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

before

SUB-COMMITTEE

of the

ASSEMBLY INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

A-1155 and A-1592

(Abortion: Parental Notification and Informed Consent)

Held:
October 1, 1980
Union County Freeholders Room
Administrative Building
Elizabeth, New Jersey

MEMBERS OF SUB-COMMITTEE PRESENT:

Assemblyman Raymond Lesniak, Chairman
Assemblyman C. Louis Bassano

ALSO:

John D. Kohler, Research Associate
Office of Legislative Services
Aide, Assembly Institutions, Health and Welfare Committee

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1 - 14:#1
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I N D E X

[OFFICIAL COPY REPRINT]

ASSEMBLY, No. 1155

STATE OF NEW JERSEY

INTRODUCED FEBRUARY 25, 1980

By Assemblymen LESNIAK and DEVERIN

Referred to Committee on Institutions, Health and Welfare

AN ACT requiring parental notification prior to the performance of an abortion on a pregnant minor.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. No physician shall purposely or knowingly perform or induce an abortion upon a pregnant unemancipated minor under the age of 18 years without first having given at least 24 hours actual notice to the parents, legal guardian, or other person in loco parentis*[, or 72 hours constructive notice by certified mail computed from the time of mailing to the last known address of the parents, legal guardian, or other person in loco parentis,]* of the intention to perform the abortion. This act shall have no application where, in the medical judgment of the attending physician, abortion is necessary to preserve maternal life or where, in the medical judgment of the attending physician, there exists a medical emergency.

Any physician who violates this act is guilty of a disorderly persons offense.

2. This act shall take effect immediately.

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

ASSEMBLY INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1155

[OFFICIAL COPY REPRINT]

with Assembly committee amendments

STATE OF NEW JERSEY

DATED: APRIL 14, 1980

This legislation requires parental notification of at least 24 hours actual notice before the performance of an abortion on an unemancipated minor. The physician must notify the parents, legal guardians or other person in loco parentis.

The committee agrees with the purpose of this legislation. The committee removed a 72 hour constructive notice requirement in light of problems raised concerning this issue.

ASSEMBLY, No. 1592

STATE OF NEW JERSEY

INTRODUCED APRIL 21, 1980

By Assemblyman HERMAN, Assemblywoman McCONNELL, Assemblymen DALTON, RILEY and STOCKMAN

Referred to Committee on Institutions, Health and Welfare

AN ACT concerning abortion and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Legislature finds and declares that the State has a vital interest in promoting and protecting maternal health through the correct and adequate provision of abortion services and that the State further has the obligation to take what steps it can to safeguard a woman's rights.

Allegations are frequently made that a woman may make the abortion decision in a vacuum, without full knowledge not only of what the medical procedure may entail but also without a complete understanding of the alternatives to abortion which may be available to her. Concern has also been raised that some women have been or are susceptible to being victimized by a small number of medical practitioners and that greater protection against this possibility may be necessary.

The Legislature finds therefore that the interests of public health will best be served by providing women facing the abortion decision with as much information as possible as well as imposing a greater degree of accountability on the physician, remembering always to balance any regulation it may impose in this sensitive area with the woman's right to privacy as it has been defined by the United States Supreme Court.

2. The Department of Health shall prepare a booklet which reasonably outlines for women all medical facts pertinent to the abortion procedure including any health risks which may be associated with abortion and how these may compare with the risks of eventual childbirth. The booklet shall also include a complete listing of alternative services available to the woman should she

choose not to have the abortion. The department shall update the booklet as it feels necessary to reflect any changes in the information it contains.

The department shall make a supply of booklets available to all licensed health care facilities and physicians in private practice engaged in the performance of abortions.

3. Before a physician performs any abortion, he shall give the patient a copy of the booklet prepared by the Department of Health and answer any questions she may have in regard to its contents. The physician shall have the patient sign a written acknowledgment that she has received the booklet and has been afforded a satisfactory opportunity to discuss the information it contains with her physician.

The acknowledgment shall be prepared and distributed to the physician by the Department of Health and shall be kept on file by him as part of the patient's medical record.

4. All licensed health care facilities and physicians in private practice engaged in the performance of abortion shall prepare a report on each abortion performed. The report shall be made on forms supplied and developed by the Department of Health and shall be submitted to the department within 10 days following the abortion procedure. In all cases the anonymity of the patient will be preserved and all reports will be treated as confidential and shall be exempt from the provisions of P. L. 1963, c. 73 (C. 47:1A-1 et seq.), however the reports will be submitted on all patients regardless of the period of gestation and will contain that information determined to be necessary by the department.

5. Any physician failing to comply with this act is guilty of a disorderly persons offense and is also liable for action by the State Board of Medical Examiners pursuant to R. S. 45:9-1 et seq.

6. Nothing in this act shall be interpreted to restrict or limit in any way a woman's right to obtain an abortion.

7. This act shall take effect on the ninetieth day after enactment.

STATEMENT

The purpose of this bill is to provide as much information as possible to any woman who seeks an abortion by requiring the Department of Health to prepare a booklet which outlines for women not only all pertinent medical facts about the abortion procedure but also a complete listing of alternative services available to her should she choose not to have the abortion. A copy of the booklet would be given to the patient by her physician prior to

the performance of the abortion. The woman would have to sign a written statement that she had in fact received the booklet and a copy of this statement would be placed in her medical file.

This bill also attempts to offer greater protection to the woman by insuring some degree of accountability on the medical practitioner by requiring reporting to the Department of Health of all abortions performed in the State.

The sponsors of this bill have attempted to balance the very urgent need for a truly informed abortion decision with a woman's right to privacy as it has been outlined by the United States Supreme Court. Although there are other aspects of the abortion procedure which are felt to warrant greater regulation, particularly the need for parental notification and consent prior to the performance of an abortion on a pregnant unemancipated minor, this issue is currently being considered by the Legislature in its deliberation of Assembly Bill No. 1155 of 1980 sponsored by Assemblymen Lesniak and Deverin and will be judged on its merits. Also, the sponsors recognize their legislative responsibility to regulate only in areas determined by recent court decisions to be those in which the State has a legitimate interest.

ASSEMBLYMAN RAYMOND LESNIAK (Chairman): I call the meeting of the Subcommittee of the Assembly Institutions, Health and Welfare Committee to order to conduct a public hearing on A-1155 and A-1592.

Seated to my right is John Kohler, who is our Committee Aide. John, have the required notices been published for the meeting?

MR. KOHLER: Yes.

ASSEMBLYMAN LESNIAK: On the Committee, in addition to myself, are Assemblyman Bassano, who is supposed to be here this morning and I expect that he will be, and Assemblyman Mays.

The purpose of the hearing this morning is to get input from the public in regard to these two bills on abortion. Both A-1155 and A-1592 are extracts similar in nature to a bill sponsored by Assemblyman Deverin which passed both Houses of the Legislature and was subsequently vetoed by Governor Byrne for both constitutional reasons and some policy decisions which he outlined in his veto. Assemblyman Deverin called me this morning and said that he would like to be here. His company, however, is on strike; and he, being part of management, is not allowed to leave the premises. But he expressed his support in general for both bills before this Subcommittee today.

One other thing, as far as the testimony is concerned, we have been notified by approximately 25 people that they would like to testify today. That is a very large group. We hope you will keep your comments brief and concise and try to avoid repetition when possible. I don't want to cut anybody off, but we want to limit your comments to approximately ten minutes so that we can be out of here before dinner time.

If you have written testimony, we will take that written testimony and it will be made a part of the record. Today, your testimony is being taken stenographically. It is compiled in a hearing transcript and that transcript is released to every single legislator, both in the Senate and the Assembly. That has to be published and distributed to the legislators prior to any vote on the floor of the Assembly on that bill. So, if you have written testimony, it does not have to be given verbatim. If you can summarize and capsulize it, it will be appreciated and we will keep the hearing moving. Nevertheless, even though you may not give it verbally today, your comments will be in the record and available for the legislators to study.

Before calling Assemblyman Herman as the first witness today, I would like to give a brief history of the parental notification legislation. I have had a hard time in making people understand that it is not parental consent; it is parental notification. I just noticed in my notes here I wrote "parental consent." The difference between the two is quite substantial. Parental consent has been declared unconstitutional by the United States Supreme Court. Parental notice has not. And there will be arguments before that body shortly regarding the requirement of parental notification. That is one of the reasons why this legislation has been moved now so that, hopefully, they will decide in favor of parental notice and New Jersey will be on its way towards implementing that requirement, if not having it in law, by the time the Supreme Court makes its decision.

This bill was released from committee earlier this year. It was resubmitted to this committee on my motion because of the concerns that I and other people had regarding issues of actual notice and constructive notice and regarding whether there ought to be exceptions to the notification requirements. There was one issue raised

that I thought was a very good point and that dealt with the case of a child who is raped or subject to sex by her father or her stepfather. I think we should consider whether, in this legislation, we ought to require in those cases that the Prosecutor be noticed because that is a question of child abuse and would probably be better handled that way.

I have received two communications which I am going to hand to the stenographer to enter into the record. One is a letter dated September 25, 1980, from Susan K. Perger from Highland Park, New Jersey. (Ms. Perger's letter can be found on page 1X.) Also we have a letter from Dr. James P. Thompson of St. Joseph's Hospital and Medical Center, dated September 10, 1980. (Dr. Thompson's letter can be found on page 4X.) These letters will be made part of the record.

At this time, I would like to call the Chairman of the Assembly Judiciary Committee, who has sponsored A-1592, and has graciously come all the way up here because of his interest and his concern to testify on behalf of his bill. He is from Gloucester County. I went down there to attend a hearing and I would say it is about a 2½- to 3-hour ride, not to mention the fact that it is totally in the wilderness. There is nothing down there. I will take back those gratuitous comments because there are some nice areas down there - the Van Rollins Chemical Disposal Plant.

Assemblyman Herman, welcome to Union County.

A S S E M B L Y M A N M A R T I N A. H E R M A N: Thank you, Mr. Chairman. I will express your regards to Thornton Wilder.

Before I begin my formal remarks - and I hope I can read them because I wrote them myself - I would like to offer in support of your bill standards relating to minors that have been propounded by the Juvenile Justice Standards Project of the American Bar Association and adopted on February 12, 1979, as part of the overall 30 some volumes on Standards on Juvenile Justice. I think you will note that there is great support for some forms of parental consent as well as parental notification in this document.

ASSEMBLYMAN LESNIAK: Excuse me, Assemblyman. We will make these standards part of the record: Section 41 Prior parental consent, "No medical procedures, services, or treatment should be provided to a minor without prior parental consent. . ." These are excerpts from Standards Relating to Rights of Minors, Juvenile Justice Standards Project, Institute of Judicial Administration and the American Bar Association, adopted by the ABA on February 12, 1979. (See page 7X for the Standards.)

I thank you for your support and I welcome Assemblyman Bassano, who didn't have a 2½-hour ride to get here this morning.

ASSEMBLYMAN HERMAN: Mr. Chairman, Assemblyman Bassano, and people gathered here today, I know of few issues affecting the national fiber that have so stoked the fires of human emotion, that have stirred more polar, more intense, more vitriolic debate than that of abortion. That debate in New Jersey has proved no exception.

I am not here today to participate in that debate nor advance the cause of one side or the other. I do not pretend to be the keepers of the king's conscience nor the last definitive word on what is moral and what is not. Rather I appear here today to advance a principle of government that I believe sacrosanct and inviolate, the obligation of every government to guarantee to all its citizens a decent standard of health care. And I believe that is exactly what A-1592 does by mandating, prior to any abortion being performed, that every citizen be fully and properly informed as to the potential dangers, the potential risks, attendant

to this surgical intervention.

The doctrine of informed consent, which is the fundamental underpinning of A-1592, is not a new concept. As early as 1914, Justice Benjamin Cardozo, then a member of the New York Court of Appeals, stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his or her own body." Since Cordozo, court after court, year after year, has aptly noted that the right to determine what should be done with his or her own body requires that each such person be advised by the physician as to what would be done, the risk involved, and the alternative, if any, to the treatment proposed. A 1972 opinion of the U. S. Circuit Court of Appeals, in my opinion, hit the nail right on the head when it noted, and I quote: "True consent to what happens to oneself is the informed exercise of a choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant to each." That is exactly what I believe I had in mind when I introduced A-1592, that every woman who seeks an abortion receive from her physician sufficient information about the risks, the benefits of the proposed treatment, and of any alternative approaches available to allow her to make a knowing, intelligent choice as to whether to proceed or whether not to proceed.

In order to accomplish these ends, the ends required in 1952, this bill provides that the New Jersey Department of Health is required to prepare a booklet, which reasonably outlines for women all medical facts pertinent to the abortion procedure. As the bill aptly notes - and I am not going to read it in its entirety, although it is not a long bill - it is required that the booklets have a complete listing of alternative services available to the woman, which I guess could be compiled on a county-to-county basis, as far as the alternative services generally there and elsewhere, and it is required that the Department update from time to time these booklets and to make them available to all licensed health care facilities and physicians in private practice. The bill also would require that the patient sign an acknowledgement that she received the booklet, that she was advised of the procedure by the physician, and that her questions were in general answered; it further would require that the physician keep the acknowledgement on file. There is the requirement of reporting by the physician, the maintenance of anonymity of the patient, etc. As I said, the bill is not a complicated bill. It basically speaks for itself in furtherance of what I believe to be the important concept of informed consent.

Setting aside for a moment, if I may, the pride of authorship - and I don't know if I can - I believe the above guidelines and mandates provide a reasonable approach in extending this concept of informed consent to an areas of surgical intervention where the patient must be given every reasonable opportunity to exercise a reflective choice based on information that is medically and socially unbiased to the extent that that is possible, so that she can weigh, herself, the potential risks involved, the potential alternatives and services that might otherwise be available should she choose not to have the abortion performed.

If it be the public policy of this State - and I believe it is - that every patient be made fully aware of the potential dangers and potential risks involved in any surgery, whether that be the fixing of one's arms, the removing of one's appendix, or the reorientation of one's nose, surely in this case under these circumstances, circumstances which are usually charged with great emotion, potential for self-doubt, where many of the patients are getting younger and younger and

younger and poorer and poorer and poorer, and do not necessarily possess the intellectual or social stability to make a rational decision freely, I firmly believe that the institution of the government, namely the State of New Jersey in this instance, should require no less than our federal counterpart requires in many other funded medical programs that the person seeking the abortion, the surgical intervention, have the best information available and all the information that is available.

If we are to set up reasonable standards of care, if we are to impose reasonable standards of information dissemination, then it is our obligation, I believe, to assure that the information conveyed in Cape May is the same that is conveyed in Union or Hudson or Bergen or any other county. That is why I believe that our Department of Health, the guarantor, the protector, the overseer of the public health in this State, be that instrumentality through which this information is gathered, prepared, and disseminated.

I know the Department of Health will appear here today to express its reluctance, its reservations. But I am sure as we proceed through the committee process that we can resolve, in fact, we must resolve, our differences, for I submit to do otherwise would be a large disservice to the people of this State. To cast this bill aside, leaves an even far greater potential for damage and for harm in this instance, that harm being the proposed 21 different standards in 21 different counties - in fact, perhaps as many standards as we have doctors in this State - in the dissemination of that type of standard to all the different patients that will be involved. I believe that as that is unacceptable for the patient, it is unacceptable for the doctor. I believe that it is unacceptable to us as legislators representing the public interest. And I believe that this result is totally unacceptable and unfair to those who might otherwise benefit most from this information, those waiting for an opportunity to be born.

There are those in this audience this morning who will appear here today in total support of this legislation. I wish to acknowledge them with a sincere thank you. Some of those who will appear in support of this bill will testify and request committee amendments. I know that this subcommittee and the full committee will fully review those proposals. Interestingly enough, there are those supporters of this bill who reflect both ends of the abortion debate continuum, which led one of my staff to observe shortly after introduction of this bill, perhaps somewhat tongue in cheek, that we had better take a second look at this bill because if both sides of the coin feel that this is a good bill and has potential for benefit, then there must be something wrong with the bill.

But tongue in cheek aside, I believe in reality, the reality that there is broad support for the goals embodied in this bill and that those realities reflect a broad social concern that has nothing to do with whether you are pro-abortion or anti-abortion. They reflect a concern that every person, especially those in these circumstances, should be entitled to the best information available prior to making the decision to proceed or not to proceed.

I ask, therefore, that those who seek to amend this bill, an effort I know that will be furthered in good faith, do so in a manner that will not lose sight of the common goal - that is to enact legislation that is fundamentally fair, that is constitutionally sound and that does not seek a moral victory, a moral expression, paramount to a view that might be counterpoint to some other person's view - but rather that we steer a legislative course, a public course, a course that will stand the test of court challenge , for I have often thought and I have often

expressed, indeed, how very unkind it is to pass legislation to satisfy the emotions of the moment when we should know or should have known that such legislation would not pass constitutional muster. To me, that is a cruel hoax indeed to play upon those whose expectations we pump and bolster.

Ladies and gentlemen, I for one do not intend to engage in that game. I will not play that game.

Therefore, if past history be our guide to future success, I know that all of those good persons involved in seeking enactment of this legislation will join with me in a way that will lend credence in our effort and constitutionality to our task. For if you believe, Mr. Chairman, and if you believe, Assemblyman Bassano, and the members of your Committe believe as I believe, and as the framers of the 1947 Constitution of the State believe, that government is instituted for the protection, security, and benefit of the people, then I will trust that you will conclude, as I have, that A-1592 by protecting the rights of the uninformed to make an informed choice, by guaranteeing to each of them the security of impartial and unbiased information, surely benefits each of them in the exercise of their liberties, in the exercise of their functional and personal freedoms, and in turn benefits all of us because, in fact, it benefits each of them.

Mr. Chairman and members of your Committee who are here and not here today, I respectfully request after what I know will be a thoughtful, comprehensive and diligent review, you release this bill for full Assembly deliberation. Together we have an opportunity to further the health, the happiness, and the general welfare of those we now represent and those in future years we may represent if this legislation is enacted into law.

I thank you for the opportunity to appear here today and I trust, after due consideration and due deliberation and listening to all the people who have lots more important things to say here today, that we will be able to enact legislation, yours included, that will be worthy of the role we were elected to serve. Thank you very much.

ASSEMBLYMAN LESNIAK: Thank you, Marty. I have one question.

ASSEMBLYMAN HERMAN: Surely.

ASSEMBLYMAN LESNIAK: What about the time element? We have run into problems with other operative procedures regarding consent forms put under the nose of somebody while they are in the hospital or in a clinic. Can it really be informed consent if it is just an immediate procedure?

ASSEMBLYMAN HERMAN: If I had my druthers, I would rather there would be some time delay. But you know the cases as well as I know the cases, and what I sought to do was to prepare a bill without --- because the issue isn't whether you are pro-abortion or anti-abortion. The issue in this bill is whether we can put together a piece of legislation that will further the goals of informed consent in this very sensitive area that will stand the test of constitutionality. Although as a personal choice I would rather see a time delay, if it means that the courts would strike it down or that there would be a great risk or potential that that would happen, I would rather have 80 percent of the ballgame than none of the ballgame, because, Mr. Chairman, I think you must note that every abortion bill that has been passed, even those that have been enacted into law in this State, have not seen the light of day.

Again, I will reaffirm that to pass legislation to raise people's expectations, their hopes and their emotions, knowing that there is a great likelihood

for a court to strike it down, may be good election fodder and may make good press releases, but it certainly is a very poor way in which to conduct oneself as a legislator. As I said, I won't play that game. I would rather see 80 percent of something than 100 percent of nothing. Otherwise, I wouldn't have introduced the bill.

ASSEMBLYMAN LESNIAK: I am not sure whether you answered the question.

ASSEMBLYMAN HERMAN: I think I answered it. The answer is I think we noted in our Committee statement that we left out the 24-hour notification because we didn't think it would be upheld. Okay?

ASSEMBLYMAN LESNIAK: That is a lot clearer, a little more specific.

ASSEMBLYMAN HERMAN: We lawyers have that problem, whether we are from Union or Gloucester.

ASSEMBLYMAN LESNIAK: Assemblyman Bassano?

ASSEMBLYMAN BASSANO: Just one thing, I also marked down "24-hour delay" which you mentioned. With regard to having the physician file reports with the Department of Health, it is not a normal practice in other areas of health care to require a physician to do that. I am just wondering if maybe we are taking one step too far by requiring that type of procedure.

ASSEMBLYMAN HERMAN: Let me respond to that reflection. I believe that abortion clinics now are required to file. I stand ready to be corrected if I am incorrect, but I believe they are. I see nothing wrong with extending it.

Likewise, where we have issues of great social concern - for instance, communicative diseases, veneral diseases, cancer - we have a reporting requirement . I think in this instance there is a strong public policy intended and underpinning the whole legislation that the State should have an idea exactly what is going on out there in the 21 counties. That is why it is included.

ASSEMBLYMAN BASSANO: Thank you.

ASSEMBLYMAN LESNIAK: Thank you, Marty, I appreciate your coming up.

ASSEMBLYMAN HERMAN: I appreciate your having me.

ASSEMBLYMAN LESNIAK: The next witness is George Halpin, Director of Child and Maternal Health for the Department of Health, State of New Jersey.

D R. G E O R G E H A L P I N: I am Dr. George Halpin. I am the Director of Parental and Child Health Services for the State Department of Health. I am here today to provide the Department's testimony on the two Assembly Bills, A-1155 and A-1592. I will try to treat them together since they both concern abortion services. I will address these two bills in the context of the Department's public health concern. I think many of the comments that Assemblyman Herman has made, you will find that when we get to Assembly Bill 1592, there is much similarity. In reference though to Assembly Bill 1155 and its requirement for prior parental notification, the following three points should be considered.

1. The primary concern of the Department is that quality health care be available to all residents of New Jersey. This concern is particularly focused on those that are in high-risk health groups. Legal barriers to the provision of services to minors who are, indeed, a high-risk health group, have posed in the past significant problems to the provision of health care to this group.

2. An adolescent's psychological, physiological and behavioral development are not determined in the same uniform way as the status of majority. These needs develop over years and in each individual at different rates. Physiological sexual maturation is occurring at an earlier age than in the past,especially in the United States. This should be reflected in the laws affecting the rights of

minors to independently assess health care. These laws should be constructed in a flexible manner to allow for this physiologic variation.

3. The courts in the cases of Roe v. Wade and Colautti v. Franklin emphasized the central role of the physician both in consulting with the woman about whether or not to have an abortion and in determining how any abortion is to be carried out, and that the abortion decision in all its aspects is inherently and primarily a medical decision.

The Department feels that the courts have clearly defined the parameters within which a state may regulate either by law or by administrative regulation the performance of abortions. Health regulations or state laws cannot be made more stringent or more specific simply because the procedure involved is abortion, and furthermore the state must demonstrate a compelling interest before intervening in what is a private medical decision.

In New Jersey in 1978, there were 279 live births to women under the age of 15. There were reported to the Department 242 elective abortions to that age group. There were also 7,695 live births and 6,987 abortions reported to women ages 15 to 19. This is not a complete count of elective abortions to minors since not all abortions performed to New Jersey residents occur within the State or in licensed health care facilities and only those that occur in licensed health care facilities have to be reported to the Department.

Each of these 15,000 or more adolescent women had to take on a very difficult responsibility. As a physician who has provided prenatal care to young women, I know that the burden of that responsibility could be lightened if it could be shared with an adult or ideally with parents. I believe from clinical experience and my own sense of human behavior that an adolescent will turn to her parents when she knows or believes from her past experiences, living with them as their child, that help will be forthcoming. When a young woman decides that she must make a decision concerning abortion without involving her parents, she does so only because she feels she has to. Legislation, I am sorry to say, cannot change poor parent/child relationships.

Under existing State law, parental consent is not required for any medical treatment in the case of a pregnant minor. Title 9:17A-5 of New Jersey Statutes specifically addresses the issue of parental notification by stating "a physician licensed to practice medicine may, but shall not be obligated to inform the spouse, parent, custodian or guardian of any such minor as to the treatment given or needed."

These laws were passed to address the real public health concern that minors in need of health care must be able to act in their own best interest despite any conflict with their parents or guardians. They also wisely provide that the physician is able to exercise mature judgment as to the advisability of notifying the parents of the minor's condition or treatment. Because the Department feels that existing laws are adequate and because of the following points that I will make, it cannot support Bill A-1155.

Specific objections come in three areas. If A-1155 is enacted into law, it will require physicians to notify parents even when in the physician's good judgment such notification would result in serious harm to the minor. For example, a physician would have to notify parents of a planned abortion in cases of incest or where the physician suspects or knows that the minor would be a victim of injurious physical abuse as a result of their decision either to abort the pregnancy or because of the simple fact they were pregnant.

The impact of this bill on the health of adolescents seeking abortions must also be considered. If A-1155 is passed, a minor in New Jersey who has the means may circumvent the law by obtaining an abortion without parental notification by having the abortion in an adjacent state. Having to seek an abortion out of state is detrimental to good health care, since it would seriously complicate the management of any medical complication that might occur after the procedure. These complications are much more difficult to manage if the patient and the physician are hours apart.

As I have stated in the beginning of my testimony, a pregnant adolescent who feels she cannot turn to her parents for help, whether this is objectively true or not, is in need of psychological help from someone. This bill by forcing that very adolescent to out-of-state clinics, reduces the possibility that through counselling services within the community this help might be provided.

And, finally, aside from the many issues just raised, the bill is technically inadequate since it does not define what is actual notice, nor does the bill state what the physician is to do if this "actual notice" cannot be given. If the intent of the bill is that a physician may not perform an abortion on a pregnant minor without successful parental notification, then the bill is more clearly unconstitutional since the term "actual notification" is merely a form of implied parental consent.

Now I will turn to Assembly Bill 1592. I think the initial points concerning the problem of enacting specific legislation which is different only because the procedure involved is abortion is a general concept which carries over to this bill as well.

However, the bill does attempt to address two areas of real public health concern. These two areas are:

First, the need for adequate informed consent by the patient prior to any medical procedure.

Second, the public health need for a more complete method of reporting of the outcomes of pregnancy.

The Department feels that it would be more appropriate if these two issues were addressed in a context which covers more than elective terminations of pregnancy and in a more flexible manner.

Let me address the issue of informed consent first.

Patient consent for treatment is basic to all medical practice; without it, the treating physician is committing criminal assault. The usual concern, however, is not whether the consent has been given, but whether the patient was sufficiently informed to give a knowledgeable consent. Informed consent as defined in federal regulation and bioethics literature and also by the courts requires a reasonable disclosure of information to the patient concerning the risks and benefits of the procedure and any alternative forms of treatment.

In the State, there are approximately 1.2 million hospital admissions annually and approximately 40 percent of these are primarily for surgical reasons. There is an undetermined number of minor surgical procedures performed in emergency rooms, outpatient clinics and physician's offices throughout the State. In each of these situations, informed consent is a necessary part of the patient/physician relationship. Before government acts in the area of informed consent for abortions or any other procedure, there should be more than "allegations" to document the need for special governmental intervention into this private patient/physician relationship. Even if there were a clear demonstration of abuse of

patient's rights concerning informed consent in a few cases, there are existing judicial and intra-professional means to address those abuses.

A-1592 cannot address the problem even if the problem were demonstrated to exist. No single booklet could address all of the issues needed to be known by the patient to make an informed consent for any operative procedure. A booklet can only address general or typical situations, but the patient needs to make a decision on a very specific case, their own case. The risks, benefits and alternatives available to the patient will vary significantly with a large number of factors.

On the other side, the benefits and alternatives will also vary according to the patient and her particular geographical location in the State. To attempt to provide for all of these factors in one single booklet in the manner described in this bill would be prohibitively expensive if not technically impossible. I will leave my prepared comments just to address some of the points that Assemblyman Herman has made.

I think he said that informed consent should be standardized. The process can be, but the nature of informed consent has to be particular to the given patient and the given procedure. What is an innocuous procedure with one patient because they are in good health can be a life-threatening procedure in another patient because of their health status. I will take an example of any minor surgical procedure that would use some sort of anesthetic. If a person has heart disease, is allegeric to that anesthetic or has other existing medical conditions, the performance of that procedure, in some cases even the performance of a simple examination of a patient, can be a life-threatening situation. And you can't make the Department say, well, these are the risks when the risks vary for everybody who walks into the physician's office.

It is the Department's position that the process of informed consent cannot be reduced to the reading of a booklet regardless of its complexity or length. The consent of a patient given to the physician must be based on the patient's understanding of the treatment situation as her physician has explained it to her. It is this process which forms the basis for the contractual aspect of the patient/physician relationship. This bill could unnecessarily involve the State through the Department of Health in each of these contractual relationships and could involve the State in malpractice litigation because the responsibility for adequately informing the patient would, as a result of this bill, be shared by the treating physician and the State.

The legislator's concern over the adequacy of informed consent could be more appropriately addressed by the Department of Health and the Board of Medical Examiners and the professional societies by the development of guidelines for physicians and all health care facilities as to the essential aspects of informed consent. Through this process, the adequacy of consent for all procedures could be addressed. These guidelines would address all of the necessary areas that should be discussed with the patient so that the patient can make a knowledgeable decision. However, because they are guidelines, they would be flexible in structure and would have general applicability to individual situations. I think an example would be that if you said that the physician had to make known to the patient all the possible complications or the reasonable expected complications, then it clearly puts the burden on the physician that that has to be done. If you say that the physician must discuss the alternatives to treatment, whether they are surgical or nonsurgical, whether, in the case of abortion, the alternative of carrying the

pregnancy to term , etc., these could be specified in the guidelines and, if it would be desired in specific instances, say, addressing, for example abortion, or for example caesarian section, where there was specific concern that in certain types of procedures informed consent may be less than adequate.

Such guidelines were provided by the Department and the Board of Medical Examiners in the proper management of terminally ill patients concerning life-support systems. This occurred as a result of the Karen Quinlan case.

The Department feels that the concern raised by A-1592 could be best addressed by a similar approach. I think also that we are currently working on another set of guidelines in another area concerning genetic services in amniocentesis. I think that this type of area where you have legal cases involved and the responsibility of the physician to perform a very difficult area which croses between medical practice and legal areas is best addressed by this type of approach.

On the issue of expanding the reporting of abortions, the Department currently receives a fetal death certificate on all pregnancies that terminate in other than a live birth once they pass 20 weeks of gestation. This is under Title 26:6-11. In addition, the Department, under regulations for health care facilities, receives summary reports on all abortions performed at 59 hospitals and licensed clinics in the State.

The Department is concerned that it has less than a complete picture of all the different outcomes of pregnancy in New Jersey. The Department's concern is broader than just the elective termination of pregnancy. Because of the growing concern over the impact of various occupational and environmental exposures to both men and women which could affect their reproductive capability, the Department sees a need for a more complete method of reporting of pregnancies that end in other than live births. Such a broader method of reporting would cover both the elective and spontaneous abortions. The changes in the reporting system described in A-1592 would not address this very important public health concern. It is the feeling of the Department that such an expanded reporting system of the terminations of pregnancy could be accomplished under existing statutes and powers.

