed.

That's absurd. That's absurd, yet we have in the Congress, pending legislation to warn against any alcohol consumption at anytime when pregnant. Now, certainly you are not going to harm your child by not drinking when you're pregnant, but there's more than the child that's involved in the pregnancy, and that is: there's the effect on the mother. We have placed an enormous amount of stress on women by these injunctions warning them about every single thing that they do with regard to their potential outcome. I'm a mother; I have two children. You spend enough time when you're pregnant worrying about every little thing to begin with, without getting a lot of gratuitous warnings not based on anything scientific about what you ought to, or ought not to do. I think we perform a great disservice when we take flimsy data and somehow incorporate it into our public health rules and our public health statutes and give that flimsy data some sort of credibility because we have incorporated it.

Life is a risky business, and I very firmly believe that I have spent my life trying to achieve standards in occupational safety and health and air pollution and for veterans that lower the risks and provide the benefit, when benefit and compensation are due. I do believe, however, that we have to look at a situation, and look at it fairly and squarely and look at the data; look at what we know and don't know and consider the rights and the health of women apart from any potential role they may have as potential bearers of any potential fetuses that they may chose to carry at some time in their lives, and that we not compromise health, well-being, and safety of mind for ephemeral data.

We have a great deal of work to do to provide a safe and healthful work environment and a safe and healthful workplace for pregnancy and for maternal well-being. We have a great deal to do in terms of prenatal care and postnatal care, education and training and availability of nutrition, and a

minimization of an exposure to toxins, both for men and for women. Each of the things that we do consider should take very carefully into consideration the role of the male, the role of the female, what we know, and what we need to truly prevent, and we must also take into consideration what we know about the demography of childbearing in our society.

DR. VAN JONES: Okay. Thank you.

MS. BERTIN: I suppose the overarching theme that connects our presentations is the notion that perceived biological differences between the sexes is profoundly important to the development of social policy about women. The emphasis here is perceived differences, because I think what we've come to talk about primarily today is the question of whether the actual differences are as important as they are perceived to be, and the extent to which those differences are, in fact, exaggerated in ways that do women a profound disservice.

There are three elements in particular that I want to draw out of Jeanne's remarks: The first is that women are seen primarily as reproducers. The second is that men are omitted from the reproductive equation altogether, and the third -- and these are merely a matter of emphasis, because Jeanne mentioned them all -- is the different standard of care applied to the reproduction when you are talking about women, and that's the zero risk issue.

There are two particular areas in which I want to talk about the policy implications of these assumptions that mold not only public thinking about women and their role in society, but also influence scientists who design and conduct research, and other scientists who read and interpret research. Lest we think that somehow scientists are not affected by the prevailing mythology of our time, I think that that's an incorrect assumption, and they plainly are, and for that reason, as Jeanne indicated, we have a dreadful inadequacy in

our research information in regard to the effects of toxins on male reproductive outcome and male reproductive function.

I was listening to a toxicologist describe the differences between the study protocols that are applied to studying female reproductive outcome, which are tremendously sophisticated, and Jeanne could rattle off, I'm sure, like 15 different study protocols, and then she said, "Do you know what we do with sperm? We look at them under the microscope."

That is a fairly dramatic representation of the difference in the level of the sophistication of our examination. It's also one of the reasons why good students don't go into male reproductive toxicology as much as they go into female: because it's not at the forefront of medical science. Nothing much is happening. I mean, I don't know when the microscope was invented, but surely it was a long time ago, and nothing much has happened since then.

That's sort of a background. Now let me talk about where we see this playing out in the employment context and in the social attitudes towards women who use -- sometimes infrequently; sometimes, not so infrequently -- drugs and alcohol during pregnancy.

First of all in the employment area. There are, abroad in the land and in the State of New Jersey, as you probably all know, employment policies which are called fetal protection policies -- a term that I think is a misnomer -- which condition the employment of women on sterility. In other words, in order to achieve full employment rights in the place of employment, a woman has to be sterile. As a result of these policies, which as you may imagine, are purportedly to protect against injuries to a fetus should a woman decide to become pregnant, some women have submitted to sterilization involuntarily, and other women have submitted to abortions involuntarily.

The abortion cases obviously occur in places of employment where employers do not allow pregnant women to continue to work. Those policies are slightly different, but they're simply a variation on a theme, which is that pregnancy is such a unique, unusual, bizarre, special -- I don't know what kind of term you want to apply to it -- situation that it simply can't be accommodated in the normal scope of things. It's sort of like the Victorian confinement. Women who are pregnant simply have to be removed because we cannot assure them the zero risk environment that they require.

These policies are prevalent in multinational corporations, many of which do business in the State of New Jersey. There was a lawsuit against the American Cyanamid Company some years ago which gained some repute. DuPont is reputed to have such a policy: Monsanto, General Motors, the list is quite a long list. We never really know who is going to pop up with one next, and indeed, we are counseling a woman who lives in Trenton and who was fired by her employer when she became pregnant, even though she had a doctor's note indicating that it was his opinion and the opinion of a medical geneticist that her employment posed no risk to her pregnancy. Her employer, nonetheless, determined that it was too risky for her to remain on and fired her. She is now without health insurance.

I probably don't need to say this in too great detail, but I do want to point out that with regard to nontraditional employment, which is the area in which these so-called fetal protection policies are most prominent, the places where women haven't traditionally worked are the places where they are, of course, most expendable; that this form of employment is profoundly important to the families and the women themselves, where the women are unskilled. Unskilled women otherwise will obtain work as a waitress, as a checkout clerk in a grocery store, cleaning homes, or some other form of minimum wage or

subminimum wage employment. Of the women that we have represented challenging policies that have excluded them from high-paying factory, unskilled factory jobs, these women report that their income tripled. Some of them were on welfare previously, but even as to the ones who were employed, the availability of this kind of employment is the difference between poverty and escape from poverty, and that is, of course, why you will see women get sterilized to keep these jobs, because of the profound economic threat.

I think that the ultimate problem is that policies of this sort don't offer true health protection. They don't protect fetuses because, as Jeanne pointed out, we need an expert to come and tell us that men participate in the process of creating fetuses, and as much to the point, they don't protect reproduction. They also don't protect parents, and it's very hard to imagine a good life for children if they have sick parents.

There's a case in the United States Supreme Court that I'll tell you a little bit about in a moment, that's a real case in point. It involves exposure to lead, and the documentation with regard to the effects of lead on males, females, and fetuses is vast. There's enormous literature about the effects of lead. It is a highly toxic substance. Every time a well conducted study is done at lower and lower exposure levels, there are findings of toxic effects at lower and lower exposure levels. In other words, the more we look the more we find out about the toxic effects of lead, and it has never really been exonerated. In any respect, we now know that at ambient air lead levels, that we -- all of us -- experience in this country, there's a significant risk of cardiovascular illness created by lead in the air for white males, in particular -- probably all males, but the studies have been done primarily on white males. It was on that basis that the Environmental Protection Agency has moved to eliminate all lead in gasoline.

So, here we have this highly toxic substance whose properties have been well documented in the literature, and we have in the United States Supreme Court an employer who operates 17 battery plants around the country who is trying to justify the exclusion of all fertile women from working in battery plants on the basis of the proposition that the fetus is hypersusceptible.

Well, the fetus is plainly not hypersusceptible. The question, however, is, as a matter of social policy will the United States Supreme Court, or Congress, or some other body such as the New Jersey Legislature, decide to protect fetuses more than anyone else? Plainly, because the protection of fetuses simply cannot be achieved at the expense of their parents, we would advocate against that.

The case is going to the United States Supreme Court under Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act -- the Federal Antidiscrimination Law. It may well solve some of these problems nationwide, but we think there's a very important role for the states to play, particularly states with strong civil rights records and histories, because it's not at all clear or even likely that the Supreme Court will invalidate these kinds of policies and this kind of an approach for all purposes. Therefore, it's critically important that we have states fill the gap here, and that we have a State law that says, unequivocally, that workplace health and safety cannot be achieved on the backs of working women, but that this State, and other states, will indeed insist on providing a safe workplace for workers of both sexes, since workers of both sexes have families to support and are entitled to that as a matter of their own dignity, in any event.

Let me now talk a little bit-- Just in terms of the employment stuff-- Your law against discrimination is certainly a good, strong law, and your history in this State is

a good, strong history. It may well be necessary, as it has been in other contexts, to provide further amendment of those statutes to make it clear that sterilization is not appropriately required as a term and condition of employment for anyone; that employers must make employment opportunities available to all persons regardless of their childbearing capacity or childbearing intentions, and that the State will assist employers in making workplace health and safety accommodations that will address the special health needs of any subset of the population, rather than resorting to the exclusion. I understand that you have prohibited the reliance on atypical hereditary cellular blood traits of individuals in this State, and similarly, you know, if those individuals required some additional public health perspectives to be directed at needs in the workplace, that would be an appropriate role for state governments. It's certainly a role in which the state governments can truly act as the laboratory for the Federal government by developing innovative approaches to the health needs of specific subsets of the population.

While I think that -- and I think Jeanne will agree with me -- by and large, the assumption of fetal hyper susceptibility is an invalid assumption, let us assume that sometimes pregnant women need special accommodation in the workplace, or that men with a history of cardiovascular disease need special accommodation. Surely, we should be prepared to provide that accommodation in ways that do not cost people their jobs or require them to alter their bodies to obtain it.

Now, the next area-- There was a point in time, I suppose -- I can't remember exactly when it ended -- when this employment stuff seemed to be a self-contained issue. I think that it isn't a self-contained issue anymore and what has happened in the last two or three years is that we have somehow come to see pregnancy as a condition that is so vulnerable and so subject to terrible conduct by mothers, that women just have to be regulated in all that they do.

While I must commend the State of New Jersey for resisting the rush to legislate in ways that will control women in all that they do when they become pregnant, I'm sure that you will all hear much about this problem in the next few years and so I want to spend a little bit of time talking about public and policy approaches to the issue of -- to the problems of alcohol and drug use during pregnancy.

The assumption, I think, underlying efforts in other states to control the conduct of women during pregnancy is that women must be forced to do virtually anything to enhance fetal interest, and of course, this is the same theme that's underlying the employment policies that I just mentioned. It's one of the themes that draws these issues together. The other themes that draw these issues together are the themes that Dr. Stellman mentioned, having to do with the way in which science is selectively used to justify punitive conduct towards women, but fails to address the equally adverse effects of alcohol and drug abuse on men and on families as family units.

Again, we see the same tendency in this area, the tendency to assign to women the whole responsibility for reproductive outcome and to impose on women very rigid and traditional standards of maternal behavior. I suppose as good an example as any is the notion that it's not acceptable for a women to work in a battery plant, where she is exposed to lead, if she is going to become pregnant, but it is acceptable for her to work in a hospital, where she is exposed to lots of infection, drugs, radiation, and a variety of other things. That's simply a reflection of what we're accustomed to seeing and where we're accustomed to seeing women, and how we have come to define a woman's role in our society.

Similarly, I think it's important to understand this phenomenon. It's almost impossible to talk about drugs and alcohol right now, because we believe so profoundly as a society that they're bad, and I'm not suggesting at all that we

should encourage women to use them; that's certainly not the point. But on the other hand, we have courts that have removed a child from a woman's custody based upon a single toxicology test of the newborn's urine -- a single positive toxicology test of the newborn's urine. That test may reveal that a woman has, indeed -- if it's a valid test -- and there's a question about the validity, but even assuming that it's a valid test, that a woman has taken a drug or smoked marijuana at some time in her pregnancy, or I should say within the last two or three weeks, because that's the length of time that you can get -- or some drug that mimics these in terms of the results of the tox screening -- but tells us essentially nothing about that woman's ability to be a parent. What I suggest to you is that the screening test may be a useful test for public health purposes, but it becomes a very destructive approach when it triggers the imposition of any type of criminal or civil penalties, including the automatic removal of a child, because -- and we know this is true -- it simply drives women away from health care providers, causes them to lie about their behavior, and causes them to fail to seek the help they need.

The issue of the use and abuse of drugs during pregnancy is an extraordinarily complicated issue and the response to punish pregnant women is an extraordinarily simplistic one. Let me just mention a couple of areas of complexity that I think need to go into the equation of any discussion about this issue:

The first thing is that we know that pregnant women who truly need drug and alcohol treatment services simply can't get them in most localities in the country. I do not have statistics on New Jersey, and it may be that no studies have been done in New Jersey, but I do have statistics on New York and Los Angeles, and the rate at which women who are pregnant are turned away from drug and alcohol treatment services is astonishingly high. Indeed, we have a lawsuit pending against

four drug and alcohol treatment centers in New York City for their outright refusal to serve pregnant women. So, you may recall catch-22? Well, this is it, because at the same time that these women are turned away from drug and alcohol treatment services, there's every likelihood that they will be exposed to a mass screening program which will pick up any drug or alcohol use, and which will then report them to social services in some localities; and if not social services, it will certainly report them -- in other localities will report them to district attorneys for prosecution.

Then there is the question that Jeanne and I insist on asking, sometimes to others' discomfort: What about Daddy? What does his use of drugs and alcohol portend for a pregnancy, for the outcome of that pregnancy, and for that child's subsequent development and existence? And why is it that we simply don't attend to this issue and address it? We do know with regard to women who are heavy users of alcohol -- very heavy users of alcohol -- that not all of them have fetal alcohol syndrome. Of those who do and those who don't, we simply have no way of predicting who's at risk and who's not. and many researchers have suggested -- although this has been silent in our public health policy -- that perhaps it is the fathers who could explain why some outcomes are bad and other outcomes are not bad. We simply must be looking at paternal behavior and requiring men to assume the same degree of responsibility that we require women to assume based upon the same level of suspicion about the likelihood that their behavior will cause injury. And here I must say that the literature exists to suggest that all of these agents have very significant effects on the male reproductive function. Whether, as Jeanne says, they then produce funny looking kids, we do not know, but we will not know unless we ask the question and do the research to find out.

Again, I think that it's important to have the skeptic's view of the data. We really do not assist women if we do not provide accurate information about reproductive risk, but if we simply are hysterical and are scared of everything, then all is lost; then nothing has any significance. Our information must be accurate and it must be rational to people, or they won't receive it. None of us can seal ourselves in hermetically enclosed environments when we're pregnant, and we know that. Therefore, life is a process for pregnant women of trying to figure out what you can safely do, what you can't, what's a sacrifice, what's not a sacrifice. Even with regard to hard drug use -- and there's every reason to believe that is bad for a human being, and, therefore, probably every reason to believe it is bad for reproduction -- we still know very, very, little about the real reproductive effects.

I just want to mention in passing a little article in "The Lancet," a medical journal, in December of 1989. It's called, "Bias Against the Null Hypothesis, the Reproductive Hazards of Cocaine." It reports that notwithstanding that the studies were of equivalent methodological value or were as good -- shall we say, in the vernacular -- the studies that reported a positive effect on reproductive outcome from the use of cocaine were much more likely to be reported in a scientific journal than the studies that reported a negative effect, or no effect. In other words, they looked at a group of people who admitted to cocaine use; they verified the cocaine use and examined the reproductive outcome, and they found nothing wrong with the course of the pregnancy reproductive outcome. Those studies didn't get published, whereas the studies that did find an effect did get published. Once again, the most that one can say for this is not that women should go and take cocaine, plainly, and not that anyone should go and take cocaine, but that we do need accurate data in order to provide rational information that makes sense to people, and that they will use in conducting their lives.

I think that all of this focus on drugs and alcohol has taken our eyes off the single most important element of insuring and promoting good reproductive outcome, and that is the socioeconomic factors. Nutrition, poverty, and education -- those are factors that we know, and we have known for years and years and years. They have dramatically negative effects on reproductive outcome, and those effects can't be sorted out from some of these other effects. But when we are looking at a population of women who use drugs and alcohol, how easy it is to forget about the fact that these are all terribly poor women, and that if we could attend in the first instance to their standard of living and to their educational status, we would dramatically improve the chances for their lives and for their children's lives.

Two more items: We can't seem to get away, in the enforcement of these social norms, from leaning more heavily on racial minorities, and therefore all of these programs that have punitive elements to them fall much more heavily on women of color. The last item is this: In some of these cases plainly we deal with a problem of hard choices, of women whose lives are terribly compromised, and men whose lives are terribly compromised, and families which are at grave risk. But in terms of how we approach this and what we do about this, one of the other things that we lose sight of is that when you take a child away from its mother or father, that child is going to go into foster care.

So, let us look very hard at our foster care system to make a decision about that; whether that's where the resources should go, if we're going to put any resources into anything, and indeed I would say that we would have a much better shot at improving the well-being of this next generation of children if instead of plucking them from their families and putting them in foster care, which is a system which we've really never been able to do very much with, we put our resources into providing

social service support systems for families at risk that truly enable people to get the education, get the health services that they need, care for their children. Because a women takes drugs doesn't mean she doesn't care for her children, I assure you. I have met many of these women, and they care very deeply for their children and want to do the best by their children that they can, but their resources are very limited. Let us assist them in improving their status so that they can provide some measure of decent loving care to their children, as opposed to having children become wards of the State.

Thank you.

DR. VAN JONES: Do you have any questions? (addressing other members of the Commission)

Any recommendation to us, as Commissioners here, what we can do about the problem, all the problems that you mentioned, the sparse number of treatment centers and so on? Any recommendations to us?

DR. STELLMAN: Well, you know, there was just a study which I haven't had a chance to read, which the NIMH -- National Institute of Mental Health -- did on dramatic improvement for low birth-weight children and their IQ by having the families visited on a weekly basis, taught something about how to raise children, and then provided with, in essence, a Project Head Start type of program, but at a very early age. At the Public Health School I was talking to a friend who used to be a public health nurse, and she said, "Oh, it sounds like they're rediscovering that we public health nurses should be back on the job doing what we used to do."

I think we have a lot of recovery to do from the last, sort of, decade of neglect, where many excellent programs were really -- had a lot of the heart taken out of them. But I really have to emphasize what Joan says: We have all these weak models of what we believe are external evils that are wreaking havoc on our children, when it's really the

commonsense social needs of maternal education, paternal education, early nutrition, loving environment, and a nurturing environment that appear to have the most profound effects, even in things like these alcohol studies. So it's--

MS. BERTIN: I have one concrete thing, you know-- We could use models of successful treatment programs that handle pregnant women. We definitely need treatment programs that provide residential care with child care facilities attached to them. I mean, if you have a woman who's pregnant who has got a kid in tow, she's not going to get treatment unless somebody can take care of her kid. So, an awful lot of treatment centers -- this is definitely true in the drug treatment area -- are geared toward the male addict, not the female addict.

DR. STELLMAN: But, life doesn't begin at conception and end at birth, you know. The more important time is after the child is born. We're focusing in on pregnancy as if that were the most vulnerable period, but it's not.

MS. BERTIN: No, but in the drug area it's the most undeserved period. It's the time in a woman's life when she is going to be the least able to get services and it's also-- The woman who has children is going to find the services that are available are uniquely unsuitable to her specific needs. I don't deny that we need an expansion across-the-board, but we see a tremendous lack of services that are suitable for women who are either pregnant or have young children. In those programs, if we could find some model programs -- there are a few of them around-- They could really be useful around the country in proving what people say, which is, it's just too hard to do this. We can't make the services available; it's just too hard.

So, that's one area. For example, in our litigation in New York, we found a number of model services that we hope will convince the judge and the New York State Supreme Court that, of course, these treatment facilities could provide these

services to women; they've just elected not to. That's one area in which I think we could--

DR. VAN JONES: Make a recommendation?

MS. BERTIN: Yeah. I also think that the same is true with regard to the occupational context, that State agencies and authorities could provide guidance to employers -- specific guidance to employers -- with regard to handling special health needs in the work environment. I don't want to focus only on pregnancy, because I don't think it's unique to pregnancy.

DR. STELLMAN: Well, and the more we learn about even adverse outcomes-- This study for the National Institute of Mental Health was on low-birth-weight, at-risk children, it was after they were born. The pregnancy is a very, very small part of this environment. The fact is, if you have a very toxic environment, the chances are more than likely that you're not going to have a successful pregnancy to begin with. That either from the male or female, you're going to have a spontaneous abortion -- a stillbirth. The number of adverse outcomes, birth defects, is relatively small compared to the huge social needs that we have for children and families and mothers and fathers and their roles in those capacities, which is where, I think, the effective discrimination lies. The lack of social support once you've had that child is just overwhelming, even for professional women. So I've never understood how women who could -- how working-class women have been able to cope, if it's hard enough when you have the money to buy services to be able to function.

That seems to me to be the ultimate discrimination against women; that now we have an economic mandate to have all of our social roles, without any economic or social assistance to enable us to carry them out.

MS. BERTIN: I suppose as President Bush prepares to veto the FMLA we could start thinking about building that from the ground up, as opposed to having it mandated from the top

down. Although, once again, it provides on the Federal level no economic support for women or men, but it at least secures employment, which is a big problem.

ASSEMBLYMAN COHEN: You may wish to contact Assemblyman Kenny, who is the Chairman on the Alcohol and Drug Policy Committee. You may want to contact him, perhaps, to set up testimony for that Committee.

There are questions about whether or not there should be or should not be notices concerning fetal alcohol syndrome or other things that may not necessarily apply. But you may want to contact the Consumer Affairs Committee that I sit on before we start doing more notices.

DR. STELLMAN: Well, the interesting thing-- Joan and I wrote an op-ed that appeared in The New York Times on these issues, and we've been besieged with letters from women who said thank you very much. You know, from highly literate women who were saying, "During my pregnancy I spent all my time wondering," or-- I had one of our student's mothers who gave birth to a child with bad teeth who sat down and reconstructed her whole alcohol imbibing. This was a woman who drank maybe three glasses of wine during her whole pregnancy. She went and looked up when teeth were formed and whether it was the glass of wine that had done this to her child's teeth.

Now, I don't think that she was particularly neurotic. I think she is actually quite typical of the pressure that we're putting on women in terms of the concepts of excessive vulnerability and-- It's a slippery slope. We don't want to start adopting the arguments that have been used historically for not controlling environments, but on the other hand, we don't want to set up conditions that are unmeetable, and that are unrealistic and unfair to women.

MS. BERTIN: Right. And it creates such a burden of guilt on women, unreasonably, and makes them think that they cannot manage their lives in a rational intelligent way without

the fear of, if they don't conform to a zero risk model, they are going to do something terrible, and that's just not rational.

DR. STELLMAN: But the problem we face as parents, as well. I mean, I still remember the time I whacked my kid once -- I hope that's not illegal in New York--

ASSEMBLYMAN COHEN: Only if it's done with an ax.

DR. STELLMAN: --and every time he does something wrong I say, "Well, maybe it was that time that I hit him," you know. I think that we become a little bit absurd in the way we conduct our affairs.