In conclusion, the Department cannot support either of these two bills as they are now written. It finds A-1155 to be directly adverse to the public's interests. However, on Bill A-1592, though it addresses public health concerns, it has major technical flaws in that it charges the Department with a task that could involve it in the process of multiple malpractice litigations which, in the final analysis, does not completely address all the public health concerns, with regard to either informed consent or the reporting of the outcomes of pregnancies.

As a final point for that bill, the Department, since it would be barred more than likely from use of federal funds because the reporting, etc. pertains directly to abortion, would have to fund the publication of the book, the printing for all the cases throughout the State, and the whole reporting system, out of State funds. And there are no State funds tied to this bill.

ASSEMBLYMAN LESNIAK: I have a few questions, as does Assemblyman Bassano.

Before I ask any questions, I did want to make a couple of comments regarding your statement that legislation cannot change poor parent/child relationships. I have to disagree with that quite substantially. Actions of the administration, the Executive body, the Judiciary, and the Legislature can effect change and can inhibit or encourage relationships amongst people. That sounds to me similar to the argument that was made against the Civil Rights Bill, that legislation cannot change one's attitudes towards people, towards your brothers and your sisters.

So I really disagree with that concept and that opinion.

Nevertheless, I do have some questions regarding a couple of issues that you did raise. As far as health concerns go, you did not address the health concerns regarding complications that may develop, either physical complications in the immediate instance or psychological complications, either immediate, interim or long term, that could arise when the minor is seeking an abortion or has an abortion without the parents' guidance, concern and input. Don't you consider that that is also a health concern? You may have an opinion regarding the weighing of the two issues, but you didn't address that as a health concern.

DR. HALPIN: Let me classify -- and specific to abortion procedures but it is true for all procedures where treatment might be afforded a minor ---

ASSEMBLYMAN LESNIAK: Will you speak louder.

DR. HALPIN: Okay. I think in all cases where a physician acts in the treatment of a minor you have two options or two outcomes. Treatment either occurs and is provided and the outcome is as expected, in which case the physician can say, "Since there have been no complications, I can respect the minor's request for anonymity concerning notification." There is no need to notify the parent. There has been no complication. In the cases - and I know of cases where complications have occurred as results of abortions, either because the pregnancy itself was a tubal pregnancy and not in the uterus and there was a major medical emergency for the treatment of that woman, requiring major surgery, or that the procedure, itself, had either intraoperative or postoperative complications which required, let's say, hospitalization --- in those cases, the physician can say, "I have got to notify your parents." And under existing State law, the physician has that prerogative. I think on the issue of the emotional ---

ASSEMBLYMAN LESNIAK: Excuse me. What about the complications arising after the child leaves the care or the immediate supervision of the physician and may be in her room? And we are talking about children as young as 12 years old possibly?

DR. HALPIN: Possibly, yes.

ASSEMBLYMAN LESNIAK: Thirteen or fourteen?

DR. HALPIN: Yes. In those cases where you have a very young minor --- and I think we need to differentiate between a minor who is 12, 13 or 14 and a minor who is 16, 17, and 18; as the figures I showed you, we are talking about roughly a small number of those under 15 and a very large number of those 15 to 19. A physician - and I can say it from having worked in city hospitals in New York City - with a minor under a certain age would say beforehand they wanted parental notification for specifically those kinds of problems. They did not feel that the minor's ability to decide and to manage the routine, not even the complications, the types of things that could happen in any procedure, was such that the parent should not be involved. But with the more mature minor where you frequently have a 17- or 18-year-old woman who was essentially living autonomously, although she lives with them, but their relationship is such that they act very independently, that involvement was not deemed necessary either by the treating physician or the staff of the facility.

So, I think again the situation varies according to the type of minor you are dealing with and that a uniform approach really does have a tying of the hands effect.

ASSEMBLYMAN LESNIAK: As far the instance of incest, isn't reporting to

the Prosecutor mandatory in that case under the current law as far as there being child abuse?

DR. HALPIN: The reporting is mandatory to DYFS for all cases of child abuse. The question is --- In other words, a pregnant minor presents herself with her mother or without her mother to a physician and it may not even be a pregnancy - it may be a veneral disease. The question would be whether they choose to go into the fact, to identify that it is incest - and they may not be completely sure it is, but they have a suspicion - they should report it, yes. There is no doubt about that at all. They should report it. Whether this bill can be made to have an exception for that kind of a case or not, I don't know.

ASSEMBLYMAN LESNIAK: I wouldn't want to have the exception. I think we certainly want that procedure to take place.

DR. HALPIN: No, I meant the exception that the physician would not have to notify the parent in this case.

ASSEMBLYMAN LESNIAK: I would assume the parent would be notified by a visit from DYFS or the Attorney General's Office or the Police Department.

Just one other philosophical point, I guess, or whatever you want to call it, you say, "The abortion decision in all its aspects is inherently and primarily a medical decision." Isn't it a fact that other medical decisions and all surgical decisions involving minors require not only parental notification but parental consent?

DR. HALPIN: Under current State law, there are three cases: relating to pregnancy for both the minor and her child after it is born, she is entitled to give all consent for any treatment, medical, surgical or whatever; and ---

ASSEMBLYMAN LESNIAK: As far as the child goes, that is an emancipated ---

DR. HALPIN: Then also for drug abuse or suspected drug abuse, a minor can initiate counselling and treatment for that condition without parental consent or notification, and also for venereal disease.

ASSEMBLYMAN LESNIAK: That is treatment. What about surgical procedures? Are there any other exceptions?

DR. HALPIN: Except in the exceptions mentioned, in all emergencies, inability to obtain consent.

ASSEMBLYMAN LESNIAK: With regard to your comments as far as the technical inadequate provisions regarding the notice, this is just a public hearing. We are not voting today to release the bill or not to release the bill. There will be amendments offered that could be considered by the Committee.

ASSEMBLYMAN BASSANO: For clarification purposes, a minor who has a child can give parental consent to medical treatment of that child? Is that what you stated?

DR. HALPIN: Yes, that is correct. That is in current State law.

ASSEMBLYMAN BASSANO: That is in State law?

DR. HALPIN: That is in current State law.

ASSEMBLYMAN BASSANO: Why don't you carry it one step further then with regard to a minor who is 16 or 17?

DR. HALPIN: Concerning?

ASSEMBLYMAN BASSANO: Concerning parental consent also for any type of surgery that may be performed.

DR. HALPIN: Well, what I might want to do and what State law will allow are two different things.

ASSEMBLYMAN BASSANO: What you are telling me though - and maybe I am

misinterpreting you - is that if a youngster 17 years old has a 6-month-old baby, she has the right to give parental consent for any medical procedure on that 6-month-old baby ---

DR. HALPIN: That is correct.

ASSEMBLYMAN BASSANO: --- who is also a minor. But if a parent is 35 and has a 17-year-old child, then there is no need for parental consent. Where do you draw the line?

DR. HALPIN: As it has been handled in some court decisions - and I won't attempt to be a lawyer in this case - the feeling is that the parental responsibility is on a continuum, that when you have a very dependent minor, parental responsibility and authority are much different than when you have a child who is progressing into adulthood; and that as that status changes, it is not a black or white "now you are a teen" situation, but that it has to be treated ---

ASSEMBLYMAN BASSANO: Unfortunately, in the Legislature, we can't deal with grey areas. It is either black or white. What you are telling me now is that there is a grey area. We in the Legislature mandated 18 years as the age of majority. I am disturbed by what you just stated.

DR. HALPIN: In terms of medical care, there are exceptions under State law that enable a minor to initiate and receive treatment in non-emergent situations without parental consent or notification. An example might be that some of the problems might be lessened if the minor had the right to access to family planning services without parental consent, but they can't. However, once they become pregnant, then they can act independently. That problem has always bothered me to some extent. But there is a need that when certain conditions do exist, especially where there may be a difference of opinions as to what should be done, that a mature minor be able to exercise what is in his best interest. I think the Supreme Court has defined this in several cases recently.

ASSEMBLYMAN BASSANO: You are giving me the word "mature" minor, which leaves a wide scope.

DR. HALPIN: I know.

ASSEMBLYMAN BASSANO: I will leave that for now. I don't think we are going to be able to come to any type of agreement on that particular subject.

I have one statement that I did want to make and that is in regard to Assemblyman Herman's bill. In your presentation, in my personal opinion, you carried what Assemblyman Herman wants to do much further than I think the Assemblyman really had in mind, what his intent is. I think in the booklet that he is talking about, he wanted to basically address general and typical situations that these people should be made aware of, not carry it to the point where a person may have a heart condition or may have other problems. I think that is what the Assemblyman had in mind.

ASSEMBLYMAN LESNIAK: Thank you, Lou.

I have a few areas I want to go into regarding Assemblyman Herman's bill. Did you say the Department is developing guidelines now for physicians regarding informed consent for abortions?

DR. HALPIN: No, I did not. I said that in the area of genetic services guidelines have been developed and they are now in the process of being circulated and exchanged between appropriate parties - the Board of Medical Examiners, etc.

ASSEMBLYMAN LESNIAK: Do you believe that there is a need for guidelines to include both medical concerns and non-medical alternatives to abortion?

DR. HALPIN: I think, personally, there is a need, first, outside of the area of abortion. I think that from the insurance company saying, yes, we will pay to have a second opinion, they feel that some practitioners may not be adequately informing the patient of all options. They are saying, "Go to another doctor and he may tell you other options." I think in specific areas, such as with cesarean sections, that all the options and all the possibilities might not be explained in, again, what is a fairly short timeframe situation in which a decision has to be made very shortly. I think there are problems or may be problems well outside the area of abortion. When you get into the area of abortion, I think some of those same problems may be in there, in that the medical community is not either fully informed of their responsibilities in terms of informed consent or they are not going at it as thoroughly as the courts and federal regulations have currently defined it. So I think there may be problems with the abortion procedure as such, but I think that is a more general type of a thing than a specific.

ASSEMBLYMAN LESNIAK: Is it your opinion or do you have an opinion that the type of informed consent that is given in an abortion clinic would be the same type of informed consent that exists in the physician-patient relationship for other surgical procedures?

DR. HALPIN: I think the question you ask concerning--I may have gotten the fine point of it, but maybe you had better repeat it.

ASSEMBLYMAN LESNIAK: Again, do you have an opinion, and what is it if you do, regarding whether the informed consent that is given in abortion clinics is the same type of informed consent for other types of surgical procedures.

DR. HALPIN: I think my experience is somewhat limited. So, I can't say that I know what the informed consent procedures are in all clinics. I think, from the experiences that I have had and because of the heated issues concerning abortion, abortion facilities have been much more careful to comply with every aspect of the law than, maybe, hospitals in general for non-controversial procedures and in physicians' offices; I don't even know if many physicians, before they do a procedure such as sew up a small wound or do certain types of examinations, which require medical equipment, actually get formal consent. Yet, this is what we're talking about. So, I think those facilities such as abortion facilities, which have been in the limelight of controversy, have been very careful, from my experience and from the consent procedures that I have reviewed, to comply with every aspect of federal regulation.

ASSEMBLYMAN LESNIAK: Of federal regulation?

DR. HALPIN: Yes, which is very voluminous.

ASSEMBLYMAN LESNIAK: But, that certainly would not include non-medical alternatives.

DR. HALPIN: That's correct. The thoroughness with which that is discussed will vary markedly and it is hard to standardize that.

ASSEMBLYMAN LESNIAK: Another matter, because I know the Department is always concerned with their budget, as we are as legislators, but we are requesting today, John, a fiscal note on Assemblyman Herman's bill; and before we vote on that in the Assembly, I am sure we will have that available. Also, since I am interested in the area of malpractice, on occasion, I am sure that we could--and that would be a concern of the state and my concern too--we could put into the bill an immunity provision for the state.

ASSEMBLYMAN HERMAN: I don't want to take the Doctor's thunder away,

but I would note,just in response to malpractice, my concern that, one, a general disclaimer to say that this is general information and the doctor is obligated to discuss the specifics of the case would certainly suffice and I would also point out to Dr. Halpin, as the sponsor of the generic drug law, that we have overcome that question by the publication of the interchange list, which is a matter of public information and there is no malpractice concern. The department doesn't have a problem, other than raising the issue, which we can easily resolve.

ASSEMBLYMAN LESNIAK: One other question. Are all the hospitals complying with the reporting requirements? I've had some information that they may not be.

DR. HALPIN: I have spoken with Mr. Watson who handles that aspect of the reporting. It is difficult in any reporting situation to say, "You are not reporting," because, how do you know they are not reporting unless you have another source of information to say, "You have done this and haven't reported to us." There are some cases in hospitals that can be checked because there are two aspects of reporting. Every hospital admission and discharge has to be reported to the state if the hospital wants to be paid for it. Based on that, they can cross-check their specific reporting on abortions and and they can check by type of diagnosis and procedures. So, from hospitals, I have been assured that their field of reporting is fairly good because, if there is a mistake, it is not systematic, it is clerical. From clinics, there is no independent way to verify that reporting and so, if they chose one month not to report as many as they did the previous month, you can check it for consistency, saying, "Last month, you did this number of procedures and this month you have only reported half of that. What happened?" But, outside of that, it is difficult.

ASSEMBLYMAN LESNIAK: So, the figures that you gave, quoting your testimony, and you did give the caveat that the private physician does not have to report, those are minimum figures?

DR. HALPIN: Those are rock-bottom minimum.

ASSEMBLYMAN LESNIAK: Thank you. Before we proceed, John, I'm going to ask you to go in the back and see if we can have that microphone turned up, the volume, please. We will take a five-minute recess.

(At which time a recess was taken)

ASSEMBLYMAN LESNIAK: The next witness will be Irene Lander, Christian Action Council.

I R E N E L A N D E R: Thank you for letting me speak now. It is my style first to give a brief statement of principle and then to follow with specifics regarding Bill 1155.

I am a member of the Christian Action Council, the largest Protestant pro-life group. Although I represent the majority opinion of of evangelical protestants, I also speak as a parent in regards to parental notification of the parents of minors regarding an abortion. My pre-suppositions are based on Scripture and,thus, I believe man is made in God's image and that the Commandment, "Do not murder," is based on this important truth. I believe that laws should be based on natural or absolute laws. The unborn child is indeed a child made in God's image. Thus, I uphold that it is morally wrong to take the life of a child for any reason, except the threat of death to the mother. Thus, I support any bill in New Jersey that seeks to regulate abortion practices. Also, I believe, in the long run, that evidence will support the biblical pre-supposition that the taking of innocent life only brings misery and the judgement of God.

It is well known that a parent's consent must be given for other types of operations. It seems that pro-abortion people believe that the Supreme Court phrase, "a woman's right to privacy," supercedes this right. I attack this on two grounds. The term, "right to privacy," does not mean a person can rightfully cut off their arm or destroy their body, much less take someone else's life, such as the unborn child's. The term, "right to privacy," should not mean that one person's right to privacy can be used to choose to terminate the life of another human being made in God's image. Hopefully, to inaugurate a parental consent bill would place a check and balance upon the child's decision to abort a child or bring it to term.

Now, apart from this absolute type reasoning or deductive reasoning that human life is made in God's image and should be protected, apart from the lives of animals and beasts, there are many practical reasons why parents should be made aware of a child's decision to have an abortion. Number one, the parents love and know the child better than anyone else. They are the child's significant others in this crisis and they are in a position to best advise their child. Two, many times, an unwanted pregnancy is only a manifestation of a multitude of other problems, many of which involve the whole family of the minor. The baby is a side issue and an abortion would not solve the minor's real problems and would probably only complicate them, such as a guilty conscience, which can destroy a person's well-being, as well as a person's reproductive future. I spoke to a professional social worker of United Family Services in Plainfield, who said that when she is counselling a young pregnant girl, they try to involve the whole family, since the problems involve the family and usually originate there, even families where there are inter-personal relational problems. She also said that just because a young girl says she wants an abortion, that is not necessarily the case. So, in these types of cases, where there are problem families and the professional counsellor involves the whole family in order to decipher what the child's problems are, it should follow that a healthy family should more so get involved in their daughters dilemma.

I believe that laws should not be based on exceptional cases, such as parental abuse or incest, but on the more normal cases. I know that I would find it horrifying if a doctor irresponsibly administered an abortion on my young daughter, a doctor that does not know her or care for her the way I do, a doctor who usurps the rights of my daughter's significant others and denies her her most important support system.

The so-called right to privacy would cause unbelievable pain and grief in my life, as well as the loss of my grandchild's life. Thus, I feel it is imperative that the State of New Jersey, in the interest of its young citizens, unborn to be citizens and adult citizens, enact the bill herein discussed. Thank you.

ASSEMBLYMAN LESNIAK: Thank you, Irene. At this time, I would like to read a letter from John K. Meeker, Jr., Freeholder of the Board of Chosen Freeholders for Union County. "Dear Assemblyman Lesniak: Please be advised that I wholeheartedly support Assembly bill 1155 requiring parental notification prior to the performance of an abortion on a pregnant minor." It is dated October 1, 1980 and I would like that entered into the record.

Our next witness will be Ann Baker from the National Organization for Women.

A N N B A K E R: My name is Ann Baker and I represent the National Organization for Women in New Jersey. I appreciate the opportunity to present our position on Assembly bills 1155 and 1592, under consideration by this Sub-committee.

To begin with, on Assembly bill 1155, when this legislation was Section 11 of Assembly bill 1285 in the 198 Session of the State Legislature, it was explicitly mentioned in the Governor's veto of that defective legislation. You may recall that the unconditional veto of the Governor was based solely on constitutional considerations.

There have been a number of lower court rulings which impinge on this proposed legislation, as well as an 8-1 U.S. Supreme Court decision on July 2, 1979.

The district court of Northern Ohio, in Akron Center for Reproductive Health vs. City of Akron, on April 27 of 1979, struck down identical language in the matter of parental notification, citing the ruling in Bellotti vs Baird II.

The Seventh Circuit Court of Appeals, ruling on an Illinois statute, observed: "That it might not be in the minor's best interest to have her parents informed of her condition in all cases is recognized by the Illinois General Assembly. A number of statutes enable minors to receive birth control devices and treatment for venereal disease and drug use with out parental notice. A pregnant minor who chooses to give birth may consent to medical or surgical treatment without the necessity of parental involvement." That is the ruling in Wynn vs Carey.

On July 2, 1979, the highest court held that mature minors have a right to make their own decisions about abortion and that no one--a parent, judge or anyone else--can override that decision. We're not advocating here a situation where all minors are deprived of the right to speak with their parents on this situation. We're simply saying that in those cases where minors fear speaking with their parents or feel that this will be adverse to their decision, then we support their right and so does the Constitution. Both mature and immature minors must, as a matter of constitutional law, have the opportunity, through an alternative judicial or administrative procedure, to obtain an abortion without parental consent or notice. This was in the Supreme Court ruling of last July 2. With respect to immature minors, the sole criterion as to whether they may have an abortion is what is in their own best interest.

I want to point out that the New Jersey State Legislature recognizes that parental involvement is not always in the best interest of the minor and that the New Jersey amended statutes, Title 97, reflects this. Given the dangers inherent in child birth for teenagers and the much lower risk usually connected with with abortion, it would be irrational to argue that there is a compelling State interest in the

protection of minors which requires notice for all abortions, but not for other treatments in which a person's privacy is necessarily protected.

While we appreciate the desire to protect a minor from a rash decision, this bill fails to consider the very real constraints under which many minors may be making that decision. It is not inconceivable that some parents would force a minor daughter to carry a pregnancy to term, regardless of her own best interests.

Furthermore, it is essential that a pregnant minor obtain medical care as early in her pregnancy as possible, and she won't if she is frightened. This basic health requirement begins with a pregnancy test and continues through her pregnancy in the form of adequate pre-natal care, if she decides to continue her pregnancy. If the state creates a climate of fear for teenagers through this kind of legislation, those young women who decide to carry to term will be slow to seek medical care. If, on the other hand, a young woman would decide to terminate her pregnancy, it is far better that she seek an early abortion, without the constraints of this kind of legislation, rather than waiting until she is well into the second trimester.

On Assemblyman Herman's bill, while this legislation is not as odious as that proposed by those who oppose abortion, it is also not as reasonable as its sponsor believes. There are narrow legal considerations at issue in this bill which I want to point to.

Section 1 maintains that"the state has a vital interest in promoting and protecting maternal health through the correct and adequate provision of abortion services...." The 1973 court ruling in Roe vs Wade held that the state's compelling interest in maternal health, in terms of enacting legislation above and beyond the regulations imposed by, in this case, the state Board of Medical Examiners and the Department of Health, the state's compelling interest in maternal health only commenced subsequent to the first trimester. Prior to that point in the pregnancy, and even seven years ago when pregnancy terminations were not as sophisticated and as simple as they presently are, first trimester abortion was considered to be minor surgery with an insignificant risk level attached. Such a low-risk procedure does not warrant state involvement through special regulations directed only at one procedure, let alone legislative enactment of the statutes.

This legislation may also be constitutionally defective because it requires the state to provide "a booklet which outlines all medical facts pertinent to the abortion procedure, including any health risks which may be associated with abortion...."

Flexible informed consent statutes leaving specific details to the doctor's best judgement have always been upheld. That was true in the case of Hodgson vs Lawson in the Eighth Circuit Court of Appeals. However, another Eighth Circuit ruling, Freiman vs Ashcroft, in 1978, the Court observed, "But, the Supreme Court did not hold that a state may require physicians to provide to each patient any and all information required by the state, regardless of its medical advisability."

In Akron Center for Reproductive Health, Inc. vs Akron, Judge Leroy Contie of the Northern District of Ohio--and this was a ruling last year--noted, "The state, however, cannot go beyond that requirement of informed consent to specify what each patient must be told. That determination must be left to the individual counselor based on the needs of the particular patient.... This is not impermissible because of any perceived interference of the rights of the physician. Rather, it is impermissible because it interferes with a woman's right to consult with a physician who is free from state interference."

The degree of risk involved also determines the physician's legal obligation to inform a patient of a possible outcome of surgery or medical treatment. In Sawyer vs Methodist Hospital, the Sixth Circuit ruled that there was no need on the doctor's part to inform of a risk with an incidence rate of .013%. In Niblack vs United States, the Federal District Court in Colorado ruled that there was no need to reveal "insignificant" risks.

Inasmuch as abortion is usually minor surgery with a corresponding low-risk level of complications, it seems intrusive for the State of New Jersey to specify the information which must be conveyed to women who are seeking abortions. Although Section 1 asserts that "allegations are frequently made that a woman may make the abortion decision in a vacuum, without full knowledge of not only what the medical procedure may entail..." there has never been any documentation, documented evidence that this is so or that abuses are occuring regularly and generally in New Jersey. It hardly seems reasonable for the Legislature to base its enactments on unproven allegations.

ASSEMBLYMAN LESNIAK: Thank you, Ann. I guess we could argue over the constitutionality all day because we're talking about dictum and that decision will be made for us, one way or another, in the upcoming session of the United States Supreme Court. I do want to correct the record. I don't think you were refering to Title 97. Although the Governor says that we enact too many bills, we haven't gotten quite that high yet.

MS. BAKER: That's right.

ASSEMBLYMAN LESNIAK: I think that's Title 9.

MS. BAKER: Title 9, right.

ASSEMBLYMAN LESNIAK: Thank you. The next witness is Reverend Earl Jabay, Chaplain for the Neuro-Psychiatric Institute.

R E V E R E N D E A R L J A B A Y: Assemblyman Lesniak and friends, I hope I can be heard and I do want to be heard in a brief statement favoring Assembly bill 1155 with regard to parental notification. That parental notification, of course, is with the obvious intention of giving some time for parental counsel. It is not consent. We understand that. But, there is need for some time to be given in that very critical situation--perhaps one of the most critical in the life of the young woman involved--for parents to give advice or to give counsel to stand with a person.

I have four reasons for favoring the Assembly bill 1155 and I would like to read them and make just the very briefest comments.

First of all, the pregnant, unemancipated minor under the age of 18 years is almost invariably unaware of the ethical implications of what she is doing. She can hardly be expected to have studied the issue pro and con. By consulting with her parents, after notification has been given to them, she will have time to consider the ethical advice of her parents and, through them, the position of her religious authorities. I would argue that this is not ethically coercive, this first point that I'm making. Ultimately, no one can be coerced, but it is for the welfare, basically, of the pregnant mother.

In the second place, the pregnant, unemancipated minor under the age of 18 years is unaware of and unprepared for the emotional backlash of an abortion. The emotional reaction of an abortion comes in the form of (1) guilt for having destroyed an unborn baby who was completely dependent on the mother; (2) there is fear that the consequences of terminating the baby's life and may I just parenthetically say here

that so many of these young women with whom I have been in contact through counselling have voiced these fears that they have had and they may be irrational, but they are very much there and they take the form of fear of cancer, fear of accident, and the belief that God will send them to hell for what they have done. Also, they have terrible fears of not being able to bear children in the future. It seems to me that because of the size of that kind of backlash it is only human that we appraise--the parents I'm speaking of now, that the parents appraise a daughter of the consequences of contemplated action. In the third place, an emotional reaction to an abortion comes in the form of anger toward the people serving her with counsel unto an abortion. So often I have heard the reaction, "Why didn't they tell me," and it seems to me that the parents are in the position, better than anyone else, to offer the right kind of counsel. In the fourth place, one of the emotional backlashes of an abortion is envy toward her peers who are mothers of small children. Mothers who have aborted their babies have told me of the unbearable agony they have when they see other mothers with their children. They begin to talk to themselves and say, "If I had had my baby, he would have been the same age of that child over there and that is a very deep and serious problem of envy, which inevitably follows the course of action if one is self-counseled in this matter of an abortion.

In the third place, the pregnant, unemancipated minor under the age of 18 years needs the advice, moral support and guidance of the parents. The medical doctor can scarcely be asked to serve her with such counsel. Her peers are even poorer counsel. Who else, other than the parents, who are still responsible for her, is there?

Then, lastly, my last point is that there is a sharp difference of opinion in the medical profession regarding the thics of abortion. Since there is no medical unanimity, parental guidance is surely the most appropriate source of counsel.

ASSEMBLYMAN LESNIAK: Reverend, I have a few questions, if I may. You are with the Neuro-psychiatric Institute?

REVEREND JABAY: Correct.

ASSEMBLYMAN LESNIAK: Can you explain what that is and what it's all about?

REVEREND JABAY: For most of my 21 years there, this has been a mental hospital. Now, it is a retardation center, treating the retarded who have emotional problems.

ASSEMBLYMAN LESNIAK: And how long have you been there?

REVEREND JABAY: 21 years.

ASSEMBLYMAN LESNIAK: And in what capacity have you been connected with this facility?

REVEREND JABAY: As chaplain, protestant chaplain.

ASSEMBLYMAN LESNIAK: And you said that you have done counseling?

REVEREND JABAY: Yes.

ASSEMBLYMAN LESNIAK: Specifically, you have obviously done counseling with minors, pregnant mothers.

REVEREND JABAY: Yes.

ASSEMBLYMAN LESNIAK: Can you give us an idea of how long and how many you see on a yearly basis?

REVEREND JABAY: On a yearly basis, a dozen or so people, a little more possibly, may be 15.

ASSEMBLYMAN LESNIAK: And over what period of time?

REVEREND JABAY: That was about six years.

ASSEMBLYMAN LESNIAK: Often the question is raised regarding the fear of the minor towards the parent's reaction. How do you handle that or have you seen that, the parent's reaction to finding out that their child is pregnant?

REVEREND JABAY: That sometimes does come up and as a counselor, as a pastoral counselor, I encourage the person, stand with the person in facing the reality of the situation, hoping very much that the parents will be taken into the particular problem that this young person is going through. This is a minor person and it seems, to me, very important that the relationship with the parents be well-established and taken into account.

ASSEMBLYMAN LESNIAK: Have you had any experience with parents physically abusing their child after they have found out that she was pregnant?

REVEREND JABAY: No, I have not. I suppose that that is possible, I haven't run into that situation.

ASSEMBLYMAN LESNIAK: Is it your opinion that it is preferable for someone to face up to a problem rather than hide from it and run away from it?

REVEREND JABAY: Oh, definately. That is only merciful and healthful for any person, young or old, to face it rather than run away from it.

ASSEMBLYMAN LESNIAK: Assemblyman Bassano?

ASSEMBLYMAN BASSANO: You are speaking about the emotional reaction of a person who has an abortion. I assume that you have dealt with people in this capacity.

REVEREND JABAY: Yes. I am dealing with one right now.

ASSEMBLYMAN BASSANO: I'm going to ask you a question right now with regard to the emotional reaction of a woman who has a child that she doesn't want. Have you dealt with that problem?

REVEREND JABAY: Yes. Occasionally, that does come up. That is somewhat rare in my experience, which is somewhat limited. But, that kind of situation can still be dealt with. The problem with the woman who has had an abortion is that there is no way of getting at the problem. It is historical. You can't deal with history. You can deal with present problems and that would be the approach to somehow dealing with the feelings and also the circumstances of the present problem that she has and to find a solution.

ASSEMBLYMAN BASSANO: What you are telling me, then, is that there are other avenues that are available to alleviate the problem, if she has the child, adoption, things of that nature, versus the pregnancy being terminated?

REVEREND JABAY: Oh, yes. I am very optimistic and I would communicate that optimism to her, that there is a solution to this problem, either that she keep the child and deal with that situation, or there is adoption or many other avenues open for the solution of that.

ASSEMBLYMAN BASSANO: Thank you.

ASSEMBLYMAN LESNIAK: Thank you, Reverend.

REVEREND JABAY: You are very welcome.

ASSEMBLYMAN LESNIAK: Our next witness will be Ann Levine of Planned Parenthood.

A N N L E V I N E: My name is Ann Levine. I am here today representing the nine Planned Parenthood affiliates in New Jersey. We are opposed to A-1155, requiring parental notification; and supporting, with some considerable reservations, A-1592, the "booklet and reporting" bill, which we are refering to that as.

Another representative of our affiliates, Giles Scofield, will be presenting legal testimony regarding A-1155, the parental notification bill, later in the day. I would like to stress our deep concern for the health and well-being of young women in this state, not just for legal reasons.

The experience of our counselors in dealing with minors seeking counseling and medical care for an unwanted pregnancy is full of cases of difficulty and delay before these young women seek help, attempts at self-induced termination, and delays that wind up meaning the minor, with or without the help of her family, must travel great distances, in oo out of the state, for a riskier and more expensive late abortion. I am attaching to this testimony that of one of our counselors, ann Larney, who testified on this point before the Legislature during the last session, which cites some specific examples of the harm that such blanket notification requirements can cause. These were cases where women thought that their parents would be informed, although it would not necessarily have been true and, in one case, there was a girl straddling a fence trying produce an abortion or using a coat hanger. There are other things like that just out of fear.

Teens typically present later in the gestation period for abortion procedures. These statistics are well established nationally and a recent study being completed by professionals in our Health Department shows that this is the case in New Jersey as well. It is also well documented that the later in pregnancy medical care begins, the higher the risk to the pregnant woman, whether she terminates or continues the pregnancy, and the higher the risk to the fetus or child if the pregnancy is continued.

Planned Parenthood prefers to involve the parents, with the minor's permission, or at least a responsible family member, particularly if the minor's ability to understand her situation is in question. But, if teens fear, the minute they come for medical help, that their parents will be informed, they are going to postpone getting the kind of supportive help that often results in getting them over those unwarranted fears of involving their parents.

We think the standars adopted for this situation by the American Bar Associaton, which Assemblyman Herman refered to--which called for parental notification by the physician when a minor seeks medical services for chemical dependancy, venereal disease, contraception and pregnancy, only with the minors permission, unless notification is medically required to avoid seriously jeopardizing the health of the minor--is a sound recommendation in this area and I have copies of those standards, which discuss the whole situation at some length, attached to testimony.

We are also submitting for your consideration the Report of the Governor's Commission to Review the New York Abortion Law as It Affects the Rights of Parents Whose Minor Daughters Seek Abortions, issued in June, 1977, and which contains some recommendations for more humane and constitutional legislation in this area than the blanket notification requirement of A-1155.

On A-1592, the "Booklet and Reporting Bill", we believe such a booklet could be of real help to women, physicians, counselors and health professionals, provided that the material provided by the Department of Health is balanced, scientifically sound and kept up to date. There is much research going on in these fields right now and and new articles are published monthly about risks, benefits, complications, alternatives and so forth. The listing of the sources of assistance, should the woman decide to carry to term, may be unwieldy, unless different listings are prepared for regions or each county in the State. We suspect that an effective date of 90 days

after enactment may not be sufficient time to prepare the material, including considerable professional consultation, print it and get it out to all the physicians who would be required, by law, to present it to patients, and we would recommend a somewhat longer period. It is not clear to us from court decision on this issue whether physicians can be required to provide patents with state supplied information.

Planned Parenthood supports the reporting requirement for all abortions in this state. The Alan Guttmacher Institute, a special research and policy development affiliate of Planned Parenthood Federation of America, does an abortion provider survey annually in which hospitals, clinics and private physicians report each quarter on the number of abortions performed in their facilities. In 1977, 44,810 abortions were reported by New Jersey providers to the AGI, whereas the Department of Health in New Jersey received reports of 30,702 from licensed clinics and hospitals, a gap of almost 1500. Those are the only facilities required to report to the Department. AGI, based on actual reports and estimates of state-of-origin of women obtaining abortions in other states, estimates that another 16,910 New Jersey women got abortions in other states in 1977. That makes a total of 60,00 abortions to New Jersey women that year.

While we think that the AGI data provides fairly accurate information on the total number of abortions at the state, county or HSA level, it does not provide information about the residence of the patient, length of gestation, type of procedure, age, complications--any of the data that would be immensely useful in health planning--targeting areas where better education, family planning services, or new clinics may be needed. Such data would also document the extent of the teenage pregnancy problem in areas where a low teen birth rate may mask a real problem. However, the present reporting system does not provide that kind of data on half the abortions performed on women in this state, as we have shown, and thus any scientific conclusions based on that data are going to be suspect.

We support a good reporting system that would not prove unduly burdensome physicians, costly to the state, and, most importantly, would not be violative of women's privacy.

We have some concerns about the reporting process and its cost, as presently outlined in the bill, and we understood, when we prepared this testimony, that the Department of Health would be making, offering some amendments or some alternatives to some of the provisions of the bill. Now that we have heard them, I think I can say, without going back and consulting my organization formally, that we would support the alternatives outlined by the Health Department as being much more comprehensive, rational and less costly to the state.

ASSEMBLYMAN LESNIAK: Ann, thank you. First of all, with your permission, I would like your entire package to be entered into the record.

MS. LEVINE: I had intended it to be.

ASSEMBLYMAN LESNIAK: I want to thank you for supplying the final report of the Governor's Commission because I think it has some very good suggestions in there. As far as your testimony goes, I do want to make one thing clear. It wasn't my intent that the parents be notified when the teenager seeks any type of counseling as far as abortion goes, but the intent is that they be notified prior to the performance of an abortion.

MS. LEVINE: Well, just the fact that there is a parental notification requirement in the law is what the teen is going to know. Teens are not very knowledgeable about the letter of the law so that they think the minute they get into the adult medical community, their parents are going to find out and that's going to be a real

problem. Right now, we have problems with teens who think that we have to notify their parents, even though that is not law now.

ASSEMBLYMAN LESNIAK: Thank you. I would like to, at this time, call Giles Scofield from Planned Parenthood and maybe we could dispose of your testimony, hopefully, quickly, because if you are going to make the legal arguments, I think we can enter that into the record because I think we both agree that your legal arguments are based on dicta, just as my legal opinion is, and the matter will be disposed of by the Supreme Court and not by us.

G I L E S S C O F I E L D: Well, I think there is some dicta, but I also think there is some case law in support of our position.

ASSEMBLYMAN LESNIAK: Well, if it is below the Supreme Court, it is not despositive of the issue, especially when the Supreme Court has certified a notification statute. So, I would prefer--you can have a minute--but I would prefer to just have your testimony entered into the record.

MR. SCOFIELD: If I can, then, just take a minute, I know there were a couple of questions raised about whether the minor can actually consent for medical treatment without notification or consent of the parents for other forms of treatment. Although I don't have that information readily at hand, I can think of three cases where other state courts and the Circuit Court of the District of Columbia have said that mature minors can consent to treatment without notification or consent of the parents. One case is Smith vs Selby out of Washington; another is Young vs St. Francis out of Kansas.

ASSEMBLYMAN LESNIAK: I don't think the issue is whether the minor can consent.

MR. SCOFIELD: Well, the issue is whether parental involvement can be infused by the state into the abortion decision and I think that the growing trend in this area is that the minor can consent without parental involvement of any sort in this one specific area.

ASSEMBLYMAN LESNIAK: Thank you very much. Betty Yerkes, Regional Consultant, Birthright.

B E T T Y Y E R K E S: I would like to thank you for the opportunity of being here today and presenting this information to you. Our centers offer girls viable alternatives to abortion with our services consisting of free pregnancy testing, medical and legal aid, shelter, clothing and furniture, transportation, psychological counselling, continued education and, in general, any help necessary for planning for a healthy, constructive future. The yearly office caseload per center, for the 21 Birthright centers in New Jersey, averages approximately 300 clients per year.

An average of 25%--and this percentage is only the clients who choose to tell us--have had an abortion and are now coming to us with a subsequent pregnancy. An average of 97% of these have had very bad experiences with their abortion and come to us for help with now a second pregnancy they choose to carry to term.

Perhaps, if their families would have notified the first time, there would not have been a second pregnancy. Only structural family communication would solve the problem that prompted the initial pregnancy.

Moreover, most of these clients are very upset--and this would probably address the other bill, 1592--because they were not told how developed their unborn child was when aborted. They would have appreciated factual fetology before making

that decision. Last year alone, three of the TV networks carried the growth of an unborn child. What a horrible realization to these girls who were told they carrying "tissue" within them. They also voiced an objection to being told that there would be nopsychological effects and that the procedure is "simple".

This brings us to medical safety. Abortion clinics do not provide complete health care. The patient is told that if she has any complications, she should see her family physician. Thus, for even medical safety, the parents should be notified in case of any complications occuring at home.

We feel that a family unit cannot grow without honesty and communication from its members. We have found in working with a family as a whole that a problem situation can actually strengthen the family unit, whereas abortion without notification creates a further barrier. Honesty helps ascertain the particular pressure or lack of responsibility that prompted the pregnancy situation and works toward preventing a second pregnancy problem.

Granted, there will always be families who are not strong enough to begin with and cannot rationally accept any adverse situation. However, by not notifying the parents, we are sacrificing those families who do have a chance for growth, thus creating an even larger number of poor family units. We have an obligation to give these good family units a chance to grow together, rather than be pulled apart for the sake of the others.

We find that in dealing with families in the majority of cases, the parents' initial, distressed reaction diminishes once they realize that there is an agency that can lend a helping hand in resolving this problem. People aren't aware of all the positive services available to them until they are actually confronted with a particular crisis situation.

I would like to submit an account by Thomas and Catherine Yassu that was delivered to a Senate Committee in Oregon on May 8, 1979 in support of a bill requiring that parents be informed before a minor daughter obtains an abortion. That is attached to the original that I submitted. I did not have enough copies to submit to everyone.

I will submit the 8 page pamphlet, but I will quote two excerpts to show you its relevance. Pages 3 and 8, page three, the mother, "We argued"--now this is with the abortion counselor--"that she"--their daughter--"had made her decision without being properly informed, insofar as she had not had the opportunity to discuss this matter with us, her parents, and therefore all of her alternatives had not been given proper or complete examination." Now, in this particular case, the girl had been whisked off to the abortion clinic by the parents of the boy. So, she had not had a chance to even go home and consult with her parents. So, when the parents had arrived at the abortion clinic, the abortion clinic would not acknowledge their daughter as being there and when pressured into just doing that, they would not allow the parents to see her.

In asking her daughter later--since the abortion clinic had refused to let them see her prior to the procedure--"Samantha, if we had been given a chance to talk and I could have told you that I love you, would care for you and your baby, would you have chosen to have had the abortion?" She said, "Mother, I waited for you to come. The answer is absolutely, no."

Regardless of what the clients decision is, they have a right to make an informed decision, which is a right they are presently denied because of a lack of fetology information being desseminated to them and also a right to be appraised

of the infertility problems that exist in many instances with future pregnancies after an abortion. In addition, they also have a right to family comfort and strength and unity which can only be secured by open, honest communication.

Are we going to continue to deny them that too for, once again, the sake of a few?

Now, I also have testimony that is from the Executive Director of Birthright, USA. She is not here to give it. Do you want it?

ASSEMBLYMAN LESNIAK: Can you just submit it for the record please? I just have a few questions. Can you give us some background on Birthright? First of all, where are you located?

MS. YERKES: We have 21 centers here in New Jersey. Most of the counties are covered by our Birthright centers. We are a volunteer organization. We do have professional people who volunteer their services. We have doctors on staff, psychologists, lawyers who will give legal aid and, sometimes, have gone the extra mile and gone in there and taken the girl through court cases. We have private shelter homes, women and men who have extra room in their home and their heart that will take a distressed girl in for the duration of her pregnancy and afterwards and, while she is there, help her plan for a healthy, constructive future and, at that time, if it is the case o a minor, we are usually able to get them continued education. So, if they are in high school, they can have a program so they are not missing out on anything.

ASSEMBLYMAN LESNIAK: Where are you located in Union County?

MS. YERKES: You had to ask for that office. We no longer have an office in Union County, I'm sorry to say. We did have an office in North Plainfield, at one time.

ASSEMBLYMAN LESNIAK: North Plainfield isn't in Union County.

MS. YERKES: I'm sorry. I assumed it was.

ASSEMBLYMAN LESNIAK: Is there an office in Westfield?

SPEAKER FROM AUDIENCE: That was just recently closed.

ASSEMBLYMAN LESNIAK: Do you receive any type of public funding at all?

MS. YERKES: None at all. The contributions come mostly from bake sales, that type of thing or from private donations. We do a lot of speaking. We go to different societies when they have their meetings and so forth.

ASSEMBLYMAN LESNIAK: Do you know if there would be funding available?

MS. YERKES: We do have people checking on that through Washington to find out if we can get some type of federal funding. We are working on that, but, as you know, money is hard to come by. We've been in existence, the Birthright organization itself, it is an international organization, and it was founded in 1969 up in Toronto, Canada. There are over 400 centers in the United States. The most are in New Jersey because, I guess, we are one of the most populated states. There are centers in Hawaii, New Zealand, England, France and even in South Africa. So, it is an international organization. They do meet once a year, as a group, to share different constructive problem areas.

ASSEMBLYMAN LESNIAK: Thank you. Fran Avallone from New Jersey Right to Choose?

F R A N A V A L L O N E: Good morning. The first thing I want to talk about, I am the mother of an 18 year old daughter who was a college freshman when she was 17,

when she was an unemancipated minor and I am very concerned about parental involvement in children's lives, daughters or sons. But, I do not think you can legislate that, even though you disagree with me. You made the mistake before of saying that you had written down consent instead of notification. I think that's the big problem; that minors will look at this bill as a consent bill. You can say notification from now until doomsday and they will still look at it as consent. There was a case in Pennsylvania of a young woman who had gone to what was proported to be a pregnancy counselling agency listed in the phonebook. It turned out to be an anti-abortion group. She went there for counselling. She wanted an abortion. The woman told her, no, she couldn't have an abortion; abortion was wrong. The girl left. While she was on her way home, the woman at this anti-abortion group called her father and when the girl got to her front door, her father beat her really horribly. She had to be hospitalized for a while. That was two years ago. She has not been back to her family since then. That was before she had an abortion. That was just because her father was told that she wanted to have an abortion.

Yes. That is unusual. Yes, it doesn't happen every day, but it does happen and we are concerned with those girls that that can happen to. We don't want that to happen to anyone. We know that if there is a good family relationship, if the parents have brought the children up with their religious and ethical and moral beliefs, whatever they may be, if they can talk to their parents, they will talk to their parents and we had testimony in the hearings last year and on and on about the fact that teenagers do talk to their parents for a lot of reasons, mainly the cost of the abortion, which causes them to bring their parents into the decision.

There was a case in a clinic recently in New Jersey of a 12 year old who was brought in by her grandmother and the police called up this clinic and said, "The mother just called us and wants to stop the abortion." But, the grandmother was there with the girl. Obviously, that 12 year old knew she could go to her grandmother for advice and help, but she could not go to her mother.

We are also concerned about parents who would prevent a girl from carrying through a pregnancy and force her to abort if she doesn't want to. My group is called Right to Choose because we believe that every woman faced with a pregnancy must make her own choice. No one can make it for her. She should get the advice of her parents if she is a minor, but you cannot force her to and if you have a law where she thinks--whether the law says consent or notification--that her parents can force her to do something that she doesn't want to do, she will go outside of the health care system and you had testimony to that effect from Dr. Robert Johnson from the College of Medicine and Dentistry who was the head of Adolescent Medicine at the College.

The other thing I want to talk about is Mr. Herman's bill. We support the intent of Mr. Herman's bill, not the specific language. We do believe that a woman should be informed of the risks of an abortion, however slight they might be and the risks of the non-performance of an abortion, whatever they may be. We have, in the past, given to this committee copies of consent forms in use around the state, in cinics around the state and we have found them, in most part, to be very comprehensive. There is even one clinic that has a paragraph in their consent form that says, "if a minor, I understand that if complications arise, my parents will have to be notified." That is in use today in a clinic in New Jersey.

I agree with most of what Dr. Halpin said and his suggestions for this type of consent. I would have no objection to the State Department of Health putting

together a standardized consent form. I know that the consent forms that are used in hospitals for surgery are woefully inadequate. They have spaces where you can change the name of the doctor and change the name of the procedure and change the name of the anesthetic, after you sign it, and I'm very concerned about all consent form, not just for abortion. But, I think that is the province of the State Department of Health and the Board of Medical Examiners and not the Legislature. I think it is their job to put forth these rules and regulations and standardized consent around the state.

ASSEMBLYMAN LESNIAK: Fran, just briefly, you spoke about the fear of the minor in telling the parents. Do you believe that often times this fear could be unjustified and that by parents knowing about it, it could often elicit a very positive response?

MS. AVALLONE: Absolutely. That can happen. But, if you've got a teenager who has never been able to talk to her parents about sex, contraception, boyfriends, drugs, drinking or whatever, and she finds herself pregnant and wants to have an abortion, she's never been able to talk to her parents about anything and she is scared. She's not going to try to talk to her parents about anything and your making it a law isn't going to force her to talk to her parents. She's going to go out of the health care community to get that abortion, rather than face those parents. I know that the great majority of parents will be sympathetic, will be caring, will be understanding when a teenager is faced with an unwanted pregnancy. I live in upper middle-class, white surburban America, East Brunswick. We just had a two day old baby left on a doorstep. Okay? What kind of family relationship--and they're pretty sure it is a teenager because the note was attached to the baby saying, "I'm going to be back for my baby when I can take care of it." It was that kind of thing. What hell did that woman go through to leave that baby on a doorstep? These things happen all the time and legislation cannot solve them.

ASSEMBLYMAN LESNIAK: To be specific or to be consistent, do you believe that teenage women or teenage girls should have the right to have other surgical procedures performed with parental notification or consent?

MS. AVALLONE: I would think it would depend on the age and the circumstances. As Dr. Halpin said, if a teenager goes to a physician for an abortion, that doctor now has the right to call that parent, if he feels that it is in the teenager's best interest and he could do that on the abortion if he felt that that teenager had another health problem that could complicate the abortion procedure.

ASSEMBLYMAN LESNIAK: How about sterilization?

MS. AVALLONE: That is a very difficult question. I have had young people say to me, "Oh, I'm going to get my tubes tied," or "I'm going to get a vasectomy," and I try to talk them out of it when they're very young. But, I think it is, again, essentially, a private decision. The state shouldn't be involved in any kind of decision like that.

ASSEMBLYMAN LESNIAK: Thank you. Mr. Frank Askin? Frank, I'm not going to cut you out, but again, I would ask you to limit your comments because, again, this is a legislative panel. The issue has not been decided on point by the Supreme Court yet and there will be arguments.

F R A N K A S K I N: I don't intend to direct myself specifically or in great detail to the legal, constitutional issues. I am Frank Askin. I a professor of law at Rutgers Law School, and I am general counsel for the American Civil Liberties Union. I do appear today on behalf of the ACLU in opposition to both 1155 and 1592, but before addressing those specific proposals, I would really like to direct myself to a broader question: Why do we have to be here at all?

Almost a decade ago, the United States Supreme Court ruled that a woman had a constitutional right to terminate an unwanted pregnancy. The court, of course, ruled that the decision to abort a pregnancy was a decision to be made by a woman and her doctor, and the State had no business interfering with the free choice of that decision. Ever since then, the groups opposed to that decision, and their political allies, have waged unrelenting, guerilla warfare against American woman of child-bearing age.

ASSEMBLYMAN LESNIAK: Just a second. I am not going to let that go without comment. I don't believe my sponsorship of this bill is unrelenting guerilla warfare.

MR. ASKIN: I suggest, Mr. Chairman, that what we have had for the last seven years is a constant effort to find ways--

ASSEMBLYMAN LESNIAK: We would like you to address your comments to the substance of the legislation. If you don't restrict yourself to the substance of the legislation, I am going to rule you out of order and call the next witness.

MR. ASKIN: Well, I believe I am addressing myself to the substance of the legislation.

ASSEMBLYMAN LESNIAK: It is my prerogative to say that you aren't, and you haven't, so please address yourself to the legislation before us today.

MR. ASKIN: All right. What I am suggesting is, Mr. Chairman, with all due respect, I think it is within the context of an unrelenting campaign to nullify the Supreme Court's decisions in the 1973 case that the ACLU opposes these two additional bills which impinge-- We are talking about the impingement upon a woman's right to freedom of choice.

Isolated from this historical context - please refer to A-1592 - A-1592 is totally unobjectionable. The American Civil Liberties Union is a vigorous supporter of the concept of informed consent. No organization is more devoted to the free and open dissemination of information necessary to people in order to make informed decisions about the events that affect their lives.

If A-1592 provided for the dissemination of information concerning any and all medical procedures, not excluding abortions and sterilization, we would applaud it. That is obviously not the intent or effect of A-1592. Even assuming the Department of Health will prepare and distribute a completely objective and impartial handbook concerning the abortion decision, it will be immediately clear to every abortion patient to whom the booklet is distributed that this is just one more social pressure to dissuade her from her decision to terminate pregnancy - a pressure brought to bear upon her by the State in order to appease those segments of the community who find abortion morally reprehensible. It will be one more subtle effort to impose that particular moral view upon others in the community who do not necessarily subscribe

to it.

That A-1592 is supported by some who support the concept of freedom of choice doesn't really mitigate this fact, since it is clear that it is put forward under the pressure of those who desire much more stringent regulation.

ASSEMBLYMAN LESNIAK: Assemblyman Herman isn't here, but he would be taken back by that comment. I happen to know Assemblyman Herman very well and I respect his opinion. He has been on the side of many controversial issues, and many unpopular stands, and I think it is a disservice to him for you to make that comment, especially when he isn't here.

MR. ASKIN: Mr. Chairman, I don't mean to be disrespectful but--

ASSEMBLYMAN LESNIAK: It is not a question of being disrespectful; it is just a question of being ignorant of Assemblyman Herman's positions. I am not talking about disrespect; I am talking about ignorance. Will you please address the bill? Thank you.

MR. ASKIN: I think I am addressing the bill. I have served, for example, as a counsel to a congressional committee, and I understand the political pressures that do exist when there are groups who feel strongly about a given area, and the give and take or compromise within the legislative arena. But, I am suggesting that the real thrust and meaning of this bill is again underscored by the fact, for example, that failure to provide the booklet whoul subject a physician to criminal sanctions. The Supreme Court made clear in 1972 that the criminal law had no business intervening in the private and confidential relationships--

ASSEMBLYMAN LESNIAK: Excuse me. I don't think a disorderly person is defined as a criminal offense.

MR. ASKIN: Well, if we are going to get to a question of semantics, it contains criminal sanctions.

ASSEMBLYMAN LESNIAK: It is a question of the statutes of the State of New Jersey.

MR. ASKIN: It will contain criminal sanctions, subject to fines and, I believe, six months in prison, if I am not mistaken. And, whether we want to call it a crime or not, it entails criminal sanctions. There are no other procedures that require a doctor, under penalty of those sanctions, to give specific information--

ASSEMBLYMAN LESNIAK: There are, especially in the area of child abuse. There are many other areas where similar requirements are given.

MR. ASKIN: You say, "concerning a doctor's requirement to explain alternative medical procedures which have already been determined." So, it seems to me that this is rather unique in that regard, as far as interfering in the doctor/patient relationship is concerned.

While it is true that the United States Supreme Court has upheld, for example, an "informed consent" provision in the Danforth case, that decision emphasized the narrow scope of the regulation there approved. While noting that it was not entirely clear what infomrmation was required to be supplied the patient under that statute, the Court, I am sure you will recall, assumed that it only required the "giving of information to the patient as to just what would be done and as to its consequences." The Court went on to suggest that ascribing any more meaning to the provision in the Missouri Law, "might well confine the physician in an undesired

straitjacket in the practices" of the medical profession.

It seems to me that 1592 appears to impose just such a straitjacket. It does not appear to be confined to the giving of information concerning "just what would be done and its consequences," which is the language the Supreme Court used. The proscribed booklet must also include "a complete listing of alternative services available to the woman should she choose not to have the abortion." It seems to me such information probably goes beyond the medical procedures and consequences approved in the Danforth case.

The additional provision of 1592 requiring the physician to submit a report on each abortion performed, it seems to us, can only serve to further chill the exercise of the constitutional right. No matter what the bill promises about confidentiality of patients' names - and we agree it is important, if there are to be such reports, that as strong a confidentiality requirement as possible be included - few people nowadays have enough confidence in governmental bureaucracy to rely on such assurances. There have been too many instances of misuse of information in government files to satisfy many women that their names will be forever safe from snoopers and busibodies.

It seems that precisely because the state exhibits such a special interest in abortion patients compared with those who undergo other surgical procedures, the reporting provision can only have the effect of dissuading some from exercising what the courts have declared to be a fundamental right.

Now, just referring very briefly to A-1155, we find it objectionable for similar reasons. To certain teenagers, the assurance that their parents will be notified if they seek an abortion will have the almost certain effect of either preventing them altogether from exercising their constitutional right to terminate an unwanted pregnancy or else drive them into the arms of dangerous, back-alley practitioners.

ASSEMBLYMAN LESNIAK: Can I ask you what personal experience you are relying upon in order to express that opinion?

MR. ASKIN: I obviously have no personal experience. It seems to me that the professionals in the field, the social scientists who have studied this phenomenon--

ASSEMBLYMAN LESNIAK: Would you restrict your comments to the areas in which you are well versed, please? I would appreciate it.

MR. ASKIN: People much better versed than I have already spoken to that question - George Halpin; Fran Avalon; and Ann Levine - and I will not address that specifically. The ACLU supports their position.

Finally, as you have stated, Mr. Chairman, the United States Supreme Court has not definitively stated whether a parental notification requirement can pass constitutional muster - that is now before the Court in the Matheson case. You are also, of course, aware that several lower Federal courts, subsequent to Bellotti, have so decided that it is a unconstitutional burden upon a minor's right to obtain an abortion. And, of course, the Utah case has gone the other way.

In any event, in light of this past history, in the context in which this issue comes once again before the New Jersey Legislature, it seems to us that enactment of such a requirement into law can only be viewed as one more cynical effort to harass and intimidate women in general, and

the most powerless and vulnerable segment of the female population in particular.

The ACLU would really urge this Committee to abandon its efforts to single out abortion as a topic of special legilation and focus much more broadly upon the general crisis of community health care, especially among the poor in our deteriorating urban centers.

ASSEMBLYMAN LESNIAK: Thank you, Mr. Askin. I have a few questions.

MR. ASKIN: Sure.

ASSEMBLYMAN LESNIAK: Does the ACLU have a position at all in reference to parental rights? Do you believe that they have any responsibilities or control over their children?

MR. ASKIN: Our national board has been involved in developing policy as to parent-child relationships for the past year. We are in the middle of adopting policy now.

I will tell you very frankly as an aside, for example, that two agencies of the ACLU happen to be on different sides of one particular issue. I am talking about the Chicago case concerning the right of the Ukrainian case - you have probably read about the case - to take their child back to Russia. I think the child is 13 years old and he wants political asylum in the United States. Very frankly, our Chicago affiliate is supporting the right of the patents because they think there is a right of parental control over the custody of the child -- that that is the basic right involved -- while our National Juvenile Rights Project in New York is probably going to go into support the child in this matter on the grounds that the child has an independent right to make political decisions about such momentous decisions that will affect his entire future. So, we have--

ASSEMBLYMAN LESNIAK: For instance, if the child wanted to join the Ku Klux Klan, the parent wouldn't have anything to say about it?

MR. ASKIN: I would say we are not necessarily unanimous on this point. We do not have clear-cut policy that binds our entire national organization, so I really could not speak with one mind for the ACLU on this question.

ASSEMBLYMAN LESNIAK: That was only a response to the tenor of some of your comments. Thank you.

MR. ASKIN: Okay. (Complete written statement on page 10x)

ASSEMBLYMAN LESNIAK: The next witness is Dr. Charles Hoffman.

D R. C H A R L E S W. H O F F M A N: I felt when I first came here very much out of place with all of the erudite professionals preceeding me. However, the more I listened, the more I felt happy to be here.

My name is Charles W. Hoffman. I am a practicing physician, a family physician, and have been so for more than 40 years. During that period my office has been in South Amboy, New Jersey. I have now, and have had for many years, a very large general practice, drawing patients from Old Bridge, Sayreville, and South Amboy.

I have delivered over 6,000 babies and have cared for them and others from infancy to adulthood. Because of this, I feel that I have a unique background from which to form an opinion concerning this bill, Assembly Bill No. 1155, by Assemblymen Lesniak and Deverin.

My experience is as follows:

Over the years, many unmarried girls in the lower and middle teens have consulted me when they discovered or felt they were pregnant. Because

of my close relationship, I was often the first to know of the problem. In many instances, the teenagers were emotionally labile. They were also immature from an educational and mental development point of view.

As you can see, I was faced with the responsibioity of advising these patients for many years prior to the Supreme Court decision of 1973. During these years, it was a crime to perform an abortion or advise that one be obtained except under rare and unusual circumstances. Also, during those yeaars from 1940 to 1973, society in general considered abortion to be grossly immoral.

My advice to the patients was based on my observation, as stated above, that they were frightened, and they were worried about parental reaction if the parents discovered the pregnancy, and that the girls in my office were often crying and emotionally unstable, and, finally, that they were not mature enough in general to make a sound judgment about an event that could affect their future in so many ways - an abortion.

I counseled them sometimes after protracted talks and dialogue to "please consult their parents." This was in the years before the Supreme Court decision.

The first reaction I got was universally negative: "My father would beat me." "My mother would be ashamed." "They would throw me out." These were some of the replies I got.

However, on being told that I had heard the same words from others in their circumstances, at least they would continue to listen. My counseling, or words, were something like this: "Listen, nobody, but nobody, could care more about you than your mother and father. Sure, they will be upset at first, but you will be surprised at how much they really love you and want to help you. They will support you better than anyone else in the world."

Talking along these lines aften, but not always, persuaded the young girls to speak to their parents. The parents, in turn, would almost immediately call me. They were shocked. My words to them were in effect that their child needed their support and needed it now. Their child needed all the love they could muster to support the daughter who, I reminded them, made a human mistake, was immature, frightened, and emotionally hurt.

Because of my large and in-depth experience as a family physician, I strongly urge the passage of Assembly Bill No. 1155, so that all young girls of New Jersey can get the wonderful support they need so much from parents who really love them.

I feel that 24 to 72 hours' notice to parents will enable them to help their daughters avoid snap judgments and actions whose future consequences they are not aware of.

Thank you for this opportunity.

ASSEMBLYMAN BASSANO: Did many of the young people that came to you, after you subsequently spoke with their parents, continued with the pregnancy and had the child? And, were there also people that you treated who elected to have abortions?

DR. HOFFMAN: Most of them had the baby. Most of them I delivered myself, and I saw the after-effects, which I can testify to if you wish. However, some elected to have an abortion. I am not here speaking on the

issue of whether or not to have an abortion. I am speaking to the issue of a 13 or 14 year old girl, who cannnot get her ears pierced, who cannot get a shot of tetanus toxoid. Doctor Halpin said that he didn't think that doctors in their offices called to see whether they could have one suture or not. Let me tell him, and let me tell everyone here, that we are very conscious of parental consent and we do - I do and most of my friends, I guess all of them - call the parents before we would even give one suture in the office.

So, I am speaking to the issue, not of abortion or non-abortion, but of a young child getting consent or advise and help from those who love that child most of all. This is my deep feeling, and this is why I am glad I have this opportunity to express it.

ASSEMBLYMAN LESNIAK: Doctor, I want to thank you for your testimony. I think if we had doctors like you, who are concerned about the individual in the abortion clinics and not just concerned with the profit motive, we would probably not even need this legislation before us today. Thank you very much.

DR. HOFFMAN: Thank you.

ASSEMBLYMAN LESNIAK: Our next witness will be Marcia Kerensky, Family Nurse Practitioner, Rutgers University Student Health Center; Chairperson, Womens' Health Problem Committee.

M A R C I A K E R E N S K Y: As a member of a College Health Center, and a concerned provider of health care, I would like to be here today to voice objection to Assembly Bill 1155.

Many of the minors who have undesired, unplanned pregnancies have already decided to terminate or to maintain their pregnancy by the time they come to clinics for pregnancy tests. They do not want help in making the decision, but they do need information about the risks, complications, and services available regarding their decision to terminate or to maintain the pregnancy.