MS. BERTIN: My personal position wouldn't be total opposition to warning signs and public health messages. We surely have to have them, but we need to have them be much more accurate, much more rational. The kind of thing that conforms to a reasonable way that you would conduct your life, and not a set of unreasonable expectations.

ASSEMBLYMAN COHEN: But, there's a difficulty in that. I mean, most of the notices are basic. You can talk to the restaurant owners, and I think they would be ecstatic to hear your testimony. There's just so much you can put on a poster in a restaurant, in the doorway, next to the cigarette machine, whatever. It's not a reading room. I mean, it's there for a quick, "This is possible."

MS. BERTIN: Right.

ASSEMBLYMAN COHEN: "You should be careful. Go see a doctor." It's probably as much as you can put on a notice document that -- where there's relative access by the public. I mean, you can go too far, or it can be too much of a scare -- not a scare tactic, but--

MS. BERTIN: Well, it was intentionally intended to be a scare tactic -- it was intentionally intended. And, of course, the population of women it reaches are the women who probably don't need its message.

DR. STELLMAN: It's preaching to the choir, in many ways, with many of these. There's no good evidence that these warnings actually affect the behavior of those who really need the warnings, and we've spent an enormous amount of time doing this without any adequate indication, for example, that the cigarette warnings actually affected behavior as opposed to the general change of society's attitude, in which smoking has become unacceptable rather than acceptable. It's no longer glamorous. We don't see that, and it's not clear that the little warning on the cigarettes-- That's part of the symptomatic of the change of societal norm, but it's not clear if that warning has, in fact, done anything, or that if you-- In polls, most people can't even tell you what the warnings are.

So, we've done-- We convince ourselves of many things. I'm not saying that we shouldn't warn. One effect of the warning has been that the tobacco companies have successfully been able to fight lawsuits by saying that they have warned. They love the warnings. They don't fight the warnings anymore, at all.

ASSEMBLYMAN COHEN: Well, they do. They are fighting the warnings in one of our committees. But, obviously if the warnings are on there, that just helps them out in stopping liability.

DR. STELLMAN: You know, these are all complex issues, and sometimes we take very simpleminded approaches and think we've effected a change.

DR. VAN JONES: Okay. No more. I don't think we have any more questions for you, Joan and Jeanne. Thank you for your testimony.

ASSEMBLYMAN COHEN: You may want to contact the Committee because-- Consumer Affairs has been doing notices and labeling, and that's the appropriate Committee. I mean, the restaurant owners would embrace you.

DR. STELLMAN: I don't--

ASSEMBLYMAN COHEN: What they said was, "We don't need these posters in here, because no one's going to change their behavior. There's not enough information on them, and it's another poster." And it scares people off from obviously drinking, which thereby supposedly reduces their business. It's a two-edged sword.

DR. STELLMAN: I don't think we're interested in becoming spokesmen for the alcohol industry, although we've gotten a flurry of interest from our op-ed.

ASSEMBLYMAN COHEN: Your responses and basis for lack of warning, or more tempered warning, or more accurate warnings, are exactly what they say.

MS. BERTIN: Well, you know, it is sometimes possible that they are right, but perhaps for the wrong reason.

DR. STELLMAN: One can't be responsible for one's bedfellows.

MS. BERTIN: I mean, the other thing is that, you know-- My own feeling about it is that, I would go away as a critic, if the warning were a fair warning. I suspect if the warning were a fair warning and were a gender-neutral warning and said, "Warning, alcohol is a reproductive toxin for men and women," then I would suspect that we would have a much more balanced response to that. "Well, of course, that must mean excessive alcohol. It surely doesn't mean just one drink." Nobody ever suggested that, but because of its limited focus on pregnancy and because of our willingness to see pregnancy in the way that we see it as a State in which the zero risk is the only acceptable model, the assumptions that are drawn from the message are quite different.

DR. STELLMAN: That's exactly the point. It's not the point against warning people; it's against singling out particular phases of the biological cycle and zeroing in on women, and especially if they are already very worried about

everything and saying this is it. This is the time that you have-- If you take care of not drinking now, then drinking isn't a problem. That's the implication.

And drinking during pregnancy-- First of all, one drink a day is not established, but secondly, at these levels males have altered spermatogenesis. You know, why shouldn't they be worried while they are sitting at that bar? Why should just the women be?

MS. BERTIN: Yeah. And why should we not be raising the consciousness overall? I mean, I think warnings help to raise a general level of consciousness about certain adverse things. Why should we not be raising the consciousness of our society that these effects on male spermatogenesis may well contribute to the 60% or 70% of birth defects of unknown origin? Most birth defects, we simply don't know how they have occurred, but we do have biologically plausible explanations for assuming that--

DR. STELLMAN: Where we've bothered to get data on relative susceptibility, spermatogenesis is much more vulnerable to adverse effects than female reproduction. With radiation-- One out of three Down's syndrome cases we know for sure comes from paternal origins. It's not just tired old ova which are producing Down's children.

MS. BERTIN: But I'll tell you, that's what I was told when I, you know, being an old mother, went in.

DR. STELLMAN: An elderly-- Elderly pregnancy; that's what it's called.

MS. BERTIN: I mean I was an elderly pregnancy, and they said, "Well, that's your old ova."

ASSEMBLYMAN COHEN: Mature pregnancy.

DR. STELLMAN: No, no. The word is "elderly." elderly pregnancy.

MS. BERTIN: I was an elderly prima gravita, but anyway. But we've--

DR. VAN JONES: Thank you.

Okay, I guess we're ready to start with our next speaker, Dorothy Roberts, a Professor from the Rutgers Law School in Camden.

D O R O T H Y R O B E R T S, ESQ.: Actually I'm an Associate Professor at Rutgers Law School in Newark.

DR. VAN JONES: In Newark, okay, very good. Let me erase this.

MS. ROBERTS: My areas of expertise -- the courses that I teach -- are in civil liberties and criminal law. I am especially interested in the reproductive rights of women of color. For the past year I have been conducting research and writing on the topic of the prosecution of women for giving birth to drug-exposed babies, so I will be covering some of the ground that the prior two witnesses testified about. But hopefully I'll give another perspective on the issues and expand on some of the points that they made.

What I would like to focus on are two related subjects: The constitutional issues raised by the criminalization of women who use drugs during pregnancy, and also a topic that was mentioned before, the scarcity of treatment for pregnant drug addicts.

A growing number of women across the country have been charged with criminal offenses because they gave birth to drug-exposed babies. At least 50 so-called "fetal abuse" cases have been brought nationwide. Women who use drugs while pregnant have been charged with crimes such as distributing drugs to a minor, child abuse and neglect, and manslaughter. In July 1989, Jennifer Clarise Johnson, a 23-year old crack addict in Florida, became the first woman in this country to be convicted of a crime for exposing her baby to drugs while pregnant. Johnson was charged with two counts of delivering a controlled substance to a minor when her two children tested positive for cocaine at birth. Because the Florida drug law did not apply to fetuses, the prosecution based its case

against Johnson on the 60-second period that a cocaine metabolite passed through the umbilical cord after the infants were delivered. In other words, they had to show that the cocaine was passed to a live born child, so they based it on the transfer of blood through the umbilical cord before it was clamped after the babies were delivered.

Since Johnson's conviction, several other women have been convicted of crimes for using drugs during pregnancy. As far as I'm aware, there have been no such prosecutions in New Jersey, but I still think it's important for you to think about it because 18 states have prosecuted women for using drugs during pregnancy. There's legislation being passed in states across the country, and I think it's important that you're prepared if such proposals are raised in New Jersey. I think they would be extremely unwise, and let me give you my reasons for saying that.

In my opinion, one of the most critical facts about the prosecutions is the identity of the women who have been charged with crimes. The overwhelming majority are poor and black, and I strongly believe that you cannot analyze this issue without looking at the racial and economic factors that are so prominent in these prosecutions. A memorandum prepared by the ACLU Reproductive Freedom Project reveals that of 46 defendants where they identified the race and ethnic background, 33 were African-American, 10 were white, 2 were Latin, and 1 was Native American, so 33 out of 46 defendants were black women. It appears that virtually all of the defendants are poor.

The disproportionate impact of the prosecutions on poor black women can be seen most clearly in the states that have initiated the most cases. In Florida, where two women have been convicted for distributing drugs to a minor, 10 out of 11 criminal cases have been brought against black women. Similarly, 18 women in South Carolina have been charged since

August 1989 with either criminal neglect of a child or distribution of drugs to a minor. Seventeen of these women were black.

This discriminatory enforcement is the result of several factors. It's not that poor black women abuse drugs more than other women. That's not the reason that they're being prosecuted in such relatively great numbers. It has to do with the identification of women who use drugs, and that depends on the ability of the government to detect them, obviously. Health care professionals report to government authorities black women who use drugs during pregnancy more readily than they report white women. This has been borne out in a recent study that was published in "The New England Journal of Medicine." Researchers studied the results of toxicologic tests of pregnant women who received prenatal care in both public health clinics and private obstetrical offices in Pinellas County, Florida. The study found that despite similar rates of substance abuse along racial and economic lines, black women were 10 times more likely than white women to be reported to public health authorities for substance abuse during pregnancy.

Even apart from the racist decisions of health care professionals, poor black women will end up as the primary defendants because they are the most closely monitored by the government. Because poor black women are in closer contact with the government through public hospitals, welfare agencies, and probation officers, their drug use is more likely to be detected and reported.

This disparate detection and reporting can clearly be seen in the screening practices of hospitals. The government's main source of information about prenatal drug use is the reporting to child welfare authorities of positive infant toxicologies by hospitals. Such testing is implemented almost exclusively by public hospitals that serve poor minority

communities. Private physicians tend to refrain from testing their patients for drug use because they have a financial stake in securing their patients' business and referrals, and because they are socially more like their patients.

Moreover, the hospitals that perform drug-testing administer the tests in a manner that further discriminates against poor black women. One of the typical criteria triggering an infant toxicology screening is the mother's failure to obtain prenatal care, and poor women are more likely to fail to obtain prenatal care than wealthier women. Many hospitals have no formal screening protocols at all and just rely on the discretionary screening of hospital workers. That allows them to use their biased attitudes about poor minority women; their belief that they're more likely to use drugs than other women, and therefore they should be tested and then they don't test other women. These women then are, again, more likely to be reported to government authorities.

I believe that these prosecutions punish women for having babies. I take this position for several reasons. The first reason lies in a technical analysis of the basis of the criminal charges. That analysis leads to the conclusion that it is the choice of carrying a pregnancy to term that is penalized. At the outset, it is important to recognize that the prosecutions are based on the woman's pregnancy, and not on her illegal drug use by itself. The defendants are not charged with using drugs. They are charged with violating criminal child abuse or drug distribution statutes, crimes that relate to the fact that they are pregnant. The mother's otherwise illegal conduct only subjects her to the charges of child abuse and drug distribution if she is pregnant at the time she used the drugs.

What I'm saying is, you can't just say these women are using illegal drugs, therefore it is all right to prosecute them. That's not the basis of the prosecution. They are

charged with crimes that very often hold greater penalties than just the crime of drug possession, and very likely if these women were not pregnant at the time they used the drugs, they never would have been arrested in the first place.

The real basis for the criminal charges is illustrated by the only definite means of avoiding prosecution. When a drug-addicted woman becomes pregnant, she has only one avenue to escape criminal charges. If she aborts the fetus, she will avoid prosecution. If she decides instead to carry the pregnancy to term, she faces the threat of criminal conviction. Thus, she is penalized for choosing to have the baby rather than choosing the alternative of abortion.

A second more fundamental reason for my position that these prosecutions constitute punishing these women for having babies is the suspect nature of the government's asserted justification for prosecutions; its concern for the welfare of potential children. The selection of poor black women as the primary objects of prosecution renders questionable any state interest in the welfare of fetuses in general. What I'm saying is, if the government was interested in protecting fetuses in general as a class, then you would expect that the policy would be more fairly applied. It's very difficult, I think, to justify a policy that just singles out a certain class and race of people to punish, and not everybody who causes harm to fetuses.

A second reason that I say this is the historical neglect of black children's condition in this country. When a society has always turned its head to the inadequacy of prenatal care available to these women, its current expression of interest in the health of unborn black children must be viewed with suspicion. The most telling evidence is the high rate of infant death in the black community. In 1986, the mortality rate for black infants was 18 deaths per 1000, more than twice that for white infants. And in some areas of New

Jersey it is just as high as that, which, by the way, is higher than the death rate in some so-called undeveloped countries. The main reason for this despicable rate of infant mortality is poverty and the inadequacy of prenatal care. I'd like to reiterate something that Joan Bertin said, which is we have a lot of information about what causes high infant mortality and low birth weight. It's, as I said, poverty and inadequate prenatal care. That's what states should be focusing on, not putting women in jail or punishing them in other ways. We should be focusing on what we know is going to benefit the outcome -- reproductive outcomes -- and that's improving access to prenatal care.

All right, let me move on to the lack of treatment for pregnant drug addicts, which is something, again, that Joan Bertin testified about, but I would like to give some more facts about the lack of treatment. Again, if the State's aim were truly to protect the health of children, of drug addicts, we would expect the government to provide adequate facilities for drug treatment and prenatal care. Instead, a drug addict's pregnancy serves as an obstacle to obtaining these services.

Let me just repeat that because I think it's an important point: Not only does the government not provide extra care for pregnant drug addicts, the fact that a drug addict is pregnant is an obstacle to her obtaining care.

The needs of pregnant addicts have been virtually ignored by drug treatment programs. Treatment centers either overtly refuse to treat pregnant women or are effectively closed to them because they are ill-equipped to meet their needs. Most hospitals and programs that treat addiction exclude pregnant women because they are harder to treat -- so they say -- and their babies are more likely to be born with health problems requiring costly care. It is feared that treating addicts with high-risk pregnancies would sap a disproportionate share of the program's resources and subject

it to obstetrical malpractice suits. For the same reasons, prenatal care clinics often turn away pregnant women who are addicted to drugs.

In addition to this all-out exclusion of pregnant drug addicts, there are several barriers to pregnant women who seek to use the centers that will accept them. Most drug treatment programs are based on male-oriented models that are not geared to the needs of female addicts. The lack of accommodations for children is one of the most significant obstacles to treatment for women. Most clinics do not provide child care and residential programs do not admit children. Treatment programs have traditionally not provided the comprehensive services, including prenatal care, gynecologic care, contraceptive counseling, appropriate job training, and counseling for sexual and physical abuse, that the women need. Predominantly male program staff and clients are often hostile to women clients and employ a confrontational style of therapy that makes many women uncomfortable. Moreover, waiting lists make treatment useless for women who need help during the limited duration of their pregnancy. If a woman is five months pregnant and there's a six-month waiting list to get into the program, it's not going to do her any good, at least for the term of her pregnancy.

The lack of facilities for pregnant addicts in two cities illustrates the problem. Again, Joan Bertin alluded to a study that was done in New York. Let me just give you the figures that Dr. Wendy Chavkin found when she surveyed 78 drug treatment programs in New York City: 54% just all out denied treatment to pregnant women; 67% refused to treat pregnant addicts on Medicaid; and 87% excluded pregnant women on Medicaid addicted specifically to crack. These are the very women who are most likely to be prosecuted; 87% of the treatment centers in New York City would not admit them. Less than half of those programs that did accept pregnant addicts

provided prenatal care and only two provided child care, meaning that out of 78 centers, there were really only two that were accessible in the real sense of the word to poor pregnant drug addicts, addicted to crack. Similarly, female drug addicts in San Diego must wait up to six months to obtain one of just 26 places in residential rehabilitation programs that allow them to live with their children.

I am aware of no studies of the availability of treatment for pregnant drug addicts in New Jersey. That might be something-- I don't know the full scope of your mandate, but that might be something you want to look into investigating. What is the status of treatment for pregnant drug addicts in New Jersey? I have reason to believe that the situation is no better here than it is in other states. A 1979 survey by the National Institute on Drug Abuse found only 25 drug treatment programs across the country that described themselves as specifically geared to female addicts.

A third reason for viewing the prosecutions as punishing women for having babies -- and I think this may be the most compelling reason for rejecting prosecutions as the solution to the problem of drug exposed babies -- is that there is ample evidence that they will not achieve the asserted goal of healthier pregnancies. Indeed, they will lead to just the opposite result. Charging drug-addicted mothers will often penalize the very women who seek prenatal care or drug treatment and discourage others from doing so. It is those pregnant addicts who seek help from public hospitals and clinics who will be detected and reported to government authorities. The women least likely to be punished are those who remain anonymous. Thus, the threat of prosecution will deter pregnant drug addicts from obtaining treatment for fear that they will be turned in.

The Jennifer Johnson case -- the one I mentioned to you -- the first women who was convicted of a crime for

exposing her children -- her babies -- to drugs while pregnant, really in my mind gave the message that if you seek help, that's going to be used against you in a trial.

If you look at the evidence that was used against her, the state's entire proof of her criminal intent were her efforts to get treatment. The prosecutor's theory was that her concern showed that she knew that her cocaine use harmed the fetus. The main piece of evidence was that while she was pregnant and had just gone through a cocaine binge, she called an ambulance to get her and take her to the hospital, and she expressed to the hospital workers that she was afraid that the cocaine -- the crack -- was going to hurt her fetus. That was the very evidence that the prosecutor used to prove her criminal intent; that she knew that this was going to harm her fetus, therefore she purposely caused injury or transferred the drugs to her fetus.

Many health care experts have observed that cases like these make women wary of providing physicians with important information, and indeed, of seeking critical health care at all. There has been testimony before other government commissions, affidavits in cases like the Johnson case, of health care workers who have said-- Women have called up and said, "I'm not going to come back because I'm afraid that I'm going to be turned in."

In the Johnson case the key witnesses against her were her obstetricians who testified, you know, "She told me that she used crack during her pregnancy. She told me that she was concerned about the fetus." That was all used as evidence against her, and I'm sure that if she had it to do all over again she might have avoided ever going to a hospital or ever talking to a physician, or at least being honest with a physician about her drug addiction.

All right, now I'd like to turn to some constitutional challenges to the prosecutions. There are, I think, a number of them. I'm going to focus on three:

Understanding the prosecution of drug-addicted mothers as punishing them for having babies transforms the constitutional issue. The question is not whether the State can justify limiting women's already illegal conduct during pregnancy to protect the fetus. It is whether the government may punish women for continuing a pregnancy, which is a constitutionally protected decision.

In the Johnson case, for example, the prosecutor, in his oral argument, framed the constitutional issue as follows: "What constitutionally protected freedom did Jennifer engage in when she smoked cocaine?" And, of course, you don't have a constitutional right to smoke cocaine, but that was not what the issue was in this case. Johnson was not convicted of using drugs. Her constitutional right to smoke cocaine was never at issue. Johnson was prosecuted only because she chose to carry her pregnancy to term. Had she smoked cocaine during her pregnancy and then had an abortion, she would not have been charged with a crime. The proper question, then, is: "What constitutionally protected freedom did Jennifer engage in when she decided to have a baby, even though she was a drug addict?"

I would submit that even though she is a drug addict, she still has constitutional rights. She still has the right to decide to carry a pregnancy to term.

I would like to present three constitutional challenges to the prosecution of drug-addicted mothers that focus on punishing women for the status of being pregnant. As I said, there are other constitutional challenges as well, but I will focus on those that deal with the punishment of the status of pregnancy. The prosecutions violate the Eighth Amendment's prohibition against cruel and unusual punishment. They deny women equal protection of the law, and they infringe on women's right to reproductive autonomy.

Punishing drug addicts for having babies violates the Eighth Amendment of the Constitution because it constitutes

cruel and unusual punishment. The Supreme Court in Robinson v. California, that was decided in 1962, held that a statute that criminalized the status of being a drug addict violated the Eighth Amendment. This was a statute that not only punished the act of using drugs or the act of possessing drugs or distributing drugs, but just being a drug addict, and the Supreme Court focused on the punishment of a status, and held that that was unconstitutional. The prosecution of drug-addicted mothers punishes women because of a combination of two statuses: drug addiction and pregnancy. Defendants are not charged simply for using drugs, but for the biological consequences of drug use that can occur only if they also happen to be pregnant. An addict who discovers that she is pregnant cannot definitely avoid punishment unless she undoes her pregnant status by aborting the fetus.

It was especially clear in the Johnson case. Part of the theory of the Robinson case as it's been interpreted by subsequent cases, is that you only can be punished for an act, you can't be punished just for being something; the status. In the Johnson case, if you remember, I explained that she was charged for transferring drugs through the umbilical cord after the babies were born. Well, that was not a voluntary act on her part. That was a biological function that resulted from pregnancy. Her act was using drugs which happened perhaps, you know, a couple of days before. I think in that case, because of the strange theory the prosecutor developed, it's especially clear that she's being charged not for any volitional act, but for her status.

The second argument is that prosecuting drug-addicted mothers violates sex equality norms. I'll elaborate, again, on what the prior witnesses testified about, this focus on women as being -- having all the responsibility for reproductive outcomes. Punishment on the basis of pregnancy affects only women. Since only female drug addicts can become pregnant,

laws that allow for their punishment alone, or that punish them more severely than male drug addicts who engage in the same conduct, have the effect of discriminating against women. Such laws also impose controls on women's lives that are not placed on men and thus limit women's ability to function equally in society. I think that was clearly shown in the laws that limit them in the workplace. Men do not have those kinds of restrictions, and clearly, if a woman is fired from her job or cannot get a job because of her potentially pregnant status, it's a clear example of how these kinds of laws restrict women in ways that discriminate against them based on their sex.

Laws that restrict women on the basis of reproductive capacity have historically served as the primary justification for denying women equal treatment under the law. I think based on this historical background, we should be especially concerned about applying them today.

Moreover, women have been the only targets of prosecution for fetal abuse, even though certain conduct by men can harm the fetus. Conduct that causes genetic damage to the sperm can result in miscarriage, birth defects, neonatal death, and early childhood illnesses. Physical abuse of pregnant women by men can cause fetal injuries or death. I was thinking during the testimony of the prior witnesses, that maybe one of the greatest effects of alcohol is that many men who are drunk beat up their pregnant wives and girlfriends, and that is a great cause of fetal injury as well. I think we should be concerned about that kind of effect of alcohol, as well as the effect on the pregnant women.

Male exposure of pregnant women to harmful substances such as secondary cigarette smoke may cause damage to the unborn. An example of the discriminatory focus on women's conduct is the 1987 case in California of Pamela Rae Stewart. This is one of the first woman to be prosecuted for prenatal drug use. The charges were eventually dropped against her

because it was held by the court that the California child neglect statutes did not apply to fetuses. But she was charged and prosecuted for this crime when her child died shortly after birth, and part of the charges were that she failed to follow her doctor's orders to refrain from sexual intercourse with her husband. Now, her husband was aware of the doctor's orders and he initiated the sexual intercourse, but, of course, he was never prosecuted. He was equally as guilty of this fetal abuse as she was, but the whole focus was on the mother.