Parental notification, when it is against the will of the minor, would mean that in many cases the health care provider would be seen as an adversary to the minor rather than as an advocate. Parental notification would also mean for patients who do not want parents involved, that any control the patient has over her decision is taken away from her. It could also mean withdrawal of the minor from school if parents bring these pressures to bear to force the minor into a decision against her own will.

Notification of parents would impose tremendous pressures on adolescents to relinquish control of their already chaotic lives back to their parents. It would also perpetuate a dependent role which has prevented the woman from exerting control over her fertility already.

I would like to support Assembly Bill No. 1592, with some reservations. As a nurse who works with minors who have problem pregnancies, I know the importance of accurate statistics regarding the outcome of those pregnancies. However, I do agree with Doctor Halpin that truly informed consent does not begin or end with the reading of a booklet, but with speaking to concerned physicians about the risks for maintaining or terminating an unplanned, unintended pregnancy.

ASSEMBLYMAN LESNIAK: Thank you.

MS. KERENSKY: You're welcome.

ASSEMBLYMAN LESNIAK: The next witness is Rita Martin, President of the New Jersey Right to Life Committee.

R I T A M. M A R T I N: Good morning. I also appreciate the opportunity to speak to you and to express the reactions of the New Jersey Right to Life Committee to both of these bills concerning abortion.

The term "abortion" has become a code word in American society, causing instant and strong reaction on both sides of the question whenever it is mentioned. However, the two bills being discussed here today afford those of us of vaying opinions the opportunity to come together in support of legislation that can only help the mother faced with an untimely and distressful pregnancy.

We in Right to Life would sincerely hope that means other than abortion can be found to solve the problems that bring a mother to the point of considering ending the life of her unborn child. However, in the realities of today's world, abortion is legal and, until such time when that law is changed, we have an obligation to protect the women seeking abortion and their future children, as much as we are able. Assembly bills 1155 and 1592 present excellent opportunities to do just that.

Assembly Bill 1155, calling for simple notification of parents of pregnant minors seeking an abortion, provides a much needed safeguard for these young ladies who are being faced with what is perhaps the first major decision of their young lives. Since one-third of all abortions are performed on adolescents, we are speaking of a very large group of young girls. Odds are that most of them are not mature enough to handle such a serious decision on their own. Telling her parents of her pregnancy is certainly a traumatic experience for a young girl and for the parents; yet, we have found in working with these girls that most parents react with love and support, even in those cases where the girl is absolutely positive that the family is going to be terribly upset and throw her out.

This bill does not call for parental consent. It gives the parents no veto right over the decision to abort, but it does give them the opportunity to offer guidance in what is a major and irrevocable decision.

Justice Potter Steward, in concurring with the majority in Planned Parenthood v. Danforth, which found parental consent unconstitutional, suggested that simple notice would be a materially different constitutional question. He wrote:

"There can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried, pregnant minor to seek the help and advise of her parents in making the very important decision whether or not to bear a chld. That is a grave decision, and a girl of tender years, under emotional stress, may be ill-equipped to make it without mature advise and emotional support. It seems unlikely that she will obtain adequate counsel and support from the attending physician at an abortion clinic, where abortions for pregnant minors frequently take place"

Notification to parents does not violate any privacy rights against public disclosure, since the minor's parents are not members of the general public, but rather guardians with responsibility for her care and nurture. Indeed, it gives the parents the opportunity to act on that responsibility and be certain that the aborting physician is aware of any pre-existing condition that could cause complications in the abortion procedure.

Many teenagers are unaware of events in their medical history that could be complicating factors, or so upset by their present condtion that they forget to mention them. Parents will be sure the doctor has this vital information. Also, in the event of resulting complications, the parents will know the reason immediately and will be able to seek the proper medical help, if they know about the abortion.

We view Mr. Lesniak's bill, A-1155, as an important piece of legislation that will safeguard the lives of pregnant minors and help maintain family relationships. We hope to see it enacted into law very soon.

Assemblyman Herman's bill, A-1592, takes a very important "first step" toward providing the information necessary to allow a mother to make a truly competent decision about the fact of her unborn child.

The decision to abort deals with deep personal issues, matters of health, and the consideration of life and death. It is imperative that it be made with full knowledge of its nature and consequences. The Southern Medical Journal of August, 1979, carried a report on 54 teenage patients who had significant complications after legal abortions. The one factor that was common to all was that none of them felt they had received adequate information about the potential dangers of the operation. Unfortunately, this seems to be true in many cases.

Mr. Herman's proposal for the Board of Health to prepare a booklet outlining the medical facts pertinent to abortion will be successful only if all health risks, both short-term and long-term, are delineated. Accompanying your copy of my testimony is a report from our medical researcher, and a booklet documenting a rather long list of abortion complications. To be completely accurate, all of these complications should be noted in the board of Health booklet. (see page 19X)

We have a concern about who shall prepare the booklet. A bias for abortion can very easily be inserted in the copy if indeed the composers feel that way, as could a bias against abortion. We would suggest a balanced panel of health personnel be given the task so the completed booklet will be factual and objective.

Also included in the booklet should be some information concerning the developing child. Accurate information on this point is indeed necessary for the patient to be completely aware of the import of her decision. After all, if a woman thinks she is carrying a "blob of cells" in her womb, and in reality she is carrying a 10-week baby with a beating heart and tiny hands and feet, it can make a great difference in her decision.

Approximately 40% of abortions done in New Jersey in 1977 occurred past this 10-week point of development, and also some 450 babies were aborted at 21 weeks, or more. Mothers at this stage of pregnancy

should certainly be told that their baby is fully formed and capable of living outside the womb. This information is essential. How dreadful for her should she find out later the size and capability of the child she aborted, and then regret her decision.

The bill calls for a listing of alternatives to abortion in the booklet. We certainly hope this would include all the programs in the State which reach out to help a pregnant woman, both governmental and private. There are positive alternatives to abortion. There are programs of care and support that will help a woman through this difficult time, and adoption services to help her find a living home for her child, if that is her choice. To opt for life over death is always a positive alternative.

There are some vaguenesses in the bill regarding the use of the booklet. It speaks of the physician giving the patient the booklet. However, in most abortion clinics, the physician sees the patient for the first time just prior to initiating the abortion procedure. I'm sure the intent was for the patient to have more time than that to read and understand the very vital information in the booklet.

The bill does not address a time frame for reviewing the information, nor does it present a method of assuring that patients reading the booklet fully understand its contents.

What of the woman who does not read English? Will it be printed in several languages? What of the woman who does not quite understand what she reads? Will she be given the opportunity to seek help and counsel? Will a very young girl be allowed to take it home to discuss with her parents or an advisor? All of these questions should be answered in the bill so the booklet can be used most effectively.

We would suggest a 24-hour time period be established for reading and reviewing the information in the booklet. This would insure the decision was well thought out. However, we are aware of court cases surrounding that 24-hour notice, so we would urge a minimum time frame of four hours. To allow any less would seem to be thwarting the intent of the bill. It will take time to read and digest and question about the material presented.

The section of the bill dealing with reporting requirements fills a very obvious void in abortion reporting. This bill requires reports not only from all licensed health care facilities, but also from physicians in private practice. Records of abortions performed in New Jersey have been very unreliable up to now because of the lack of reports from private practice. This statute will help to truly measure the impact of abortion on maternal health in New Jersey.

Yet, here too there is a lack of specifics. The bill does not delineate what should be reported. We would suggest that age of gestation, type of abortion procedure, many immediate complications, and tissue report from a certified pathologist be minimum requirements on such reports. Medical practitioners in the State may, perhaps, suggest other information that they would like to see included. The pathologist's report is essential to establish that a pregnancy was indeed removed, and diminish the possibility of ectopic pregnancy. Recurring news

stories of abortions being performed on women who were not truly pregnant call for this test as an added safeguard for the patient's health.

It is distressing for me to be here speaking to a bill that regulates abortions. I would far rather be speaking to a bill designed to provide help and counsel to a woman with a distressful or untimely pregnancy. But, in each pregnancy there are two patients, the mother and the baby. Since the law of the land prohibits us from protecting the baby in certain circumstances, then let us protect the mother as best we can.

Mr. Herman's intent in this bill, informed consent of the abortion patient, is to be applauded. But, true informed consent will not be achieved by the bill in its present form. We sincerely hope the sponsors and the Committee will review this legislation in light of the comments we have raised.

ASSEMBLYMAN LESNIAK: Thank you, Rita. I don't have any questions; I just have two comments. I agree with you. I don't know if this point has been brought out, but I often wonder why the doctor in an abortion procedure - generally in a clinic - just sees the patient for the first time when he performs the abortion. I know of no other surgical procedure where the relationship between the physician and the patient is so tenuous.

MS. MARTIN: That's true. Sometimes the patient is already slightly sedated when she meets the doctor, so she doesn't even have a real picture of who this man or woman was.

ASSEMBLYMAN LESNIAK: Second, I would like to say that I really agree with you wholeheartedly on the time period. I would far rather be speaking to a bill designed to provide help and counsel to women with a distressful, untimely pregnancy. I think we certainly could do more in that regard. As you know, the Supreme Court has said that the State does not have to be neutral on the issue of abortion, that we certainly can fall down on one side, and be on the side of carrying pregnancy to term, as long as we don't interfere with their definition of what the right to privacy is. I certainly think that we can do more from what I have heard during the testimony today in that regard.

MS. MARTIN: We would support any bills to do that.

ASSEMBLYMAN LESNIAK: Donna Hildreth, Legal Services of New Jersey.

D O N N A H I L D R E T H: I would like to correct the record. I am not here from the Legal Services of New Jersey. I am here as a private citizen.

ASSEMBLYMAN LESNIAK: You are with Legal Services though, are you not?

MS. HILDRETH: I work with Legal Services. I am here basically as a feminist, as a citizen of New Jersey, and as someone who has worked in social service agencies for over 10 years now, and as a parent.

ASSEMBLYMAN LESNIAK: Are you an attorney with Legal Services?

MS. HILDRETH: No, I'm not an attorney.

I would like to support, with reservations, 1592. I agree with what Mr. Halpin said this morning: there is a necessity to have records kept of how pregnancies end, and not just people who elect

to terminate pregnancies. I worry a little about having a woman sign. I don't really feel that is necessary.

As for standardizing procedures and regulating what a woman should be told about pregnancy, and how to terminate it, or other alternatives, I wouldn't argue with that. I think anything that makes medical treatment more humane and gives women, and all patients, more dialogue with their doctors is a good thing. I am not sure, through, that that is what the bill is going to do, but I hope it is.

I am opposed to 1155, and for a lot of reasons that have been said here by other people. I know that the majority of parents are concerned about their children and will try to act in their best interest. But, I am concerned about the minority of parents that don't act in the best interest of their children, and I don't think that the instance of that happening is as insignificant as we would like to think. We don't really know what the instances are of incest or rape within the family. We don't have all that information. Studies are starting to come out about it, and it is alarming. It is more prevalent than we had ever thought. I personally feel that we have a duty to protect children who might be abused by their family.

In the case of incest - and Assemblyman Bassano you mentioned--

ASSEMBLYMAN LESNIAK: Excuse me, I don't mean to interrupt you, but I just want to point out that I intend to - if it is needed - add a supplement to the current law that exists - although I kind of believe that it is covered - requiring that incest and rape be reported to the prosecutor's office. In turn, of course, the parents would be notified one way or the other.

MS. HILDRETH: I know, but I wanted to bring out what Assemblyman Bassano said,that the Legislature is concerned with black and white, and not with grey areas. In family situations where there is incest, I think we are dealing with a lot of grey areas.

ASSEMBLYMAN LESNIAK: But, as far as this bill goes, if it is not included under the law, it would be reported to the prosecutor's office.

MS. HILDRETH: Yes. That may not be the comfort that you think, or that you would like it to be. I just want to register my opinion about this. I do think it is dangerous.

ASSEMBLYMAN LESNIAK: Let me ask you on that, is it your opinion that it should go to the-- I consider that child abuse.

MS. HILDRETH: I consider it child abuse too.

ASSEMBLYMAN LESNIAK: And it should come under the child abuse law.

MS. HILDRETH: Yes, but I don't think you can put in a law that requires parental notification and make exceptions, and expect that.

ASSEMBLYMAN LESNIAK: No, I'm sorry. The doctor would have to comply with the child abuse law.

MS. HILDRETH: Right, which should take place anytime a child goes to a physician, so that is already provided for in the law. You don't have to make exceptions. But, a girl may not report that that is the case. She may just report that she is pregnant. There may be

all sorts of reasons why she would not want to admit at the time, even to a physician, that this is going on. The feelings that are involved in this are very complicated.

ASSEMBLYMAN LESNIAK: In the case of an incest or a rape, don't you think we ought to adopt procedures, standards, regulations, and laws that would have that effect? I don't see anything wrong with us trying to protect people from themselves, especially in the case of minors. I am very concerned that we are not doing our utmost to insure that minors would report cases of child abuse. I think we have failed in that regard, and I think, on the contrary, that we should be adopting measures that are more in that direction rather than less.

MS. HILDRETH: Right. But, what I am saying is happening right now is that the atmosphere about this problem is not so enlightened at the present time that you could expect a child to just come out with it and have her own protections provided for by doing that. She may keep it a secret. The parents will receive notification and that could be a very dangerous and volitle situation that is exposed and the child has no protection at that point.

ASSEMBLYMAN LESNIAK: You don't consider that that child is already exposed to a very dangerous and volitle situation that nothing is being done about?

MS. HILDRETH: Yes, and nothing will be done, and it may end in a really tragic way.

ASSEMBLYMAN LESNIAK: Nothing is done. Well, anyway--

MS. HILDRETH: Okay. All I am saying is that it will allow for something. Well -- we will only go around about this. I don't want to do that.

ASSEMBLYMAN LESNIAK: Please proceed. I'm sorry.

MS. HILDRETH: Okay. I would just like to reaffirm what other people said, that teenaged girls will not see this as notification, as opposed to consent. They won't make that legal distinction, and I think that will send them outside of the health services of this State, maybe to illegal measures.

ASSEMBLYMAN LESNIAK: Thank you. Are there any questions?

ASSEMBLYMAN BASSANO: I have one question. What is your opinion regarding some type of legislation, picking the age of 14 or 16 years, whereby any type of medical procedure would not require parental consent -- if we were to change the statutes in that nature, where we would, again, not be in a grey area? It would either be black or white, as the case may be. We would say that at a certain age a person - other than the age of majority, a person 14 or 16 - would have the right to any medical treatment they so desired.

MS. HILDRETH: I'm afraid I am going to be asked a leading question; you are going to say to me "sterilization." It happened before. I don't really know how to answer that all the way. I do think that a lot of us are here, and the people who are here and testifying against 1155 are concerned primarily about a woman's right to control her own body. We are sincere about that, and we have been struggling about that for years. We can't just assume that it is a woman over 18 years

of age who will exercise that right, but it has to start when they are girls. We have to develop an attitude about our bodies that starts when we are young.

I think the way to go about solving this problem is not so much to notify parents. Of course, they have a right to know, and in healthy relationships, girls will tell their parents. But, I think maybe we should explore things, such as expanded sex education in schools and in the community, where parents are made part of it, and families can take part in this. I think that is the way to go about it, to open things up and to make them more public.

I'm sorry, I can't answer your question.

ASSEMBLYMAN BASSANO: You didn't answer my question.

MS. HILDRETH: I can't answer it; I'm sorry.

ASSEMBLYMAN BASSANO: In a situation such as I just outlined it would also take into consideration young men of the same age group who may need an appendectomy, or something of that nature. So, it is a very wide area. I was wondering what your opinion was. If you can't express it, I appreciate your trying anyway.

MS. HILDRETH: I think minor surgical procedures - perhaps something like abortion at a certain level - the child must be able to consent to. There are other things to consider, and I really wouldn't want to speak to that. Thank you.

ASSEMBLYMAN LESNIAK: Thank you.

Mary Louise Gans, Central Jersey Coordinator, New Jersey Coalition of Concerned Parents.

M A R Y L O U I S E G A N S: Thank you very much for the opportunity to come and address you. First let me explain, because of the organizational title I represent, you may ask why I am here. You know that as the Coalition of Concerned Parents we have turned our efforts to reaching the public and the Legislature with an appeal to preserve parental rights in the most intimate area of family life and sex education training, so that our children would not be mandated to attend interdisciplinary courses through many years of elementary and secondary school, without the consent either of child or parent. That area is still our deep concern. We still pray that legal restraint will be applied to return the control of our children's psychological, spiritual, and moral, sexual training to their parents, instead of being given to an omnipotent state.

But, just as we seek to retain our parental position in this area of intellectual and spiritual development, we also see the enormity of destruction in the parental-child relationship which occurs when a child, as yet incapable in any other area of self-determination - by legal definition - is allowed, even encouraged, to choose life or death for an unborn offspring, a grandchild of its parent, assuming at the same time a risk of unknown proportion in relation to her own present and future health, health which the parent is, by law, responsible to maintain and safeguard. This bill does not give parents the right to prevent this course, but only allows that they may be alerted to possible danger to their child. My child may not ride a school bus on a field trip without a written permission. My child may not have a

cavity filled without my signature, nor any other medical procedure, no matter how trivial, without my authorization. How can she be allowed to take my grandchild's death and her future life and health into her own hands without informing me?

We are before you today to ask you to come to one of the most honorable decisions you will ever need to make. You may have been led to believe that public sentiment is against this bill, as it is said by opponents "to be an incursion on the concept of total and unrestricted freedom of choice. But, unrestricted freedom has never been the code of an ethical society. All of us have believed that to control our desires, to be considerate of the needs of our fellow citizens, is essential to an ordered, efficient, even a workable society, one that is not an anarchy. All of us have known that even adults must submit themselves to safe and just codes of conduct, even when they somehow limited our choices.

Now, we have a situation where children are being given the authority to make grave, medical decisions without any parental guidance or assistance. Can you justify, on one hand, laws which require that parents be punished as unfit if they fail to maintain their children's health, to keep them under proper surveillance, and train them to observe law and order, if on the other hand you refuse to grant to them the right even to know what their children are doing?

Aside from the moral and medical aspects of an abortion, consider only the financial aspects of one. If parents are not informed, who is paying for this procedure? Will the generous providers of abortion give them freely without charge, meaning then that our taxes and United Way Fund contributions will be providing them? Or, will our young aborting child-mothers be carrying debts to unknown "friends"? How will these debts be repaid? In what "coinage"? Do the fourteen-year-old girls we seek to protect have hundreds of dollars available to them for procuring abortions? Are parents who allow minor children hundreds of dollars in unaccounted spending money lax parents?

Defenders of the right of privacy and the freedom of choice suggest intrustion on a woman's right. In what other area is my child a woman? Again I say, I am responsible in law for her health, her conduct, her school grades and attendance, and every debt she may incur. Forget the God-given right of parental authority. In what business partnership would any man take so much responsibility for another's actions without some voice in them? Can it be too much to ask just to be informed?

Admittedly, we who ask you to pass this bill are asking you to risk a measure of disapproval from those who would demand total freedom and the "right of choice:" they say we are seeking to control their morality. We say they are seeking to control ours, and our childrens'. If you do not pass this bill, you say to them, "yes, you have the right to usurp all parental authority." There is no parental authority or right, only responsibility to provide whatever the omniscient individual or the State may demand. Look closely at the people who demand that you prevent this legislation, and those who support the State-mandated Family Life Programs, and you will discover that their names and interests

overlap -- a conflict of interest, perhaps? They do not seek to stop ignorance, venerial disease, and abortion. They do not seek to strengthen families and teach parenting. They seek to prevent and circumvent families.

You have in your power with this bill one small way to restore a little measure of parental rights in our State. Don't be fooled by the horror stories of cruel and inhuman parents, unfeeling and abusive of their child in her time of need. If any of these do exist, the courts have all power to circumvent them already. No child need suffer, and many agencies and advisors are available to inform the children of this. But, all children, even without the Mandated Program, through t.v. childrens' specials, magazines, and many school programs, are already being informed to avoid parental counsel in time of trouble because "parents might become emotional or attempt to influence your decision, or impose their values." Whose influence and values will be imposed?

The average happy teenager usually needs advice to decide what skirt to purchase, what movie to see, and even what sundae to enjoy. Surely, on this grave decision she will seek advice. Will that advice from strangers be wiser, more loving, be based on more knowledge of the child herself, and of her needs? Will the unity of the family in this Year of the Family be increased by taking this bond in tragedy away from the family and binding the child to secrecy from her parents?

Who, by the way, will write the note to the school, explaining that Mary is ill, bleeding and dizzy, and can't take gymn? Not mother; she doesn't know. And, if Mary is one of the unlucky ones, no one will ever know why she got the fever and died so suddenly. Probably, she won't die perhaps she will only fail a course or two because she had no one to talk to to expalin her distress. Perhaps the Mandate will be applied and Mary can be the class example of how each child must form his or her own values, learning to be tolerant of values that differ from her own, as Susan Wilson has said.

Please, if you value the inviolable rights of your own families, protect them and your State and grant this obvious right back to parents. Tell the young people of this State and of this nation that parents are their support and not their enemy. Allow the chance to love and help their own children. For the Year of the Family, send the families back together.

ASSEMBLYMAN LESNIAK: Thank you.

MRS. GANS: I thought you might be interested in these too. They are pertinent to the other bill, which discusses the progress of a child at eight weeks. It is a noticible baby. At sixteen weeks, which is somewhere close to the usual abortion time-- No one aborts in the first four weeks. You know, they don't know that it has happened and they don't spend the money unless they are positive, and they have missed two periods. So, they are already up to the twelfth week. By the eighteenth week it is an adorable child with its thumb in its mouth.

ASSEMBLYMAN LESNIAK: All right.

MRS. GANS: And, this is the child's bill of rights, as printed in Ms. Magazine. If we get those rights for children, forget parenting entirely.

ASSEMBLYMAN LESNIAK: Thank you, Mrs. Gans.

MRS. GANS: This is another piece of information that might be included in that booklet for young children.

ASSEMBLYMAN LESNIAK: Thank you. I will enter this into my file. It does not comment on the bill. The Child's Bill of Rights -- I think we are aware of that.

The next witness will be Louise Halper, National Lawyer's Guild. Louise, I will ask you the same question I asked the representative from the ACLU and the legal representative from Planned Parenthood. If your comments are regarding the constitutionality of the legislation, I would prefer that you encapsulate them and submit your testimony for the record.

L O U I S E H A L P E R: No, they are not.

ASSEMBLYMAN LESNIAK: Okay.

MS. HALPER: Gentlemen, I have my testimony here for your reference.

ASSEMBLYMAN LESNIAK: Thank you.

MS. HALPER: Gentlemen, my name is Louise Halper. I am a mother and an attorney, and I appear here today on behalf of the Abortion Rights Task Force of the New Jersey Chapter of the National Lawyers Guild.

Speaking for that organization, I can say that we view both A-1592, and A-1155 as an attempt to further narrow the rights of women to the privacy of their bodies and, in specific, to their rights not to bear unwanted children.

On its face, A-1592 attempts a laudable aim, to give preoperative patients all the possible information about the procedure they are about to undergo, and about the possible alternatives to it. It would seem, in fact, to bolster the goals of freedom of reporductive choice for women. But, I ask this group to take notice of other facts about this bill, facts about what this bill omits.

This bill omits any provision for informed consent on the part of women about to undergo procedures just as central to their reproductive rights such as hysterectomies, laporatomies, or other forms of sterilization. There are no procedures more irreversible in regard to a woman's reproductive future than these, no procedure whose abuses cry out more for the imposition of an informed consent requirement. But, this bill which is ostensibly directed toward "promoting and protecting maternal health" and protecting women against "medical victimization" by imposing "a greater degree of accountability" on a physician, nowhere speaks to the issue of women who are compelled to be sterilized. We can be sure that if a woman goes to a doctor for an abortion, she wants an abortion. Who can be sure that a woman in labor who consents to sterilization has really given her informed consent to that procedure, particularly when we know that sterilization of poor and minority women is regarded by some doctors as an answer to social problems, and used by them as such?

We know it is a fact that in this country sterilization statistics are much higher for Black women, Spanish-speaking women, and poor women than they are for White, middle-class women. Yet, the concern for women's

rights to be informed has not led to sponsors of this bill to deal with this abuse through requiring use of informational informed consent booklets for sterilization procedures. I am afraid that this reveals quite clearly the essential direction of A-1592, which is simply to discourage women from choosing to have an abortion.

As to A-1155, it should be noted that the Supreme Court has already held that mature minors have a right to an abortion without parental intervention. This bill purports not to require parental consent, but merely parental notification. This parental notification takes place in the context of the situation where a minor has already decided to have an abortion, and in that context it is quite clear parental notification can only mean an opportunity for parents to attempt to pressure a young girl or woman not to have the abortion.

Of course, those of us who are parents want to share with our children their problems, especially in situations as serious as this. But, I believe that even as parents, we cannot force our choices on our children; and, realistically, in this sort of situation, would we want to? It is easy to say a thirteen-year-old is not mature enough to make decisions about her future. But, in that case can we say a pregnant thirteen-year-old who chooses not to become a mother is making a less sensible choice than her parents who might want her to have a child? Who is making the sensible choice in that case? Do we really want to make it State policy that parents be allowed to pressure young girls into becoming teenage mothers? Are we really providing for family unity in such a case?

It seems to me that all the arguments in favor of parental notification -- the child's lack of maturity, her inability to decide for herself, etc. -- are arguments which go directly to the question of whether she is fit to be a parent.

If a girl decides she is not fit to be a parent, it would be wrong to allow her parents the opportunity, through persuasion or pressue, to reverse that decision and force her to do what she feels incompetent to do, that is become a parent herself.

Finally, let me say that legislative concern with parents and their children, which seems to express itself in these bills, needs to find a new direction. In this State, there are 125,000 parents and 325,000 children who are on Aid to the Families of Dependent Children and who our legislature keeps on budgets which amount to less than 65% of what the United States Bureau of Labor statistics says is minimally adequate low income family budget.

There is a day care program which this legislature refuses to fund at a level which comes anywhere near meeting the rate of inflation. There is a program for battered women which does not even provide one shelter per county for those unfortunate victims of family violence, even though the shelters which do exist are constantly full to capacity and beyond.

There is a family planning program whose budget this legislature has held to a 5% increase since 1975, although we all agree that family planning is the key to guaranteeing women's reproductive rights.

It is a waste of this legislature's time to hedge about, in petty and unfeeling ways, the rights of women to reproductive freedom, particularly when the rights to women and children to a decent life are not being attended to.

Thank you for this opportunity.

ASSEMBLYMAN LESNIAK: Thank you. I will make sure that Assemblywoman McConnell gets a copy of your comments, especially on page two here you say, "I'm afraid this reveals quite clearly the essential direction of A-1592, which is simply to discouraging women from choosing to have an abortion." She is the co-sponsor of the legislation.

MS. HALPER: Obviously, Assemblyman, people differ.

ASSEMBLYMAN LESNIAK: Thank you.

Jill White will be our next witness.

J I L L W H I T E: Mr. Chairman, members of this Committee, my name is Jill White. I am a resident of Hamilton Township, New Jersey, and I very much appreciate the opportunity to speak to you today with regard to Assembly Bills Nos. 1155 and 1592.

First, I would like to direct my remarks to Assembly Bill No. 1155, introduced by Assemblymen Lesniak and Deverin, which calls for the notification of parents prior to the performance of an abortion on a pregnant minor.

As a concerned citizen, and as the parent of six children, I believe it is the reponsibility of government to protect and to promote parental rights, and for this reason, I fully and enthusiastically support this bill. I am convinced that if this legislation should be enacted it will ensure parents in New Jersey the opportunity to discuss and advise their minor children prior to the abortion decison.

As you and I know, parents are responsible for virtually every aspect of their children's lives, be it medical, educational, spiritual, nutritional, or economic. Therefore, to make an exception in this particular instance of parental notification prior to abortion would not only be inconsistent and inappropriate, but would, in fact, be downright unjust.

So again, I support this legislation and I sincerely hope that it will become law in the very near future.

With regard to Assembly Bill No. 1592, although I fully support the concept of this proposed legislation, I do believe that certain amendments will have to be made if it is to succeed in its goal, which is to safeguard a woman's right to full information prior to the performance of an abortion.

I'm deeply concerned by the fact that this bill calls for the Department of Health to be the sole preparer of the informational booklet. My concern stems from my knowledge that Dr. Joanne Finley, Commissioner of that Department, was formerly a director for Planned Parenthood in the State of Maryland. Clearly, this constitutes a conflict of interest because Planned Parenthood has been and is now recognized as one of the foremost promoters of legal accessible abortion. And, I would ask that you please look at my attachments to this written statement, which reinforce my view.

Certainly, in view of this fact, we cannot possibly be assured

that this booklet would be prepared by Dr. Finley's Department without bias. It should not and it must not turn out to be merely a propaganda vehicle that would enhance abortion as a positive alternative, and portray childbirth as a negative one, and assurances to this effect should be built into the language of this proposed legislation.

A-1592, as it is now written, is extremely vague and it in no way addresses itself to certain very important specifics. For instance, exactly what information will be included in the booklet? Will it be depicted in pictures as well as words? Will the information include "all" the major and minor physical, mental, and emotional complications surrounding the procedure itself as well as any and "all" complications which might result later? Will it include problems which might arise if and when subsequent pregnancies should occur? Will the booklet make it crystal clear that abortion does not remove a part of a woman's body, that it does not remove merely a mass of cells, or a blob of tissue, but rather that it does remove a developing human being who if left in utero for a period of nine months, would almost certainly result in a normal, healthy, live baby?

Will the booklet be produced in languages other than English in order to safeguard the rights of a woman who might have difficulty comprehending the English language? Will the booklet be given to the woman immediately before the abortion, or will there be a twenty-four hour, or better yet, a forty-eight hour time span in which she might be able to consider its content and perhaps discuss it with a family member or a friend. I might add that this time span could conceivably prevent a woman from making a hasty decision and perhaps one which she might later bitterly regret.

So, in summary, I would say that should this bill be enacted in its present form, it will only serve to protect the abortionist and the institution or clinic wherein he or she performs the abortion procedure. Furthermore, unless this booklet is prepared by an individual, or a committee of individuals, uncommitted to a pro-abortion philosophy, and the information contained within it is all inclusive and prepared in languages and given to the woman well in advance of the performance of the procedure, then it cannot and it will not fulfill its goal, which is to guarantee her the right to an informed consent. Thank you.

ASSEMBLYMAN LESNIAK: I want to thank you for your testimony. I wasn't aware that Dr. Finley was the director of Planned Parenthood in Maryland.

Esme Ambos will be the next witness.

E S M E C. A M B O S: My name is Esme Ambos and I speak as a private citizen. I support Assembly bill 1155, but with reservations. This bill requires parental notification prior to the performance of an abortion on a pregnant minor child.

The right of parents to guide and counsel their children is inherent. A child is the responsibility of the parents from birth. In effect, the child "belongs" to its parents. A child born in New Jersey does not belong to the state.

The thread of life, of blood relationship, extends from the pregnant child to her parents, and their parents, and their grandparents. Likewise, the family lineage extends from the grandparents to parents, to the child and the child in utero.

The unborn child is already a member of the family by virtue of its bloodlines. Therefore, the claim of the parents on the life of the unborn baby is obvious. To deny the parents knowledge of the intention of their child to have an abortion is to rob them of their grandchildren, their hope in the next generation.

The parent-child relationship, unchanged by time or by culture, cannot be severed by the state. This is a law of nature that no man-made law can change. It is incredible to me that in a civilized society, laws must be passed to reaffirm these basic truths.

It is also incredible that our country and our government, which are dedicated to saving lives and promoting human rights, would deny its citizens the most fundamental right of all--the right to be born.

While I believe that parental notification is insufficient to uphold the rights of parents and grandparents to protect their progeny, under the restrictions made by recent Supreme Court decisions, this is the best that can be done at this time. This bill should become law.

ASSEMBLYMAN LESNIAK: Thank you. The next witness is Dr. Marguerite Larsen, Rutgers University Health Center.

M A R G U E R I T E L A R S E N: Chairman Lesniak and fellow citizens, I am here for the first time testifying in public. So, please, be patient. I have a lot of ridiculous notes and I will try to make them clear.

I am grateful to be here today to present my views on the two bills, 1155 and 1592. I am a physcian of the past 23 years, trained in internal medicine and since 1973, I have been working in student health services and have become a family care physician, family practice physician, where I am on the staff at Rutgers Medical School.

I am also here as a mother of three teenage children--two teenage children and one nearly teenage child. I want to oppose 1155, not because I don't think that parents should or should not be informed. This is the kind of information that I feel should be at the discretion of the physician. I can only agree with my colleague, Dr. Hoffman, that parental help is desirable. I feel uncomfortable with the state legislating that I must tell the parent, even when I may believe it is not to the benefit of that patient in health care.

Other people who have been here have brought up the arguments that can come up in individual cases and that is the situation that I attend to. I am a family physician or a primary care physician and my concern is for my patient and what I feel I can do that is best for the patient's welfare.

I feel, also, that 1155 breaks down patient confidentiality, which is so important to me in the caring of adolescents and in caring for all patients, but specifically in caring for adolescents today. There is something that comes into

my mind, that we may even be colluding in an unhealthy family relationship, when you find that the young adolescent might be getting pregnant in order to get back at the parents and if I am forced, by virtue of legislation, to partake in this, I feel uncomfortable about that.

As a caring physician, I keep my patients' health, mental and physical, as primary. Concerning the patient's mental health, I fear 1155 may add, not necessarily, but may add emotional pressure in an already emotion filled situation. I am not against parental involvement, but I would like to reserve the right to decide when it is best for my patient and not be forced to do something illegal or to send my patient to another state for doing something that I think is best for their health.

I am glad for our respect of young people's rights. It has helped me to be able to start to control venereal disease because, in this situation, we have had some laws where we do not have to inform the parent about the treatment that we are doing and it has been an advance, I feel, in the care of the patient. That pretty much describes how I feel about 1155.

On the other bill, 1592, I support the idea of better reporting of abortions. I was glad to hear Dr. Halpin say that they may be doing something where we would be reporting to them on this and I hope that does come about in some way so that we can work with our Department of Health to get this data, which is very important.

However, I am concerned about the booklet that I would have to give to the patient. I am concerned for different reasons. I was for patient inserts many years ago when that debate came about. It was a good idea and this booklet is a good idea, but when I see what has happened with patient inserts, in practice, when a patient reads the insert and because of the way it is worded or even if, let us say, the booklet was very good, some patients still interpret what is there in their own way and become very concerned and they, therefore, may not take medication or have unnecessary concerns that I feel are, again, a detriment to good medical care. So, on 1592, the booklet, I am fearful, might cause more damage, in the long run, than what we would intend by having that information available. I do agree that that information should be given to the patient and I think it is my medical society's responsibility to insist that we feel that responsibility. I can only say, in my own practice, this is carried out and all information is given to the patient, all options are given to the patient because we know full well that this act that they are going into is with them for the rest of their lives.

I don't like the idea of their having to sign something and that, again, might add to the emotional trauma of the situation. It adds to a certain amount of fear that I want to prevent them from not being able to come back and get help from me in the future. I think that pretty much says it.

The only other thing, I want to support--I have listened to other people while I was here--and I want to support the American Bar Association that states that a parent's support should be enlisted, but with the minor's consent. I am in full agreement with that. I try very hard to do that. In student health, it is very important that the student understand that the parent is not going to be informed about what they are telling me or what will go on there and I have learned that this is very important to get the minor's consent in something like this and I would want that to happen with my children.

ASSEMBLYMAN LESNIAK: Thank you very much, Doctor. I would probably put you in the same category as Dr. Hoffman as far as being a caring physician.

However, you have a family practice, you are a family care physician.

DOCTOR LARSEN: I'm a student health physician.

ASSEMBLYMAN LESNIAK: Okay. Would you say that your attitude is prevalent in terms of the physician-patient relationship that exists in the abortion clinics.

DOCTOR LARSEN: I cannot say. I would hope so and if it isn't I would do just as much within my power to get it in that same way.

ASSEMBLYMAN LESNIAK: Certainly, your relationship with your patients is not a tenuous one. You just don't see them for a half hour or an hour.

DOCTOR LARSEN: Right.

ASSEMBLYMAN LESNIAK: Just one more question. I have a difficulty resolving, philosophically, that as far as informed consent and as far as parental notification, why the abortion procedure is singled out as being different from other surgical procedures because I've heard that argument being used that it should not be different and yet, it is different. Are not informed consent forms for surgical procedures signed by patients?

DOCTOR LARSEN: We do a lot of signing of procedures and that is usually legislated by the people who I work with or by lots of things. All I am saying is, please, don't put another one on me.

ASSEMBLYMAN LESNIAK: Thank you very much. Is there anyone else who would like to testify who is not on the list. Could we have your name please?

J U D Y R O B E R T S O N: I am Judy Robertson. I am a registered nurse, working presently, and I'm a mother. I wish I had had more time to prepare some thoughts, but I just have a few very fast reactions. One, as a nurse, I did work in labor and delivery and many of the abortions, especially the early ones, are done very, very similarly, if not exactly, as D&C's, dilitation and curettage, which I think most everyone here knows about. I worked in a very guarded situation in a hospital where all facilities were available at my fingertips. There is no way for a doctor to say that this woman is not going to have a complication. The most healthy young woman, not as some of the doctors said, a high risk teenager or a very young girl, you would say, "Well, she'll have no problem at all. One, two, three, she'll be done. We'll watch her and she will progress and be healthy." As anyone in the field knows, you cannot be certain of that.

ASSEMBLYMAN LESNIAK: Excuse me, did you hear Dr. Halpin's testimony?

MS. ROBERTSON: Yes, I did and he did say some things which I could not justify. First, he said that they are very high risk and then he is saying, well, we really shouldn't tell the parents about this. I have seen situations change in five minutes from a very healthy woman, with vital signs perfect, to someone hemorraging. I say, if this done where a young girl comes into an abortion clinic, has her abortion done with, I would say, very minimal counselling, let's be honest about it, and then she goes home and the parent knows nothing of her situation and can proceed to have some minimal to very, very severe side effects and the parent doesn't even know. Perhaps the mother is at work. Now, that is one hell of a pickle to be in as far as I am concerned.

Also, I hear everyone gasp when they say, in the literature, if we get this booklet where people will be informed, if we have fetal development in there, it will be an affront to a young child. They shouldn't see this. They can't comprehend it. Well, then we should take many, many lovely programs off of Channel 13 because we see it there and it is on there. They have some marvelous scientific programs

where they show the developing child. I think, if you are going to hide this from the young woman who is going to choose for the abortion and then she sees it on TV, you have done her a terrible disservice. Thank you for allowing me to speak.

ASSEMBLYMAN LESNIAK: Thank you. Is there anyone else. Could we have your name please?

H E L E N B U N I N: My name is Helen Bunin and I am Judy Robertson's sister and I can't let her have the last word. I am a registered nurse and I practice nursing at a hospital in Summit, one of the most progressive hospitals in the state.

I would also like to to say that I am the mother of eight children. I've had five teenagers at one time. So, I know all about teenage raising. I would just like to say that I think before there were courts of law, before there was a Constitution, before there was anything like this, there were parents and there were children and I think we ought to regard this as a basic right, the right of a parent to be with children in a crisis. Believe me, this is a crisis situation, when a child comes in and wants information about an abortion. Thank you.

ASSEMBLYMAN LESNIAK: Thank you. I would like to thank everybody again. The record for today's proceedings will be available sometime in the future in the bill room in the State House. Thank you for coming down.

(Hearing Concluded)

124 Montgomery Street, 2Q
Highland Park, NJ 08904

September 25, 1980

Assemblyman George J. Otlowski, Chairman
Assembly Committee on Institutions,
Health and Welfare
State House
Trenton, NJ 08625

Re: Proposed Assembly Bill No. A.1155

Dear Assemblyman Otlowski:

Because I am unable to attend the public hearing on October 1 on the above-mentioned proposed bill, I would like the Committee to include the enclosed written testimony when considering the enactment of the bill.

Thank you.

Sincerely,

Susan K. Perger

cc: Raymond Lesniak
Thomas J. Deverin

124 Montgomery Street, 2Q
Highland Park, NJ 08904

September 25, 1980

Assemblyman George J. Otlowski, Chairman
Assembly Committee on Institutions,
Health and Welfare
State House
Trenton, NJ 08625

Re: Proposed Assembly Bill No. A.1155

Dear Assemblyman Otlowski:

As a tax-paying resident of New Jersey, I would like to submit comment on proposed Assembly Bill No. 1155, requiring parental notification before performing an abortion on a pregnant minor.

Faced with an unwanted pregnancy, abortion is never an easy decision - not for a woman of 40, 30 or 20. It is even more difficult, and perhaps more frightening, for a young woman under 18. Many young women do go to their mothers/parents for guidance and support when faced with such a difficult situation. Those who do not, however, most likely have a valid reason for keeping quiet...for example, the 16-year-old who was raped by her stepfather, resulting in her pregnancy. Fearing reprisal from her mother, she arranged with support from an older relative to have a legal abortion. Although her mother found out beforehand and attempted to stop her daughter (blindly refusing to accept the fact that her husband was capable of committing such an act), the young woman's doctor was able to perform a legal abortion, sparing her a life-long reminder of a horrible violation.

If you were a young woman of 16, what would you have done?

Having been present at several pre-abortion counselling sessions, I can relay some of what I saw and heard...

> ...a 16-year-old who still didn't understand how "it" happened. She couldn't tell her mother - "She'd kill me." (Do we blame the schools for poor or no sex education, or the parents for lack of communication?)

...a 17-year-old high school senior who had been using a contraceptive but still got pregnant. She loved her boyfriend but wanted to finish high school and go to college. She knew she couldn't pursue her ambitions if she had a child a t such a young age. "My parents wouldn't understand. I'll never tell them."

...a 15-year-old who was afraid of having an abortion but knew she had no other option. "My boyfriend is waiting outside, but I'll never tell my parents. I'm afraid they'd beat me to death."

All these young women made the correct decision for themselves. They believe in a woman's right to control her own life and body. It is a right that a woman is entitled to - whether she's 15 or 50.

If men (including "unemancipated minors under the age of 18") could get pregnant, I wonder if this bill would have ever been introduced.

I strongly urge the Assembly Committee to vote against this bill.

Sincerely,

Susan K. Perger

cc: Raymond Lesniak
Thomas J. Deverin

St Joseph's Hospital and Medical Center
703 Main Street • Paterson • New Jersey 07503 • (201) 684-7500

Abortion

Continuing Commitment to Care

September 10, 1980

Mr. Raymond Lesniak
District 21
N.J. General Assembly
60 Prince Street
Elizabeth, N.J. 07208

Dear Mr. Lesniak:

I have recently become aware of Assembly Bill A 1592 introduced by Assemblyman Herman on April 21, 1980. As a pro-life obstetrician active in the subspecialty of perinatology (care of complicated pregnancies) I am opposed to the termination of any pregnancy - be it spontaneous or induced - that will jeopardize and even preclude the life of the newborn. I do, however, observe laudatory points in the Bill as proposed and would ask the members of your Committee to amplify on two issues prior to submission of the completed Bill.

The induction of abortion is a surgical procedure and as such has its attendant complications. These can readily be divided into immediate and delayed. Hemorrhage and infection are the most serious of the immediate and these can indeed be life-threatening. Perforation of the uterus may occur with the surgical instrument because of the softened condition caused by the hormones of pregnancy. Following the abortion by periods of days to years certain complications are well recognized but easily overlooked by physician and patient alike because of the passage of time. A focus of pelvic infection may be initiated by the abortion and flareups in the future may render the patient infertile. Scarring of the lining of the cavity of the uterus may result in cessation of menstrual activity and the inability to get pregnant. Rh sensitization - all but "cured" since the introduction of a vaccine in 1968 - may result because of the inability of the patient to receive Rho Gam (R) (the vaccine) because of lack of knowledge of blood groups of the father of the baby and the fetus. This can result

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Continuing Commitment to Care

September 10, 1980

in loss of wanted pregnancies in the future. Along this line literature from Middle European countries has shown that the incidence of premature deliveries in future pregnancies bears a direct relationship to the number and technique employed in performing the abortions. We are all well aware of the expense entailed in the sustaining of life in these tiny newborns and the burden on society of maintaining them throughout life if permanent injury occurs because of their premature birth. If we are to consider women seeking abortions as mature adults acting within their rights we must also accept the fact that adverse psycologic implications may accompany their decision just as all adults must accept the consequences of their daily interactions. Careful, long term studies do show that the majority of women undergoing abortion do harbor feelings of guilt long after the procedure has been performed.

The medical community is well aware of the rights of patients undertaking any form of treatment to know the good and bad consequences of undertaking such treatment. The conventional manner of obtaining patient compliance is to explain the procedure; detail the most common advantages and disadvantages and allow the patient to consider these and return with a decision. Patients contemplating abortion should be afforded this same luxury.

As the Chairman of the Subcommittee on Maternal Mortality of the State Medical Society, I report to you that there were twenty-seven maternal deaths in New Jersey in 1979 and two followed abortions. There were about 93,000 live births and an estimated 30,000 abortions. It is essential that some means of data collection be established promptly to evaluate the impact of abortion on maternal health and well-being.

Basic to this report should be the number of pregnancies and number of children of the aborted patient; the length of the pregnancy and the type of procedure performed. In addition, the blood group should be recorded and, if the patient be Rh negative, the administration of Rho Gam(R) should be noted.

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The noting of early complications should be mandatory and it would be highly desirable to have physicians be required to report late complications of abortion as well. As with the majority of other surgical procedures the pathology report should accompany the required form. This should insure that pre and post-operative diagnoses were accurate and also diminish the possibility of an ectopic pregnancy if none were noted in the uterus in the patient with a positive pregnancy test and symptoms of pregnancy.

May I ask that you give thought to the above points and include them in the Bill?

Sincerely,

James P. Thompson, M.D.

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Family Planning Public Affairs Office
32 West Lafayette St.
Trenton, N. J. 08608

Excerpts from STANDARDS RELATING TO RIGHTS OF MINORS, Juvenile Justice Standards Project, Institute of Judicial Administration and the American Bar Association. Adopted by the ABA, February 12, 1979.

Example

Part IV: MEDICAL CARE

4.1 Prior parental consent.

A. No medical procedures, services, or treatment should be provided to a minor without prior parental consent, except as specified in Standards 4.4-4.9.

B. Circumstances where parents refuse to consent to treatment are governed by the Abuse and Neglect volume.

4.2 Notification of treatment.

A. Where prior parental consent is not required to provide medical services or treatment to a minor, the provider should promptly notify the parent or responsible custodian of such treatment and obtain his or her consent to further treatment, except as hereinafter specified.

B. Where the medical services provided are for the treatment of chemical dependency, Standard 4.7, or venereal disease, contraception, and pregnancy, Standard 4.8, the physician should first seek and obtain the minor's permission to notify the parent of such treatments.

1. If the minor-patient objects to notification of the parent, the physician should not notify the parent that treatment was or is being provided unless he or she concludes that failing to inform the parent could seriously jeopardize the health of the minor, taking into consideration:
   a. the impact that such notification could have on the course of treatment;
   b. the medical considerations which require such notification;
   c. the nature, basis, and strength of the minor's objections;
   d. the extent to which parental involvement in the course of treatment is required or desirable.

2. A physician who concludes that notification of the parent is medically required should:
   a. indicate the medical justifications in the minor-patient's file; and
   b. inform the parent only after making all reasonable efforts to persuade the minor to consent to notification of the parent.

C. Where the medical services provided are for the treatment of a mental or emotional disorder pursuant to Standard 4.9, after three sessions the provider should notify the parent of such treatment and obtain his or her consent to further treatment.

4.3 Financial liability.

A. A parent should be financially liable to persons providing medical treatment to his or her minor child if the parent consents to such services, or if the services are provided under emergency circumstances pursuant to Standard 4.5.

B. A minor who consents to his or her own medical treatment under Standards 4.6-4.9 should be financially liable for payment for such services, and should not disaffirm the financial obligation on account of minority.

C. A public or private health insurance policy or plan under which a minor is a beneficiary should allow a minor who consents to medical services or treatment to file claims and receive benefits, regardless of whether the parent has consented to the treatment.

D. A public or private health insurer should not inform a parent or [illegible] holder that a minor has filed a claim or received a benefit under a health [illegible] policy or plan of which the minor is a beneficiary, unless the physician has previously notified the parent of the treatment for which the claim is submitted.

4.4 Emancipated minor.

A. A minor who is living separate and apart from his or her parent and who is managing his or her own financial affairs may consent to medical treatment on the same terms and conditions as an adult. Accordingly, parental consent should not be required, nor should there be subsequent notification of the parent, or financial liability.

1. If a physician treats a minor who is not actually emancipated, it should be a defense to a suit basing liability on lack of parental consent, that he or she relied in good faith on the minor's representations of emancipation.

4.5 Emergency treatment.

A. Under emergency circumstances, a minor may receive medical services or treatment without prior parental consent.

1. Emergency circumstances exist when delaying treatment to first secure parental consent would endanger the life or health of the minor.

2. It should be a defense to an action basing liability on lack of parental consent, that the medical services were provided under emergency circumstances.

B. Where medical services or treatment are provided under emergency circumstances, the parent should be notified as promptly as possible, and his or her consent should be obtained for further treatment.

C. A parent should be financially liable to persons providing emergency medical treatment.

D. Where the emergency medical services are for treatment of chemical dependency (Standard 4.7); venereal disease, contraception, or pregnancy (Standard 4.8); or mental or emotional disorder (Standard 4.9), questions of notification of the parent and financial liability are governed by those provisions and Standards 4.2 B., 4.2 C., and 4.3.

4.6 Mature minor.

A. A minor of sixteen or older who has sufficient capacity to understand the nature and consequences of a proposed medical treatment for his or her benefit may consent to that treatment on the same terms and conditions as an adult.

B. The treating physician should notify the minor's parent of any medical treatment provided under this standard.

4.7 Chemical dependency.

A. A minor of any age may consent to medical services, treatment, or therapy for problems or conditions related to alcohol or drug abuse or addiction.

B. If the minor objects to notification of the parent, the physician providing treatment under this standard should notify the parent of such treatment only if he or she concludes that failing to inform the parent would seriously jeopardize the health of the minor, and complies with the provisions of Standard 4.2.

4.8 Venereal disease, contraception, and pregnancy.

A. A minor of any age may consent to medical services, therapy, or counseling for:

1. treatment of venereal disease;

2. family planning, contraception, or birth control other than a procedure which results in sterilization; or

3. treatment related to pregnancy, including abortion.

B. If the minor objects to notification of the parent, the physician providing treatment under this standard should notify the parent of such treatment only if he or she concludes that failing to inform the parent would seriously jeopardize the health of the minor, and complies with the provisions of Standard 4.7.

4.9 Mental or emotional disorder.

A. A minor of fourteen or older who has or professes to suffer from a mental or emotional disorder may consent to three sessions with a psychotherapist or counselor for diagnosis and consultation.

B. Following three sessions for crisis intervention and/or diagnosis, the provider should notify the parent of such sessions and obtain his or her consent to further treatment.

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Excerpts from Commentary section:pp. 56-57:

"The complexity of the issues and the variability in individual situations preclude adopting an absolute rule either barring disclosure or requiring notification under all circumstances where a minor has received medical treatment without prior parental consent. Nothing in this standard prevents the minor from informing the parent himself or herself, nor the physician, on the basis of sound medical judgment, from attempting to persuade the minor of the desirability of parental involvement. Rather, the standard attempts to resolve the physician's dilemma in those instances where the minor either expresses no position or voices opposition to parental disclosure."

"In dealing with this issue of notification of parents, this standard distinguishes between those types of treatment in which the interests of the parent and the minor will normally coincide and where notification of parents is appropriate and mandatory, and those circumstances where the interests of parent and child may conflict and the minor may or does object and notification is discretionary. In the latter instances, the overriding social interests in enabling the minor to obtain the particular treatment dictate that unless the minor's health will be seriously jeopardized by failing to notify the parents, the minor's objection to disclosure should be honored by the treating physician."

....."Standard 4.2 B. authorizes deviation from the norms of notification and consent of parents when compliance with these policies would inhibit the provision of needed medical treatment in certain identifiable medical problem areas where minors will be likely to require medical treatment; they are likely to object to parental notification; and the social desirability of providing services outweighs the potential negative impact of nondisclosure on family autonomy. In such instances, Standard 4.2 B. 1. permits parental notification when exceptional circumstances require, but suggests several factors and considerations that may weigh against parental notification. The importance of minors obtaining treatment for chemical dependency, or for venereal disease, birth control, and pregnancy; the potential deterrent effect that disclosure may have in a particular instance; and respect for the autonomy and independence of the minor in such circumstance, requires substantial respect for the minor-patient's objections to parental notification." (Emphasis added)

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Testimony of Frank Askin

for the American Civil Liberties Union before the Subcommittee of the New Jersey Assembly Committee on Institutions, Health and Welfare, on A. 1155 and A. 1592.

October 1, 1980

I appear today on behalf of the American Civil Liberties Union and the American Civil Liberties Union of New Jersey in opposition to A. 1155 and A. 1592. But before addressing those specific proposals, I would like to direct myself to a broader question -- Why do we have to be here at all?

Almost a decade ago, the United States Supreme Court ruled that a woman had a constitutional right to terminate an unwanted pregnancy. The court ruled that the decision to abort a pregnancy was a decision to be made by a woman and her doctor, and the state had no business interfering with the free choice of that decision.

Ever since then, the groups opposed to that decision and their political allies have waged unrelenting guerrilla warfare against American women of child-bearing age. Those forces that have refused to accept the constitutional mandate enunciated by our highest tribunal have sniped at this liberating concept from one end of our land to the other, attempting to forbid as many women as they possibly could from effectuating their fundamental right to control over their own bodies. And, unfortunately, these anti-constitutional attacks have had their most profound impact on those women least able to protect and enforce their own rights -- the poor and the young. For these most vulnerable groups, the price of exercising a woman's most basic civil right has been made dear indeed!

The bills before this Committee today are additional examples of these anti-constitutional attempts to prevent certain women from enforcing their rights.

I and the American Civil Liberties Union say the time has come when legislative bodies should cease in their efforts to circumvent the enforcement of women's constitutional rights and turn their attention to the real and serious needs that face the young and the poor in our state, particularly those who inhabit our deteriorating urban centers.

It is within the context of this unrelenting campaign to nullify the Supreme Court's decision in the 1973 abortion cases, that we oppose these two additional bills which impinge upon a woman's right to freedom of choice.

Isolated from this historical context, A. 1592 is, of course, not clearly objectionable. Certainly, the American Civil Liberties Union is a vigorous supporter of the concept of informed consent. No organization is more devoted to the free and open dissemination of information necessary to people in order to make informed decisions about events that affect their lives.

If A. 1592 provided for the dissemination of information concerning any and all medical procedures, not excluding abortions and sterilization, we would applaud

it. That is obviously not the intent or affect of A. 1592. Even assuming the Department of Health will prepare and distribute a completely objective and impartial handbook concerning the abortion decision, it will be immediately clear to every abortion patient to whom the booklet is distributed that this is just one more piece of social pressure to dissuade her from her decision to terminate pregnancy -- a pressure brought to bear upon her by the state in order to appease those segments of the community who find abortion morally reprehensible. It will be one more subtle effort to impose that particular moral/view upon others in the community who do not necessarily subscribe to it.

That A. 1592 is sponsored by some who support freedom of choice does not mitigate this fact, since it is clear that it is only being proposed under the pressure of those who desire much more stringent regulations.

The real thrust and meaning of this bill is underscored by the fact that failure to provide the booklet would subject a physician to criminal sanctions. As the Supreme Court made clear in 1973, the criminal law has no business intervening in the private and confidential relationship between a pregnant woman and her physician. There are no other procedures that require a doctor under penalty of criminal sanctions to give information concerning alternatives to the medical procedure which has already been determined.

While it is true that the United States Supreme Court has upheld an "informed consent" provision in Planned Parenthood v. Danforth,* that decision emphasized the narrow scope of the regulation there approved. While noting that it was not entirely clear what information was required to be supplied the patient under that statute, the Court assumed that it only required "the giving of information to the patient as to just what would be done and as to its consequences." The Court went on to suggest that ascribing any more meaning to the provision "might well confine the physician in an undesired straitjacket in the practices" of the medical profession.

A. 1592 appears to impose just such a "straitjacket." It does not appear to be confined to the giving of information concerning "just what would be done and its consequences." The proscribed booklet must also include "a complete listing of alternative services available to the woman should she choose not to have the abortion." Such information obviously goes well beyond the medical procedures and consequences approved in the Danforth case.

The additional provision of 1592 which requires the physician to submit a report on each abortion performed

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*428 U.S. 52 (1976).

can only serve to further chill the exercise of the constitutional right. No matter what the bill promises about confidentiality of patients' names, few people nowadays have enough confidence in governmental processes to rely on such assurances. There have been too many instances of misuse of information in government files to satisfy many women that their names will be forever safe from snoopers and busibodies.

Precisely because the state exhibits such a special interest in abortion patients compared with those who undergo other surgical procedures, the reporting provision can only have the effect of dissuading some from exercising what the courts have declared to be a fundamental right.

A. 1155 is objectionable for similar reasons. To certain teenagers, the assurance that their parents will be notified if they seek an abortion will have the certain effect of either preventing them altogether from exercising their constitutional right to terminate an unwanted pregnancy or else drive them into the arms of dangerous, back-alley practitioners.

It is well settled now that a parent may not veto a teenager's right to obtain an abortion. Planned Parenthood v. Danforth and Bellotti v. Baird.* In formal terms,

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*99 S.Ct. 3035 (1979).

the requirement of notification is not the same as a parental veto, but in practical terms the notification can have the same result. Parents who strongly disagree with their daughter's decision have many ways to punish her even if she decides to proceed. They may try to force her into a marriage she does not want and that could substantially harm her future life. They could refuse to send her to college or to provide her with clothes and other necessities.

Even if a young woman decided ultimately to proceed with an abortion against the wishes of her parents, the notification requirement may well cause a dangerous delay in decision. As recently reported in an article in the New England Journal of Medicine, "Teenagers as a group already obtain abortions later in gestation than do older women, and fear of telling their parents, even without this [legal] requirement, has an important role in this delay."* That same article noted that "the risk of complications increases approximately 20 to 30 per cent and the risk of death increases approixmately 50 per cent each week that the abortion decision is delayed."

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*Cates, Gold and Selik, "Regulation of Abortion Services -- for Better or Worse?", 301 New England J. of Med. 720, 722 (1979).

In the best of all possible worlds, it might be desirable for a young woman to consult with her parents before obtaining an abortion. The problem with this proposal, however, is that the notification requirement falls with equal force on both sympathetic families and unsympathetic ones. It does not require notification only of parents who are understanding and can help their daughter make a decision in a sound and responsible way. It also requires notification to parents who are harsh or vindictive, parents who might want to punish their daughter for having engaged in sexual activity or whose own personal philosophical opposition to abortion may blind them to their daughter's right to make her own decision in this matter. As the Supreme Court observed in Bellotti, "many parents hold views on the subject of abortion, and young pregnant minors, especially those living at home, are particularly vulnerable to their parents' efforts to obstruct...an abortion..."

While the United States Supreme Court has not definitively stated whether a parental notification requirement can pass constitutional muster,* several lower federal courts have decided subsequent to the Bellotti decision that such a provision is an unconstitutional

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*See H.L. v. Matheson, ___ Utah ___ (Dec. 6, 1979), prob. jur. noted 48 U.S.L.W. 3554 (Feb. 26, 1980).

burden upon the right of a minor to obtain an abortion. See Akron Center for Reproductive Health Inc. v. City of Akron (Civ. Act. C-78-155A, N.D. Ohio, 8/22/79); and Women's Community Health Center Inc. v. Cohen (Civ. No. 79-162P, D., Me., 9/13/79).

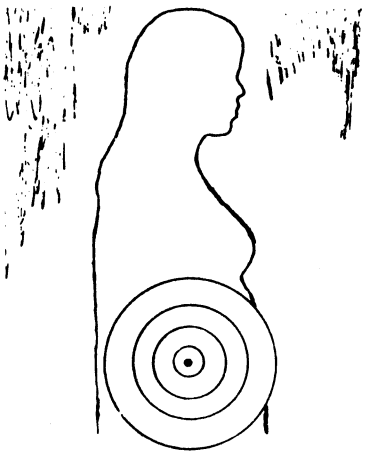
In light of this past history and the context in which this issue comes once again before the New Jersey Legislature, enactment of such a requirement into law could only be seen as one more cynical effort to harass and intimidate women in general, and the most powerless and vulnerable segment of the female population in particular.

The American Civil Liberties Union would urge this Committee to abandon its efforts to single out abortion as a topic of special legislation and focus much more broadly upon the general crisis of community health care, especially among the poor in our deteriorating urban centers.

every woman

has

a right



to know the

DANGERS

of legal abortion

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A FIVE YEAR PLAN: 1976-1980

for the PLANNED PARENTHOOD FEDERATION of AMERICA, Inc.

Contents

Approved by the PPFA Membership
October 22, 1975; Seattle, Washington

PREAMBLE TO THE FEDERATION FIVE YEAR PLAN

In the spirit of this Country's Bicentennial Year, we preface the new Five Year Plan with two truths which we "hold" to be "self-evident":

I - The Federation believes that "universal reproductive freedom" is a most essential, if not the most essential step in providing our civilization the opportunity to solve the most critical problems of hunger, deprivation, and the homelessness of poverty as well as the deterioration of our water, air and land. The Federation must be mindful that its movement is not the solution to these problems.