Finally, punishing drug addicts for continuing a pregnancy also violates their right to reproductive autonomy. In my mind this is the strongest constitutional argument against punishing pregnant drug addicts. The decision to bear children has been acknowledged in numerous Supreme Court cases as being at the very heart of choices protected by the right of privacy. The Court, in Eisenstadt v. Baird, which struck down a statute that prohibited the distribution of contraceptives to unmarried persons, recognized the vital nature of the freedom to choose whether to give birth to a child. Quoting the Supreme Court opinion: "If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted government intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." Once it is established that the decision to procreate is entitled to this high level of constitutional protection, it follows that the government may not unduly burden this choice. Convicting a woman of a crime because she is pregnant is perhaps the most direct and heaviest of governmental burdens on the decision to bear a child.

In conclusion, I'd like to say that a policy that attempts to protect the health of future children by denying the humanity of their mothers will inevitably fail. The tragedy of crack babies is initially a tragedy of crack-addicted mothers. It is only by affirming the dignity of

these women that the health of their babies will be ensured. The first principle of the government's response to the crisis of drug-exposed babies should be the recognition of their mothers' worth and entitlement to autonomy over their reproductive lives. A commitment to guaranteeing these fundamental rights of poor women of color, rather than punishing them, is the true solution to the problem of damaged babies.

Thank you, and I'd be happy to take questions, if you have any.

ASSEMBLYMAN COHEN: What type of statutory protections do you think would be necessary, whether it's to limit rules of evidence or limit what can be turned over by a doctor? Prosecutions in most cases are only tempered by the sense of morality that an individual county prosecutor has -- or an attorney general. In some situations you may not even need a statute, but for those situations where those who wish to gain some type of national notoriety upon an issue perhaps they see as well, this is only one individual. "I'm going to prosecute because this might get me on Ted Koppel."

MS. ROBERTS: Yes, well, it's worked. It worked last night. If you saw Ted Koppel, there was a prosecutor from South Carolina on last night. He was prosecuting pregnant drug addicts.

ASSEMBLYMAN COHEN: There's a real danger, because someone else in a higher court may even accept the premise somewhere else in the country, that this is a viable prosecution. Even though nothing may have arisen at this point in time in New Jersey, I think it's an area where we need statutory protection to guard against abuses that may occur in the future. I don't want to wait for any spiraling effect. Sometimes these things are self-perpetuating, and it can be in a local newspaper one day and "Time" magazine the next day.

That is a danger that shouldn't be visited on any woman or male in the State, and that the full protections of Roe v. Wade and everything since--

I would like to see any suggestions that you may have, or anyone else in the constitutional law field may have to draft legislation.

MS. ROBERTS: Well, first, let me agree with you wholeheartedly that what we're seeing is prosecutors in little towns -- Rockford, Illinois and Pinellas County, Florida, and South Carolina -- which are being raised to national prominence because they've instituted this policy of dragging women -- sometimes literally -- out of the hospital to be arrested because there's some evidence of drug use. They can use statutes that are already on the books like drug distribution statutes and child abuse statutes.

One thing, I think, that we have to be careful of are legislative efforts to make it easier for prosecutors. Some of those efforts have been to specifically insert the word "fetus" in child neglect statutes and child abuse statutes and manslaughter statutes to make it easier for prosecutors to prosecute fetal abuse cases. One thing is to be aware of that and to try to avoid that.

Now, as you mentioned, the prosecutors can take statutes that are on the books, as in the Jennifer Johnson case, and come up with theories like she transferred the drugs through the umbilical cord, getting around the problem of using a statute that was not at all intended to prosecute a woman who used drugs during pregnancy.

ASSEMBLYMAN COHEN: There's a doctor in Boston who was prosecuted several times in the '70s, and they used an 1896 statute to-- Since you couldn't impact on a woman because of certain rights, they went after the doctor. I forget what the doctor's name was, but it was a national cause celebré because they were prosecuting him, I think, for homicide, for performing an abortion, I believe, after the first trimester.

It's that kind of prosecutorial creativity; simply, there should be statutory temperament of that.

MS. ROBERTS: Yeah. Well, I suppose there could be some way to make clear that these statutes are not intended to apply to fetuses. Maybe there's some way to add wording to them. I'm not as familiar with the legislative process as you probably are, but some way to clarify that these are really distortions of the intent of the statute.

Secondly, there may be some way to strengthen the doctor/patient privilege. I assume there wasn't very much argument in the Jennifer Johnson case concerning that, and I'm not really sure how it is that a doctor could divulge all these confidences of a patient except there may be an exception because it was in connection with a crime. There may be ways to strengthen the privilege so that pregnant women can be assured that if they confide in a doctor because they want help for their pregnancy and/or their addiction, that this is not going to be used against them in court, and there could be evidentiary rules that are enacted to make that clear.

Another--

ASSEMBLYMAN COHEN: There may have been a difference between the communication aspect between the patient, and the physical result, physical testing.

MS. ROBERTS: Well, there were both though. You see, some states have enacted statutes that require doctors to report positive toxicologies either to child welfare authorities or to prosecutors. That's one issue which can be challenged as well. That does not have to be a law. They could be considered confidential.

But then, there's also the issue of a doctor divulging confidential communications, and that was done in the Jennifer Johnson case. The doctors testified as to what their patient, Jennifer Johnson, told them about her drug use during pregnancy and also about her concern for the fetus. I think it's

outrageous that a doctor would get on a stand-- Obviously he was compelled to testify, so I'm not blaming him personally. But just that this could happen, that a doctor would get on the stand in a criminal trial and testify against his patient, using her concern for her fetus against her-- So, it's-- I would want to be on the lookout for laws that would make it easier for doctors to testify and also give these results to prosecutors, and maybe also to strengthen evidentiary laws, to make sure that these confidences are kept confidential.

I'd also just repeat what Joan Bertin said about the importance of making sure that drug treatment centers are really open to pregnant women; that they are forced not to exclude pregnant women and also that they are made accessible in the sense of child care and the kinds of services-- It may also be that pregnant drug addicts need treatment centers that are exclusively for women, because many do feel uncomfortable in treatment where there's one or two women surrounded by men, especially since in most of these cases these women have been subjected to physical or sexual abuse. That's very common among drug addicts and this kind of counseling has to be incorporated into the treatment, as well.

ASSEMBLYMAN COHEN: It's going to raise more and more interesting questions because we have, as part of the Drug and Alcohol Committee, the issue of health insurance, requiring the health carriers, the HMOs, to provide health insurance for treatment for drug abuse. In many instances it's already there for alcohol abuse, but they create two different sections. The problem is, when you-- The confidentiality aspect is going to be interesting in that context, where you submit your form and you're seeking help for drug usage. I mean, the simple fact of usage means possession, and possession is a criminal offense, and you are certifying at the bottom that these are the treatments being rendered to you on the days that you went for them, and it creates a--

MS. ROBERTS: A chilling effect?

ASSEMBLYMAN COHEN: --catch-22, as referred to earlier in the--

MS. ROBERTS: That's right. Even more so for pregnant women. If there's-- In a town where the prosecutor has said, "We're going to prosecute any woman who uses drugs during pregnancy," they're even more likely to be afraid to sign up.

ASSEMBLYMAN COHEN: I don't think we need any Scopes trials on this in New Jersey.

DR. VAN JONES: Okay, any more questions? (no response)

MS. ROBERTS: Okay.

DR. VAN JONES: Okay, thank you.

We will reconvene at 1:30.

(RECESS)

AFTER RECESS:

DR. VAN JONES: Good afternoon. I want to welcome you to the hearing before the Commission on Sex Discrimination in the Statutes, and I want to welcome you all.

This afternoon our first speakers will be Amy Bahruth, Staff Representative and Health and Safety Coordinator from CWA 1031, and Vince Trivelli--

V I N C E N T T R I V E L L I: Trivelli (pronounces name).

DR. VAN JONES: Trivelli, okay. I'm known to do that. Par for the course. Legislative Political Coordinator for CWA, District 1.

Welcome, and who is going to go first?

A M Y J. B A H R U T H: Okay. I'm going to go first, presenting testimony for my Local, and also for Local 1033.

DR. VAN JONES: Okay.

MS. BAHRUTH: My name is Amy Bahruth and I'm a staff representative for the Communications Workers of America, Local

No. 1031. I would like to thank you for this opportunity to present testimony about the health hazards of VDT use. Local No. 1031 represents State workers at the nine State colleges and the Department of Higher Education central offices. Local No. 1031 primarily represents women clerical workers, so the health and safety problems associated with computers is very real to our members.

Over the past few years, computers have become the norm in State offices, virtually replacing the typewriter. In fact, with row upon row of computer terminals, many State offices now look like computer assembly-line operations. However, even though the clerical support staff needs to learn new skills to be able to use the new technology introduced, the State's position is that the computer has merely replaced the typewriter and made clerical jobs easier. So, clerical jobs, especially data entry jobs, remain underpaid and undervalued.

More and more of our members spend their entire day, or a good portion of it, sitting in front of a VDT screen punching in data at a high stroke rate or producing reports and other documents. Some departments in State service go to the extreme of disciplining workers if they don't make their quota of strokes in a given hour. Other departments offer bonus incentives to workers who go above and beyond the required stroke rate, which inspires most workers because they need to compensate for the low salaries.

Various health problems have been associated with the use of VDTs, including: visual problems; muscle and joint problems; repetitive motion injuries, such as carpal tunnel syndrome and tendinitis; and job stress. In addition, questions have been raised about reproductive risks and about the effects of low-frequency radiation.

The most common complaint from VDT operators are of visual problems. Prolonged attention to visual detail with limited eye movement in a restricted visual field can cause

eyestrain and other problems. Tasks which require an operator to look back and forth from screen to text can produce visual strain. This is especially true if the display has light letters on a dark field, which is the reverse of print on most documents. In addition, eyestrain is caused by too much light in the visual field of the operator and by reflections on the screen. Symptoms of visual problems include: itchy eyes, burning sensations, eyestrain, headaches, blurred or double vision, and changes in vision prescriptions. Severe eye discomfort may not go away within a short period of time following work and may even be present at the start of the next day's shift. Data suggests that some types of VDT work produce greater levels of visual complaints than traditional office work, because of the special visual demands of VDT work.

Muscle and joint problems are also a major concern for VDT operators. Because the body is designed for movement, a fixed position is more tiring than moderate movement. When the body is still, circulation is slowed, and as a result, fewer nutrients are delivered to the muscles, and fewer wastes are removed from the muscles, blood vessels, and spinal discs. The result can be muscular pain and, in some cases, injury. When workstations are poorly designed, which is the case in most State offices, posture is poor and strains are placed on particular groups of muscles. We are already seeing the indications of a severe health problem in our members as many VDT operators suffer from stiff neck and shoulders; shoulder pain; back pain; hand cramps; swollen muscles and joints; sore wrists, pain down their arms; loss of strength in their hands and arms; and loss of feeling in their fingers.

Many of these symptoms are early warning signs of repetitive motion injuries, also known as cumulative trauma disorders. These injuries are associated with three occupational conditions: awkward postures of the wrist or shoulders, excessive manual force, and high rates of manual

repetition. Specifically, carpal tunnel syndrome -- CTS -- which is becoming a common problem with VDT operators, seems to emerge from repetitiveness of the task more often than from force. Simply defined, carpal tunnel syndrome is when the nerve that runs down the forearm to the hand to allow finger movement is squeezed or pinched as it passes under the wrist into the hand. The tendons for flexing the fingers, the median nerve and blood vessels pass through the carpal tunnel, and if any of the tendon sheaths become swollen in the cramped carpal tunnel, the median nerve may be pinched. This pressure on the median nerve is what creates the numerous symptoms I mentioned before.

With the number of VDTs used in the workplace expected to grow in the 1990s to over 80 million, the number of workers adversely affected by carpal tunnel syndrome and other health problems will certainly mushroom. We are already seeing the impact of this new technology from the statistics of occupational illnesses and injuries compiled by the Bureau of Labor Statistics. The latest report indicates that workplace injuries caused by repetitive motion have increased sharply, and experts called the rise of computer technology a major factor. The report also says repetitive motion disorders accounted for 48% of all workplace illnesses last year, up from 38% in 1987 and just 18% in 1981.

The CWA has surveyed its membership about repetitive motion injuries in the public sector in New Jersey and the preliminary results are frightening. Testimony will be presented as to specific examples, but suffice it to say that State workers are getting injured because of their job at an alarming rate.

Many job stresses often associated with VDT work have also been identified. Psychological stress can worsen the effects of physical stresses by causing muscles to tense more, or by leading to increased headaches and fatigue. These

stresses include excessive work load or work pace, machine monitoring, not enough job control, or minimal decision-making, job insecurity, and lack of social supports.

Finally, concerns about reproductive risk have been raised by several clusters of miscarriages and birth defects among VDT operators. A study conducted at the Kaiser-Permanente Medical Care Program in Oakland, California in 1988 concluded that women who used VDTs for more than 20 hours each week in the first three months of pregnancy suffered almost twice as many miscarriages as women doing other types of office work. Three possible causes of potential reproductive problems have been suggested: radiation, psychological stress, and awkward work postures.

Several countries recognize the importance of providing a healthful work environment for VDT operators and have mandated ordinances governing such things as workstation design, lighting, vision care, and breaks. In the United States, nine states have VDT ordinances, guidelines, or executive orders, and Suffolk County in New York State has a legally binding regulation. In New Jersey, the Department of Health has developed the most comprehensive guidelines in the country which cover work environment, such as lighting, glare, and noise; VDT design; VDT workstation equipment, including specifications of chairs and tables; vision care requirements; job design considerations; and training for both operators and supervisors. These guidelines are meant to be a preventative measure and the New Jersey Department of Health believes that successful implementation of these guidelines will help avoid the health problems associated with poor VDT working conditions as well as increase operator satisfaction and productivity. However, the guidelines are just that. They are not enforceable as a standard by PEOSHA.

Currently, CWA is working on getting the New Jersey Department of Labor to promulgate these guidelines into an

enforceable standard. In addition, CWA is working with legislators in developing a VDT bill which would include the provisions in the guidelines, which Vince Trivelli, CWA's legislative and political coordinator will discuss in more detail.

Thank you, and now I'm going to move on to 1033's testimony.

This is testimony from CWA Local No. 1033. They represent over 7000 State workers in the Trenton area who work for approximately 10 departments.

Our Local represents one of the largest groups of video display terminal operators, over 600 employed by the Division of Motor Vehicles and the Taxation Division. Of these, over 90% are women.

At the Division of Motor Vehicles, operators continuously input information to process licenses, registrations, and suspensions. Many of these operators are simultaneously fielding telephone inquiries from the public while also inputing data. They are secretly monitored by management which contributes to their stress.

At the Division of Taxation, operators keypunch tax returns and checks all day and are on a quota system which requires a minimum of 8500 keystrokes each hour.

We recently conducted a survey of Taxation VDT operators of which 250 were returned to our Local. The responses revealed the following symptoms: 89% experience regular neck or back pain; 79% experience regular arm or shoulder pain; 76% experience hand or wrist pain; and 85% experience vision problems such as headaches, blurred vision, watering, and itchy eyes.

Over the years, union representatives have attempted to correct these glaring health problems with Taxation management. Even though research has shown that more frequent breaks, proper lighting, adjustable tables and chairs,

antiglare screens, and footrests are remedies to this health hazard, Taxation management has been unwilling to spend money to prevent the adverse health effects on their employees.

We wonder whether this situation would continue for so long if these operators were primarily men?

The short-term costs of these standards is nothing compared to the State's expenses involving lost time and medical bills resulting from these symptoms. There are several Taxation employees who have suffered permanent damage to their hands and wrists as a result of prolonged VDT operation.

Employers must be held to a uniform standard for VDT operators, and there should be strict government enforcement of these standards if we are serious about protecting the health of millions of American women.

MR. TRIVELLI: Let me just put this into a little perspective: The CWA represents in New Jersey about 70,000 people. We represent them both in the public sector and in the private sector. We represent AT&T, New Jersey Bell, as well as State workers and a good number of local government workers.

There are many issues which the union brings to the workplace. We need to deal with this; we need to deal with that. Now, the question of VDTs and the health effects on the membership has really come from the other direction. We've been getting it in New Jersey and around the country, frankly, saying that something needs to be done. You go to meetings and you see people who raise their wrists because they've had operations to try to relieve the pain and suffering they get from working on the VDTs. These VDTS have worked their way into so many jobs now.

We have, as Amy mentioned, in New Jersey, tried to -- begun to do a few things to try to correct it. We've come here today to really urge you to support this.

First are the guidelines that she mentioned: Under the Public Employee OSHA Law, you've got a situation where

you've got a very tangled bureaucracy, and you've got three departments which need to pass on regulations before they become law, before they become regulations. We have pushed this State, through the Public Employees OSHA Law, to issue VDT guidelines for many, many years. Finally, at the very end of the Kean administration, Dr. Coye of the Department of Health put out a draft regulation, basically as a guideline. It is a very comprehensive document, as Amy has mentioned. It covers a lot of areas very well. The problem is that it's only a guideline. It suggests that this happens, and it asks that they do this, and make a lighting change, and these types of things. It has no force of law. She was unable to get the past administration to take that document and turn it into a regulation which would have the force of law. So, we do have these guidelines, but they do not have the force of law, and we are trying to make this new administration look at that and make those into law.

What we've also done is come to the State House and said that we've asked for a long time to do it through the regulatory process, and maybe it's now time to do it through the legislative process. Assemblyman Tom Foy has a bill -- A-3015 -- which has some portions of the regulations in it, not all of them. He and Assemblyman Lou Gill have agreed to amendments which would take the document -- the guidelines -- change them into legislative language and amend that bill to do that. They're talking about having hearings on it, probably in the fall when the Legislature comes back after this budget mess.

They deal with a lot of issues that are not dealt with in the original bill. They deal with changes of lighting and VDT exhaust. They deal with noise; they deal with equipment changes; they deal with training; and they deal with changing the job tasks, so you can get at some of the problems associated with the VDT in the workplace. Also, they extend it to both public workers and to private workers. The guidelines

only apply -- if they apply at all -- to public employees, not private employees. There is no outstanding regulation for private employees, and it's time that there is.

The other area that I want to just comment on briefly is the area that -- again, Amy mentioned quickly -- of electronic monitoring. I was counsel to the Labor Standards Subcommittee of the House of Representatives in a former life, and there were a number of hearings that were held by the Education and Labor Committee in Washington down there on the problems of VDTs. Now, there are some bills being considered down there on VDTs and on the problems of monitoring. What we learned in those hearings, and we see it more and more now, and two things: One, is that work in front of VDTs has almost become piecework; that the faster you work, the more you make, and if you don't work at a certain rate, you get disciplined for it. How they know that is through extensive electronic monitoring of the employees.

We've seen situations where employees are, in fact, locked into the machine in the morning and then unlocked to go to the john at the coffee break time and that sort of thing. Their entire life is governed by the machine. It records every aspect: how fast, how slow, how hard they push on the keys. Every aspect of their life is determined by that machine. They are disciplined for not meeting certain standards. They lose pay for not meeting certain standards.

The stress involved in that is tremendous. As I say, every aspect of their working life is monitored by the machine if they are on the VDT. Then we have people who work on VDTs who are operators, who are not only seated in front of a VDT and are monitored based on how much they put into the keyboard, but are also monitored through the telephone conversations that they have with the outside world. You've got supervisors listening in to how quickly they are able to answer the question and respond; you know, deal with the VDT at the same time and get on to the next question.

The stress involved with that is dramatic. It causes all sorts of problems for people. It exacerbates other problems -- heart problems and other sorts of problems, and we believe that that aspect -- the monitoring aspect -- has to stop as well.

Assemblyman Schwartz has a bill -- A-210 in the Assembly -- which there have been public hearings on already, two days long of public hearings in front of Assemblyman Patero's Assembly Labor Committee. The transcripts of those should be ready relatively soon, and I would urge the Commission to get a copy of those, because there was extensive testimony on the psychological and other problems related to the stress of the monitoring in front of the VDTs by several qualified doctors. I would urge you to get those because it is-- I mean, you talk to people and you can't believe the amount of stress that they have. I mean, they have to answer a call within six seconds. They have to look up the number. They have to do a whole series of things, and their entire life is monitored.

We are also moving that bill, A-210. The reason, I think, that we are here, is that if a male works in front of a VDT, they have the same problems, but unfortunately, the way that the society has worked out, it's not been work that has been highly valued, I would say, and a vast majority of the people we have in the private sector, such as AT&T or New Jersey Bell operators or information people, or when you work for the State or counties who work in front of VDTs-- The vast majority of those are women. And I think that Amy's right, that if these problems had been associated with men, there would have been corrective action. As I say, we had hearings on similar issues to this in the early '80s in Congress, and here we are today still talking about it. We believe the time for talk has really passed, and we need action by the administration and by the Legislature on these issues. I'll answer any questions, and I'm sure Amy will, as well.

DR. VAN JONES: Is there any support service? You talked a lot about the psychological counseling, the stress, and stress-related things. Do they have any sort of support service?

MR. TRIVELLI: Well, some of our employers and employees do have employee assistance programs, but none that are directed, specifically, at these kinds of stress-related problems. Because of this, in fact, in the bill that I mentioned -- in Mr. Schwartz's bill -- there is a requirement that if you are going to do any kind of electronic monitoring -- and the bill, I neglected to mention, limits it to a very, very small amount -- you have to set up an employee assistance program to assist people with stress-related problems, because it creates tremendous stress.

The bill, just briefly, allows -- says no secret monitoring can go on. Whenever there is any monitoring, everybody has to know. It's also a privacy issue, because the public doesn't know they are being listened to. If you call the Division of Taxation now and you talk about confidential tax information, a supervisor -- and more than one supervisor -- can be listening in on that conversation, which is none of their business. So, we believe it's a civil right, as well, but it limits it to the first six weeks; no secret monitoring, and notice monitoring for the six weeks for training purposes, but certainly not for discipline or anything else, and then once a year for a month with a fair sample, again not for discipline, just for training and quality control type things.

We would prefer to see it totally abandoned. Frankly, the employer community is not supportive of that idea, but like I say, the stress is amazing, and Assemblyman Schwartz's bill has a provision about employee assistance programs for stress.

DR. VAN JONES: Any other recommendations for the Commission that we should consider in this whole area? You mentioned a couple of bills that we could watch. Anything else?

MR. TRIVELLI: Not at the moment, but I'll certainly think about it.

MS. SAMPIERI: Can you give me an approximate time when the hearings were held on A-210?

MR. TRIVELLI: Within the last two months.

MS. SAMPIERI: Okay. Thank you.

MR. TRIVELLI: Probably within the last month, maybe. The budget time sort of destroyed my-- I've been here too many days.

MS. SAMPIERI: Thank you.

DR. VAN JONES: Okay, thank you.

Our next speaker will be Barbara Price, from the New Jersey Coalition for Battered Women. Oh, I went ahead of myself. Linda Greene. Sorry, Linda.