II - If the Federation is to attain the objectives set over the next five years, it must raise one-half Billion dollars or more. We must count on almost one out of every three dollars to come from private sources. Without a complete dedication at all levels of the Federation to develop new resources and to improve our present base of support, the goals set forth in this Plan cannot amount to more than a few pages of noble "sounds signifying nothing".

A FIVE YEAR PLAN FOR THE PLANNED PARENTHOOD FEDERATION OF AMERICA: 1976-1980

INTRODUCTION

Purpose of the Plan:

a) A declaration of goals for the PPFA over the next five years, consistent with the stated Purpose and fundamental policies, and reflect the Federation intended role in the family planning field.
b) A planning outline providing a framework to base individual affiliate and headquarters plans and budgets. As a planning document it also provides benchmarks for measuring the achievements of the Federation as a whole.

How the Plan Has Been Drafted:

This revision represents the collective thoughts and suggestions of all levels and segments of the PPFA. The National Expansion and Policy Committee has the continuing responsibility for drafting and recommending to the Membership a five year plan every two years. The process of revision is dependent on the thoughts of the Membership. All regions have given their initial thoughts on the plan during the Spring meetings. Together with this input and the suggestions of PP-WP staff, other Board Committees, other groups, a draft is conceived which is then submitted to the Membership for its consideration and approval at the Annual Meeting.

WHO WE ARE

PPFA - The organization, known collectively as the Planned Parenthood Federation of America, is the country's leading private family planning agency. It is composed of a national headquarters office and regional offices, 174 medical service affiliates, 12 educational affiliates. The medical affiliates operate 729 clinics. The national headquarters, including the regional and Washington D.C. offices, comprise the entity called Planned Parenthood-World Population (PP-WP).

PPFA is an organization in which policy, goals and standards of operation are established by a volunteer body (the Membership) and in which policies, goals and standards are actualized by a corps of staff and volunteers.

Age - The oldest affiliate still in operation today was formed in 1922. Since then over 200 affiliates have been organized. The growth in the number of affiliates mainly occured in two stages: 1922-1940 (74 organized) and 1960-1973 (107 organized). Therefore, affiliates tend to be either long established (over 30 years old), or relatively young (under 15 years). In general, the older the affiliate, the larger its caseload. Other characteristics also tend to correlate with age.

Basically Urban - Most of PPFA's affiliates are located in metropolitan areas. In FY 1974 approximately 93% of PPFA's patients resided in metropolitan areas. This compares to a 72% metropolitan patientload of non-Planned Parenthood organized programs (hospitals, health departments, other agencies).

Emphasis on Youth - In 1974 approximately 32% of the total patients (and 43% of the new patients) were under 20 years. Over 40% of total patients were between 20 and 24. The percentage of patients with no living children rose to 71% in 1974, up from 68% in 1973 and 56% in 1971.

Emphasis on the Poor and Near Poor - Nearly 71% of all contraceptive patients served had incomes classifying them below 150% of poverty (equivalent to an annual family income of less than $7,557 for a family of four). An additional 14% fell between 151-200% of poverty (equivalent to $7,558-10,076 for a family of four).

Facilitator in Initiating and Upgrading Contraceptive Usage - Planned Parenthood has enabled persons to initiate contraceptive use. Planned Parenthood has also been instrumental in helping patients upgrade their method of contraception. Of the new patients served in 1974, 52% had previously used ineffective methods or none at all. At the time of their last visit reported, 87% were using the most effective methods (pills, IUD, sterilization), 6% less effective methods, and 7% no method.

Sources of Federation Financial Support - The proportional mix of financial support from the three major sources (fundraising, government, and patient fees) depends on a number of variables including size of patientload, age of affiliate, and the average disposible income in their area of operation. Government funding forms the largest source of income of all groups ranging from 70% in the youngest affiliates to 40% among the 20+ year groups. Fund raising income from the private sector is clearly linked to the effective buying power of the population in the affiliate's area. Patient fees tend to increase in proportion among the larger, long estalbished affiliates.

BASIC ASSUMPTIONS CONCERNING THE ENVIRONMENT OVER THE NEXT FIVE YEARS

1. U.S. Fertility - It is assumed that U.S. fertility will remain near replacement level over the next five years. Because of the larger proportion of women entering their reproductive years, the number of births will continue to rise along with the Crude Birth rate, reaching a crest in the mid 80's.

2. Closing the Gap - It is assumed that one-third of the low and marginal income individuals will continue to remain unserved unless services are expanded.

3. Abortion - Abortion will continue to be a heavily contested subject. It is assumed that access to abortion services will continue to improve but with wide variations from state to state.

4. National Health Insurance - Passage of a National Health Insurance program is highly unlikely for 1975. It is assumed that, even if some form of National Health Insurance legislation is passed in 1975, it would be a number of years before financing and service mechanisms were developed sufficiently to affect affiliates.

5. The Involvement of Affiliate in Health Maintenance Organization Programs (HMO's) It is assumed that the HMO concept will not have general affect on the operations of affiliates over the next five years.

6. Government Financing of Programs - Future projections for the level of government funding of family planning programs beyond FY 1976 remains indeterminant. It can be assumed, however, that government funds will continue to flow into the field in some form. Project grant financing, adminstered chiefly through the Federal Government, will most likely shift somewhat to per-patient cost reimbursement mechanisms which will be administered by individual states.

   As in the previous Plan, a set of three assumptions has been postulated for the level of government funds through 1980. It is further assumed that the Federation must continue to rely on government funds for financing a part of its service programs.

Assumptions on the Level of Government Funds* Supporting Family Planning Services

($ Millions)	FY 1976**	FY 1977	FY 1978	FY 1979	FY 1980
Assumption I (Moderate Growth 10%)	175	193	212	233	256
Assumption II (Maintainance)	175	175	175	175	175
Assumption III (Cutback)	175	150	125	100	100

*Combined estimates for Titles X, V, XIX, IVA and XX.
**FY 1976: Federal grants (V and X) = $125, State Administered = $50.

7. Sterilization - Voluntary sterilization will continue to grow among men and women. It is assumed that sterilization will remain an irreversible procedure.

8. Youth - It is assumed that teenagers will continue to have inadequate access to fertility management services or will use less reliable methods, which will result in higher incidences of unwanted pregnancy (as high as 10% of all female teenagers), higher rates of complications in childbearing, and higher rates of birth defects among this age group. In FY'75 an estimated 4.1 million teenagers were at risk of an unplanned pregnancy. Of these 1.6 million could be classified as poor or near poor.

PURPOSE (Article II From the PPFA ByLaws)

The Purpose of the Federation shall be:

a) to provide leadership

- in making effective means of voluntary fertility control, including contraception, abortion and sterilization, available and fully accessible to all;

- achieving a U.S. population of stable size in an optimum environment;

- in stimulating relevant biomedical, socio-economic and demographic research;

- in developing appropriate information, education and training programs;

b) to support the efforts of others to achieve similar goals in the United States and throughout the world.

We recognize that attainment of these goals is essential to the social, economic, mental and physical health of the family, the nation, and the world.

Positions and programs adopted in pursuit of the above goals should be constantly reviewed and reevaluated in the light of changing conditions.

The Federation reaffirms that where any program with which it is acquainted becomes tainted with racial bias, it will vigorously avow its disapproval of it, and in the absence of prompt change, disassociate the Federation from it.

* *

OBJECTIVES OF THE FEDERATION

The Federation's central objective shall be to bring about the virtual elimination of unwanted pregnancy in the United States by the end of the decade. Such an enterprise --establishment of universal reproductive freedom in this country--will require, at the very least, the following elements of social change over the next five years:

- extending family planning services to meet the needs of those whose ability to regulate their fertility is presently limited by age, economic, geographic or other barriers;

- reaffirming and protecting the legitimacy of induced abortion as a necessary back-up to contraceptive failure, and extending safe, dignified services to women who seek them;

- committing society's educational institutions, including the family, to the improvement of sexual literacy, understanding and responsibility among all people, especially the young;

- abolishing the arbitrary and outmoded restrictions--legal, regulatory and cultural--which continue to limit the individual's freedom of choice in fertility matters;

- promoting biomedical and socio-demographic population research as a key priority among the nation's research establishment, with the object of developing blueprints for a new and more perfect generation of fertility regulation techniques by the end of the decade.

Our two important secondary objectives shall be (i) to secure and sustain the long-term trend in the nation's birthrate towards a zero rate of natural population increase, and (ii) to assist human, economic and social development throughout the world through the provision of financial support and technical assistance in population-related programs.

Rationale: The past decade has been one of unprecedented achievement for the family planning field in this country. Landmarks reached by 1975 include achievement of the lowest birthrate in U.S. history, surpassing the long-term condition for a zero rate of natural population increase; wide availability and use of modern birth control techniques many times more effective than their predecessors; an educational and service framework within which an estimated four out of five U.S. couples practice birth control with a fair degree of assurance; an annual allocation of U.S. government funds for services and research here and overseas of almost $500 million; establishment of induced abortion as a safe, legal back-up to failed contraception, with the health and personal ravages of dangerous, illegal procedures condemned to history; and fast-growing legal and social recognition that access to birth control information and services should be governed by the choice of the individual, rather than by arbitrary restrictions based upon age, income, marital status or any other factor.

Behind these triumphs, however, there remains a tragic pattern of double standards in our field. Though the whole has moved forward, inequitities among the parts persist, and may actually have increased. For too many persons, in too many places, the opportunity to decide whether or when to bear a child remains an accident of age, or of economic status, or of geography. The problems confronting the teenage sector of America society are especially compelling. Half of all young women have had sexual intercourse by the time they are 19 years of age, but only a very small proportion of them use effective methods of contraception. Of all young women having premarital intercourse, 30% experience a premarital pregnancy. As a result, one-half of out-of-wedlock births and one-third of all abortions are to teenagers. Moreover, a disproportionate number

of teenage marriages, precipitated by a premarital pregnancy, end in divorce.

These conditions, including the teen problem, are unacceptable for the world's most affluent nation entering upon the last quarter of the twentiety century. For the nation, as a whole, it is a continuing shame. For the organization which for more than 60 years has pioneered and led the drive for freedom of choice in childbearing, it poses a mighty challenge: to break down the double standards which mar this field, and to create in their place a universal bill of rights under which every individual and couple would have the opportunity to decide with assurance whether or when to bear a child. It is this central challenge which frames our objectives and plans over the next five years.

On the world scene, we take encouragement from the results of the world conferences on Population, Food, and the Status of Women, and recognize the important responsibility of developed countries to frame sensitive, respectful programs of financial, technical and research assistance to meet the needs of the population-related programs of the nations of the developing world. Such assistance shoud be carefully framed in the context of overall human, social and economic development, and governed by the cultural patterns and desires of the recipient countries themselves.

Role of the Planned Parenthood Federation: In pursuing the grand social objectives outlined above, the role of the Planned Parenthood Federation is central. Our mission is to serve as the nation's foremost agent of social change in the area of reproductive health and well-being. In practice, this role means to spur the institutions of society --voluntary agencies, professional associations, academic research centers, government agencies, civic groups and others--to devoting their own resources and energies, in widely diverse ways, to help fulfill the objectives of reproductive freedom. We accomplish this role in several ways: by providing the service models, testing the pilot programs, publishing and distributing the relevant social economic and clinic research, and mounting an affirmative public information strategy to convey facts, indicate needs, dispel myths.

Central to this overall strategy is the Federation's service and educational programs at the community level. These programs do more than service many millions of individuals who come to us for help year after year. It serves also as a beacon of practical excellence to other institutions and agencies in the community--a living witness that the job can be done, and an important model as to how to go about doing it.

In this context, the various activities we undertake are not somehow "separate", and certainly not competing. Rather, they are all complementary parts of a single national strategy. Our medical service, for example, is not a distinct and separate strategy from our role as "catalyst" or change agent; it is part of it. With the service program, our ability to command authority in the councils where national decisions are made is immeasurably enhanced. It distinguishes us from other "national" advocacy groups which must earn their credibility in other ways, and gives us the firm community base and nation-wide information network which is essential to mounting a truly national strategy.

In this Five Year Plan, our fourth since the process was begun in 1971, we join together as a Federation to frame our overall purposes and cite specific programs and projects necessary to the accomplishment of these purposes. Much of the document is necessarily detailed, and "in-house"; to have it otherwise would be to lose the important function of such a document as a specific guide to action as well as an instrument of overall policy. The key criterion is not whether this or that program listed here is too detailed, or too internal to the organization itself, but whether it survives the test of compatibility with the external mission of the Federation.

NOTE ON THE FORMAT OF THE FIVE YEAR PROGRAMS SECTION:

On the following pages are a set of eight programs for the Federation to continue to move toward over the next five years. The format of this section differs from previous plans because there is a category called "Basic Program Elements" which are to be considered absolutely necessary for the agency to accomplish its basic mission. Under "Additional Projects" there are a number of activities which would greatly enhance the operation and scope of the Federation.

As in previous plans, assignment of responsibility for the implementation of the program elements has been made.

Because of the special nature of fundraising in support of Federation programs, it is treated separately. The dollar goals combined with broad strategies listed on the next page represent merely the beginning of the development of a sound fundraising plan of action. It is recommended that the more detailed function of developing such programs be assigned to the Resources Committee for consideration over the next months.

FINANCIAL SUPPORT OF THE FEDERATION: 1976-1980

The Federation's success in raising funds to support its ongoing programs and the development of exciting, new programs will determine to what degree the following can be accomplished. The Federation derives income from three general sources; 1) Private Donations, 2) Government Sources, and 3) Clinic Income from Fees for Services and Sale of Goods.

Overall Goals in Federation Fundraising:

a) Growth - To maintain 12-15% growth rate in total income per year. This shall consist of:

   1. Private Donations - 15% pa
   2. Government Funds - up to 20% of the total available from state and federal sources. The growth rate is dependent on government appropriations (see assumptions on Government Funding).
   3. Clinic Income - 20% pa (including patient fees, and sales of materials).

b) Limits - To maintain the highest degree of independence by keeping income received from any single source below the level of dependency.

c) New Strategies - To raise the level of fundraising and fee income through the development of new approaches including, but not limited to:

   1. A National Unified Campaign - developed by PP-WP, a national public relations effort coupled with a fundraising message;
   2. Expanding Earned Income Sources - increasing income from sales by developing marketable items and marketing approaches;
   3. Expanding Patient Fee Coverage;
   4. Other Cooperative Fundraising Activities with PP-WP and affiliates on a local and national basis.

d) Federation Income Goals: 1976-1980 -

The table below is divided into three major columns labled I, II, III. The differences in the grand totals reflect the different levels of government financing listed under the Assumption 6 on page 4. Column I represents a moderate increase in government funds, Column II - maintenance at current levels, and Column III represents a cutback. Assumption I would allow for the greatest amount of program activity beyond the basic programs; Assumption II would allow a limited degree of new activity; and Assumption III would permit very little program expansion beyond the basics.

FIVE YEAR FEDERATION INCOME GOALS

Source of Income Agency			I					II					III				
	CY1974 $	1975 $	CY1976 $	1977 $	1978 $	1979 $	1980 $	CY1976 $	1977 $	1978 $	1979 $	1980 $	CY1976 $	1977 $	1978 $	1979 $	1980 $
Private Donations:*																	
Affiliates -	16		19	22	25	29	33	19	22	25	29	33	19	22	25	29	33
PP-WP -			5	6	7	8	10	5	6	7	8	10	5	6	7	8	10
SUSED Government:**																	
Affiliates -	26		30	36	42	48	55	30	30	30	30	30	30	30	25	25	25
PP-WP -			4	5	6	7	8	4	5	5	6	6	4	4	4	4	4
Clinic Income (Affiliates only):***	17		21	25	30	36	43	21	25	30	36	43	21	25	30	36	43
Sub-total: Affiliates	59		70	83	97	113	131	70	77	85	95	106	70	77	80	90	101
Sub-total: PP-WP			9	11	13	15	18	9	11	12	14	16	9	10	11	12	14
TOTAL FEDERATION:			79	94	110	128	149	79	88	97	109	122	79	87	91	102	115

NOTES: *Private donations assumed to reach rate of growth of 15% by 1980.
**Income received by affiliates assumed to be 20% of the total available to the field by 1980.
***Clinic Income, consisting of patient fees and income from sales of goods and materials, assumed to increase at 20% per year.

1976 - 1980 PROGRAMS FOR THE PLANNED PARENTHOOD FEDERATION OF AMERICA

PROGRAM I: Direct Clinical Services - To maintain a major role in the provision of fertility management services with emphasis on services to those not covered by other programs. Service load goals are found on pages 14-16.

The delivery of fertility control services will remain the principle activity of affiliates. The location and type of services provided is dependent on the needs of the particular community, and the type of services provided by others. It shall be the intention of the Federation to provide fertility management services where the need exists either because of lack of availability of where an alternative service program is desirable.

While the Federation intends to maintain a significant direct patient service program indefinitely, the Federation does not consider itself as the primary provider but as one important component of a total service delivery system that also includes public agencies and private physicians.

Basic Service Program Elements - Services to be made available at all clinics include a choice of all methods of fertility management including:

All Non-prescription Contraceptive Methods;
Prescription Contraceptive Methods;
Abortion Services (or local referral);
Voluntary Sterilization Services (or local referral);
Infertility Services (or local referral);
Related Screening and Diagnostic Services (including VD);
Related Educational Counseling Services.

Service Program Emphasis - Emphasis shall be put on services to:

Persons with low and marginal income;
Teenagers and young adults.

Standards and Review - PP-WP, The Federation Headquarters, shall be responsible for setting and updating clinic standards and procedures and monitoring performance. PP-WP to establish a peer-review clinic evaluation procedure to review each clinic facility on a regular basis. The highest possible standards of medical service will be maintained throughout all Federation facilities.

Additional Projects -

Project 1 - Rural Service Delivery
Project 2 - V.D. Treatment
Project 3 - Services to Mentally Retarded
Project 4 - Services to the Physically Handicapped
Project 5 - Additional Gynecological Treatment
Project 6 - Services to Institutionalized Populations

PROGRAM II: Program Development - To stimulate the development of the field of family planning through training, technical assistance, and program planning.

Basic Program Elements -

a. Human Resources Development -

PP-WP in cooperation with affiliates, to develop and identify training capabilities within the affiliate structure. To develop training curricula, materials,

and needs assessment techniques. By 1980 to have a fully operational inter-affiliate training program chiefly for affiliates with capabilities at least in the following areas: Board development, medical and administrative clinic staff training, Executive Director development, volunteer worker training.

PP-WP to maintain or move toward at the national level the capacity to provide training in the following areas: Resource development, Management, budgeting and accounting, securing grants, Board development, medical review/evaluation, international relations, community affairs and personnel relations.

b. Technical Assistance -

PP-WP to develop, with the assistance of the affiliates a resource pool of high quality training and technical assistance resources among affiliates throughout the country and make these resources known within the Federation. Areas of assistance will be provided in: Outreach techniques, working with interagency councils and civic and community groups, medical and educational services development and evaluation, and contract negotiation, accounting systems, and central administration of decentralized delivery systems.

PP-WP also to maintain or move toward maintaining the capacity for on-site consultation: Accounting, computer technology, demography, recordkeeping, family planning law, insurance, medical service delivery and evaluation of the quality of clinic services.

c. Program Planning and Monitoring -

PP-WP: To continue to assist in the development and revision of plans for the provision of family planning services to low-income women in the U.S.; and to continue to conduct planning studies on the organization and administration of consolidated, multi-agency, statewide programs in family planning and related health services.

d. Information Clearinghouse -

PP-WP: In cooperation with the affiliates, to serve as the clearinghouse for information on family planning programs. Affiliates, who will be the chief contributors, will be submitting information on their programs which, when collected nationally, will be useful for policy and program decisions as well as prove useful to other agencies. PP-WP to issue regular bulletins.

Program Emphasis - Emphasis will be put on attaining uniform excellence at all levels of affiliate programs.

Additional Projects -

Project 1 - Program Innovation -

Affiliates, with the support and review of PP-WP, to develop and make known new service and educational program approaches which can be copied and duplicated by other agencies. Areas of continuing interest would include: Teen clinics in schools, genetic counseling, prenatal care, obstetrical services, well baby care, sexual dysfunction counseling.

PROGRAM III: Public Information - To engage in activities aimed at maintaining a consistently high reputation and position of authority in the field of family planning.

Much of the Federation's strength as an advocate of policies and practices furthering the Federation's Purposes is dependent on the ability to maintain a high degree of local and national prominence and authority among both professional and non-professionals. Moreover, the enhancement of a public image is fundamental to success in attracting financial support.

Basic Program Elements -

a. Promotion with the Mass Media - PP-WP to promote its cause and enhance its national image through favorable and frequent coverage of PPFA by national television and radio networks, magazines, the press, and other media reaching a wide audience. Affiliates to engage in similar activities emphasizing local media.

b. Professional Publications - PP-WP to continue to publish Perspectives, the Washington Memo, The Family Planning Reporter, and other professional-oriented publications.

c. Information Network - PP-WP to establish an information network for affiliate use designed to speed important and timely information to all appropriate individuals in the Federation simultaneously.

d. National Advertising Campaign - PP-WP, to design and produce a series of national advertisements on family planning which describe the Federation and its goals in a favorable fashion.

e. Association of PP Physicians - The Federation to maintain close working ties with the APFP, and to make available the proceedings from the APPP to all relevant professionals in the field.

Additional Projects -

Project 1 - Relations with Professional Associations - PP-WP and the Affiliates to work actively with national and local professional organizations in order to acquaint them with the activities and policies of the PPFA and to motivate organizations of action in the expansion of family planning services to all persons. Emphasis will be placed on developing directional rapport with professional health, social welfare and environmental associations including AMA, ACHA, ACOG.

Project 2 - Relations with Civic and Community Groups - The Federation to maintain a high degree of recognition within other organizations through continued membership and participation in community improvement programs. Emphasis will be given to youth services groups; women's rights groups; religious, health advocacy, civil liberties organizations, community health education groups.

Project 3 - Relations with Institutions of Education - Affiliates and PP-WP, to establish dialogues with universities, community colleges, and other institutions of higher education for research and programmatic purposes.

Project 4 - Public Relations Seminar - PP-WP, in cooperation with affiliates, to devise and conduct a series of seminars at convenient locations on public relations techniques.

PROGRAM IV: Public Affairs - To advocate, through information and testimony, the adoption of policies by all levels of government, the health professions, and other relevant groups which will lead to the elimination of unwanted pregnancies.

Basic Program Elements -

a. Public Policy - PP-WP to continue to function, through the Washington Office, as PPFA's central source of information on state and federal legislation and policies affecting the field of family planning. PP-WP also to continue to serve as the principle spokesperson for the PPFA at federal legislative hearings. Affiliates, with assistance from PP-WP, to assert leadership in the development and operation of state

level public affairs activities through the formation of state coalitions of health agencies which will monitor, inform and provide testimony on policies and legislation affecting statewide family planning programs. Affiliates also to support PP-WP efforts in Federal Policy on the local level.

b. Coalition Building - PP-WP to develop strong working relations with national organizations whose goals and policies are consistent with those of the PPFA. To increase support for key national issues especially: Keeping abortion legal; increasing the level of public support for family planning services; increasing support from both the public and private sectors for contraceptive and fetal research; improving the quality of sex education in schools; and in increasing the commitment of private physicians to the medically indigent. Affiliates to continue to build a wide base of support of organizations in the local community utilizing both volunteer and staff resources.

c. Legal Activism - PP-WP to develop a program designed to support laws and opinions favorable toward the elimination of restrictions toward access to all fertility management methods.

Program Emphasis - Areas which will continue to require emphasis are: 1. Sustained flow of government funds into family planning services research, and training,
2. Keeping abortions legal and accessible to all persons,
3. Keeping programs free from undue government control.

PROGRAM V: Public Education - To raise the level of awareness among all persons of family planning, human sexuality, population growth, and health in general. Public education may be defined as the dissemination of specific information designed for target audiences with the objective of modifying attitudes, behavior change and or skills.

Basic Program Elements -

a. Printed and Audio-Visual Material - The Federation to develop materials and to establish a national cooperative inventory of printed and audio-visual material produced by affiliates, PP-WP, and other organizations. Affiliates to continue to produce materials serving their needs which may be added to the national inventory. PP-WP to continue to develop annual themes and fundraising materials for national use by affiliates. Moreover, all pertinent printed material will be made available in Spanish.

b. Development and Delivery of Sex Education Programs - Affiliates to assert leadership in developing and promoting educational programs in human sexuality in clinics, in local schools, and other organizations. Affiliates to continue to include sex education as part of their services to teenagers and young adults. PP-WP to increase efforts to coordinate the exchange of ideas among affiliates, and by providing assistance in curriculum development.

PROGRAM VI: Stimulating Bio-medical Research in Contraception - To stimulate relevant sectors of society to support and undertake bio-medical research in the search for better, safer, more acceptable and less expensive forms of contraception.

Basic Program Elements -

a. Participation in Contraceptive Testing - PP-WP to assist Affiliates by maintaining up to date guidelines and standards for research. Protocols for research to be reviewed by the National Medical Committee prior to affiliates undertaking carefully controlled final phase testing of new or improved contraceptive in cooperation with reputable drug companies.

PROGRAM VII: Support to the International Field of Family Planning - To support the International Planned Parenthood Federation and other agencies in promoting voluntary fertility control world-wide.

Basic Program Elements -

a. IPPF Support - PP-WP to serve for the Federation as a major agency for raising funds in the U.S., for the IPPF.

b. Direct Support to the International Field of Family Planning - PP-WP to promote, through the application of funds, technical assistance (including exchange), and material resources, the advancement of family planning services in the less developed countries.

PROGRAM VIII: Organizational Development - To engage in activities designed to strengthen the Federation and maximize the leadership contribution of its volunteers. This objective contains a list of some specific activities which could enhance the strength of the Federation and accelerate the achievement of the seven previous objectives.

Basic Program Elements -

a. Maintenance of Regional Offices - PP-WP to continue to maintain regional offices around the country for the purposes of providing support and coordination to affiliates in their development and program expansion. The regional offices also to continue to provide the vital communications link between the local affiliate and PP-WP.

b. Merging Affiliates - Affiliates to move toward the consolidation of affiliates when such a move would enhance the program in terms of service capability, manpower utilization, volunteer strength, cost effectiveness, funding mix, and organizational stature. PP-WP, utilizing the appropriate regional offices, to assist in the consolidation of affiliate operations.

c. Volunteer Leadership Development -

1) PP-WP, in cooperation with Affiliates, to develop a statement of rights and responsibilities of volunteers and to demonstrate and share model volunteer development programs throughout the Federation.

2) PP-WP and Affiliates to recruit, train and supervise volunteers for special projects; to encourage volunteers' suggestions for consideration and possible implementation; and to maintain an up-to-date roster of volunteers with special skills.

3) PP-WP and Affiliates to identify special areas and activities where volunteers can contribute directly to the achievement of the Federation's objectives. Among them;

a. Liaison with other national and local organizations, institutions and individuals (e.g., health, education, media, special interest) to broaden the base of support to the Federation.

b. Innovative program areas in health delivery and referral systems; work with service providers and recipients.
   (i) expansion of existing programs
   (ii) integration with other health programs
   (iii) special target populations

c. Establishment of a Federation Speakers' Bureau and development of appropriate back-up resource materials.

d. Public affairs; work toward expansion and clearer definitions of opportunities and limits of 501(c)3 organizations.

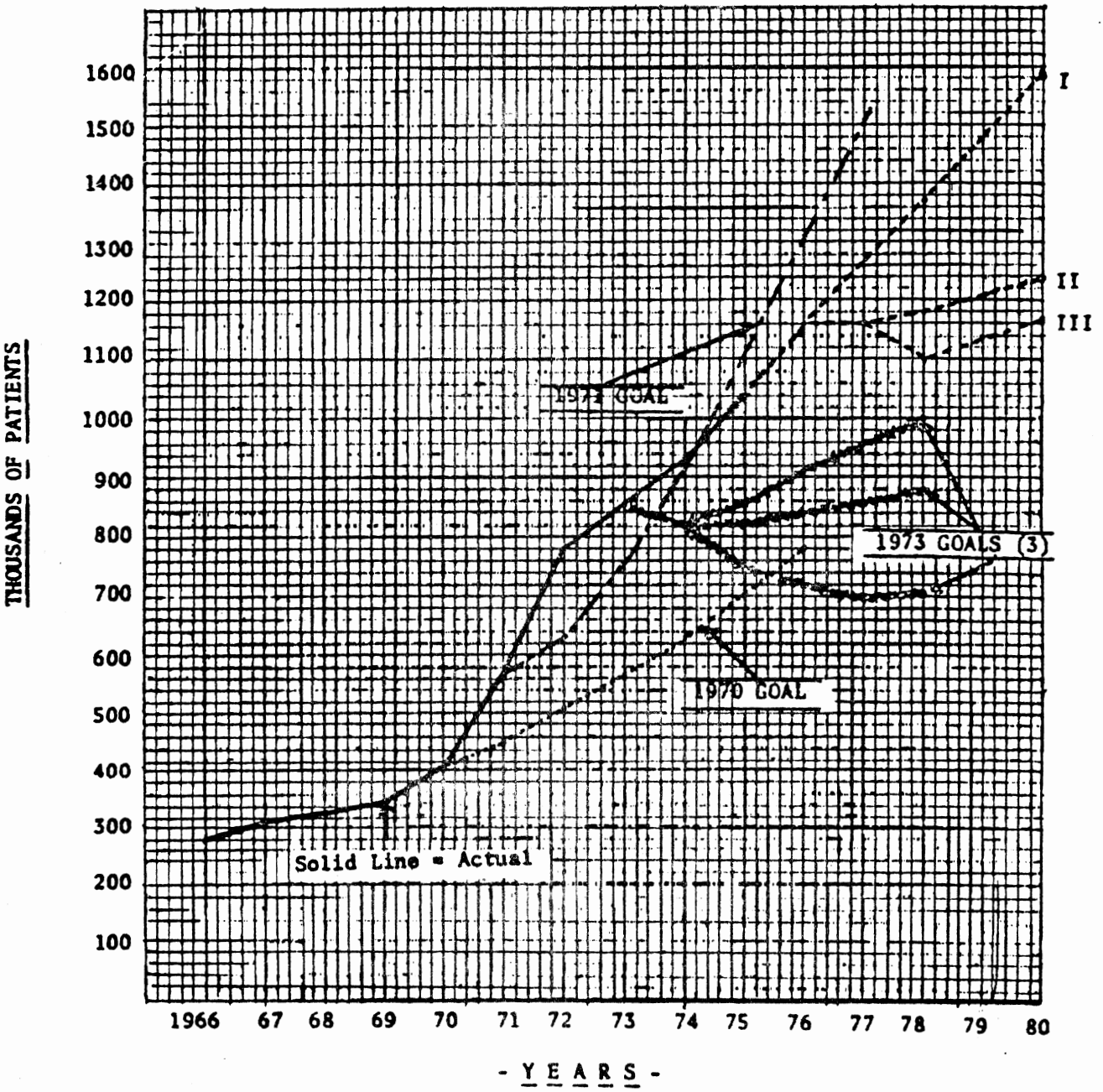
e. Fund raising.