L I N D A I R E N E G R E E N E, ESQ.: I'm Linda Irenegreene. I'm an attorney here in New Jersey. I wear several hats, but the major hat that I wear is I function as a consultant to midwives and midwifery organizations. I have been counsel to the Midwives Alliance of North America, which is an international umbrella organization of all midwives. I currently represent the Midwives Alliance of New York State, and act as a consultant to individual attorneys throughout the United States and Canada on midwifery cases that become issues, largely regulatory cases, although I have participated in some criminal cases.

I have with me today a midwife who is going to speak with you anonymously because she practices here in New Jersey without a license, and obviously, we do not wish to subject her to any surveillance or any liability because of her willingness to talk to you about her profession. I also have brought with me copies of the current regulations, N.J.A.C. 35:2.6 et. seq., and the American College of Nurse-Midwives, New Jersey Chapter's, proposed modifications to the regulations.

From an organizational perspective, what I'd like to do is first remind you of what the current law is in New Jersey. Secondly to point out what's good and bad about the current regulations and the proposed modifications, and then to talk a little bit about the state of the practice of midwifery -- the reality of the practice of midwifery in the State of New Jersey. I encourage you to stop me and ask me questions, because I probably could go on too long.

There is a statute on the books in New Jersey -- 45:10 -- which enables something called a lay-midwife in this State. I'm not quite sure that we have any notion of what those words mean because it would seem to me that if you go to school and you have been granted a license and you are a professional, there is nothing "lay" about you, but, that's old terminology that has hung around. Chapter 45:10, among its many provisions, provides for the educational path to getting such a license. That educational path consists of 1800 hours in a school, and the terminology in the statute is, "accredited in its own jurisdiction."

We have made some efforts in the State of New Jersey through the Board of Medical Examiners to have them administer something called an examination -- and we've been very open about what such an examination might be -- to people who could meet that requirement. They have been -- I use the word advisedly -- "recalcitrant." We had a great deal of difficulty getting them to acknowledge that such an exam could exist, or would exist, or that they could prepare one.

Then they finally prepared one and would not certify anybody's education to take it. What has happened is that those people who were willing to attempt to do that have left the State. Some of them continue to practice without a license, but most of them have gone elsewhere to practice their profession, so you get a drop-off of this group of highly qualified professional midwives unavailable, despite the fact that they can apparently meet the requirements of the statute.

Certified nurse midwives are qualified to practice in the State of New Jersey by virtue of their certification from the American College of Nurse Midwifery. There is a school in New Jersey at the University of Medicine and Dentistry in Newark, that gives a certificate program to people who are already R.N.s. There are -- at last count, I think -- 17 other schools in the United States, only two of which combine getting an R.N. and a C.N.M. -- a registered nurse degree certificate and a certified nurse midwifery certificate. The balance of them make you a certified nurse midwife at the end of their program, having already gotten an R.N. or a B.S., a bachelor's in nursing. A couple of programs are master's programs where you actually end up with a master's of science in nurse midwifery, so that there's that spectrum of kind of education for certified nurse midwives. In New Jersey they are recognized, essentially, by virtue of having that certificate current, and of having a current R.N. in New Jersey.

When I went into practice in 1978, if you called the Department of Health in New Jersey they told you that there were 18 licensed lay-midwives in New Jersey. My last call to the Board of Medical Examiners to get that information was, "We don't know, and we wouldn't tell you anyway." I said, "But it seems to me that's public information."

"Well-- But-- You know-- Since we don't give them out anymore, they're not really okay."

"But there were licenses, right? If people renew them properly under the law, you supposedly can use them?"

Clunk. That was the response that I got from the Board of Medical Examiners of the State of New Jersey.

I admit that I did not pursue that because my sense was that that gut reaction through the phone was exactly accurate. That's exactly how they're functioning. I then began to speak with the midwives in this State who, of course, I have intimate contact with because of the profession that I

am in, and because they come to me when they get in trouble. What I discovered was that those 18 licenses were all very, very old. They predate 1959, which means anybody who still holds one is probably 90, and beyond that, that the number of people practicing as midwives without licenses in this State has diminished, and diminished, and diminished, so that when I went into practice in 1978 there were probably 15 to 25 unlicensed midwives providing midwifery care to women who wanted to birth at home and could not secure the services of anybody with a license to do it, or who went to these women because they knew they were professional and qualified and wanted to have them.

That number is down to four, and the reason I know that is because I went around the State calling all the people I know to find out who is still practicing. I also just returned from the North Atlantic Regional Conference of the Midwives Alliance of North America, which is a very good place to be in touch with these people.

So, we have a situation of two different groups of midwives -- three really -- licensed and unlicensed quantities called lay-midwives in this State, and certified nurse midwives. All of whom practice under a set of regulations, or within the ambit of a set of regulations passed in 1983.

There was much turmoil at the time of the passage of those regs. Public hearings, hundreds of people, and they finally came up with a set of regs that essentially creates a world in which once you are a midwife you can practice under pretty much -- not 100% -- but pretty much the same conditions. You can attend births anywhere; home or at a birthing center or in a hospital, according to the regs, except we all know that somebody who is not a nurse is not going to be able to practice in a hospital under these rules. Except for the ability under protocols of a nurse midwife to prescribe and give certain medications. Largely because she's a nurse in

this State, the rules are essentially the same. They attend normal births. A nurse midwife is given the opportunity to comanage an increased -- a high-risk birth. And that has been the situation under which people have been practicing since 1983.

As I travel around the country I kind of use New Jersey's current regulations as a model of almost being where we'd like to be, and then comes a proposal to change them. There are some wonderful changes in the proposal. They give midwives prescriptive power. They give them the opportunity to do what they are trained to do; to say that you need pitocin during this birth, that we need to do an episiotomy, and we need to use xylocaine to make it more comfortable; to prescribe things for an ordinary urinary tract infection under protocols, pre-, antinatal, and postpartum -- the things that midwives can do, are trained to do, know how to do, and safely do.

But, another thing they do is that they lose this thing called a lay-midwife. She's gone out of these regulations, as if the statute no longer existed; as if there is no other way to get to be a midwife. The reality in our world is that there are all different ways to learn how to do something, and once you learn your profession, you can be accountable, your skills can be measured, and you can practice that profession. You can be regulated.

You will hear from a practicing midwife in this State that regulation is what they are willing, and want to have. They do not want to practice outside the law. They do not want to look over their shoulders to see who's coming down the pike. They want to comfortably be able to say to a client family, "This birth no longer belongs at home. Let's call the doctor," openly and comfortably, and consult with the doctor and perhaps go to the hospital, or perhaps have the doctor say, "Wait a little while. This is what I think is happening."

They can't do that. Not only can't they do that, but certified nurse midwives who choose to practice at home can't do that, either, because the physicians in this State won't back them. They won't acknowledge that birth at home can be a safe and wonderful experience. There is this requirement for written protocols that continues from the old regs to the new -- new proposal -- without acknowledging that docs won't do it.

For reasons that have to do with status, that have to do with malpractice insurance, that have to do with peer pressure -- we could go on and on -- that have to do with economic competition, every baby that is born without the attendance of an obstetrician is-- Pick your dollar number: $1000, $1500, $2500? Without that money to the hospital that desperately needs that easy money for normal births, we're creating or continuing a situation where we are requiring something we can't get.

Let me tell you some of the things that I know about why and how you can't get it. I represent a certified nurse midwife practice in the northern part of this State. In order to get hospital privileges and a good collaborative relationship with a reputable physician, they have to agree to never do a home birth in New Jersey; not, "with another doctor," not under "unsafe conditions," never, if you want to maintain your relationship with this hospital and this physician, will you do a home birth. That has happened twice with two certified nurse midwife practices that I represented. One in the last two years, and one about four years ago; with reputable hospitals and reputable doctors. That's economic competition and fear.

We need as we look at the statute and at the rules, to make provisions for families to get the services that they want and for professionals to practice under the conditions to make that possible.

What are some of the things that they can do? We have in the proposed statute in New York State what we call "institutional backup," where a family can arrange with the local hospital to provide their backup care; not only can they, but that the local hospital must accept them. So that if they have an emergency room and they have an obstetrical ward, if there is a need for a transport, which is transfer in labor, or a transfer, which is transfer of care before labor, or collaboration, that hospital is available.

In addition, we need to have not written protocols between the midwife and the physician, but collaborative agreements that are either between the midwife and the physician, which would be wonderful -- and all midwives want them, but you can't get them -- or between the family and the physician, so that the client family can go to the obstetrician and say, "I would like to come to you in the first trimester and in the last trimester to have you check up on things. I would like you to know that my baby is going to be born at home. I would like you to know the name of the midwife so if she needs to call you, you will feel comfortable, and I will pay you a fee for that service."

Currently what we have is the client family going to the local obstetrician and signing up fraudulently, and saying "I'm going to come here for prenatal care, and I will go to your hospital where you have privileges, and I will register." And then she disappears, because really what she needs is the lab work so that her midwife can practice safely. And what her midwife needs is for her to get the prescriptions that she can't write.

That's not the way it ought to be. We ought to be providing solid, safe health care under a reasonable scheme of regulation, so that I don't have to represent people who broke the law, because essentially the representation that I do is not for bad outcomes, but for what I call, "mere presence"

cases. Somebody finds out there was a midwife there, and they go to prosecute her. This doesn't make any sense. I don't have to make a living that way. I'll throw away these cards and say I won't represent midwives any more. That would be fine with me, if we could have a reasonable regulatory scheme.

Please, ask me questions.

DR. VAN JONES: What is the cost of the birth, you know, for a midwife? You gave us the data for the hospital, $1000, $3000.

MS. IRENEGREENE: It varies. Unlicensed people, obviously, do not charge as much as people with a license. They have that sense-- You can ask the midwife who is going to talk to you about their fees. Certified nurse midwives, those few who do births-- I mean, there's one certified nurse midwife who practices in this State, minimally, at home, without backup, and there are a couple of private practices with hospital privileges. The private practices with hospital privileges get somewhere between $2300 and $2700 for everything. That's all the postpartum, antipartum care, the birth, postpartum, whatever. I've heard fees that range from $900 to $1700 under other kinds of conditions.

I don't know what Family Born, which is the birth center down on the shore gets, but they used to get around $2800 complete, including the birth-center birth. Fees range all over the place. In New York State, they range up to $3000 for a midwife-attended birth in a hospital. Of course, if it's a home birth, there is no hospital bill. The transport rate is very low for most midwives, largely because they spot problems very early. There is a much lower cesarean rate; the midwives I represent have a cesarean rate anywhere from 2% to 6%. The State average is way, way up, almost at 20%. The national average is way over 25%, so that we're looking at good health care. We're looking at what people like to call "intuitive health care." I think it's experiential. If you do this long

enough, you begin to spot what the problems are. We're looking at a group of professionals who want to practice their profession, many of whom practice it even if you won't give them a license, because there is a demand.

MS. PERELMUTER: Can you talk a little bit about other states and their regulations of midwifery and what percentage -- if you know if the percentage of births in hospitals dropped off when they instituted regulations, and that kind of information?

MS. IRENEGREENE: Interesting. One of the things that happens is that the data that's kept for home birth, categorizes it very often when it's underground, as an emergency. They hide behind, "The baby got born too fast," okay? So that it's not real clear how the changes-- However, I can give you some hard statistics.

In the State of Washington, which has a school of midwifery where you do not have to be a nurse, there is a 10% nonhospital birth rate with licensed professionals attending the birth. Now, in Washington naturopaths can attend births, midwives can attend births, certified nurse midwives can attend births. In Oregon they have a very, very, high number of births outside of hospitals. Oregon midwives are governed by their state organizations' regulations. There is no state regulation of midwives.

There are 17 states that regulate the practice of midwifery for those who are not nurses. Of those 17 states, about a half dozen have a didactic school requirement, New Jersey being one of them with that 1800-hour requirement, and 45 test, and the balance have a -- what I call -- a mixed requirement, a combination of practical experience, demonstration of skills through an examination, observations, chart review, etc. New Mexico has the most extensive examination of apprenticeship training of all of the states. New Hampshire has a certification process after apprenticeship training.

I do not pretend that there is any relationship between the practice of midwifery and maternal care in the State of New Hampshire and the State of New Jersey. A rural state with a very low population is not the same. I do not propose that it is, but that gives you an idea of the spectrum.

Some states have reciprocity, and I suggest that if we were looking at writing really good regulations, we would build in a way to have a person who is a professional in another state with this set of skills to be able to come into the State of New Jersey and in the same way that a C.N.M. can practice, if I am a certified midwife from Washington, I should be able to be a certified midwife in New Jersey, given that there could be a review of the regs. I've written model regs and model legislation which I would be delighted to make available to you.

The point is that we have to get unstuck from the notion that the only way to get to be a midwife is to be a certified nurse midwife. Certified nurse midwives have wonderful training. Please do not think that I am here to denigrate that training; I'm not. There are other ways to arrive at the same level of professionalism and skill.

I heard you ask the question before, "What can the Commission do?"

DR. VAN JONES: Yes, the recommendations.

MS. IRENEGREENE: I would like to offer to participate with the Commission to write proposed regulations. The statute does not need to be changed. The regs need to be looked at so that they reflect the intent of the statute, and the Commission could do a wonderful service for this State, to propose modernization of the regulations.

MS. SAMPIERI: I heard you mention twice the word "apprentice," or "intern," in connection with this. Is an apprenticeship--

MS. IRENEGREENE: Absolutely. Not only is it, it is in actuality. Most of the midwives who practice in the United

States, no matter how they got to be there, have apprentices working with them.

MS. SAMPIERI: Either a formal or an informal--

MS. IRENEGREENE: Right. In New Mexico, it's very formal. In some other parts of the country, it's less formal. The state organizations that are highly sophisticated and have certifications and regulations have a process of apprenticeship.

In New York State we are in the process of proposing a program -- which is essentially a university without walls -- toward a midwifery degree which would embody the general education that you don't have to get in a classroom. If you want to sit at your dinning room table with the midnight light and learn anatomy, physiology, and the nursing skills, and take an exam, challenge a program, why not? This is a very complicated world and women, by and large, have three jobs, not one. If that's the way to go to school, then we need to acknowledge it and use it, because we don't want to lose those skills.

MS. SAMPIERI: I have one last question: Are any of the forms of midwifery in New Jersey covered by any of the health insurance programs?

MS. IRENEGREENE: Certified nurse midwives get third-party reimbursement for antipartum care and birth. They get it in a highly varied way. They get a scheduled fee which is less than what obstetricians get from some of the insurers. From some of the other insurers they just-- You submit a bill and they get 80% of it, like any other bill. It's varied.

Some of the states, now that they are licensing midwives, and certified nurse midwives, having been regulated for a very long time, are beginning to look at third-party reimbursement and how those formulas are arrived at. Obviously, in those more sophisticated places the push is to have the same level of reimbursement as physicians. The same services are provided. If we would get through this, we need

to build into it not only institutional backup, not only client backup, but the requirement that a family that is insured can use their insurance, and it doesn't make it more expensive to have a midwife-attended birth.

MS. SAMPIERI: Thank you.

DR. VAN JONES: Another question that is sort of related to this: The physicians' assistant, I think it's--

MS. IRENEGREENE: Physicians' assistant, yes.

DR. VAN JONES: Have you done any collaboration, because they seem to have the same kind -- you know, similar problems of the barrier, competition--

MS. IRENEGREENE: Okay. I have informally worked with the physicians' assistants in New York State. I have formerly, worked with the physicians' assistants in California and in New York State, and in fact, many of the midwives who belong to the Midwives Alliance of New York are physicians' assistants who practice midwifery. It was the route they chose in order to legally practice their profession when they couldn't get to be midwives without being nurses. I'm sure you know that historically there is a whole negative thing about being a nurse because of the subordinating profession that nursing was, and hopefully will not be any longer.

DR. VAN JONES: Thank you.

MS. IRENEGREENE: Let me introduce you to a person whose name you are not going to know, and I hope that you understand that we do not wish to expose her.

A N O N Y M O U S M I D W I F E: Shall they ask me--

MS. IRENEGREENE: Why don't you speak.

MIDWIFE: I'm here today because I have worked with pregnant families for 40 years, and have come to the absolute conviction that the female body is so wonderfully designed to give birth, that we really owe it to women to give them back their birthright. I believe that many of the midwives, both certified nurse midwives and the lay midwives, feel much the same way.

Linda had said that there are four practicing lay-midwives in the State of New Jersey right now. I'll tell you that's not nearly enough. We get calls from distant parts of the State; these four are primarily in the center, the mid-portion of the State. There's no one down south, there's not one south and east of Trenton, no one up in the northwestern corner.

There is one certified nurse midwife who will attend home births right now. She does one a month; not enough. There is a greater and greater call for families who want to have their babies at home because they want to have-- They want that birthright.

We have had as clients M.D.s, psychologists, people very high in the educational system. We've had truck drivers and carpenters, and managers of businesses; everybody, clear across-the-board.

We absolutely do not like working outside of the law. It is not a comfortable feeling. One does not like to have to park their car three blocks away when they go to a birth because they think there may be somebody who is unhappy about this.

We are professionals. We're experienced professionals, and we'd like to be recognized as such, and we'd like to practice and do those things which are within the law and which are for the safety of our clients.

If you all meet everyday, you probably didn't see Geraldo's program yesterday at 4:00.

DR. VAN JONES: What was the topic?

MIDWIFE: It was on birth. Home birth, or out of hospital birth, versus hospital birth. They quoted from at least four states, the statistics of birth.

The program was pretty good, actually. The obstetrician who was speaking for hospital birth was good. He was not down and out, stamping his feet and screaming, but it

was well presented. They, of course, as Geraldo does, invited from the audience a number of different people to talk about their births. But I liked the fact that they put some real statistics out there. The doctor had said, "Oh, the AMA has proven that home birth is twice as dangerous as birth in the hospital," when the statistics really do not prove that at all; much to the contrary. The people who stood up and spoke had quite a few things to say about that, too.

DR. VAN JONES: What were some of the recommendations at the end? You know, what were the issues, and what were some of the recommendations? Did they talk about that?

MIDWIFE: No.

DR. VAN JONES: Some of the solutions? They just gave you the story?

MIDWIFE: Yeah. I think they were really encouraging women and families to find out. Even the obstetrician said that you can have as good a birth in the hospital as you can -- these things, which people, women, call "good birth" -- at home, and more and more hospitals are changing. I'm not too sure about that part, but it's true; you can. Women can have a really good birth in the hospital, but boy, they have to fight for it for nine months and maybe not always with a guarantee at the end. But there are no guarantees in life at all, so they're not looking for a guarantee.

The families that we've worked with have been extremely responsible families. They absolutely understand what they're undertaking. They have made it their business to become well-informed, and they have a very strong conviction that as the parents, they are responsible for this unborn child and this born child, and that they need to have the choice of things to be done or not to be done to them. This is one of the reasons why many people are opting for home birth; so that they can maintain that choice.

MS. SAMPIERI: When there were statistics given on yesterday's program, did anybody indicate where the statistics had come from?

MIDWIFE: Oh, yes. North Carolina has a very good study. The interesting thing about most of these studies is that they did not set out to prove that home birth was safer than hospital birth, or vice versa. They compared such items as-- Hemorrhage is always a good one to talk about. There were many more episiotomies done in the hospital than there were at home, but it really shows that generally you go into the hospital and if they're going to take these accountable things they may say to you, "Well, let us just do this one thing." And one thing becomes two things, and then two things become four, and four become eight, and eight become sixty-four, and it just multiplies until the woman, the family has lost it and no longer has any control -- I don't like that word "control" -- but doesn't have any say-so about her own body and her own baby.

There are certainly at home, far fewer episiotomies, and far, far, fewer instances of hemorrhage, because things that are done with women at home do not create hemorrhage. For the most part, hemorrhage is a created situation. If it's not, there are those very rare instances where it is not recognizable in advance and it just happens. You don't find a reason for it, and it's handled the same way as it would be in the hospital. I was a little amused yesterday to hear one woman say, "I'm much safer in a hospital because I know if there is a problem they can handle it immediately." Now, I've worked in hospitals, and I know "immediate" can be anywhere -- seldom five minutes, but more like 45 minutes -- in which length of time that woman could be from home to hospital, if that was the care that she needed.

Certainly, we don't do cesarean sections on the kitchen table anymore. I think that in the county in which I

live -- and I sort of work in about four or five counties -- the cesarean rate is over 30%, which is way too high; way, way, way, too high. Just seldom, whether we-- You know, everyone is screened, is talked about, they're discussed, they themselves discuss that they are low risk. The majority of women are low-risk people, and when you find somebody who doesn't fall into that category, then that's probably not appropriate to be done at home, and they recognize that and they accept it.

DR. VAN JONES: What about malpractice insurance and all that -- that whole category, because that's been the school of thought regarding C-sections -- that it's safer. A lot of doctors will say that it's safer, you know, if they have a difficult birth; a C-section is about the best thing to do and, you know, afraid of--

MIDWIFE: There's one study that asked the obstetricians to list the 10 top reasons for doing a cesarean section. Number one was fear of malpractice, and number seven was safety of the baby. Something's wrong there.

MS. IRENEGREENE: Dr. Jones, there were two very important articles, and I will try to find them for you and send them to you, but I can identify the authors for you. One was by Dr. Ruth S. Hubbard, from Harvard, on the efficacy of cesarean in which she did an extensive and exhaustive review of the literature on cesarean section and found that not only was it more dangerous, but that the intervention when not necessary caused problems both with the baby and with the mother. The other was by Janet Gallagher, who is a lawyer currently working for the City of New York, but who was Director of Very Special Women in the Law Program at Hampshire College in the Consortium In Amherst, Massachusetts. Janet also looked at the efficacy of cesarean from the point of view of forced cesareans.

What she found was that when the hospital feels out of control is when they demand that they be allowed to do a

cesarean, so that the notion of fear of malpractice is a fabricated one. I believe the doctor believes it. I do not think that they make it up, but it has been imposed on the doctor from the outside. The doctor has been taught that birth is not normal, and therefore in order to protect this abnormal happening, there must be a major intervention.

We have a lot of educational work to do, and licensing midwives is not going to solve that problem, but it certainly takes -- allows those people who want to be outside that institutional system and to protect themselves from interventions they don't need, to have that option. I think that's the important perspective.

DR. VAN JONES: Are there any more questions? (no response)

Thank you.

MIDWIFE: Thank you.

MS. IRENEGREENE: Thank you.

DR. VAN JONES: We'll take a 15-minute break and then we'll resume. Thank you.

(RECESS)

AFTER RECESS:

DR. VAN JONES: Hi, Barbara.

B A R B A R A P R I C E: Hi.

DR. VAN JONES: I'm glad you could come this afternoon for the hearing on the Commission before Sex Discrimination in the Statutes. We would like you to begin.

MS. PRICE: My name is Barbara Price, and I'm the Executive Director of the New Jersey Coalition for Battered Women. I would like to give testimony today on the detection and treatment of domestic violence by health care professionals.

I would like to talk to you today about two different women from New Jersey who each entered the health care system

in different ways. The first woman is deaf. She is deaf as a result of repeated blows to her head during 30 years of abuse by her husband. In spite of multiple admissions to the hospital and emergency room, there is no indication in any of her medical records that she was ever questioned about the possibility of abuse. There are, however, comments by nurses about an adoring husband, always at her bedside hovering around her. While he was present she never spoke up, and since no one separated her from him to ask questions about her injuries, the abuse continued. He was finally prosecuted and is now serving time in prison.

A study done at Yale-New Haven Hospital reported that one out of five women treated for injuries in hospital emergency rooms was abused. Other studies indicate that 40% of all emergency injuries are a result of domestic violence.

Another young woman suffered two miscarriages at 28 weeks of pregnancy as a result of premature labor. She was constantly abused by her husband during her pregnancies. She also never missed any of her prenatal visits to her obstetrician who never recognized her abuse. Again, her husband was present for all her doctors visits and the doctor never separated her from her husband to ask about her injuries.

The same Yale-New Haven Hospital study reported that 28% of pregnant women are battered, while a Texas study reported 25%. The March of Dimes considers this an important issue, and has produced a video titled, "Crimes Against the Future," and training material for nurses on how to detect domestic violence during pregnancy. The video discusses March of Dimes research that indicates battered women are four times more likely to deliver low birth-weight babies than non-battered women. Low birth-weight babies are at 40 times more risk of dying and having other handicaps than average-weight babies. Also, miscarriages are doubled among battered women.

How is all this missed when the majority of battering injuries are to multiple sites, especially the head, neck, face, throat, chest -- especially breasts -- and abdomen? What happens when a woman goes to her doctor or the emergency room?

A battered woman seeks care for an injury. She is more likely than a non-battered woman to exhibit signs of depression, anxiety, family, marital, and sexual problems, and somewhat vague medical complaints. She is then treated for her symptoms, not domestic violence. She is often given tranquilizers to calm her down. The results are a feeling of isolation because her underlying problem has not been recognized and the medication may also lower her ability to react.

These feelings of isolation can than lead to other psychosocial problems such as addiction, phobias, panic disorders, and suicide. Studies indicate that 53% of alcohol-addicted women and 70% of women cocaine users are abused. Seventy-five percent to eighty percent of drug and alcohol abuse started after battering began.

One in four women who have attempted suicide were battered within a few days of that incident, and usually attempted suicide with the drugs prescribed to calm her down. Why does this occur? It is the result of a lack of knowledge, lack of suspicion, and lack of separation of the woman for treatment from the batterer by health care professionals.

I don't mean to paint a bleak picture; progress is being made. The hospital training done by Courtney Esposito from the Division on Women and the work of Dr. Howard Holtz, of the New Jersey Coalition for Battered Women and his associate, Cathy Furniss, of the Governor's Advisory Council on Domestic Violence, have gone a long way toward making a difference in New Jersey.

Physicians are interested in learning about this problem. After the publication of a recent article by Dr.

Holtz, he received 50 requests from doctors for protocols on detection of domestic violence. However, more needs to be done. Research by Dr. Holtz shows that less than half of U.S. medical schools include domestic violence in the curriculum. Physicians and nurses need to screen universally for domestic violence, and receive training on what to say if they get a, "Yes" answer.

Unfortunately, with recent budget cuts at the State level, the hospital training that has been done by the Division on Women will be virtually impossible to continue. The New Jersey Coalition for Battered Women and its member organizations will see no increase in funding this year, which will make it difficult to maintain current programs, let alone pick up the programs eliminated by the Division at the Division on Women.

Mandating that domestic violence be included in the curriculum of New Jersey medical and nursing schools would be helpful, but doesn't cover people already in the field or those from out-of-state institutions. The State of New Jersey has been a leader in the area of domestic violence legislation and service, and we need to decide if we want to continue that commitment to violence-free lives for our citizens now and in the future.

Thank you. I'd be glad to answer any questions, if I could.

DR. VAN JONES: Do you have any recommendations, or anything of that sort that the Commission should look at regarding those issues that you just raised about battered women?

MS. PRICE: Well, I think it is important--

DR. VAN JONES: It's very bleak.

MS. PRICE: I think it's really important to have training in domestic violence in medical schools so that new physicians coming out get the information they need in order to

be able to recognize abuse when they see it. We, obviously, need to continue the training programs that are already in place, and I'm not sure how that's going to happen at this point.

I also think it's important-- One of the things in the March of Dimes film shows a Houston hospital prenatal care clinic, where they screen universally for domestic violence, both when the patient arrives and after delivery. I think that would be a wonderful means of helping women. It's done in a very nonthreatening way. They're told that everyone is screened for it; it's just like you take a blood test, you have a urinalysis, you get your pregnancy test, and you answer some questions about domestic violence. They ask them if they know about it, are they aware of it, are they in that situation, and then they provide information for them.

I'm not talking about a system that we have where physicians are required to report child abuse. That would not work in domestic violence because that would be threatening to the woman; if it was reported, then you could jeopardize her situation. But just the fact that health care professionals who are usually the people who see these women the most often would be able to screen for it and at least provide information, even if it's only a card or a phone number that they could carry around-- At the point that they feel comfortable about making that phone call, or getting help, they could get it. Right now that doesn't always happen. We try to provide information at hospitals, but that's assuming that the people who are encountering these women are going to do that; are going to, one, recognize domestic violence, and two, offer them the information.

MS. FRANCIS: I have a question: I wasn't here before. I'm Roberta Francis and I'm incoming Director of the Division on Women -- the Senate willing -- next week. I appreciate some of the comments you made about fiscal cuts

jeopardizing some of what the Division has done. Do you have any other direct comments on that, and also, could you describe the other agencies in State government that deal with the issue? Do you have any ideas about better coordination of effort within State agencies?

MS. PRICE: Mostly the organizations that are dealing with domestic violence at a State level are the Division on Women and their Section on Domestic Violence. The Division of Youth and Family Services, which funds the Coalition and all its member organizations, has a section on domestic violence. They have one person who is sort of a technical assistant too, and available for technical assistance beyond each person's contract administrator, who really just handles fiscal responsibilities. That person has been taken off domestic violence at this point. She's been put onto dealing with child care in DYFS, so I would say that at least 75% of her job now has become child care and only about 25% is domestic violence.

Also, domestic violence -- the area in DYFS that funds domestic violence -- is not a line item in the budget. It's just part and parcel of the whole amount of money that goes-- I think it would be really important to make it a line item in the budget under DYFS so that that money would be committed, given the budget cuts and the deficit, and we've had some lack of funds that have normally been distributed -- have just kind of gotten absorbed this year. Everybody's facing that problem, but it wouldn't be as easy to absorb if it was a line item in the budget and not just, you know, whatever. I think that goes for the Division on Women, as well. I'm not sure how it is in their particular area of domestic violence, but I know that they had requested a larger sum of money for training. From what I understand, it was, like, $119,000 that they requested, and they've been getting somewhere around $83,000 to $89,000. What is being proposed is $20,000. So, that's a major cut in training.

The training that the Division on Women does is primarily hospital training, and police training. That's really in jeopardy at this point. We're hoping it's going to be restored, but I don't know what's going to happen.

But those are the two primary organizations that have funding for domestic violence, and the funding through DYFS is basically to fund the shelters and services of the New Jersey Coalition and its member organizations.

We're hoping that the marriage license tax will be passed. It's pending, and that will help raise revenues. It's a way of raising revenues without allocating more money in the budget, which we all understand is a major problem right now, so we're not asking for that. But if we could just pass the marriage license tax, that would be a significant amount of money that would come to the shelters. It would also help fund new shelters, because when the tax was originally put in, it was only funding the current shelters. Three or four shelters have opened since then, and it's been very difficult to fund them through the marriage license tax because it originally didn't cover them.

MS. FRANCIS: That would go from $5 to $25?

MS. PRICE: That's right.

MS. FRANCIS: That's a user fee from what I understand?

MS. PRICE: Right.

DR. VAN JONES: Has there been any movement toward helping the man, the batterer?

MS. PRICE: A number of our programs do offer batterers' programs. We have a batterer network in the Coalition, and a number of our shelters offer counseling for batterers. There's also a group working with the Division on Alcoholism and Drug Abuse, and the Coalition is working together to come up with domestic violence resource centers. We have a proposal that will be eventually introducing legislation to propose some sites -- probably in the north and

the south, maybe in three regions of the State -- for pilot programs that would be-- They would work, more or less, like the alcohol resource centers work now for driving under the influence, and if a person was found to be a batterer, he would be required to go to these resource centers for help.

MS. SAMPIERI: Are you aware of any studies that have been done associated with the costs? You gave some pretty significant figures in terms of one in five women treated in the emergency room being a victim of some kind of abuse. Has there been any study that you are aware of on the costs to both society and to any private insurers and private parties?

MS. PRICE: I'm not aware of any specific studies. There have been estimates made that, based on the number of people reporting, then you have this number who normally go, that it would be this kind of, you know, but-- They're just estimates based on the numbers of people, rather than actual dollars or studies that I'm aware of. I haven't seen anything specifically.

MS. SAMPIERI: The Commission has--

MS. PRICE: But, obviously the costs have got to be really great.

MS. SAMPIERI: Yeah. The Commission has tried to shake loose some kinds of figures in terms of not only emergency room visits, but the cost of missing time at work and what happens to the children and what happens in family therapy costs and the rest of it, to give some sense of the economic cost to society of not really tackling this.

MS. PRICE: I haven't seen any studies specifically done. Usually what you find is something mentioned here or there, you know, and you'd have to really pull different pieces from different studies that have been done. But I haven't seen a study done specifically. I know there is someone in Chicago who is doing a study right now, following women who were battered during pregnancy and their children who were born

afterwards, for five years, to see the effect that this long-range -- over the long range -- that the battering during pregnancy has had. I guess we'll be hearing about that within the next few years.

MS. SAMPIERI: Thank you.

DR. VAN JONES: Any other questions?

MS. FRANCIS: I just have one more about the statutes, since obviously our directive is to look at sex discrimination in the statutes. My sense, from the beginning of the '80s when we passed our domestic violence bill-- Around that time, we were considered in the forefront nationally in dealing with the issue. Do you have some comment about whether we have maintained that ground, or have lost some of that ground? How the current amendment to that bill might affect this? Are we staying abreast of what we need to in our general domestic violence legislation?

MS. PRICE: I think we are if the amendments go through that have been proposed to the Domestic Violence Act. Unfortunately, there have already been amendments to the amendments which will not put us in the forefront, but which will put us behind, I think.

MS. FRANCIS: Could you be specific about those?

MS. PRICE: The one specific amendment that the Senate Judiciary applied-- Well, they put on two: One is that -- and we had asked that-- The current law says that a victim and the perpetrator would have to be of the opposite sex, and the new amendments eliminate that phrase, "opposite sex." So, it allows anyone who has been domiciled together or a blood relative, or that kind of a relationship that if there's domestic violence, that's considered domestic violence. The Senate has put back in "opposite sex." Their reasoning being, while it has never been said publicly, although it has been said privately, they do not want to condone homosexual relations.

In putting back in "opposite sex," however, they are overlooking the fact that elderly people who are abused by the same sex, caretaker, or disabled or handicapped people who are abused by their caretaker -- same sex, caretaker -- will not be covered. Neither will be college roommates. There are a whole host of people who will not be covered by this bill.

We've had a recent situation in New Brunswick -- in that area -- where a gentleman who is not specifically classified as retarded -- his IQ is just over the line -- has been living with a family for about 25 years. He works on their farm; they've been taking care of him, as well as he works there. This is his home. He's being abused. There is nothing we can do for this man under the current law because he is being abused by a same sex person who is not related to him by blood. It is not a homosexual relationship; he is working on this farm. The Association for Retarded Citizens can't help him because he is not classified retarded; his IQ is just a little too high. Of course, we are trying to do something for him. We're trying to have him retested to see if we can prove his IQ is lower, and then they'll have to handle it, or whatever. But, I mean, it's really a sad situation. That's a prime example of the kind of person who will not be protected if that amendment goes through the way it is.

And then, of course, the other thing that they have put on is the amendment that there will be a notification on temporary restraining orders that if you file false charges of domestic violence, that would be considered perjury. It's perjury now to file false charges on anything, but there is some feeling that there are a lot of women out there rampantly filing false charges of domestic violence, and that just isn't the case. My concern is that we have not really determined what false charges will be considered. If a woman files a temporary restraining order and then doesn't follow through out of fear or threats or whatever to get a permanent restraining

order, is that considered false charges? What if the judge finds that there is no domestic violence, and there are plenty of cases where judges have found that in spite of contrary evidence? Does that mean it's false charges and she has to go to jail? A man does not have to go to jail now if he hits his wife, but if she files false charges, she would?

MS. FRANCIS: Just to clarify that point: Those words are not required on any of the other documents where it would be perjury to file false charges? It's only in domestic violence--

MS. PRICE: It's perjury to file false charges on any document that you file, with, you know, bringing charges against anyone. But this specifically will put it on this particular form, which is really an insult to women that they would lie more than men, and men file false charges as well. Hopefully, it will have a deterrent effect on them, as well as it would on women.

MS. FRANCIS: Just to reiterate: If those two Senate Committee amendments were taken off and the bill moved as it was originally proposed, you would say that it would keep New Jersey close to the forefront?

MS. PRICE: I would definitely say that. You have to realize that other states have recognized homosexual marriages, even. So, I don't see why this has anything to do with that. We're just trying to protect as many citizens as we can under this particular law.

DR. VAN JONES: Okay. Thank you.

We'll take a five-minute break, and then we'll resume.

(RECESS)

AFTER RECESS:

DR. VAN JONES: We see our guest has arrived. Hi. Welcome to this afternoon's hearing before the Commission on

Sex Discrimination in the Statutes. We're so glad that you came to talk with us today.

Your name is Dr. Arlene Bardeguez?

A R L E N E D. B A R D E G U E Z, M.D.: Bardeguez. (corrects pronunciation)

DR. VAN JONES: Bardeguez. Okay, and welcome.

DR. BARDEGUEZ: Thank you. Good afternoon. First of all, thank you for inviting me to participate. It's really a great experience for us because we might be able to share some information that will be helpful for you.

DR. VAN JONES: Excuse me. I don't know if they can hear you in the back. Can you hear her in the back? (No audible response) Maybe if you moved a little closer to the microphone.

MS. PERELMUTER: The microphone is just for the transcriber.

DR. VAN JONES: Oh. It's for the transcriber.

DR. BARDEGUEZ: I'll try to project. Basically my testimony is going to be in reference to the human immunodeficiency virus infection in women and how that affects some of the studies on New York State.

DR. VAN JONES: Maybe close the door? I'm sorry. They're still having a problem in the back. They can't hear.

Maybe you could come up to the front. Those in the back who can't hear, do you want to come up to the front? No? You're okay?

Okay, sorry.

DR. BARDEGUEZ: The human immunodeficiency virus, as we know, is the etiologic agent for AIDS. We know that this virus basically grows in monocyte and lymphocyte, but also in macrophage. The clinical manifestation of this disease will range anywhere from asymptomatic infection up to the wasting syndrome characterized by opportunistic infection and dementia that we know as AIDS.

Even though the first cases of AIDS were reported among homosexual males in 1981, the numbers of cases reported -- not only in the United States but also in the whole world -- have been increasing to the range that we now call it the AIDS epidemic, starting in the 1980s.

As of June 1, 1989 the World Health Organization reported an accumulative total of 157,191 cases of AIDS, and those were only from 149 countries that were reported. Of course, as we see, this is year-old data. This projection of the number of infected people is worldwide, and not everybody who is infected is going to show symptoms. That points out that between five million to ten million people were infected during the decade of 1980. What that means for the United States is that at least one million to two million people are infected, many of whom we don't recognize yet.

The toll to our society of this problem is overwhelming. There is no discrimination among the people who are going to be infected, so it is affecting our children, our females, and affecting our households. Even more tragic is that about 80% to 90% of the cases reported now with AIDS are individuals at the peak of their reproductive potential. This gives us very little hope for the future of our nation unless we do some active intervention in terms of promoting education and intervention in this disease process.

According to the Webster Dictionary, discrimination originates from the Latin word "dis," which means apart, and the word "crimen," which means verdict. To discriminate means to distinguish or make distinctions in treatment to a particular group. Society has a subtle way of discriminating against groups in terms of education, access to health care, and job opportunities. We can close our eyes and not look at what's happening around us because we are not affected. The sad consequence of this view is that it will always come back and hit us. Witness of that we can see through history, and if

we read Matthew 25:31-46, it describes when Jesus will exert judgment over all those who do not feed him, calm his thirst, shelter him, or support him in sickness when he was in need. What he meant by that was that if you don't do it to one of his beloved, you're not going to do it for him.

As of April 31, 1990 (sic) the number of cumulative cases of AIDS reported to CDC were 132,510 cases. For the State of New Jersey the number of cumulative cases as of May 31, 1990 was 8951 cases. The counties of Essex, Hudson, Passaic, and Union carry most of the load for this State, but the numbers of cases identified in other states have been continuously increasing. New Jersey is the fifth state in the nation with the highest number of reported AIDS cases.

Although this epidemic has affected mostly male individuals, the proportion of females has been drastically increasing over the past decade. Women now constitute 9% of the total population of AIDS cases. Based on the transmission category report to CDC for the State of New Jersey: 64% of the cases occurred among intravenous drug abusers; 29% of the women have contracted the disease through heterosexual contact; 4% happened to get infected secondary to transfusion or blood component use; and 3% are undetermined.

The racial distribution for our State among women showed that 54% of the cases occur in black females, 34% in white, and 12% in Hispanics. These figures drastically differ from the national ones. In New Jersey we have the highest proportion of AIDS cases in women of the nation. We also recognize that AIDS is the number one cause of mortality among childbearing age black women.

This dramatic strain to our society contrasts sharply with our present provisions to educate, offer medical and psychological support, and assist this group of underprivileged ones.

The State of New Jersey has set up demonstration pediatric regional centers in five areas of need, namely: New Jersey, New Brunswick, St. Joseph's, Camden, and University Hospital in Newark. Beth Israel is now an affiliate institution to our program in University Hospital. Because of recognition on pediatric activists -- we can call it in a way -- they recognize that early intervention in children can only be achieved by early intervention in their mothers. They have been able to open in some of these centers the capability to offer perinatal testing and HIV education and follow-up for some of the serving population. However, the only formal OB and pediatric link is at the University Hospital in Newark.

At the present time probably only two centers in the whole State will be capable of offering some of the drug trials that are going to be investigational, including the ACTU 076 for the women infected in our State.

In the OB/GYN Department of University Hospital in Newark, we basically serve as the tertiary center for the whole area of Essex County, mostly for Newark, but we also get referrals from neighboring counties. We do about 2500 to 2700 deliveries each year, and in an anonymous seroprevalence study done in 1988 we noticed that at least 4.3% of our deliveries were positive for HIV infection. These were patients that not only have the ELISA but also have the western blot proof of it. This basically reflects one of the highest prevalence for the whole nation if you look at other seroprevalence studies done in similar populations. During the same study period, less than 1% of these cases were identified prenatally, because as I mentioned before, this was an anonymous seroprevalence study made in cord blood.

Therefore, at that time our department adopted a policy that education, risk assessment, and the offering of HIV testing should be given to any woman receiving prenatal care in

our institution. This has been possible through support from the State Perinatal AIDS Prevention Project, and the NIH funded study of perinatal transmission.

We have centered all our efforts in the adult pregnant population and basically only in the new patients that arrived at the clinic since January 1989. The benefits of such dramatic policy at present are even more crucial, because now we have effective support and intervention that we can offer to these mothers, that at the time we started this initiative, we didn't have.

Our experience from September 1989 to April 1990, which is when we have more strongly documented cases, is that of 1170 new patients seen during that study period, only 56.5% of the women were able to be contacted. This basically was because of lack of resources because we don't have -- even though we have two grants working on it -- enough personnel to provide active people in the clinics everyday.

Sixty-two percent of those patients agreed to be tested, which is one of the highest yields based on voluntary testing of people, and 4.3% were positive. One of the things that we learned from it is, not only that we can have a big turnaround on people who get tested and identified early prenatally, but also that we can provide education, which is even more important, so even those who have not agreed to be tested can reduce their risk factors and the risk and the exposure. Only 15% of HIV positive cases admitted substance abuse; therefore, the rest will belong -- most of them -- to heterosexual contacts.

Although this is a dramatic improvement from our efforts in 1987, there is still a lot of work to do. We have not extended our efforts to the growing number of teenagers afflicted with this disorder. There is actually, to my knowledge, no data on how many teenagers we actually have going through our prenatal care system who are infected. We have not

touched the gynecologic group population with a consistent approach, so any woman who would come not necessarily with a sexually transmitted disease and be offered HIV testing but people who would come for other reasons to an OB/GYN clinic are not getting offered the tests on a really consistent basis.

We have not contacted the other 43.5% of our prenatal population either. Even more depressing are the number of referrals of infected patients abandoned by their private physician once an HIV test has returned positive. Many of these women have never received notification or were not aware that they had been tested by the private physician.

From October 1, 1989 to April 30, 1990, we had 621 births at University Hospital, and of those 147, or 23% of those patients, had no prenatal care, so we have no knowledge either on how this disease is afflicting that population.

When and how do we provide help for all these women in desperate need? I also want to add -- it's not in my notes -- the fact that for the State of New Jersey, there is actually a limited number of centers that will offer care for pregnant women who are IV drug abusers. So, even though we counsel them and we tell them that they have to get off drugs, we have to provide them with some resources, and we don't have them. In Newark, there is no clinic that actually accepts pregnant women on trial for cocaine abuse.

To summarize, even though we have improved our approach to the AIDS epidemic, God knows that we need a lot more help from you and the community to make a difference. University Hospital is only a sample of what's happening in Newark, in Essex County, in New Jersey, in the United States, and in the world. We can make a difference and stop the discrimination against availability of health care and support for women with HIV infection if we really want to, and maybe it will not be-- We won't have to wait for the judgment day, because unless we do something now, this epidemic is going to destroy us all as a nation.

Thank you.

DR. VAN JONES: What sort of recommendation do you have for us whereby we could help in this area, a very frightening one, a very frightening future for all of us? As Commissioners, what would you recommend that we do to help provide for those things that you're talking about?