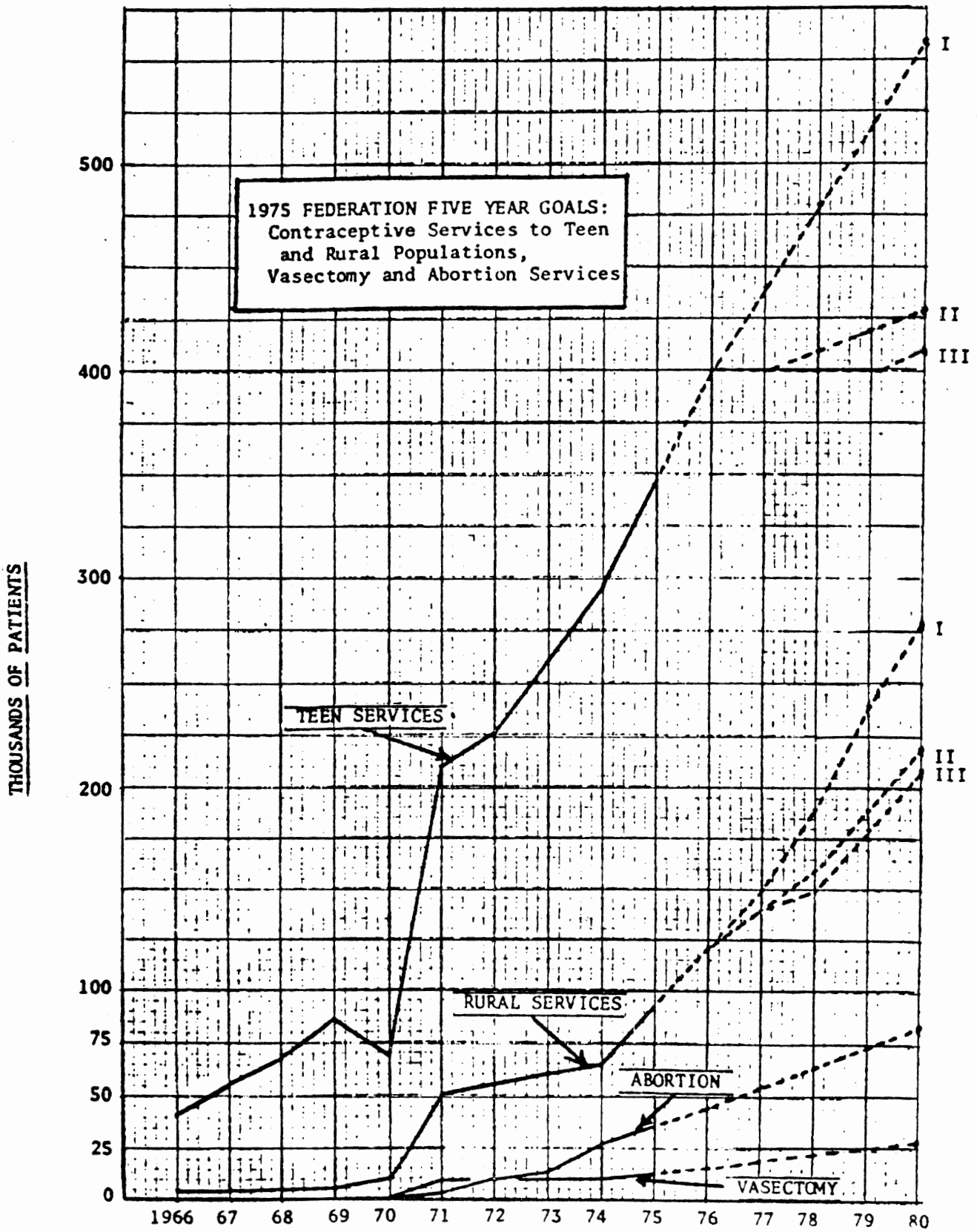
SUMMARY OF PPFA PATIENT LOAD
GOALS FOR CONTRACEPTION, STERILIZATION AND ABORTION
(Thousands)

	ASSUMPTION NUMBER	1976	1977	1978	1979	1980
Total Female Contraceptive Patient Load	I	1160	1270	1370	1490	1590
	II	1160	1160	1180	1210	1240
	III	1160	1160	1100	1140	1170
Poor + Near Poor (85% of total patient load) (part of total patientload)	I	980	1080	1160	1260	1350
	II	980	985	1000	1030	1050
	III	980	985	930	970	990
Teens (35% of total patient load) (part of total patientload)	I	400	440	480	520	560
	II	400	400	410	420	430
	III	400	400	400	400	410
Percent Non-Metropolitan (part of total patientload)		10%	12%	14%	16%	18%
	I	120	150	190	240	280
	II	120	140	160	190	220
	III	120	140	150	180	210
Vasectomies		17	21	23	26	30
Abortions		45	55	65	75	85

*Percent of the total estimated need met by PPFA by 1980: I - 12%, II - 9%, III - 9%.

1975 CONTRACEPTIVE PATIENT GOALS BASED ON ALTERNATIVE FUNDING ASSUMPTIONS (Compared to 1970, 1971 and 1973 Goals)





Solid Lines = Actual Services
Dotted Lines = Alternative Goals

Good Morning.

My name is Giles Scofield. I am an associate attorney with Smith, Stratton, Wise & Heher in Princeton, and a member of the Medico-Legal Liason Committee of the New Jersey State Bar Association. I appear this morning on behalf of the Conference of New Jersey Planned Parenthood Affiliates to speak in opposition to Assembly Bill No. 1155, the parental notification bill.

By way of further introduction, I would like to briefly acquaint the committee with my background in the sensitive constitutional and health law related areas this statute raises. Prior to my present employment I served as research assistant to Professor Sylvia Law of the New York University School of Law and the New York City Bar Association Committee on Law and Medicine in their investigation of physician licensing practices in New York State.

Thereafter, I worked as an assistant to the legal affairs department of the Planned Parenthood Federation of America, the

national headquarters of Planned Parenthood. During my term with the Federation I co-authored an article entitled "Informed Consent for Fertility Control Services" which appeared in Family Planning Perspectives[1] and which discussed in part the obstacles imposed by parental notification statutes such as the one proposed here.

Finally, I assisted in the research and writing of the amicus curiae brief the Federation submitted to the United States Supreme Court in Bellotti v. Baird, where the court affirmed a lower court's decision striking down one such consultation statute.

As I am certain you are aware, the scope of parental involvement the State may legitimately infuse into the pregnant minor's decision on how to terminate her pregnancy has been the subject of considerable legislative and judicial activity.

Ever since the United States Supreme Court ruled in 1976 that a State may not require the consent of a parent or person acting in loco parentis as a condition for performing an

abortion on an unmarried minor, much ink has been spilled trying to determine what degree of parental involvement will not unduly burden the minor's right to privacy regarding this extremely sensitive decision. See Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Bellotti v. Baird, 428 U.S. 132 (1976).

In its 1979 decision in Bellotti v. Baird, the Court restated its view that:

> "The abortion decision differs in important ways from other decisions that may be made during minority. The need to preserve the constitutional right [to seek an abortion] and the unique nature of the abortion decision, especially when made by a minor, require a State to act with particular sensitivity when it legislates to foster parental involvement in this matter."

Noting in part that:

> [M]any parents hold strong views on the subject of abortion, and [that] young pregnant minors...are particularly vulnerable to their parents' efforts to obstruct...[the minor's access to] an abortion,"

the Court flatly held that an abortion statute that requires parental consultation and notification in every instance, without providing adequately for "mature" minors to consent themselves to treatment cannot withstand constitutional scrutiny.

The survival rate of statutes limiting a minor's access to abortion has been notoriously poor. While the precise issue framed by this statute has yet to be addressed by the Supreme Court -- oral argument is scheduled for next week -- it should be noted that all but two lower court decisions have overturned statutes similar to this one.[2] In fact one of these decisions, Margaret v. Edwards, 488 F. Supp. 181 (E.D., La., 1980), is

directly on point for the proposition that the statute proposed here is unconstitutional.

While parental notification statutes are subject to criticism on a number of grounds[3], two problems are clearly raised by the statute as currently proposed. First it provides no expeditious judicial mechanism permitting mature minors to avoid involving their parents in their abortion decision, a requirement imposed by Bellotti and related cases. Second, insofar as New Jersey law currently permits a pregnant minor to consent as an adult may to hospital, medical and surgical care related to her pregnancy[4], the proposed legislation raises a serious constitutional problem. For if the fundamental right to privacy consists of the right to decide when and how to terminate a pregnancy, then attaching different burdens to a woman's option chills her right to choose and creates an unjustifiable distinction between young woman who carry their pregnancy to term and those who do not.[5]

Beyond identifying the problems plaguing this particular

statute, I want to further suggest that any statute requiring parental involvement is both unconstitutional and simply improvident from a policy standpoint.

Such statutes are unconstitutional because they always unduly burden, and in fact endanger, the minor's decision to seek an abortion, in a way that no amount of legislative or judicial finetuning can avoid. Such statutes are unnecessary because the concerns they purportedly further can be better accomodated through legislation that protects the minor's right to privacy.

One reason repeatedly raised in support of statutes such as this one is that it furthers the parents' interest in guiding their child's upbringing. It is difficult to see how a notice requirement furthers this interest. In families where an open dialogue on sex already exists, the statute will have no impact. In those families where parental feelings about adolescent sex and abortion are hostile, the statute will only thrust a young woman already upset by an unwanted pregnancy

into an unsupportive, perhaps brutal, home situation - hardly the sort of forum giving rise to the meaningful dialogue the statute supposedly encourages. As one commentator has noted

> "Even if a minor is unable to understand fully the broad consequences of abortion, parental input may do little to increase her comprehension. Paents can seldom supplement the attending physician's explanation of the medical risks of abortion and may in fact seriously distort the dangers inherent in the procedure. Nor can it be reasonably assumed that parents will objectively portray the non-medical [aspects] of the decision. [A] minor's pregnancy and decision to abort [will] typically fragment the family unit.*** The tendency of a minor's pregnancy pregnancy to polarize the family automatically

limits the ability of the parents to counsel their children effectively.*** In this context, parental advice cannot be expected to be dispassionate, supportive and effective.[6]

Even so staunch a supporter of the family unit as Yale Law School's Joseph Goldstein[7] has noted

"As for pregnancy, the justification for emancipation [in this situation] appears to stem from a recognition that those who insist on parental consent are concerned less with the child's well being than with strengthening their general opposition to abortion, which they cloak in the magical notion that law can improve family communications by compelling a young woman in trouble to consult with her parents when such family trust does not exist."[8]

The relevant caselaw indicates the range of parental reaction notification may create, and the futility of supposing that such statutes will create a nurturing, supportive dialogue.[9]

In fact, statutes requiring parental involvement will most certainly endanger rather than improve the prospects for a healthy resolution of the minor's situation. A minor facing an unwanted pregancy and wishing to avoid a parental confrontation the notification statute creates will simply delay seeking the medical attention she needs and wants. Postponing the decision to obtain an abortion simply increases the risk of complications once an abortion is obtained, and may even result in foreclosing the abortion option altogether.[10] The result in some cases will be that the woman attempts suicide, a self-abortion or seeks the services of an abortionist willing not to comply with the notification statute.

The adverse health consequences this statute will create are clearly inconsistent with its purported concern for the minor's well being.

An alternative to this statute that adequately meets the concerns raised of the pregnant minor seeking an abortion and which does not the onerous obstacles created by mandating parental involvement in every instance is available.

The American Bar Association's Juvenile Justice Standards Project has drafted a model statute that simply permits a minor of any age to consent to contraceptive and pregnancy related health care, including abortion.[11] This statute leaves the question of parental involvement up to the patient and her physician, avoiding the unnecessary and counter-productive confrontation mandatory notification creates.

Since health care professionals who provide medical services to minors are sensitive to their special needs, adequate counseling and information concerning the abortion procedure will be available, in confidence. Clinics providing such services often have access to or retain in-house social workers or other pediatric professionals able to assist the pregnant minor through this difficult time.

Financing such procedures could be arranged without violating the minor's desire not to involve her parents, by requiring some contribution from the patient, if she has the money, by making state funds available, or by requiring group carriers to provide coverage for such services. Insurance legislation of this sort has been adopted in Maine, for example.

To persist in promoting statutes such as A.1155, however, is a futile task and one that is likely only to embroil the courts in a continuing and unnecessary controversy that will only disservice the minors about whose health and well being we should be concerned.

Thank you

NOTES

1. Paul and Scofield, "Informed Consent for Fertility Control Services," 11 Family Planning Perspectives 159 (1979).

2. Akron Center for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 1201-1202 (N.D. Ohio, 1979); Women's Community Health Center v. Cohen, 477 F. Supp. 542, 546-548 (D. Me., 1979); Women's Services, P.C. v. Thone, 483 F. Supp. 1022 (D. Neb., 1979); Margaret v. Edwards, 488 F. Supp. 181, 202-205 (D. La., 1980).

   See also, Jones v. Smith, 474 F. Supp. 1160 (S.D. Fla., 1979); Planned Parenthood Ass'n. v. Ashcroft, 483 F. Supp. 679 (W.D. Mo., 1980); Wynn v. Carey, 582 F.2d 1375, 1386-1388 (CA7, 1978); State v. Koome, 530 F.2d 260 (Wash., 1975); Ballard v. Anderson, 4 Cal. 3d 873 (1971).

   The decisions upholding such statutes are H.L. v. Matheson, now pending in the Supreme Court, #79-5903; and Planned Parenthood League of Mass. v. Bellotti, Civ. No. 80-1166-MA, stayed pending review by the First Circuit Court of Appeals.

3. See generally, Wilkins, "Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors," 1975 Ariz. St. L.J. 31; Note, "The Minor's Right to Privacy: Limitations on State Action after Danforth and Carey," 77 Col. L. Rev. 1216 (1977); Note, "Parental Notification as a Prerequisite for Minors' Access to Contraceptives: A Behavioral and Legal Analysis," 13 U. Mich. J. Law Reform 196 (1979).

4. N.J.S.A. 9:17A-1.

5. Wynn v. Carey, 582 F.2d 1375, 1387 (CA7, 1978); Planned Parenthood of Kansas City v. Ashcroft, 483 F. Supp. 679, 688 (W.D., Mo., 1980); Ballard v. Anderson, 4 Cal. 3d 873, 484 P.2d 1345 (1971).

6. Note, "The Minor's Right to Privacy: Limitations on State Action after Danforth and Carey", 77 Col. L. Rev. 1216, 1238-1239 (1977).

7. Freud, Goldstein and Solnit, Beyond the Best Interests of the Child (1973); Before the Best Interests of the Child (1979).

8. Goldstein, "Medical Care for the Child at Risk: On State Supervention of Parental Involvement," 86 Yale L. J. 645, 661-662 (1977).

Robert Bennett, another supporter of the family unit notes,

> The argument for child autonomy gains persuasiveness when, as in the abortion or birth control cases, the matter is a highly personal one with obvious implications for the child when [she] becomes an adult, parental judgment is likely to be clouded, reasoned communication between parent and child is likely to be difficult, a plausible cut-off age is provided by nature, and the externalities likely to result from requiring parental consent are far greater than those of the likely child decision.

Bennett, "Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis", 62 Va. L. Rev. 285, 325 (1976).

9. "[T]here are a variety of reasons why it would be in a minor's best interest for one or both of her parents to be kept in ignorance of her pregnancy. Parents, physically or emotionally unwell, may be injured by the shock, thus causing the minor deep feelings of guilt. Some parents are child abusers; others at least become actively hostile on such disclosure. [T]he evidence shows that an appreciable number of parents are not supportive. These include not only those who would inflict physical harm, but parents who would insist on an undesired marriage, or on a continuance of the pregnancy as punishment." Baird v. Bellotti, 450 F. Supp. 999, 101 (D. Mass., 1978).

See also, Wynn v. Carey, 582 F.2d 1375, 1388 (CA7, 1978); Women's Community Health Center v. Cohen, 477 F. Supp. 542, 547 (D. Me., 1979); In re Diane, 318 A.2d 629 (Del. Ch., 1974); In re Smith, 16 Md. App. 209, 295 A.2d 238 (1972); State v. Koome, 530 P.2d 260, 265 (1975).

10. "The class of minor women plaintiffs seeks to exercise a constitutional right which, with every passing day, becomes physically more dangerous, to the end that their constitutionally guaranteed decision to terminate their pregnancy may be totally frustrated if they are prevented

from acting with dispatch." Wynn v. Scott, 448 F. Supp. 997, 1004 (N.D., Ill., 1978); aff'd. sub. nom. Wynn v. Carey, 582 F.2d 1375 (CA7, 1975); Jones v. Smith, 447 F. Supp. 1160, 1167 (S.D. Fla., 1979).

The medical implications of delay are spelled out in Cates, et al., "The Effect of Delay and Method Choice on the Risk of Abortion Morbidity," 9 Family Planning Perspectives 266 (1977); "The Earlier the Safer Applied to All Abortions," 10 Family Planning Perspectives 243 (1978).

11. ABA/Institute of Judicial Administration, Rights of Minors, §4.8. See also, Ballard v. Anderson, 4 Cal. 3d 873, 484 P.2d 1345 (1971); Meisel, "The 'Exceptions' to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Discision-Making," 1979 Wisc. L. Rev. 413, 442, n. 104.

TESTIMONY ON A-1155

SUBMITTED TO THE INSTITUTIONS, HEALTH AND WELFARE SUBCOMMITTEE, OCTOBER 1, 1980

by
Linda Ershow
128 Berwick Street
Elizabeth, NJ 07202

In general I agree with the principle that parents should talk with their children about pressing matters related to the health, social and perhaps the sexual activity of the children. Values and ethics, and responsible behavior, are generally best taught in the home. Ideally, daughters faced with a problem pregnancy should be able to turn to their parents for support, guidance and advice in making a critical decision about that pregnancy. However, the reality of parent-child relations, and specifically parent-daughter relations, is neither so simple nor so ideal.

I worked for three years as a counselor at a Women's Crisis Center in New Brunswick. I handled many hotline calls as well as in-person counselling sessions. Numerous calls came in from teenage girls with problem pregnancies. These were girls who came from every imaginable sort of background. Some were in parochial high schools, some in public highs, some from the urban area of New Brunswick, others from outlying suburbs. They came from single and two-parent households, peaceful homes and violent homes. The circumstances of how they became pregnant were also varied.

The overriding concern of these teens in seeking a solution to their dilemna was confidentiality, and that their parents wouldn't have to know they had "gotten into trouble." I always made it a point to ask them what the problem was that they seemed so afraid to talk to their parents. Let me share with you some of their reasons.

A girl in Catholic school, 11th grade, had parents who frequently remarked about the immorality of sex and the importance of saving herself until marriage. They had told her the year before, in no uncertain terms, that if she ever "dishonored" them by becoming pregnant, she would never be allowed to step foot in their house again. This girl also felt personally terribly guilty on account of her religious convictions.

A girl in 10th grade lived with a father who often beat her and accused her of being a tramp, even though she was home almost all the time. He had threatened to kill her if she ever got pregnant, and she was afraid he would do just that.

A girl whose father molested her and her sisters and battered her mother became pregnant by him. He had threatened to beat her to death if anyone ever found out what was going on. This girl needed an abortion so neither her father nor her mother would know that she had become pregnant by him.

One girl used contraception regularly but it failed one time and she became pregnant. Her parents had always sternly disapproved of pre-marital sex and refused to ever talk to her about that issue when she brought it up.

Another teenager called up who had been raped by two fellow classmates, and had become pregnant. Her mother had become violently angry with her when she first found out about the rape, accused her of bringing it on herself, and told her she would get no sympathy if anything happened as a result of her promiscuity.

Each of these young women told me that they sincerely wished they could turn to their mother and/or father for support and help, but had either tried and failed, or simply knew there would be disastrous consequences if the parents found out.

By legislating parental notification of a daughter's need for an abortion, regardless of her circumstances and the family relationships involved, I am truly afraid that we will be forcing some, perhaps many, teens to deal with a level of parental anger and possible violence that many of us have the good fortune to never experience.

All too often, communication in families around the subject of sex, pregnancy and childbirth is very limited. Many parents are understandably uncomfortable with talking about these subjects with their peers, no less their children. It would be wonderful if parents and their children could all talk openly about such sensitive, difficult and moralistically-charged life issues. I do not believe that legislating parental notification will create this marvelous communication. Instead, we will find many teens lying about their age for fear of the

consequences if their parents find out they are pregnant. They will then not only have to worry about being young and pregnant, about the health risks to their young bodies of bearing a child, about the money to obtain an abortion and about possibly stopping their education and going on welfare. They will have to worry about being possible law-breakers. Many, many more parents than we would EVER like to acknowledge have threatened to kick their daughter out of the house if she becomes pregnant. Many more have beaten their daughters as a punishment for her act.

When parents have certain feelings and attitudes, and then feel that their daughter has betrayed those values, there can be a violent reaction. I found this to be true during 2 years of working in a battered women shelter, where a number of my clients were young women who had been battered by their parents and then faced severe punishment for having gotten pregnant.

We cannot make a simple comparison between parental consent for general operations on their children, and parental consent to an abortion for their daughter. This issue is too emotion and value-laden to legislate parental notification and still protect the health, safety and possibly the life of the pregnant teen. I believe the decision about parental notification must be left up to the teenager and her doctor, who can best manage what the consequences will be. I urge the committee to consider the grave implications of this bill, and to not release it from this committee. Thank you very much.

TESTIMONY ON ASSEMBLY, No. 1592

RESPECTFULLY SUBMITTED BY; Lyda M. Figueredo (Hispanic Women of N.J.)
501 Herkimer Ave.
Haworth, N.J. 07641
(201) 385-7232

TO:Committee on Institutions, Health and Welfare.

DATE: October 1, 1980.

Honorable Assemblymen. My name is Lyda M. Figueredo. I am here to present testimony on Bill A-1592, an Act concerning abortion and supplementing Title 26 of the Revised Statutes, on behalf of the Hispanic Women of N.J.

I sincerely thank you for the opportunity you are giving me to speak up for all the Hispanic women who, because of our culture and moral values,are very opposed to abortion.

However, a great percentage of the Hispanic women are facing financial problems that may coerce them into going for an abortion. For instance, the booklet called DATE PROFILE: HISPANICS IN N.J., issued by the Puerto Rican Congress of N.J., located at 222 West State Street, Trenton, N.J. 08608, shows on page 4 that the percentage of Puerto Rican families in poverty is 24.3, compared to 6.1 for all residents.Families with income 125 percent of poverty level is 34.6, compared to 9.0 for all residents. It also shows that the percapita income as percent of that of total population is 50.0 for Puerto Ricans, half of the per capita income of all residents.

I am submitting these figures to show how easily the economic pressures may push a Hispanic woman to go for an abortion, a step contrary to her convictions. To make a decision that she will not regret for the rest of her life she must be informed of the facts concerning the physical development of her unborn baby, who is called by the abortionists "only a mass of cells", the physical and psychological effects of the abortion procedure, as well as the alternatives to abortion available to them such as counseling, pre-natal care, shelter homes, foster homes and adoption services.

But, how can a Hispanic woman be duly informed of the atrocities of the abortion issue when many of them can't neither speak, nor write, nor read English? Also, many of our women are illiterate on our own Spanish language.

I urge the Committe on Institutions, Health and Welfare to print the booklet Bill A-1592 calls for and that we are considering here today, in Spanish and in other languages, so that the women living in this great country, but can't speak English, have the correct information, in their native language, before they can make the right decision as to whether or not kill their unborn babies.

(more)

The necessity of having this booklet available in other languages is shown by the report of the Department of Education, Division of School Programs - Bureau of Bilingual Education, issued on February 1978. It reveals that 49,852 students of N.J. are served by the Bilingual Education Programs. In many cases the figures also include persons who speak other foreign languages. We must take in consideration that those students come from families where none of the members can speak English.

The number of Hispanics keeps on growing in N.J. May I read to you Subtitle "DEMOGRAPHICS", on page 1 of the DATA PROFILE:HISPA_ NICS IN N.J." booklet I cited previously. I must refer to these records because I have been informed by Mr. David Matos, Assitant to the Governor, that the final figures from the 1980 Census will not be ready until 1982.

"DEMOGRAPHICS

The 1970 Census counted 310,476 residents of New Jersey as persons of Spanish Language!

During the perios 1960-1970, while the total population of the State of New Jersey increased by 18.2%, Hispanics increased by a rate of 145.1% over the same decade. This rate of unparalleled growth permits a projection of 639,436 Hispanics in New Jersey by 1978.

With one out of every four residents being Hispanic, Hudson County has more Spanish-speakers than does Ponce, Puerto Rico. Passaic Cumberland and Essex counties follow Hudson as counties with large concentrations of Latinos. Newark, with more than one hundred five thousand, has more Spanish-speakers than the combined populations of Mayaguez and Aguadilla, Puerto Rico.

The New Jersey Office of Business Economics has characterized the ongoing Hispanic population growth rate as "phenomenal."

May I add to the above statments that they were written before the afluence of Cuban refugees in New Jersey. Mrs. Julia Valdivia, Assitant to the Mayor of Union City, informed me that this City alone received 6,000 Cuban refugees during the last months.

Also, the Office of Business Economics, Department of Labor and Industiry; Population Estimates of New Jersey of Trenton, N.J., shows that in 1978 there were in N.J. 639,436 Hispanics.

The State of New Jersey cannot forget three quarters of a million residents who have the right to be informed about abortion, because when a woman decides to go ahead with the distrction of her unborn, the whole family is affected, one way or the other.

But I must call your attention again to the fact that many of our women can't read English.I am hear to urge you to print the abortion booklet in Spanish, The booklet must also contain pictures to convey the message to those who have difficulty with their native language. The pictures must show the development of the unborn baby. They must show that at the time when most women go for an abortion, at three months of pregnancy, the unborn is completely formed, with a heart that started to beat at 21 days of conception and a brain that transmitted waves at 48 days, a tiny baby whose vital systems, all of them are functioning. Pictures of the methods of abortion where

(more)

they could see that the Suction and D & C abortions tear the baby into pieces; pictures of the Saline abortion where after 24 hours of martyrdom the baby is burned to death by the saline solution. Sometimes these unborn babies are six months, aborted alive, and still no help is given to them! Finally, they must know that if they are after their 48th week of pregnancy, the Histerotomy performed by the doctor will remove an alive baby from her womb, and again that baby will be left to die!

It is also imperative to present the Hispanic women with drawings of the complications of abortion such as hemorrhage, sterility and death. They must clearly know that legal abortions are not necessarily safe abortions!

Finally, if the purpose of this bill is to duly inform the women in order to obtain their written consent for an abortion, a slide presentation should be available for those who have trouble reading both English and their native language.

I would like to offer my services to your Committe for the publication of booklet. I hold a Degree on Home Economics Teacher and a Dregree on Journalism, from the School of Journalism, Havana, Cuba.

May I thank you again for the opportunity you have given me today to protect the Hispanic community as a whole and the Hispnaic women in particular, born and unborn!

Respectfully submitted

Lyda M. Figueredo

My name is Ann Fitzpatrick Larney.

I am currently employed by Planned Parenthood Association of the Mercer Area as a social worker and Coordinator of Counseling Services. My job is to provide individual, family, and group counseling for Planned Parenthood clients. I train and supervise a group of eleven volunteer pregnancy options counselors. The purpose of the Pregnancy Options Counseling is to offer complete counseling and referral services for pregnant women. This includes referrals for adoption, abortion, foster care and pre-natal care.

My comments will be addressed to those parts of the bill which concern mental health issues and directly effect the counseling process. I will use my day to day experience and that of the counselors to illustrate some of the serious problems that women will have to face if this bill is passed. Other speakers have/will discussed findings based on research.

I would like to begin by commenting on the requirement that a doctor or counselor must inform the woman that psychological trauma is inherent in the abortion procedure. In my experience, this view is erroneous. I see women in all stages of pregnancy: Some choose to terminate the pregnancy, others choose to continue. Some are happy about their pregnancy, others are not. Individual attitudes and circumstances determine how a woman reacts to the abortion experience. There are feelings - both positive and negative that need to be expressed and explored - and should be in a good counseling session regardless of the decision concerning the pregnancy. This does not necessarily mean that psychological trauma is involved. I see the same difficult decision making process and the same feelings expressed by women who have chosen to continue the pregnancy or women denied abortion for various reasons.

To summarize, women differ with respect to feelings and attitudes toward pregnancy, childbearing and abortion. One cannot say that psychological trauma is inherent in the abortion procedure any more than one can say that psychological trauma is inherent in childbearing. Before any type of causal relationship is established, intervening variables and their influence must be considered. The counselor must access each woman individually and let this guide the process of exploration of feelings and information given.

The next issue I would like to address is the mandate that a counselor or doctor give specific facts concerning the development of the fetus and use the term "unborn child" instead of the correct term embryo or fetus.

In my opinion this is an obvious indication of judgement that will automatically interfere with the counseling relationship and the counselor's ability to help the woman. It violates one of the basic principles of the mental health profession which is to make no assumptions or judgements and to begin where the client is. One of the first things I was taught in graduate school was that the counseling process should be guided by the needs and requests of the client.

Let me emphasize that in no way am I minimizing the importance of informed consent, and the need for women to have the most accurate and complete information possible before making a decision concerning a pregnancy. As a Planned Parenthood affiliate, we are mandated by the Standards and Guidelines of the National Federation to provide complete and accurate information on all pregnancy options.

I would like to relate an experience of one of my clients to illustrate the point. To protect confidentiality some of the less significant aspects of the situation have been changed.

The woman is in her early thirties with two children, very recently widowed and under severe financial stress. She decided after much thought to terminate the pregnancy. She sought help from someone who consistently used the term "unborn child", insisted she listen to details of fetal development, and showed her pictures of developing fetuses. The client felt her privacy was invaded and that she did not receive the help she had sought. She had not asked for that information, did not want or need it to make her decision, and she felt that control of this difficult situation was forcibly taken from her. No school of social work would either teach or support this type of counseling. The result for the woman was severe emotional upset & an unnecessary emotional burden. This will happen over and over again if the content of the counseling process is legislated and not based on the individual need of the woman.

In regards to the forty-eight hour waiting period, let me first say that Planned Parenthood is in no way against women taking time to adequately evaluate the decision to terminate a pregnancy. But there are some real issues that must be considered before specific waiting time is legislated.

A practical point to consider is that by the time a woman has a pregnancy test, learns the results, comes in for counseling, reaches a decision and makes an appointment for the procedure, more than forty-eight hours have passed. The decision to terminate a pregnancy is not taken lightly by many women. Days and even weeks are often spent thinking about the decision before the woman even contacts us. Legislating a further waiting period would mean unnecessary emotional stress.