DR. BARDEGUEZ: Every time we talk about provisions, people get frightened because they think costs, but definitely the new approach for HIV infection is to test the people that are infected early, in the period they are asymptomatic. So one of the first things that we have to do is really try actively to enroll people in the community, church, civic groups, women's groups, and any other entity that we need, even in terms of the educational system to our teenagers to provide them with education about how they can get infected, about how many women there are dying in our State from this disease, so that that will modify risk behavior. It cannot be a one-time issue. It's really going to have to be on a consistent basis or a periodic basis in order to be able to make a difference, because what happened to a lot of the women who I take care of is, they go there and after they do the test they don't even believe the reality of, "Yes, I'm positive." They believe that, "Well, I have two kids. I have many women in my house. Why does this happen to me now?"

So, we definitely have to warn them that you can have sex, but you have to use protection whenever you have sex, because it's a consented act.

The other thing is, we have to actually establish perinatal regional centers the same way we did for pediatric and obstetric groups. Probably that will come through expansion of the pediatric ongoing groups that are active, but they have to open new centers in other areas. Those centers could provide for outpatient identification through testing and probably also follow-up, and many of the early symptoms could be handled on an outpatient basis. That could probably

minimize the number of people who come into the hospital needing critical care -- intensive care intervention -- which is more costly, and at that point we have very little to offer.

There's a lot of new medications, as we all read in the press everyday and in the medical journals. For example, AZT, DDI, and all these other drugs can actually prevent the progression of the disease and make the life of these people more fruitful and actually more bearing to our society.

I think that would be my greatest recommendation for the Commission; that we open our eyes before it's just too late.

MS. FRANCIS: Could you clarify that? This is more of a medical question, but you're saying if people who are identified as HIV positive, but who are still without symptoms, are put on a drug regimen at that point, then there is a fair amount of success in keeping that from turning into full-blown AIDS?

DR. BARDEGUEZ: Okay. Basically what has happened is, during the last year, the middle of 1989, the first drug trial on AZT and the homosexual population -- basically male; I think there was a limited number of women, I don't think they came to more than 20 cases in the whole nation -- actually proved that not only in AIDS cases but also in asymptomatic patients, AZT use could prevent progression of the disease. There have also, in the same trend, been other drug trials using DDI, and showing also that it is effective in some of the patients who cannot use either AZT or have side effects of AZT.

There have been multiple other studies on the use of erythropoeitin, for example, to treat anemia and the use of pentamidine to prevent pneumocystis carinii. Most of all this-- Not most, basically all of these trials have been on male population and only recently some of these trials have been extended to the pediatric groups.

I'm one of the participants of one of the OB teams for the ACTU, where we are recommending that some of these drugs be

opened up to the women who are pregnant. Of course, as we know, it has caused a lot of controversy, because up to now we have said that we try to avoid medications during pregnancy because of the side effects. But when you think about the mortality the disease takes, and the fact that if the mother dies then there's no baby to take care of, then we have been reconsidering our position. There are a lot of groups nationwide -- I can quote you the group from Brooklyn, Howard Menkoff, and the group from -- Maryjo Sullivan, in Florida -- who are actively using ACT and other drugs on people who are identified as higher risks.

MS. FRANCIS: Including pregnant women?

DR. BARDEGUEZ: Including pregnant women. We're trying to establish that as a national policy, and we haven't been that successful yet. But there are certain things that we can do. For example, at University Hospital what we do, with the help of some of this grant and other patients, just through Medicaid, we do lymphocyte counts on all of these patients. On those who are considered at high risk, meaning that they have lower than a 300 helper cell count, we have offered them prophylaxis for some disease. For example, we offer them prophylaxis for hepatitis, which is one of the diseases that these people can get. We're working on a protocol for prophylaxis for TB using INH. We are trying to find a system to use AZT on some of these women.

There are a lot of things that are still in debate, but they are coming. The reality is that unless we start moving and offering this to our pregnant women, it is really going to be dreadful -- what is going to happen.

MS. FRANCIS: That leads me to the other question that I had: Looking back at your numbers -- this may be coincidence -- on the next-to-last page, your 1988 study at the University Hospital said that 4.3% of the deliveries were HIV positive, and your study the next year, or your experience from September

of '89 to '90 is that, of the patients who have been tested, 4.3% of the mothers were positive. I mean, if you put those 4.3s together, does that mean that every HIV positive mother has an HIV positive baby?

DR. BARDEGUEZ: No. You cannot interpret it that way. Basically, of all the mothers who are HIV positive, only-- The baby initially is going to test positive immediately after birth, and you basically have to follow this baby up to 18 months to see if the baby develops its own response--

MS. FRANCIS: Oh, okay.

DR. BARDEGUEZ: --because of the transfer of maternal antibodies into the baby. At that point in '87 where we found out that we had a 4.3% incidence, and we only identified less than 1%, we knew that there was a lot of work to do. Right now, we identify 4.3%, but as I show you in the numbers, we're only testing half of the population. So we probably have an even higher incidence of what we identified two years ago. The other issue is that a lot of these patients, as I mentioned, have been referred -- sort of like "acute" referrals -- from these private practitioners who found that these women were positive. We definitely are concentrating more positive cases in our institution than what you might generate from some of the public hospitals in that area, or private hospitals.

MS. FRANCIS: Let me just, again, go out-- The question that I would be interested in, would be that you are saying that some of the protocols, or some of the rules perhaps, that you're going by are that you can't give pregnant women certain drugs because of what it might do to the fetus, right?

DR. BARDEGUEZ: Right.

MS. FRANCIS: What prevents you from--

DR. BARDEGUEZ: It's more in terms of what drugs are going to be used on a research basis -- let's say

investigational basis -- and are given to this woman. I mean, there's no holdback at this point if a woman has low lymphocite counts. I can tell her, "Okay, there's no data on pregnancy. There's going to be a protocol opening in six months, but you're so sick that if you want it I can give it to you." I can get a consent form, stipulate that, have her sign it, and give it to her.

MS. FRANCIS: So then you can go ahead?

DR. BARDEGUEZ: Right.

MS. FRANCIS: Okay, I just--

DR. BARDEGUEZ: Right, right. And then the other issue is that there are other things that you become aware of when you have this woman. For example-- I mean, I have learned a lot with this disease. A lot of times you see a patient who is walking around and looks healthy and you think, "Oh, there's no problem," because they are asymptomatic, right? But when you do immunologic studies, the immune system of this woman is really awful. So once we identify them, we keep a closer surveillance on them and on the baby. Years ago we were not doing that.

Therefore, if they come with the first episode of a pneumonia, I'm going to hit this women with everything that I have, because I know she is not going to respond right away.

MS. FRANCIS: Yeah. I asked the question in the context of other issues. I'm sure Jeanne Stellman this morning probably talked about workplace hazards and so on where we choose to treat a woman, not thinking of her entirely, but thinking of the fetus also. Where do you strike that balance between saying she is the human being we are treating, not the potential development, you know, the life that is to come? So, I was wondering if, in fact, we were treating pregnant women differently because of the implications for the fetus?

DR. BARDEGUEZ: That is one of the issues that has come out in all these national meetings. I mean, it always

comes up. The fact is that a lot of the data, even with drugs like INH that have been long-standing and known in our community-- Most people didn't use it in pregnancy because they felt, well, pregnancy is a limited time period. It's only nine months. You can wait until postpartum and then use it. But the difference now is that those nine months you can have miliary TB because you have a low lymphocite count, and the disease progresses.

So, it was not really based on bona fide data showing that that drug was detrimental to the pregnancy. Even on the registry that we have nowadays for AZT -- I don't have the exact numbers -- but there has been no consistency in terms of congenital anomalies produced by this drug. The rate, basically, is the same as the background rate of naturally occurring congenital anomaly, which is 2% to 3%. Okay?

MS. FRANCIS: So, you can't even show that there is an effect.

DR. BARDEGUEZ: There is an effect. And if you look at the case-- If I looked at it maybe six months ago, it was not consistent. Usually a drug that is going to be teratogenic will give you cardiac anomalies all the time or limb anomalies all the time, and the cases that they presented were not consistent with the same problem. So that is why a lot more groups have been advocating for women in terms of allowing them to be treated if they need to be. I think that the hardest part, again, for women, is that they don't learn, or they don't know how to be their own advocate. I mean, if we compare the massive campaign that has been going on for the gay group, and all the achievement that they have gotten from '81, when the first cases were being reported until now, it's dramatic.

I mean, they have been able to balance this; not any more increase in the number of homosexual cases. For women, we have increased from 5%, I think, in 1986, to 9% now. It will still be increasing, and that's only AIDS cases, and not even identifying the ones that are positive.

MS. FRANCIS: Again, I guess, in terms of what statutes would relate to that, do you have any specific suggestions? I mean, some of this is medical practice that happens within the medical profession, as opposed to other elements of this which would be dealt with by legislation. Can you address what legislative part of it would be helpful?

DR. BARDEGUEZ: Well, I was reading in May -- sometime in May -- that there was going to be-- It was addressed to one of the committees in Washington, the fact that Medicaid should support more the management of AIDS patients, asymptomatic AIDS patients, so that's one of the issues that I think our State should put in the front line in supporting that bill whenever it comes up, so that all the hospitals that get a big burden of AIDS cases can be helped with a load of income, so we can get more personnel to take care of them.

Again, I think that one of the most -- even though people don't want to hear it -- is education. I mean, we really need to-- I mean, I take care of pregnant women who are HIV infected, but there are so many out there that are not infected yet, and I would like to tell them, "Hey, don't do this, because otherwise you can get infected." At this time what is happening is, they don't think it's going to touch them. You know, that happened to that other patient who was a junkie, or that happened to that other patient who was messing around with people with drugs, is never going to happen to me. And the amount of patients that I have seen during the last year who actually just -- through sexual contact-- It is really depressing. I mean, you are there, you support them, but it's really hard to give them anything to, uplift their spirits.

The other thing is that we actually -- except for bona fide voluntary help -- have very little in terms of psychological support and social support for this group of women. With many of them, the first reaction is, "How am I

going to tell my partner? He's going to kill me. How am I going to tell my partner? He's going to throw me out of the house. How am I going to leave my job? If I leave my job when I get sick -- because I'm the only one supporting my family and my four other kids?" So, resources for all those areas need to be provided.

MS. FRANCIS: In general, probably that's true for both men and women -- I mean what you're saying -- both men and women patients with AIDS. Are there specific sex-based differences in any of what you said that--

DR. BARDEGUEZ: I think that women are more vulnerable than men in the sense that a lot of the relationships that we see among women are that they are the receivers. They want this husband or partner to love them. They completely depend upon them. They have no resources or no education, and when it comes to being honest to their partner and tell them their results, the last that they think of is, "Maybe I got it because of him." The first thing that they think is, "He's going to hit me because I gave it to him." Okay? It's so dramatic because we don't know who gives it to whom. I mean, it doesn't matter which came first, the chicken or the egg. The fact is that-- The same way that we deal with infertility, "You're a couple and you have to deal with it." Somehow we have not been able to effect the same mechanism for this disease.

MS. FRANCIS: Thanks very much.

DR. BARDEGUEZ: You're welcome.

DR. VAN JONES: Okay. Thank you.

Thank you for coming.

(HEARING CONCLUDED)

APPENDIX

Lucile Markness Pfleeger

210 Dickinson Road
Glassboro, New Jersey 08028

Testimony - Hearing
Health
New Jersey Commission on Sex Discrimination in the Statutes

June 20, 1990

Why is a 68 year old retired public school music teacher concerned for reproductive health issues?

Personal: Daughter, Daughter-in-law and three teenage granddaughters.

Community Involvements: learned about accessibility of health care.

1. Housing Authority Commissioner (10 years) - concerned for the welfare of poor minority tenants - teenage pregnancies abounded and women were denied total reproductive health care because of medicaid funding restrictions. (Legal care which is available to affluent women.)

2. President, Board, PASA (Shelter for Battered Women) for Gloucester County. (Learned that males who use physical force and mental and psychological abuse have a need to control and dominate women.)

Question: Are pregnant women in shelters operated by Catholic Charities presented with all options? Or, is Gag Rule applied?

Concern: Proposed spousal and parental consent laws give males more power to dominate and control women.

3. Member, Board of Family Planning Services for Cumberland, Gloucester and Salem counties.

Concerns: Governor Florio's proposed budget, being debated this week, cuts Family Planning Funds by $100,000. (Federal funds have been drastically cut during the Reagan and Bush administrations - from $161 million in 1981 to $135.6 million in 1990. Need (rock bottom) $230 million in 1991. To adequately serve the eligible population in 1992, $800 million is needed. Title X needs to be reauthorized federally.

Locally: on June 14, 1990 we were forced to vote to cut the "Teen Parent Advocacy Program" for Cumberland county where the rate of births to teens is 20%. The program taught parenting, and aimed to prevent second teen pregnancies.

I am concerned that the courts may make possible the reinstatement of the "Gag Rule" which prevents the presenting of all options for pregnant teens and adult female clients.

Family Planning has few contraceptive options to present - there is a high percentage of failure of existing contraceptive methods. Research and development is needed for new methods.

Most teens come to Family Planning already pregnant. There is a great need for early sex education and Family Planning services in school based clinics - not possible now because of state regulations.

4. Former President, Legislative Chair, Reproductive Rights Chair and presently Co-Chair (with Dr. Kathleen Ruben) of Clinic Defense for the Alice Paul-South Jersey Chapter of the National Organization for Women.

IX

For several years I have volunteered on Saturday mornings to escort patients into the Cherry Hill Women's Center in Cherry Hill, N.J.. Originally, only two or three volunteers were needed to shield the young girls and women patients from the demonstrators walking on the sidewalk in front of the clinic.

In 1985 there was an invasion of the clinic when several persons, mostly males, forced their way into the clinic. Health Center employees suffered broken foot bones and broken ribs. The trespassers chained themselves to chairs and disrupted the operation of the clinic for several hours.

In November of 1987 Randall Terry and "Operation Rescue" staged a trial siege, or blockade, at the CHWC in preparation for a weeklong assault on New York City clinics. It took several hours for the police to carry away the demonstrators. Since then the CHWC has had three major "hits" by Operation Rescue.

As a result of these assaults on the CHWC and other health centers the defenders of clinics, under the leadership of NOW, have become organized. On each Saturday morning from 20 to 50 volunteers arrive at the CHWC at 5:30 a.m. and stay at least until 10:00 a.m. to escort patients. If we have a major "hit" we alert our phone tree, and extra emergency volunteers arrive on the scene to assist. Our volunteers include teenagers and senior citizens, both male and female, who volunteer for this service.

The leaders of the blockades are always men. Women participate, but they are given orders which they must follow. Most of the leaders of both the blockades and the regular Saturday morning picketing are clergy.

For instance, two fundamentalist preachers routinely bring their youth groups (preteens and teens) to the CHWC on Saturday mornings to harass and annoy women, an early lesson in sexism. They risk the lives of these children as they purposely send them across the driveway as patients are making left turns, across two lanes of traffice, into the driveway of the Women's Center. I predict a terrible accident will happen because of this tactic.

These clergy have been highly incensed when I have reminded them that clergy are one of the top four categories of men who beat their wives, and that their harassing of women patients expresses a need for them to dominate and control women.

Catholic clergy and laypersons loudly recite their rosaries and vociferously accuse both patients and defenders of being "Agents of Satan."

2x

Women's Health Centers provide routine gynecological health care which includes pelvic examinations, PAP tests, breast examinations, sexually transmitted diseases testing, contraceptive services, pregnancy testing, counseling services, laboratory services (RH factor, hemoglobin and hematocrit, etc.) as well as first and second trimester abortion procedures under local or general anesthesia.

Young girls and women seeking these gynecological services must enter the clinic while assaulted by ugly posters and barraged by men with bullhorns who harangue and harass them.

Women scheduled for abortions have been required to fast and are frequently feeling weak and queasy. On the days when the clinic is under siege women are forced to wait outside in their automobiles, sometimes for several hours, for the police to clear the blockade. Some become distraught, and staff and volunteers attempt to comfort them.

Some women are in the second day of a two-day process (laminaria) and must receive attention immediately or they can suffer severe adverse effects. On the days the clinic is blockaded these women must be sent immediately to another facility several miles away.

In August of 1989, while giving instructions to one of these women, a trespasser, who was harassing the patient, reported to the police that I had "touched" her. A policeman threatened to arrest me even though I was wearing a clinic escort sign and was assisting patients at the request of the CHWC. The trespasser was violating the law by being on the property.

During the April 29, 1989 blockade attempt our clinic escorts were able to hold the door and were able to assist all patients in reaching the door even though the trespassers pushed, shoved and kicked the patients, our volunteers and the police. During the invasion I was knocked to the ground, and later, when I was crushed against the door, I felt panic and understood how it was possible for those soccer fans to be killed. Some patients were thoroughly terrorized.

I left the CHWC at 11:00 a.m., called the New Jersey State Police to report that the situation at the CHWC was out of control, and asked for their assistance. (We had previously had a conference concerning the Clinic Blockades with a representative of the State Police, at their request.) I was told later that State Police are not allowed to provide assistance unless requested to do so by the municipality.

3x

We request this commission to investigate the possibility of revising this regulation. We question why, when blockades occur, one municipality should be expected to assume the expenses of the police, courts and jails when Women's Health Centers serve women in all municipalities in all counties in large regions of our state.

Presently, there is no uniform law enforcement of existing ordinances against blockades. Women are discouraged by officials from filing complaints. They are told that the chances of successful prosecution are slim. I feel that a state ordinance is needed which would require police to arrest those who invade clinic property, before they have the opportunity to "seize" the door, and would require courts to levy and enforce strong penalties.

We request this commission to investigate the possibility of drafting an ordinance which would require "Operation Rescue" to notify the police as to the location of their proposed "blockade," as was required by the police during their assaults in New York City. Much time, expertise and resources are wasted by the police and the volunteers who defend the clinics because of having to be constantly ready to respond to a blockade or siege.

We request this commission to investigate the possibility of drafting state regulations which would prevent the harassment of Women's Health Center employees off the site and would prevent the targeted picketing of their homes.

We request this commission to investigate the regulations which prevent licensed medical facilities from advertising free pregnancy testing services but which permit unlicensed <u>non-medical</u> church-sponsored "Crisis Pregnancy Centers" to advertise free pregnancy testing. These Centers have no medical personnel on staff, and they do not adhere to "truth in advertising" regulations. Their sole purpose is to coerce young women to carry pregnancies to term, and they specialize in using scare tactics to accomplish their purpose.

In summation, I feel that the blockading of "Women's Health Centers, thus denying women access to legal health care, is discrimination against women. The First Amendment does not grant the right to be violent or intimidating in expressing one's opinions.

Women are not offered equal access to medical facilities and basic health care. Poor women are denied medical care which is available for affluent women.

In addition to opposing abortion, most of those, especially the males, who lay siege to women's health centers also oppose birth control and sterilization. Yet, they do not harass or prevent men from obtaining vasectomies nor intimidate them when they seek routine urological health care.

There is no segment of our society, other than women, which is denied access to health care and/or harassed while seeking health care which is their right.

Respectfully submitted,

Lucile Harkness Pfleeger

Lucile Harkness Pfleeger

5X

10 Adams Ct.
Marlton, N.J. 08053
June 20, 1990

Senator Wynona M Lipman, Chair
N.J. Commission on Sex Discrimination in the Statutes
142 W. State Street
CN 095
Trenton, N.J. 08625

Dear Senator Lipman,

My testimony concerns the need for a state law which would guarantee women the right of equal access to medical care. A modified version of a Maryland statute (see attached), it would carry a mandatory fine of $500 for the first offense and $1000 for the second offense and/or a term of imprisonment of up to 90 days for obstructing a person's passage to or from a medical facility. Passage of this law would be the first step in redressing the damaging effects of discriminatory municipal law enforcement that has commonly been the response to violent demonstrations at N.J. health care facilities that offer abortion services.

There are many complex reasons for this discrimination. Local officials may argue that protestors are protected under the 1st Amendment. Anti-choice protestors who demonstrate at the clinics are, according to this argument, simply exercising the right of free speech as guaranteed by the Constitution, and must be allowed to do so. This seems reasonable until one actually visits a clinic when it is under siege by Operation Rescue. The violent nature of the demonstration becomes obvious--200 individuals (mostly men) trespass on clinic property, blockade the door, and assault escorts, patients, staff, and physicians.

In light of this activity, the Supreme Court has indicated that the blocking of a clinic door is not a protected form of free speech. It upheld an injunction against this behavior that is in force in Georgia, and let a similar injunction stand in New York. The N.Y. case calls for fines in excess of $100,000 for each offender and authorized collection through liens on income and bank accounts. It found that the blocking of clinic doors was not a acceptable form of communication in a democratic society, and that the civil rights of women were being violated. The court compared these women's rights to those of blacks who attempted to gain access to segregated establishments in the early days of the civil rights movement. Federal marshals were assigned to escort blacks into these buildings because of the volatile nature of the situation.

These volatile conditions affect all New Jersey women who seek gynecological or abortion services at local women's health care facilities. I have had first hand experience with the violence that has been focused on women who attempt to enter these clinics. As Coordinator of the South Jersey Clinic Defense Task Force, I have helped to organize teams of escorts to help women into the clinics. Most of my work has been done at the Cherry Hill Women's Center, but I have also conducted training sessions for teams in other parts of New Jersey, and have spoken with clinic administrators. The story is pretty must the same--one or two groups of individuals travel from clinic to clinic tc disrupt service.

It doesn't matter whether or not the woman is young or old, whether she's the doctor or the patient, or whether she is there as a volunteer to help the clients, she is a target for violence, harassment, and verbal abuse. We can't even imagine this happening to men on a routine basis--if priests or bishops were knocked down every time they tried to enter their church, we'd see quite a different response. Because the women involved are young and most likely without money or influence, its easy to see them as victims.

6x

The impact on these women is devastating. One woman who was nine months pregnant was recently surrounded by anti-choice individuals who tried to keep her from entering her doctor's office in Willingboro for vital prenatal care. They asked her repeatedly not to kill her baby. During other Operation Rescue attacks, individuals who are there to provide safe passage for clients are often pushed against clinic doors or walls by crowds of over 200 individuals in their attempt to blockade clinic doors. I have been caught in that crush and have been kicked, elbowed, and nearly choked. During these incidents, a clinic administrator was taken by the hair and thrown to the ground, a doctor was surrounded and knocked done after emerging from his car where he had been trapped for over 30 minutes; a nurse was punched in the face. I've seen patients pushed to the ground and surrounded by the angry mob, while another was lifted to the top of a car to escape--they were extremely distraught and openly sobbing. I've been knocked down by one individual who goes from clinic to clinic and knocks down escorts in order to videotape the patients and their car licenses for future harassment. People have suffered broken toes, car accidents, and bruised ribs. One women whom I helped was afraid to walk to the bathroom at the nearby gas station. She had been sitting in the hot sun for several hours without food or drink as medically required and she wasn't feeling too well. She had to get into the clinic and have her procedure done that day because she had a laminaria in place to dialate the cervix. If left unattended, she risked infection and possibly death from complications. On our way to the gas station she told me a story about her friend who wanted to abort so badly that she drank bleach. I assured her that she would not be faced with that decision because she would eventually get into the clinic if she could make it. After six hours of extreme duress, she finally did get in. (See attached photocopies--chairperson has several originals.)

It is vital that women have access to local clinics for routine gynecological services, prenatal care, and abortion services. 97% of all abortions are performed in local non-profit and private clinics. Without these clinics, women would not have access to safe and legal abortion, irrespective of the laws safeguarding that right in principle--because they would not be able to afford hospital procedures. Only 13% of all abortions are performed in hospitals , in part because of the high cost of $1000 to $1600 per procedure. This low percentage also reflects the fact that most abortions are performed before 15 weeks gestation (95.8%) and do not require a high level of medical technology. While hospitals may accept Medicaid patients, clinics must meet special requirements to do so. Four such clinics exist in New Jersey and have been targets of anti-choice activity. Since all of these clinics play a key role in assuring that women have access to safe, legal, and affordable abortion and gynecological services, they have been repeatedly attacked by Operation Rescue with the ultimate goal of putting them out of business.

Recently, the U.S. Supreme Court determined that Operation Rescue was involved in a conspiracy to close these clinics permanently, and found that the clinic that brought the case to court was entitled to triple damages under the Racketeer Influenced and Corrupt Organizations (RICO) Act. However, most Operation Rescue members have already transferred their assets and make it impossible to recover legal fees, which were in excess of $150,000 in this case. Operation Rescue wears down individual clinic owners by involving them in lengthy and costly law suits, by harassing staff and physicians at their homes, at the clinics, and even in public places such as restaurants, making normal life seem impossible for those involved. In addition, demonstrations create noise, traffic hazards, and unsafe conditions for those who live in the neighborhood. Even though most individuals in the community support the clinic involved, they still yearn for peace and tranquillity. This has instigated a groundswell of

7x

of support for laws such as the one I am asking you to support today.

Local officials have also expressed frustration over this continued disruption in the communities. Each time that the Cherry Hill Women's Center is attacked by Operation Rescue, it costs over $6000 in costs that are primarily police overtime pay. The perception that this money and effort is largely wasted because nothing is being done to deter the behavior and change the situation has led to a reduction of police intervention in some communities. Police complain that they break their backs and risk injury to themselves time and time again and nothing ever happens to the individuals who are breaking the law. Their cases take years to be heard and when they finally are heard, the offenders get another warning and are asked to pay yet another token fine. The high cost and low police incentive due to uneven judicial enforcement may account for insufficient police protection at some New Jersey clinics. However, a more insidious explanation of both the lack of adequate police protection and inconsistent judicial action should be seriously considered. It involves the tendency to view the issue as an ideological one rather than one concerned with the maintenance of law and order for the common good. The escorts, clinic staff, and patients are seen as forming one army or team, and the Operation Rescue trespassers are seen as forming an opposing team. These two armies are using the local clinic, according to this view, as a battleground where the battle over whether it is "right" or "wrong" to have an abortion will be fought. Police, judges, and town council members are free to base their actions on their own personal beliefs on the issue of abortion and equal rights for women, and root for the team of their choice. Since the clinic then becomes a war zone, the normal laws that apply are suspended.

Individuals who are assaulted during this time are told not to bother to file charges because Operation Rescue members routinely file countercharges, and the judge, who hears both of them as part of a "demonstration" group being tried, throws the case out of court. Operation Rescue members are allowed to trespass on clinic property for several hours at some clinics before police action is taken. The current laws on the books which prohibit trespass and assault leave enough to the discretion of local police and officials to render them inadequate to mandate non-discriminatory law enforcement in communities with women's health care facilities. Even though some progress has been made in communities such as Cherry Hill which has passed an ordinance which prohibits blocking access to and egress from a health care facility, and in other communities where injunctions have been obtained, enforcement is still uneven and inadequate. In many communities, Operation Rescue offenders are still given token fines and repeated warnings. In Cherry Hill, police protection has increased and offenders have been given relatively serious fines, with the risk of a suspended driver's license or jail term for non-payment. Under the ordinance, police can take direct action to remove individuals who block clinic door without a complaint filed by clinic personnel. Police file the charges and testify in court, saving the clinic time and money. However, offenders have yet to be sentenced under the new ordinance, apparently because of the description of "medical health facility" and its applicability to clinics such as the Cherry Hill Women's Center. This has become another excuse to continually debate the issue and postpone the enforcement of the ordinance.

The changes in Cherry Hill are the result of extensive lobbying which is a continuing process. It requires an incredible amount of energy and perserverance. Even if it were possible to mount this campaign in every community, it would take years to accomplish what would be accomplished by the enactment of the state law which I am proposing. Local response changes with the change in personnel and policy, and since personal bias plays such a prominent role in this arena, the solution to this problem

8x

must not be left to local officials or ordinances. These ordinances do not bring the full range of legal remedies to bear in each case, nor can council members, police, or judges be expected to safeguard the civil rights of women at the clinics.

In conclusion, inadequate police protection and inconsistent judicial enforcement have denied women equal protection under the law. These practices are discriminatory insofar as they fail to protect the civil rights of women who attempt to gain access to the medical facility of their choice. I am a woman among many who has been injured while trying to gain access to the Cherry Hill Women's Center for myself as escort, as well as for the patient who I was assisting. I feel that the state of New Jersey has the obligation to protect women like myself who may find themselves at a local women's health care facility for whatever reason. Women should be able to stand in front of any private business in New Jersey without fear of bodily harm. And yet it is a frightening experience to stand in front of a clinic before dawn, perhaps knowing that anti-choice demonstrators are converging on the clinic and that they will soon be attacking. The worse part of it is knowing that there may be periods of time during the siege when no laws are in force to protect you, and no police officer is there who would care to.

We desperately need this law to remove the legal immunity now enjoyed by Operation Rescue members in various communities, and to provide impetus to local governments to clear protestors from private clinic property with all due speed, to arrest and charge all individuals who have trepassed on clinic property, impeded access to the clinic, or assaulted women, and to prosecute them to the fullest extent of the law.

Sincerely,

Dr. Kathleen Ruben,
Coordinator, S.J. NOW Clinic
Defense Task Force

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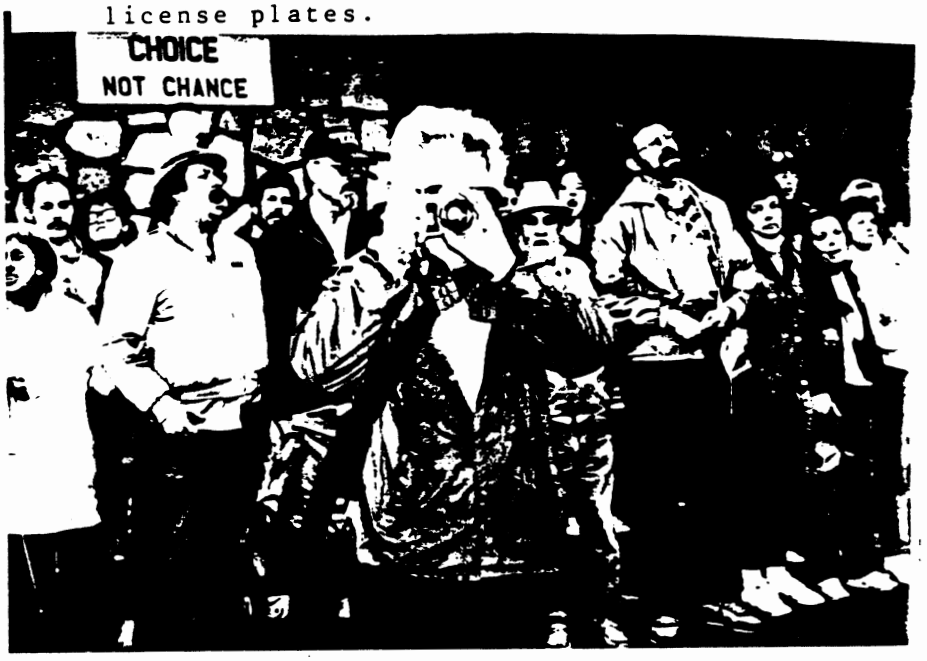
Women in cars or attempting to enter the center were harassed by men with cameras who were trespassing on private property to take photos of patients, cars, and license plates.



April 29, 1989 Cherry Hill Women's Center

Approximately 250 people blocked the doors. All of the staff members are female and could not get in to work. Approximately 30 women were scheduled for either abortions, check-ups or ultrasound exams that morning and they could not get in. CHWC provides free pregnancy tests to women, and anyone needing this service was also denied entry.

Kemp

Man in tan sweater is pushing the administrator as she attempts to enter. A nurse helps patients climb over a car. This nurse was punched in the jaw by a large man and the administrator was thrown to the concrete by her hair by two men. (Channel 29 filmed one and Channel 6 captured the other.

6-9-89 A patient with a towel over her head to hide from the cameras is escorted by staff after she was unable to get to the door.

11X

ARTICLE 27. CRIMES AND PUNISHMENTS.

I CRIMES AND PUNISHMENTS

TRESPASS

Md. Ann. Code art. 27, @ 577B

@ 577B. Interference with access to or egress from a medical facility.

(a) Definition. -- (1) In this section, the following words have the meanings indicated.

(2) "Action" does not include speech.

Press <ESC> for Local Help CD

Md. Ann. Code art. 27, @ 577B =B=

(3) (i) "Medical facility" means:

1. A facility as defined under @ 10-101 (e) of the Health-General Article; or

2. A health care facility as defined under @ 19-101 (e) of the Health-General Article.

(ii) "Medical facility" includes an agency, clinic, or office operated under the direction of the local health officer or the regulatory authority of the Department of Health and Mental Hygiene.

(4) "Person" does not include:

(i) The chief executive officer of the medical facility;

(ii) A designee of the chief executive officer of the medical facility;

(iii) An agent of the medical facility; or

(iv) A law enforcement officer.

Press <ESC> for Local Help CD

Md. Ann. Code art. 27, @ 577B 12X =B=

(b) Prohibited act. -- A person may not act alone, or in concert with others, and with the intent to prevent an individual from entering or exiting a medical

facility by physically:

(1) Detaining the individual; or

(2) Obstructing, impeding, or hindering the individual's passage.

(c) Construction. -- This section may not be interpreted to prohibit any picketing assembly in connection with a labor dispute as defined in Article 100, @ 74 of the Code.

(d) Penalties. -- A person who violates this section is guilty of a misdemeanor and on conviction is subject to a fine of not more than $ 1,000 or imprisonment for not more than 90 days or both. (1989, ch. 807.)

NOTES:

Editor's Note. -- Section 2, ch. 807, Acts 1989, provides that the act shall take effect July 1, 1989.

Press <ESC> for Local Help CD

13X

LOCAL 1031
AFL-CIO
COMMUNICATIONS WORKERS OF AMERICA
84 Culver Road, Monmouth Junction, NJ 08852
(201) 274-2171

TESTIMONY AT THE COMMISSION ON SEX DISCRIMINATION IN THE STATUTES
PUBLIC HEARING ON HEALTH
WEDNESDAY, JUNE 20, 1990

COMMUNICATIONS WORKERS OF AMERICA, LOCAL 1031

My name is Amy Bahruth and I'm a staff representative for the Communications Workers of America, Local 1031. I would like to thank you for this opportunity to present testimony about the health hazards of VDT use. Local 1031 represents state workers at the nine state colleges and the Department of Higher Education central offices. Local 1031 primarily represents women clerical workers, so the health and safety problems associated with computers is very real to our members.

Over the past few years, computers have become the norm in state offices, virtually replacing the typewriter. In fact, with row upon row of computer terminals, many state offices now look like computer assembly-line operations. However, even though clerical support staff need to learn new skills to be able to use the new technology introduced, the States position is that the computer has merely replaced the typewriter and made clerical jobs easier. So, clerical jobs, especially data entry jobs, remain under-paid and under-valued.

14 x

More and more of our members spend their entire day, or a good portion of it, sitting in front of a VDT screen punching in data at a high stroke rate or producing reports and other documents. Some departments in state service go to the extreme of disciplining workers if they don't make their quota of strokes in a given hour. Other departments offer bonus incentives to workers who go above and beyond the required stroke rate, which inspires most workers because they need to compensate for the low salaries.

Various health problems have been associated with the use of VDTs, including visual problems; muscle and joint problems; repetitive motion injuries, such as carpal tunnel syndrome, and tendonitis; and job stress. In addition, questions have been raised about reproductive risks and about the effects of low-frequency radiation.

The most common complaint from VDT operators are of visual problems. Prolonged attention to visual detail with limited eye movement in a restricted visual field can cause eyestrain and other problems. Tasks which require an operator to look back and forth from screen to text can produce visual strain. This is especially true if the display has light letters on a dark field, which is the reverse of print on most documents. In addition, eyestrain is caused by too much light in the visual field of the operator and by refections on the screen. Symptoms of visual problems include itchy eyes, burning sensations, eye strain, headaches, blurred or double vision, and changes in vision prescriptions. Severe eye discomfort may not go away within a

short period of time following work and may even be present at the start of the next day's shift. Data suggests that some types of VDT work produce greater levels of visual complaints than traditional office work, because of the special visual demands of VDT work.

Muscle and joint problems are also a major concern for VDT operators. Because the body is designed for movement, a fixed position is more tiring than moderate movement. When the body is still, circulation is slowed and as a result fewer nutrients are delivered to the muscles, and fewer wastes are removed from the muscles, blood vessels and spinal discs. The result can be muscular pain and, in some cases, injury. When workstations are poorly designed, which is the case in most State offices, posture is poor and strains are placed on particular groups of muscles. We are already seeing indications of a severe health problem in our members as many VDT operators suffer from stiff neck and shoulders; shoulder pain; back pain; hand cramps; swollen muscles and joints; sore wrists, pain down their arms; loss of strength in their hands and arms; and loss of feeling in their fingers.

Many of these symptoms are early warning signs of repetitive motion injuries, also known as cumulative trauma disorders. These injuries are associated with three occupational conditions: awkward postures of the wrist or shoulders, excessive manual force, and high rates of manual repetition. Specifically, carpal tunnel syndrome (CTS), which is becoming a common problem with VDT operators, seems to emerge from repetitiveness of the task more often than from force. Simply defined, CTS is when the

nerve that runs down the forearm to the hand to allow finger movement is squeezed or pinched as it passes under the wrist into the hand. The tendons for flexing the fingers, the median nerve and blood vessels pass through the carpal tunnel and if any of the tendon sheaths become swollen in the cramped carpal tunnel, the median nerve may be pinched. This pressure on the median nerve is what creates the numerous symptoms I mentioned before.

With the number of VDT's used in the workplace expected to grow in the 1990's to over 80 million, the number of workers adversely affected by CTS and other health problems will certainly mushroom. We are already seeing the impact of this new technology from the statistics of occupational illnesses and injuries compiled by the Bureau of Labor Statistics. The latest report indicates that workplace injuries caused by repetitive motion have increased sharply and experts called the rise of computer technology a major factor. The report says repetitive motion disorders accounted for 48 percent of all workplace illnesses last year, up from 38 percent in 1987 and just 18 percent in 1981.

CWA has surveyed its membership about repetitive motion injuries in the public sector in NJ and the preliminary results are frightening. Testimony will be presented as to specific examples, but suffice it to say that state workers are getting injured because of their job at an alarming rate.

Many job stresses often associated with VDT work have also been identified. Psychological stress can worsen the effects of physical stresses, by causing muscles to tense more, or by

leading to increased headaches and fatigue. These stresses include excessive workload or work pace, machine monitoring, not enough job control, or minimal decision-making, job insecurity, and lack of social supports.

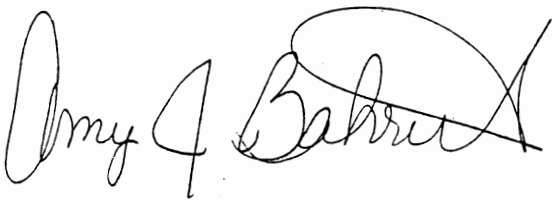
Finally, concerns about reproductive risk have been raised by several clusters of miscarriages and birth defects among VDT operators. A study conducted at the Kaiser-Permanente Medical Care Program in Oakland, California in 1988 concluded that women who used VDTs for more than 20 hours each week in the first three months of pregnancy suffered almost twice as many miscarriages as women doing other types of office work. Three possible causes of potential reproductive problems have been suggested: radiation, psychological stress and awkward work postures.

Several countries recognize the importance of providing a healthful work environment for VDT operators and have mandated ordinances governing such things as workstation design, lighting, vision care and breaks. In the United States, nine states have VDT ordinances, guidelines, or executive orders, and Suffolk County in New York state has a legally binding regulation. In NJ, the Department of Health has developed the most comprehensive guidelines in the country, which cover work environment, such as lighting, glare, and noise; VDT design; VDT workstation equipment, including specifications of chairs and tables; vision care requirements; job design considerations; and training for both operators and supervisors. These guidelines are meant to be a preventative measure and the NJDOH believes that successful implementation of the guidelines will help avoid the health

problems associated with poor VDT working conditions as well as increase operator satisfaction and productivity. However, the guidelines are just that . . . they are not enforceable as a standard by PEOSHA.

Currently, CWA is working on getting the NJ Department of Labor to promulgate these guidelines into an enforceable standard. In addition, CWA is working with legislators in developing a VDT bill which would include the provisions in the guidelines, which Vince Trivelli, CWAs legislative and political coordinator will discuss in more detail.

Thank you again for hearing this testimony.



Some Who Use VDT's Miscarried, Study Says

By LAWRENCE K. ALTMAN

Women who used video display terminals for more than 20 hours each week in the first three months of pregnancy suffered almost twice as many miscarriages as women doing other types of office work, according to a new study.

The authors of the study, researchers at the Kaiser-Permanente Medical Care Program in Oakland, Calif., said the findings did not necessarily mean that the termminals themselves had caused the miscarriages and that such unmeasured factors as job-related stress and poor working conditions could also have been responsible.

The study, showing more a statistical than a causal correlation, involved almost 1,600 pregnant women. The researchers found that heavy users of VDT's were more likely to have children with birth defects, but the increase was not statistically significant, the researchers said.

Terminals Long a Target

Some scientists and organizations of office workers have speculated about links of VDT use to miscarriages or birth defects. But these findings are the first epidemiological evidence based on substantial numbers of pregnant VDT operators to show a statistically significant increase of miscarriages among those who use the terminals more than 20 hours a week.

The researchers, whose findings appear in the June issue of The American Journal of Industrial Medicine, said that larger, more elaborate studies were needed.

Since 1979, news organizations have reported several small clusters of miscarriages and birth defects among VDT operators in the United States and Canada. However, there are disputes about their meaning. Some scientists regard the cases as clues to a more serious problem, while others consider them statistical quirks.

The few studies that have been completed have resulted in equivocal findings. Others are underway.

15 Million Terminals in Use

About 15 million VDT's are in use in the United States, and about 3 million more are added annually, according to VDT News, an industry newsletter. About half the estimated 10 million people who use the machines on the job are women of child-bearing age.

The Kaiser findings grew out of a study that was originally meant to determine the effects on pregnant women of pesticides used to combat Mediterranean fruit flies in California in 1981 and 1982. The researchers, Marilyn K. Goldhaber, Michael R. Polen and Dr. Robert A. Hiatt, surveyed 1,583 pregnant women who attended three Kaiser-Permanente obstetrics and gynecology clinics in northern California.

Their study found increased risks of miscarriage in both the first and second trimesters of pregnancy for all women who worked with video display terminals for more than 20 hours a week, in comparison with nonworking women. No statistically significant increase was found for women who had used the terminals less than 20 hours a week, the researchers said..

The researchers also reported an increase of about 40 percent in birth defects among the children of pregnant women who used VDT's more than five hours a week. But the researchers said that finding was not statistically significant.

Some experts have suggested that low-level electromagnetic radiation from VDT's may be able to alter or disrupt cellular development. According to VDT News, experiments with mice and chicks have shown such effects.

The National Institute of Occupational Safety and Health has said that VDT's do not emit unsafe levels of electromagnetic radiation. Critics counter, however, that any additional radiation imposes additional risk. The institute, whose acronym is Niosh, has identified clusters of miscarriages and other complications of pregnancy among VDT users but no cause and effect relationship has been established.

Mrs. Goldhaber said that when she heard accounts of the VDT problems, she was "surprised to find that there was very little published in medical journals and no organized epidemiological study."

Dr. Michele Marcus, who is studying the possible hazards of video display terminals at the Mt. Sinai School of Medicine, said the earlier, inconclusive studies were designed in ways that led them to underestimate any link between VDT use and complications in pregnancy.

Dr. Marcus and Dr. Philip J. Landrigan, a professor of environmental medicine at Mt. Sinai, termed the Kaiser study good and credible. "This is an important area that needs to be pursued in detail," Dr. Landrigan said.

A Question 'We Cannot Answer'

Members of the Kaiser team said they did not consider their findings definitive because the study was not designed to determine the cause of the miscarriages. Mrs. Goldhaber said: "We cannot answer the question of how this is happening — whether the increased rise that we found was related to the computer itself, or to the workplace, or stress in the workplace such as from seating discomfort, or even maybe some socio-economic differences between those who use computers a lot and those who do not use them,"

It is possible, the researchers said, that "recall bias" might have led women who had miscarriages to overestimate the time they spent at terminals. But Mrs. Goldhaber said the researchers discounted this possibility because there had been no such bias in reporting insecticide exposure.

Some key answers may emerge from a study that Dr. Landrigan and Dr. Marcus have begun with the support of the March of Dimes.

Dr. Landrigan and Dr. Marcus said that they were seeking a grant from the National Institutes of Health to study 8,000 women who work in offices, divided equally among those who use video display terminals and those who do not.

The Mt. Sinai researchers plan to measure emissions of ionizing and electromagnetic radiation from the machines the women use, and study the configuration of their desks, chairs and the VDT's; their use of VDT's; and other factors such as smoking and use of alcohol. Also, the researchers plan to use questionnaires and measuring devices to determine the effects of stress.

Further, the Mt. Sinai researchers plan to use a very sensitive urine tests to determine exactly when pregnancy occurs. Preliminary work using this technique indicates that independent of VDT use about one-third of all pregnancies end spontaneously, Dr. Landrigan said.

The proposed study will compare the rates of miscarriage and other problems among the two groups. "The problem is that pregnancy is such a common event and pregnancy loss is so common that the clusters could be due to chance alone and there is no way to disentangle them except to do a proper epidemiologic study," Dr. Landrigan said.

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New York Times 6/5/88

Video Terminals and Health: A Reawakening of Concern

By PHILIP M. BOFFEY
Special to The New York Times

WASHINGTON, June 15 — After years of relative quiet, the possible health effects of video display terminals have again become a public issue, fueled by a new scientific study and a new law on Long Island. These appear against an unsettled scentific backdrop in which some dangers are discounted but others are still open to question.

The latest research raises new fears that the terminals might be linked to miscarriages or birth defects in pregnant women, but the findings are only preliminary and suggestive, according to the researchers.

The evidence on eyestrain is more conclusive, experts say. The consensus of authoritative scientific groups is that terminals do not ruin the eyes permanently by causing cataracts or other physiological damage, but they can cause eye irritation, fatigue and headaches in workers who spend long hours staring at their machines.

Paradoxically, the danger most feared by many workers, the radiation emitted by the machines, appears to be the least likely source of problems, according to experts who have studied the evidence.

The video display terminals, which look much like television screens attached to a keyboard, are rapidly replacing typewriters and other office machines in many businesses, raising sporadic fears that, like any new technology, they may introduce unexpected health problems after prolonged use.

Indeed, the terminals have become increasingly pervasive in such industries as airlines, insurance and newspapers.

Although virtually every expert group that has reviewed the evidence in recent years has largely discounted the risks of major or permanent health damage, a fresh wave of concern rippled through the work force this month after two unrelated events, one scientific and the other political.

The scientific event was a new study, the most extensive yet conducted, which found a statistical correlation between miscarriages in working women and long hours of VDT use. The study was conducted by researchers at the Northern California Kaiser-Permanente Medical Care Program who interviewed almost 1,600 pregnant women two and a half years after their pregnancies and asked them to recall what exposure they had to video terminals, pesticides or other potential hazards.

The study found that clerical and administrative support workers who recalled spending more than 20 hours a week at their terminals in the first three months of pregnancy were almost twice as likely to have experienced a miscarriage as working women who did not use terminals.

The study reignited smoldering concerns about the possible adverse effects of the terminals on human reproduction. Several smaller studies and investigations of clusters of miscarriages or birth defects had previously found hints that terminals could adversely affect the outcome of pregnancies but this study provided the first significant evidence.

But the scientists acknowledged that their findings might result from factors in the work place that are unrelated to the terminals. They called for further large-scale epidemiological studies to determine whether a reproductive health problem exists.

Marilyn K. Goldhaber, chief author of the study, said the findings surprised the researchers because there is no biological mechanism postulated to explain how the terminals could cause miscarriages. She said the results "could be entirely due" to a tendency by women who suffered miscarriages to overestimate the time they spent at VDT's as a possible explanation of their misfortune, although the study found no such bias with respect to exposure to pesticides.

Medical Groups' Conclusions

She said that if the correlation her study found was real, her "best guess" was that the miscarriages were not caused by any radiation from VDT's, largely because the amounts of radiation emitted are "so tiny."

More likely, she said, the miscarriages would be related to discomfort in the seating or work arrangement at the VDT, or to stress related to the monotony or pressure of VDT work.

The American College of Obstetricians and Gynecologists concluded in 1984 that the radiation emitted by terminals was "insufficient to cause spontaneous abortions and birth defects," and the American Medical Association's Council on Scientific Affairs concluded in 1986 that "no association has been found" between radiation from VDT's and reported spontaneous abortions, birth defects, cataracts or other injuries.

Experts caution that the birth data are preliminary.

'A Red Warning Flag'

Dr. Harry Jonas, a former president of the obstetricians' group who is now an A.M.A. official, said today that these positions remain in force but that the new study has raised "a red warning flag" that more studies are needed to evaluate possible reproductive hazards. Meanwhile, he said, there is still no firm scientific evidence that terminals are a hazard to pregnancy.

The National Institute of Occupational Safety and Health is conducting a major epidemiological study that may clarify whether VDT's are associated with miscarriages.

Meanwhile, the agency's latest position remains what it was in 1984, a spokeswoman said today, namely that video terminals are not a source of dangerous radiation, that there is "some evidence" that they can cause physical or emotional stress, and that effects on reproduction cannot be ruled out although no physiological mechanism is available to explain such an effect.

Televisions use the same sort of cathode ray tube as VDT's, experts say, and thus would subject people who sit close to them to some of the same kinds of radiation. But concern over televisions has died down in recent years, industry observers say.

The chief concern over television sets, discovered in the 1960's, was leakage of X-rays, a form of ionizing radiation that is deemed hazardous because it can disrupt the molecules in the body. But design changes mandated by Congress eliminated that concern, and field surveys have consistently shown that both televisions and VDT's emit far less ionizing radiation than is considered dangerous under existing standards.

Cathode ray tubes also emit nonionizing electromagnetic radiation, which some laboratory studies have suggested might pose a biological hazard but most expert groups have largely discounted as a risk. Dr. Louis Slesin, editor of the newsletter VDT News, said possible hazards of nonionizing radiation "are not a live issue" with respect to televisions, partly because few people sit within two feet of a television and the radiation decays very rapidly beyond that.

The second factor igniting concern over VDT's this month was a law passed Tuesday by the Suffolk County Legislature requiring companies to subsidize annual eye examinations for VDT workers and eyeglasses or contact lenses if needed because of working on terminals.

The law was not based on concerns about radiation emissions or miscarriages, according to its backers, but rather on studies that detected such ailments as eyestrain, stiff necks and crippling hand and wrist pains among workers who put in long hours at terminals.

The American Academy of Ophthalmology today reiterated its position that "there is no convincing scientific evidence that VDT's are hazardous to the eyes." The levels of radiation emitted, the academy said, "are well below those required to produce cataracts or other eye damage even after a lifetime of exposure."

But the academy said VDT'S could be associated with eye irritation, fatigue, headaches, and difficulty in focusing. Such complaints, it said, "can be remedied by either changing elements in the work station design or providing proper glasses for the user." Although eyestrain is annoying, the academy said, "it is not an indication that use of the eyes must be discontinued to avoid permanent damage."

A committee of experts convened by the National Academy of Sciences concluded in 1983 that "the symptoms of ocular discomfort and difficulty with vision reported by some workers who use terminals appear to be similar to symptoms reported by people performing other near-visual tasks," such as reading under difficult conditions.

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CAUSE	POSSIBLE SOLUTIONS
Neck Ache/Shoulder Pain	
* Position of screen	* Tiltable screen * Proper chair giving good support * Rest breaks * Exercise program
Wrist/Arm Pain	
* Position of keyboard (too steep or high)	* Detachable keyboard * Proper palm support
Back Ache/ Leg Fatigue	
* Position of chair & table (tall people get leg cramps if chair too low; short people's legs dangle, puts pressure on thighs if chair too high)	* Adjustable chair and table; good back support in chair
Stress	
* Work pace too fast; Electronic monitoring; Harassing supervisor	* Redesign job
Reproductive Hazards	
* Radiation from terminal	* Manufacturer install metal shielding; periodic radiation monitoring
Skin Rashes	
* PCB inhalation from insulation coating on some VDT transformers & capacitors	* Repair/replace machine

CAUSES & SOLUTIONS TO SOME VDT HEALTH PROBLEMS

CAUSE	POSSIBLE SOLUTIONS
Visual Problems	
* Glare from overhead lights	* Install indirect lighting; change cool fluorescent to warm; overhead dimmer
* Glare from sunlight	* Use windows shades, blinds; keep away from window
* Glare from light bouncing off smooth surfaces: walls, furniture, paper	* Paint wall flat finish; use matte finish; desk lamp for some kinds of work
* Color of characters too harsh; characters on screen distorted	* May need new terminal; periodic servicing
* Sitting too close to machine; inappropriate eyeglasses	* Should sit 18-20" from terminal; May need glasses reground. Most ground for 10-12" distances

VDT HEALTH PROBLEMS

VISUAL PROBLEMS

Most common:

Itchy eyes

Burning sensation

Eye strain

Headaches

Needing different glasses

Less common:

Blurred vision

Double vision

Changes in color perception

Cataracts

MUSCLE & JOINT PROBLEMS

Most common:

Stiff neck/shoulders

Shoulder pain

Back pain

Hand cramps

Swollen muscles/ joints

Less Common:

Sore wrists

Pain down arm

Loss of strength in hands/arms

Loss of feeling in fingers

REPRODUCTIVE PROBLEMS

Scattered reports:

Miscarriage

Birth defects

Spontaneous abortion

STRESS SYMPTOMS

General fatigue

Irritability

Nervousness

OTHER

Skin rash

Fainting

24x

NJ VDT GUIDELINES

People who work with video display terminals (vdts) have complained for years about:

- Eye irritation
- Headaches and vision disturbances
- Back, neck, shoulder, arm, wrist, hand, and finger problems
- Stress from work overload, insufficient breaks and monitoring

These health problems can become quite severe, even debilitating, if proper precautions are not taken to improve the vdt work environment.

In November, 1989, the NJ Dept. of Health issued the most comprehensive guidelines on vdt use in the United States ever issued by a state government. The guidelines come after many months of pushing from a coalition of public sector unions in New Jersey, including CWA LOCALS 1031, 1032, 1033, 1034, 1037, 1038.

As a result, tens of thousands of public sector CWA members in New Jersey working in state and county agencies could benefit from these guidelines. The NJ Dept. of Health views these guidelines as a prelude to a PEOSHA standard on vdts. Although these guidelines do not yet have the force of law, nevertheless, they offer employers detailed instructions on how to provide a healthy vdt workplace.

Here are the highlights of the guidelines:

VDT FURNITURE

* Chairs-- adjustable for height and tilt
* Tables-- adjustable for height
* Accessories-- adjustable copy holders, foot rests, & palm or wrist rests

VDT EQUIPMENT

* Keyboards-- detachable from monitor
* Monitors-- tiltable

WORK ENVIRONMENT

* Lighting-- designed to reduce glare
* Noise-- acoustic covers for impact printers
* Heat-- vdt exhaust directed away from users

VISION CARE

* Eye exams every 2 years, more often if symptoms occur (for vdt operators who work 10 hrs. or more per week on vdts)

REST BREAKS

* 15 minutes after 2 hours of work on the machines (for vdt operators who spend 10 hrs. or more per week working on vdts)
* discretionary breaks of at least 1 minute each as needed (for vdt operators who spend 10 hrs. or more per week working on vdts)

25x

JOB DESIGN	* no more than 4 hours a day should be spent working on a vdt (for vdt operators who use machines 10 hrs. or more per week) * vdt operators should have input on work station design, job design, and workload
MONITORING	* electronic monitoring "discouraged"
TRAINING	* supervisor training in awareness of the health effects of vdts and the impact of poorly designed, stressful work on productivity. * vdt operator training given on work time (for operators who work 10 hrs. or more per week on the machines) training includes "hands-on" practice in how to adjust vdts, hairs & tables; eye and body relaxation exercises. refresher course every 2 years.

What's missing from the NJ VDT Guidelines?

The guidelines are simply guidelines. They're not enforceable by law.

The guidelines do not include any provisions regarding radiation. The NJ Health Dept. plans to issue separate guidelines on radiation, pending the outcome of more research on reproductive risks of vdt use.

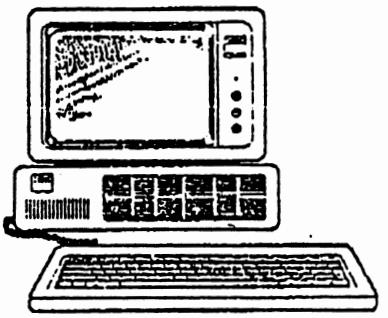
However, prudent employers can take steps now to prevent radiation exposure by doing the following:

1) keep vdts at least 39 inches from the sides or backs of any neighboring vdts & provide glare filters for vdt screens

   or, alternatively,

2) purchase vdts which have been designed with little or no radiation emission

3) provide alternate work for pregnant vdt operators on request, if step 1 or 2 cannot be taken



COMMUNICATIONS
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LOCAL 1031

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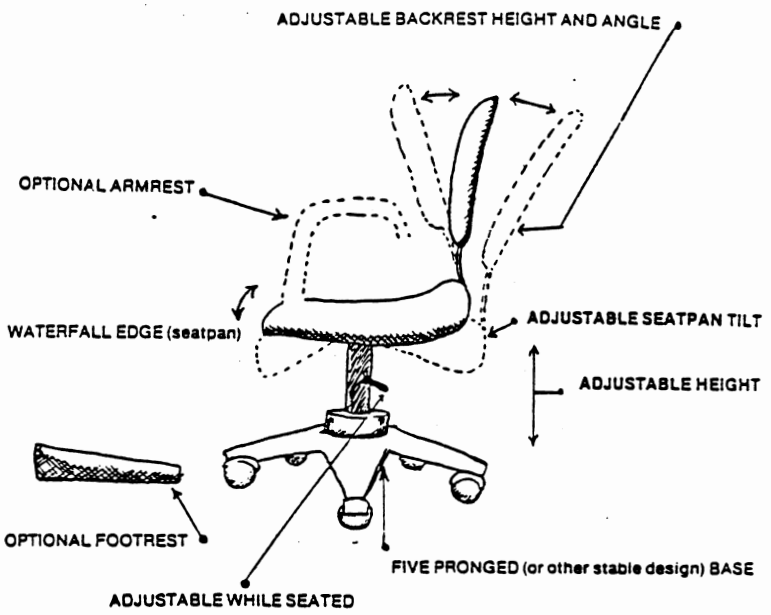
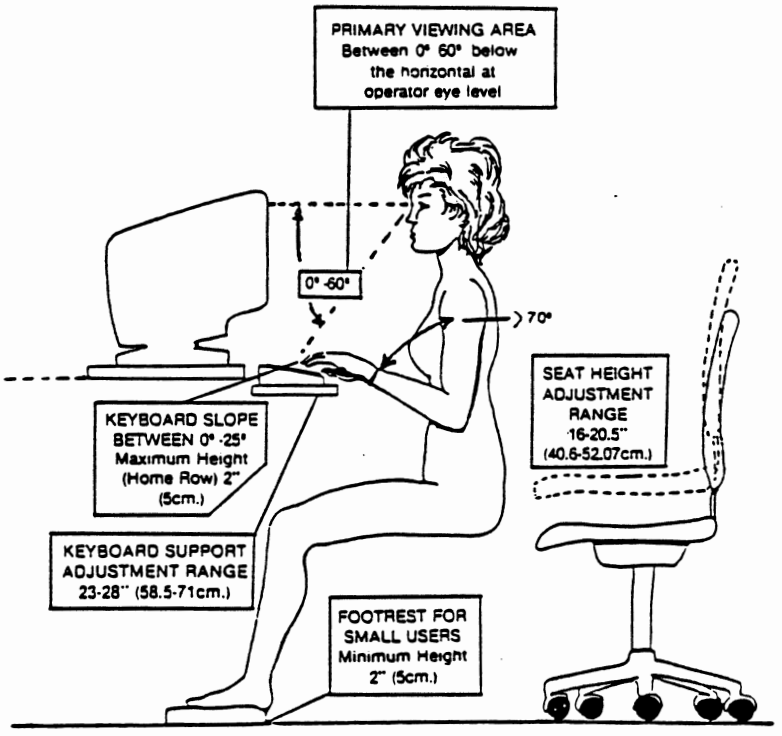
Ergonomics in the Office



Properly designed chair and workstation



reprinted from VDT Health and Safety, pgs. 49 and 51.

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COMMISSION ON SEX DISCRIMINATION IN THE STATUS STATE OF N.J.

PUBLIC HEARING : JUNE 20, 1990

FROM : ARLENE D. BARDEGUEZ, M.D.

ASSISTANT PROFESSOR

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

UMDNJ-NEW JERSEY MEDICAL SCHOOL

The human immune deficiency virus (HIV) is the etiologic agent for the acquired immune deficiency syndrome (AIDS).

This retrovirus growths in monocytes, macrophages and lymphocytes preferentially. The clinical manifestation of this disease range from asymptomatic cases to a wasting syndrome characterized by opportunistic infections and dementia (AIDS). The first case of AIDS was described in 1981, but since then this disease has reach epidemiologic proportions. As of June 1, 1989, the World Health Organization (WHO) reported an accumulative total of 157,191 AIDS cases from 149 countries. Their projections of the number of infected people worldwide with the HIV virus during the 1980's was between 5 and 10 million. Recent projection for the USA revealed that approximately 1-2 million people are actually infected.

The toll to our society is overwhelming because this disease have no discrimination of the individual it would infected. Children, men and women are dying every day as a consequence of HIV infection. Even more tragic to our society it the fact that 90% or more of affected individuals are on their peak of reproductive potential leaving us with little hope for our future as a nation. Unless we actively design and implement new strategies for early

identification and support of infected individuals to improve the quality of their life and productivity and prevention of new cases by mass education of our community.

According to the Webster Dictionary, discrimination originates from the latin work dis - which means apart and the work crimen - which means verdict. To discriminate means to distinguish or make distinctions in treatment to a particular group. Society have a subtle way of discriminating against groups in terms of education, access to health care and job opportunities. We can close our eyes and not look of what's happening around us because we are not affected. The sad consequence of this view is that it will always hit us back. Witness to this effect are abundant in history and Matthews 25:31-46 describes how Jesus will exert judgement over all those that did not feed him , calm his thirst, shelter him or support him in sickness when he was in need.

If the unrighteous ones asked him when did this happen. He would respond "Because you did not do it for one of my beloved, you did not do it to me."

As of April 31, 1990, the number of cumulative cases of AIDS reported to CDC was 132,510. For the State of New Jersey the number of cumulative cases reported on May 31, 1990 was 8,951. The countries of Essex (2,899), Hudson (1,484), Passaic (672) and Union (663) carries most of the load for this State but the numbers of cases identified in other countries has been continuously increasing. New Jersey is the fifth State in the nation with the highest number of reported AIDS cases (6.7%). Although this epidemic has affected mostly male individuals the proportion of

females cases has been drastically increasing over the past decade. Women constitutes 9% of the total population of AIDS cases. Based on the transmission category report to CDC for the State of New Jersey 64% of cases occurred among intravenous drug abusers, 29% on heterosexuals, 4% are secondary to transfusion or blood component and 3% are undetermined. The racial distribution for our State showed 54% of cases are among blacks, 34% in Whites and 12% in Hispanics. These figures drastically differs from national ones. In New Jersey we have the higher proportion of AIDS cases in women of the nation, and AIDS is #1 cause of mortality among childbearing age black women (88% cases occurred between ages of 20-49 y/o).

This dramatic strain to our society contrast sharply with out present provisions to educated, offered medical and psychological support and assist economically these group of under privileges ones.

The State of New Jersey have set up demonstration Pediatric Regional Care Centers in 5 areas of need, namely, Jersey City, New Brunswick, St. Joseph, Camden and University Hospital in Newark, Beth Israel is an affiliate Institution to this last program. Because recognition by the pediatric group that early intervention on children requires early intervention in mothers many of these centers have capability to offer perinatal testing for HIV education and follow up for the serving population. However, the only formal OB link between Ped-Ob is at Newark University Hospital.

At the present time probably only two centers in the State

will have the capability of offering investigational therapy to those mothers in need once the ACTU 076 or any other protocol get instituted. (This protocol will provide AZT to pregnant women with HIV infection during 3rd trimester and intrapartum).

The Ob/Gyn Department of University Hospital in Newark provide care for Newark and serves as tertiary referral center for Essex County and other neighboring counties. There are approximately 2,500 to 2,700 deliveries every year. An anonymous seroprevalence study in 1988 revealed that 4.3% of our deliveries were positive for HIV infection. During the same study time frame less then 1% of the cases were identified prenatally. Therefore our department adopted a policy of education, risk assessment and offering HIV testing for any women receiving prenatal care in our Institution in 1989. This has been possible through support from the State perinatal AIDS prevention project and the NIH funded study on perinatal transmission. We have centered over all new patients seen in the adult prenatal clinic. The benefits of such policy is more dramatic at present where effective support and intervention can and should be given to asymptomatic HIV individual.

Our experience from September, 1989 to April, 1990 is as follows. Of 1,170 new patients seen during study period 56.5% were contacted. (662), 62.6% of those patients agreed to be tested (415) and 4.3% (18) were positive. Only 15% of HIV positive cases admit to substance use. Although this is a dramatic improvement from our efforts in 1987 there is still a lot of work to do. We have not extended our efforts to the growing number of teenagers afflicted with this disorder, we have not touch the gynecologic

population with a consistent approach, we have not contact the other 43.5% of our prenatal population. Even more depressive are the number of referrals of infected patients abandon by their private physician, once on HIV test have return as positive. Many of these women never receive education and were not aware that their physician was testing them for HIV.

From October 1, 1989 to April 30, 1990 we had 621 births in University Hospital 147 of those patients had no prenatal care (23%). When and how do we provide help for all these women on desperate need?

We have improve our approach for the AIDS epidemic, but God we need so much more help from you, the community to make a difference.

University Hospital is only a sample of what's happening in Newark, Essex County, New Jersey, USA and the World. We can make a difference and stop the discrimination against availability of health care and support for women with HIV infection, if we want to and maybe we will not wait for the judgement day, because unless we do something now this epidemic will destroy us all as nation.

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LOCAL 1033

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TESTIMONY AT THE COMMISSION ON SEX DISCRIMINATION IN THE STATUTES
PUBLIC HEARING ON HEALTH
WEDNESDAY, JUNE 20, 1990

COMMUNICATION WORKERS OF AMERICA, LOCAL 1033

CWA Local 1033 represents over 7000 State Workers in the Trenton area who work for approximately ten departments.

Our Local represents one of the largest groups of VIDEO DISPLAY TERMINAL OPERATORS - over 600 employed by the Division of Motor Vehicles and the Taxation Division. Of these, over **90% are women.**

At the Division of Motor Vehicles, operators continuously input information to process licenses, registrations and suspensions. Many of these operators are simultaneously fielding telephone inquiries from the public while also inputing data. They are secretly monitored by management which contributes to their stress.

At the Division of Taxation, operators keypunch tax returns and checks all day and are on a quota system which requires a minimum of 8,500 keystrokes each hour.

We recently conducted a survey of Taxation VDT Operators of which 250 were returned to our Local. The responses revealed the following symptoms:

. . . 89% experience regular neck or back pain

. . . 79% experience regular arm or shoulder pain

. . . 76% experience hand or wrist pain

. . . 85% experience vision problems such as headaches, blurred vision, watering and itchy eyes

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Over the years, Union representatives have attempted to correct these glaring health problems with Taxation management. Even though research has shown that more frequent breaks, proper lighting, adjustable tables and chairs, anti-glare screens and footrests are remedies to this health hazard, Taxation management has been unwilling to spend money to prevent the adverse health affects on their employees.

We wonder whether this situation would continue for so long if these operators were primarily men.

The short term cost of these standards is nothing compared to the State's expenses involving lost time and medical bills resulting from these symptoms. There are several Taxation employees who have suffered permanent damage to their hands and wrists as a result of prolonged VDT operation.

Employers must be held to a uniform standard for VDT Operators, and there should be strict government enforcement of these standards if we are serious about protecting the health of millions of American women.

Michael Lohman

Michael Lohman

Local 1033 Staff Representative &

Health and Safety Coordinator

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