Added financial burden would also result from a mandatory waiting period since it would mean two trips to the doctor's office or clinic. Planned Parenthoods throughout the state see a high percentage of low income women. Many have no cars so must depend on family, friends or public transportation. Often times family and friends are unwilling or unable to take off two days from work. Public transportation is usually expensive and difficult to use. Because there are so few abortion facilities in Mercer County, many of our clients have to travel at least twenty miles. The two closest facilities that we refer to are not accessible to public transportation. If the client does not have her own transportation, she must go to New York or Philadelphia. The cost of two trips is often prohibitive.

The above mentioned factors illustrate that the mandatory waiting period would provide an undue financial and emotional burden for women seeking abortions. This, added to Dr. Josimovich's point that the health risks of the procedure increase as time passes clearly indicates that there would be little benefit derived.

The last issue I will discuss is the requirement for parental notification in cases of pregnant minors seeking abortions. I would like to emphasize that Planned Parenthood prefers to involve the parents with the client's permision. Most teens are not accustomed to handling crises. This is often the first significant decision they have to make and emotional support of someone they trust is needed. This is clearly not always a parent.

When we counsel teens with a problem pregnancy, the session is more intense. Our counselors usually spend more time exploring feelings and issues. If the teen is reluctant or refuses to involve the parent, we try to explore the basis for this decision. Often times the teen realizes the fears of parental involvement are groundless. After careful counseling many will confide in a parent. However, there are some instances when parental involvement is just not possible. This is when a legal requirement is detrimental.

Here are some examples from my own caseload that will illustrate the dangers in requiring parental notification in all cases. I am sure any counselor in the state could give similar examples.

One teen did not know she could get an abortion without her parents knowing. The idea of telling her family was so terrifying, she climbed a chain-link fence and **lay** across the top to try to induce a miscarriage.

Another teen had an older sister who became pregnant at sixteen. She told her parents and was immediately thrown out of the house and the locks were changed. A temporary foster home placement had to be found. Needless to say, this discouraged my client from confiding in her parents.

One seventeen-year-old client with one child came in for counseling. Her family had been very cold and rejecting of both her and the baby. Because she was so frightened about telling them she was pregnant again, she continued to delay discussing the situation with them. Because she waited so long out of fear, she had to go to New York for a saline abortion.

My last example is of a seventeen-year-old girl who, rather than tell her father she was pregnant, used a coathanger to try to induce an abortion. She became frightened and came in to the clinic for help. Fortunately a forgotten tampon prevented any serious injury.

If it were the best of all possible worlds, parental involvement would be no problem. However, in real life it is obvious that all parents are not capable of providing the necessary support and guidance.

My purpose in sharing these examples throughout the testimony is not to be sensational but to illustrate the real life problems that will be exacerbated if the bill is passed.

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FINAL REPORT

OF

THE GOVERNOR'S COMMISSION TO REVIEW THE NEW YORK ABORTION LAW

AS IT AFFECTS THE RIGHTS OF PARENTS

WHOSE MINOR DAUGHTERS SEEK ABORTIONS

The Commission whose study and deliberations resulted in this report was established by Governor Hugh L. Carey in the fall of 1976.

Its members were:

Joseph M. McLaughlin, Dean, Fordham Law School
Chairman
Dr. Louise M. Dantuono, Consulting Gynecologist,
Bellevue Hospital
Dr. Ian Morrison, President, Greer Children's
Services
Archibald R. Murray, Executive Director, Legal
Aid Society
Joyce Austin, former Special Assistant to the
Mayor of New York City
Mildred Shanley, Catholic Charities
Oscar Gonzalez-Suarez, attorney and member of
the Mayor's Judiciary Committee
Jacob Trobe, Executive Vice-President, Jewish
Child Care Association of New York City

The Governor released the Commission's report in June, 1977, to "be studied," he said, "by all those who are concerned about this sensitive issue and seek a constitutional way to know when their children face a situation of personal anguish and crisis."

I. INTRODUCTION

Few problems rival in complexity and intensity the problem of abortion. But the problem is there. It is real and must be addressed.

In what has already been decried as the "Dred Scott Case of the Twentieth Century," (1) the United States Supreme Court settled some of the abortion issues in Roe v. Wade. (2) The Court expressed its own discomfiture:

> "We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion." (3)

Roe v. Wade went on to hold that inherent in the right of privacy is a woman's right--albeit qualified--to an abortion. It is not an "absolute" right, but neither is it one that can be overridden simply by merely "rational" state legislation. Rather, it is a prima facie, specially protected, qualified right to have an abortion that is subject to regulation only on the showing of a "compelling state interest." Legislation or regulations affecting such a right must be "narrowly drawn to express only the legitimate state interests at stake." (4)

The Roe Court indicated that the state's interest in the health of the mother was not "compelling" during the first trimester of pregnancy and, therefore, during this period of time, the abortion decision and its effectuation must be left to the patient and her doctor, free of interference from the state. (5) State interest in the health of the mother becomes "compelling" at approximately the end of the first trimester, justifying regulations reasonably relating to the "preservation and protection of maternal health." (6) Insofar as the fetus is concerned, the state may regulate, and even prohibit, abortion to protect the state's interest in this potential human life during the period subsequent to viability. (7)

The broad generalities of Roe v. Wade became specific limitations in Doe v. Bolton (8) decided simultaneously. In Doe, the High Court held that the State of Georgia had no "compelling interest" in (one) insisting that all abortions be performed in an accredited hosptial, (two) after obtaining the approval of the hospital staff abortion committee, and (three) only after the performing doctor's judgment was confirmed by two other independent physicians. In short, procedural hurdles placed in the way of a young woman's decision to have an abortion must be firmly rooted in some "compelling interest" of the state.

The New York Experience

Neither Roe nor Doe had any immediate impact on the New York abortion statute, which had been enacted in 1970. (9) The New York statute permits a woman to obtain an abortion within twenty-four weeks from the commencement of her pregnancy, and even

later if it is necessary to preserve her life.

A major constitutional difficulty arose, however, when the Senate Bill Number 7031 was passed by the Legislature in 1976. This Bill would have amended Public Health Law Sec. 2504(3), so that minors (those under eighteen) could not obtain abortions without the prior consent of a parent or legal guardian.

Anticipating serious constitutional difficulties with the amendment, the Governor vetoed the Bill. Shortly thereafter, his judgment was vindicated in Planned Parenthood of Central Missouri v. Danforth (10) (hereafter referred to as Danforth) where the United States Supreme Court held it unconstitutional to cede a veto power over abortion to the parents of a minor.

In Veto Message #24, Governor Carey expressed his deep concern with the same problems that had prompted the Legislature to pass S.7031; and he stated that he would appoint a commission to "achieve a workable legislative solution" to the problems faced by families whose daughters suddenly find themselves faced with a decision of great personal anguish.

This commission has met on numerous occasions and has consulted with interested and knowledgeable persons, and is honored to present this Report and a proposed statute.

II. TEENAGE PREGNANCY: THE PROBLEM

Changing social mores among young Americans are reflected in the statistics that show that 11 million of the 21 million young people who are between the ages of 15 and 19 years of age have had sexual intercourse. (11) Further, it is estimated that twenty per cent of the eight million 13 or 14 year olds have been sexually active. (12)

Each year more than one million young women between 15 and 19, representing approximately ten per cent of the women in this age category, become pregnant. Two-thirds of these pregnancies are conceived out-of-wedlock. (13) The sexual activity of those under 15 years of age results in an additional 30,000 pregnancies. (14)

Perhaps the most comprehensive, and certainly the most authoritative, study of teenage abortions was done by the Center for Disease Control in 1976. (15) Its "Abortion Surveillance" report indicates that, in 1974, women who had legal abortions could be classified as follows: approximately one-third of women were in their teenage years; one-third, 20-24 years; and one-third, 25 years or older. (16) (See Appendix 1). Only California had more teenage abortions than New York. (See Appendix 2). More pregnant women below the age of 15 underwent abortion than had a live birth in 1974 (1,156 abortions per 1,000 live births). (17) In 1974, in New York State, approximately 64,000 teenagers became pregnant; about half of these pregnancies were terminated by legal abortion. (18)

The potential health risks involved in pregnancy are especially prominent among teenagers. Pregnant minors have a 50 per cent higher incidence of high blood pressure with kidney and liver involvement, nutritional deficiencies, prolonged labor, miscarriage and death than do older women. (19) For those children who become pregnant before they are 15, the death rate from complications of pregnancy, birth and delivery is 60 per cent greater than for those mothers who are in their early twenties. (20)

In addition to the numerous health risks involved with pregnancy, a high percentage

of adolescent mothers experience serious restrictions on educational opportunities. Approximately 80 per cent of all teenage mothers never complete high school. (21) Many have no job experience at the time of giving birth. Many are on welfare. (22)

III. TEENAGE PREGNANCY: SOME SOLUTIONS

This commission recognizes that minors have the greatest need to be made aware of alternatives to abortion. However, we also recognize that due to their youth, they may be the most ill-equipped to make an informed decision regarding the termination of pregnancy. Thus, confronted with the task of balancing the needs of these pregnant minors with the state's interest in an informed decision the commission deliberated over, and finally rejected the following approaches:

Parental Consent

The most direct way in which to "control" teenage abortions--if this were thought desirable--would be to require parental consent before any abortion is performed on a minor. Whatever the merits of such a proposal, that route has been closed by the United States Supreme Court. As earlier noted, the Danforth (23) decision squarely held that it is an unconstitutional violation of the young woman's right of privacy to give her parents a right to veto her decision to abort. This is true regardless of the age of the minor. (24)

Danforth is the constitutional blueprint against which any legislation affecting a minor's right to an abortion must be measured. That right may be limited only where there are "compelling state interests" that make the limitation reasonable.

Parental Consultation

One step removed from parental consent would be a statute requiring that before the abortion is performed on a minor, her parents be consulted. In its favor it may be noted that requiring parental consultation would serve three important functions: (one) parents would be notified of the troublesome situation which their daughter is in; (two) minors would receive mature advice regarding the abortion from those who would presumably be acting in the minor's best interest; and (three) the pregnant minor would have someone to turn to for emotional support.

The arguments in favor of parental consultation, however, proceed upon the assumption that all family relationships are "ideal," and fail to consider that in many families an older sibling, aunt or grandparent is performing the parental function. In still other situations, no one is functioning as a parent and to require consultation in these situations would be, in effect, to bar the abortion.

A possible solution to the "non-functioning parent" problem would be to enlarge the category of people to be consulted so that it included clergymen, social workers, psychiatrists, and others. This merely raised additional problems. Those outside the medical profession would generally be unqualified to explain the nature of the abortion procedure and to answer questions concerning complications that might arise from either continuation or termination of the pregnancy,factors which are important in arriving at a mature decision. To require medical consultation with someone other than the treating doctor would unfairly prejudice those from poorer backgrounds, and would seem to run afoul of Doe v. Bolton. (25)

The longer this was debated, the more obvious it became that mandatory consultation would either be impossible or would degenerate into a formality that served little purpose. After much deliberation, we concluded that mandatory consultation is ineffectual, and, indeed, could operate to defeat the purpose of the present abortion legislation by driving some pregnant minors to illicit abortions.

Parental Notification

We then considered the feasibility of a provision which would require the treating physician to send notification of the proposed abortion to the pregnant minor's parents. In many cases, such a provision might subject the pregnant minor to severe emotional distress if her parents disapproved of her decision and attempted to dissuade her from an abortion. To avoid such pressure, a woman might well choose an illegal means of terminating her pregnancy.

In addition, it is not unlikely that an across-the-board mandatory notice to the pregnant minor's parent(s) would be unconstitutional. The state's interest could be to insure that the pregnant woman's physician exercises his best medical judgment. It is assumed, therefore, that the notified party will communicate information relevant to the patient's physical and emotional health. If this be the purpose of the notice provision, it is arguable that it would be unconstitutional under the holding of Doe v. Bolton. (26) The Doe court held unconstitutional a provision requiring the treating physician who was consulted about an abortion to consult with other doctors to insure that the treating physician exercised his best medical judgment. Information from a parent, a non-professional, who might have a personal motive for preventing the abortion seems less justified than a second medical opinion; and thus, if the purpose of a notice requirement is to promote the admittedly important state interest of insuring that the physician exercise his best medical judgment, the provision would probably be invalid.

The state's interest could also be to insure that the pregnant young woman receives sound advice on a matter of crucial significance to her. If this be the purpose of a mandatory notice requirement, the statute may well be constitutional, but the commission is simply unpersuaded that the statute will work. It is evident that mandatory notice to parents will, in many cases, simply drive a wedge between the young woman and her family. What the Supreme Court said in Danforth, when it struck down parental veto power, is no less apt when directed toward mandatory parental notification:

> "One suggested interest is the safeguarding of the family unit and of parental authority. . . It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant." (27)

Certainly a statute should not be passed that would significantly enhance the possibility of family friction. In short, notification should be encouraged, but not mandated.

IV. TEENAGE PREGNANCY: CONCLUSIONS

Having carefully considered the options available to the commission, we have agreed upon the attached Bill. We recommend that the Public Health Law be amended to add a new section, to be section twenty-five hundred five. It will provide as follows:

PROPOSED AMENDMENT

S.2505. Consent to abortional acts.

1. No abortional act shall be committed upon a person under the age of eighteen years in the absence of a written statement voluntarily entered into by the person upon whom the abortional act is to be performed, whereby she specifically consents thereto. The statement shall assert that she (one) has been advised of the possible adverse consequences, (two) has been advised of the medical procedures to be followed, and (three) has been counseled regarding alternatives to abortion and the availability of supportive services relating thereto. If the patient signs a separate statement so authorizing him, the physician may notify a parent or legal guardian of the patient of his intention to perform the abortional act and of his availability to consult with them regarding the operation.

Comment

Subdivision one requires the written, informed consent of a woman under eighteen years of age before having an abortion. The age limitation accords with the New York Civil Practice Law and Rules definition of "infancy" (CPLR 105(j)), as well as the "right to vote" provisions of the Twenty-sixth Amendment to the United States Constitution.

The written consent requirement will insure that the pregnant minor makes the decision to terminate her pregnancy "with full knowledge of its nature and consequences." (28) The constitutionality of such a provision was upheld by the United States Supreme Court in Planned Parenthood of Central Missouri v. Danforth, (29) even when no similar document is required for other medical procedures.

The bill would further require as a condition to the patient's consent that she be advised of services supportive of childbirth, adoption and other alternatives to abortion. The commission notes that President Carter's budget proposal provides thirty-five million dollars for alternatives to abortion including a system that would insure the availability of adequate counseling. Certainly the state should be expected to do no less.

The final sentence of subdivision one authorizes the physician, with the patient's consent, to notify a parent or legal guardian of the pregnant minor that he intends to perform the abortional act. It is hoped that the physician will urge his patient to give him this authority, thereby safeguarding both the family unit and parental

authority. However, since the patient's consent to such authorization is a prerequisite to sending notification, the state will not be the motivating force behind any fear of embarrassment or emotional distress that the patient might experience. The risk that minors might choose an illegal means to terminate a pregnancy in order to avoid such pressure is thereby minimized.

PROPOSED AMENDMENT

2. Any person under the age of eighteen who (one) has been married or (two) has had a child or (three) is an emancipated minor shall be deemed capable of giving effective consent for an abortional act. Any other person shall be deemed capable of effective consent if, after consultation with the physician, the physician determines that the person is sufficiently mature and intelligent to be capable of such consent.

Comment

The subdivision is borrowed from Public Health Law S.2504, and is a recognition of the fact that certain minors are already functioning as adults and should be treated accordingly. Under S.2504 of the Public Health Law, a minor is emancipated for purposes of consenting for medical care if she has ever been married or is the parent of a child. A minor will generally be deemed emancipated if she lives apart from parents, is self-supporting and generally controls her own life. (30) A minor living apart from parents with their consent may be emancipated even though they still support the minor. There is case law indicating that a minor who still lives in the parental home may be emancipated if she pays living expenses to the parent and uses the remainder of the earnings as she sees fit. (32) A minor can also be emancipated by failure of the parents to meet their legal responsibilities, such as failure to support the child. (33)

The last sentence of this proposed subdivision reflects recognition of an emerging rule that a minor may consent for his or her own medical treatment where the minor is capable of understanding the nature and consequences of the treatment and it is for the minor's benefit. (34) This has come to be known as the "mature minor doctrine." The March, 1976 issue of Pediatrics contains a report of a medical "Task Force on Pediatric Research, Informed Consent and Medical Ethics," Horace L. Hodes, M.D., Chairperson. The Task Force concluded that age is not always a true measure of maturity or intelligence, and that there is no sound justification for denying a minor, who is mature enough to comprehend the nature and consequences of the procedure, the right to accept or reject treatment.

PROPOSED AMENDMENT

3. Except as provided in subdivision three of section twenty-five hundred four of this chapter, if the physician determines that a person is not capable of giving effective consent, no abortional act shall be performed upon such person without first obtaining the consent of a parent or legal guardian. If such consent cannot be obtained promptly from a parent or guardian, or if there is good reason not to seek it, consent may be obtained by order of a justice of the supreme court for good cause shown on application by a relative, friend or other interested party. Said court proceeding shall be confidential and shall be given expedited consideration. The decision of the court shall be based upon a consideration of the best interests of the patient.

Comment

Except in a medical emergency, no medical procedure may be performed without consent. If a minor is incapable of giving effective consent, consent must be obtained from the minor's parent or guardian. If the parent or guardian refuses consent, consent may be obtained by court order.

This subdivision will aid in protecting the treating physician from liability. In addition, although preferring parental consent, it does not give parents a veto power. Thus, under the guidelines suggested in Planned Parenthood of Central Missouri v. Danforth, supra, such a provision should withstand constitutional attack.

PROPOSED AMENDMENT

4. Anyone who acts in good faith based upon the representation by a person that she is eligible to consent pursuant to this section shall be deemed to have received effective consent.

Comment

Subdivision four is not intended to add anything new to the law of New York. The wording of subdivision four tracks that found in S.2504(4) of New York's Public Health Law. The purpose of both provisions is to afford legal protection to a doctor who performs an operation on a patient whom he believes, in good faith, to be over eighteen, or to be married, etc.

This will not provide physicians with carte blanche to perform abortions on all pregnant minors since reliance on the minor's ability to give effective consent must be in good faith.

* * * *

We believe that, within the constitutional limitations set forth by the United States Supreme Court, our recommended bill adequately reconciles (a) the right of a young woman--including one from a broken home or with absent or non-functioning parents--to obtain a legal abortion with (b) the right of a parent to care for his child.

Respectfully submitted,

Joseph M. McLaughlin, Chairman
Joyce Austin
Louise M. Dan[illegible]ono
Oscar Gonzalez-Suarez
Ian Morrison
Archibald R. Mur[illegible]y
Jacob Trobe

SEPARATE STATEMENT OF MILDRED A. SHANLEY

I differ from the report of my fellow Commission members in the following regard:

There is a compelling state interest in the preservation of family life. The family is the basic unit of our society. It is the family through which the fundamental beliefs, upon which this country was founded, are communicated generation to generation.

To preserve the family unit, it is essential that the delicate balance between the rights and responsibilities of parent to child be maintained. A child's right to food, clothing, shelter, education, and medical care and the parents' responsibility to provide them is unquestioned. A child also has the right to psychological development and emotional security and it is the parents' responsibility to assure the child's growth in these areas as well.

Any deviation from the norm, which represents a limitation on parents' primary responsibility and control over their dependent children, must first be carefully assessed as to its effect on the role of the family in our society. Removal from parents of such responsibility and control in the case of the pregnancy of their child would destroy the integrity of the family and deprive the child of familial strength and support.

Pursuant to the decision in Danforth, the state may identify a compelling state interest which would limit the absolute right of a dependent minor to secure an abortion. In the case of a minor dependent on the family for mental, moral, emotional, physical and financial support and growth, preservation of the parents' role in the minor's decision is critical to preserving the family unit.

This was recently the decision of a federal district court in Michigan in Doe v. Davis. There the court sustained a prior notice requirement to parents in the distribution of contraceptives to their children on the basis that parents have a right to privacy in the care and control of their minor children. The court held that absent a showing of compelling state interest, or a showing of superior rights in the minor child, the State may not totally exclude parents from the decision of their minor, unemancipated children.

I strongly recommend, therefore, a statute which would require notice to parents and legal guardians that a minor intends to secure an abortion in the case of those minors who are dependent on their families for mental, emotional, moral, and financial support. This requirement will encourage minors to seek out their parents assistance and will result in support for the minor in carrying out her decision.

Such a statute must also provide a judicial procedure whereby the notice requirement may be waived in those cases where the notice is likely to result in endangering the life and health of the minor.

The existence of the family is dependent upon parental rights and responsibilities to build, maintain and guide the family morally, mentally, physically and emotionally. The public policy of this state should support the integrity of the family at every opportunity.

Respectfully submitted,

Mildred A. Shanley

Mildred A. Shanley

FOOTNOTES

1. C. E. Rice, The Dred Scott Case of the Twentieth Century, 10 Houston L. Rev. 1059 (1973).

2. 410 U.S. 113 (1973).

3. Id. at 116.

4. Id. at 155.

5. Id. at 163.

6. Id. at 163.

7. Id. at 163-64.

8. 410 U.S. 179 (1973).

9. N.Y. Penal Law §125.05 (McKinney 1975).

10. 428 U.S. 52 (1976).

11. Alan Guttmacher Inst., 11 Million Teenagers at 9 (1976).

12. Id.

13. Id.

14. Id.

15. Center for Disease Control, HEW, Abortion Surveillance 1974 (April 1976).

16. Id. at 2.

17. Id.

18. N.Y. State Dept. of Health, The Problems of Teenage Sexuality (1975).

19. See, U.N. Dept. of Economic and Social Affairs, Demographic Yearbook 1975 at 380, 768 (1976).

20. See, Demographic Yearbook 1975, supra, note 19, at 306, 330, 363 (1976). See also 11 Million Teenagers, supra, note 11, at 23.

21. L. A. Bacon, Early Motherhood, Accelerated Role Transition and Social Pathology, Social Forces (March 1974).

22. 11 Million Teenagers, supra, note 11, at 26. In a New York City study, 72% of those mothers between 15 - 17 years old were receiving welfare.

23. 428 U.S. 52 (1976).

24. As the Court noted, ho-ever, this "does not suggest that every minor, regardless of age or maturity, may give effective consent for termination of her pregnancy." 428 U.S. at 75. While the meaning of this sentence is not entirely clear, the commission believes it has accommodated the special needs of the immature teenager in its proposed amendment to Public Health Law §2505(3), infra at p. 14.

25. 410 U.S. 179 (1973).

26. Id.

27. 428 U.S. at 75.

28. Id. at 67.

29. 428 U.S. 52 (1976).

30. Cohen v. Delaware, L & W RR, 150 Misc. 450, 269 N.Y.S. 667 (Sup. Ct. N.Y. Co. 1934).

31. Matter of Stillman v. School District, 60 Misc.2d 819, 304 N.Y.S.2d 20 (Sup. Ct. Nassau Co. 1969), aff'd, 34 App. Div.2d 553 (2d Dept. 1970).

32. E.g., Giovagnioli v. Fort Orange Construction Co., 148 App. Div. 489, 133 N.Y.S. 92 (3d Dept. 1911).

33. Murphy v. Murphy, 206 Misc. 228, 133 N.Y.S.2d 796 (Sup. Ct. Madison Co. 1954).

34. Bach v. Long Island Jewish Hospital, 49 Misc.2d 207, 267 N.Y.S.2d 289 (Sup. Ct. Nassau Co. 1966); Younts v. St. Francis Hospital, 205 Kan. 292, 469 P.2d 330 (1970); Bakker v. Welsh, 144 Mich. 632, 108 N.W. 94 (1906); Gulf & Ship Island RR v. Sullivan, 155 Miss. 1, 119 So. 501 (1928); Lacey v. Laird, 166 Ohio St. 12, 139 N.E.2d 26 (1956).

Excerpts from STANDARDS RELATING TO RIGHTS OF MINORS, Juvenile Justice Standards Project, Institute of Judicial Administration and the American Bar Association. Adopted by the ABA, February 11, 1979.

Part IV: MEDICAL CARE

4.1 Prior parental consent.

A. No medical procedures, services, or treatment should be provided to a minor without prior parental consent, except as specified in Standards 4.4-4.9.

B. Circumstances where parents refuse to consent to treatment are governed by the Abuse and Neglect volume.

4.2 Notification of treatment.

A. Where prior parental consent is not required to provide medical services or treatment to a minor, the provider should promptly notify the parent or responsible customdian of such treatment and obtain his or her consent to further treatment, except as hereinafter specified.

B. Where the medical services provided are for the treatment of chemical dependency, Standard 4.7, or venereal disease, contraception, and pregnancy, Standard 4.8, the physician should first seek and obtain the minor's permission to notify the parent of such treatments.

1. If the minor-patient objects to notification of the parent, the physician should not notify the parent that treatment was or is being provided unless he or she concludes that failing to inform the parent could seriously jeopardize the health of the minor, taking into consideration:
   a. the impact that such notification could have on the course of treatment;
   b. the medical considerations which require such notification;
   c. the nature, basis, and strength of the minor's objections;
   d. the extent to which parental involvement in the course of treatment is required or desirable.

2. A physician who concludes that notification of the parent is medically required should:
   a. indicate the medical justifications in the minor-patient's file; and
   b. inform the parent only after making all reasonable efforts to persuade the minor to consent to notification of the parent.

C. Where the medical services provided are for the treatment of a mental or emotional disorder pursuant to Standard 4.9, after three sessions the provider should notify the parent of such treatment and obtain his or her consent to further treatment.

4.3 Financial liability.

A. A parent should be financially liable to persons providing medical treatment to his or her minor child if the parent consents to such services, or if the services are provided under emergency circumstances pursuant to Standard 4.5.

B. A minor who consents to his or her own medical treatment under Standards 4.6-4.9 should be financially liable for payment for such services, and should not disaffirm the financial obligation on account of minority.

C. A public or private health insurance policy or plan under which a minor is a beneficiary should allow a minor who consents to medical services or treatment to file claims and receive benefits, regardless of whether the parent has consented to the treatment.

D. A public or private health insurer should not inform a parent or policy holder that a minor has filed a claim or received a benefit under a health insurance policy or plan of which the minor is a beneficiary, unless the physician has previously notified the parent of the treatment for which the claim is submitted.

4.4 Emancipated minor.

A. A minor who is living separate and apart from his or her parent and who is managing his or her own financial affairs may consent to medical treatment on the same terms and conditions as an adult. Accordingly, parental consent should not be required, nor should there be subsequent notification of the parent, or financial liability.

1. If a physician treats a minor who is not actually emancipated, it should be a defense to a suit basing liability on lack of parental consent, that he or she relied in good faith on the minor's representations of emancipation.

4.5 Emergency treatment.

A. Under emergency circumstances, a minor may receive medical services or treatment without prior parental consent.

1. Emergency circumstances exist when delaying treatment to first secure parental consent would endanger the life or health of the minor.

2. It should be a defense to an action basing liability on lack of parental consent, that the medical services were provided under emergency circumstances.

B. Where medical services or treatment are provided under emergency circumstances, the parent should be notified as promptly as possible, and his or her consent should be obtained for further treatment.

C. A parent should be financially liable to persons providing emergency medical treatment.

D. Where the emergency medical services are for treatment of chemical dependency (Standard 4.7), venereal disease, contraception, or pregnancy (Standard 4.8); or mental or emotional disorder (Standard 4.9), questions of notification of the parent and financial liability are governed by those provisions and Standards 4.2 B., 4.2 C., and 4.3.

4.6 Mature minor.

A. A minor of sixteen or older who has sufficient capacity to understand the nature and consequences of a proposed medical treatment for his or her benefit may consent to that treatment on the same terms and conditions as an adult.

B. The treating physician should notify the minor's parent of any medical treatment provided under this standard.

4.7 Chemical dependency.

A. A minor of any age may consent to medical services, treatment, or therapy for problems or conditions related to alcohol or drug abuse or addiction.

B. If the minor objects to notification of the parent, the physician providing treatment under this standard should notify the parent of such treatment only if he or she concludes that failing to inform the parent would seriously jeopardize the health of the minor, and complies with the provisions of Standard 4.2.

4.8 Venereal disease, contraception, and pregnancy.

A. A minor of any age may consent to medical services, therapy, or counseling for:

1. treatment of venereal disease;

2. family planning, contraception, or birth control other than a procedure which results in sterilization; or

3. treatment related to pregnancy, including abortion.

B. If the minor objects to notification of the parent, the physician providing treatment under this standard should notify the parent of such treatment only if he or she concludes that failing to inform the parent would seriously jeopardize the health of the minor, and complies with the provisions of Standard 4.7.

4.9 Mental or emotional disorder.

A. A minor of fourteen or older who has or professes to suffer from a mental or emotional disorder may consent to three sessions with a psychotherapist or counselor for diagnosis and consultation.

B. Following three sessions for crisis intervention and/or diagnosis, the provider should notify the parent of such sessions and obtain his or her consent to further treatment.

* * * * * * * * *

Excerpts from Commentary section: pp. 56-57:

"The complexity of the issues and the variability in individual situations preclude adopting an absolute rule either barring disclosure or requiring notification under all circumstances where a minor has received medical treatment without prior parental consent. Nothing in this standard prevents the minor from informing the parent himself or herself, nor the physician, on the basis of sound medical judgment, from attempting to persuade the minor of the desirability of parental involvement. Rather, the standard attempts to resolve the physician's dilemma in those instances where the minor either expresses no position or voices opposition to parental disclosure."

"In dealing with this issue of notification of parents, this standard distinguishes between those types of treatment in which the interests of the parent and the minor will normally coincide and where notification of parents is appropriate and mandatory, and those circumstances where the interests of parent and child may conflict and the minor may or does object and notification is discretionary. In the latter instances, the overriding social interests in enabling the minor to obtain the particular treatment dictate that unless the minor's health will be seriously jeopardized by failing to notify the parents, the minor's objection to disclosure should be honored by the treating physician."

....."Standard 4.2 B. authorizes deviation from the norms of notification and consent of parents when compliance with these policies would inhibit the provision of needed medical treatment in certain identifiable medical problem areas where minors will be likely to require medical treatment; they are likely to object to parental notification; and the social desirability of providing services outweighs the potential negative impact of nondisclosure on family autonomy. In such instances, Standard 4.2 B. 1. permits parental notification when exceptional circumstances require, but suggests several factors and considerations that may weigh against parental notification. The importance of minors obtaining treatment for chemical dependency, or for venereal disease, birth control, and pregnancy; the potential deterrent effect that disclosure may have in a particular instance; and respect for the autonomy and independence of the minor in such circumstance, requires substantial respect for the minor-patient's objections to parental notification." (Emphasis added)

STATEMENT BY

THE MEDICAL SOCIETY OF NEW JERSEY

REGARDING ASSEMBLY BILLS 1155 and 1592

TO THE ASSEMBLY INSTITUTIONS, HEALTH & WELFARE COMMITTEE:

The Medical Society of New Jersey opposes Assembly Bills 1155 and 1592 in the belief that both bills intrude on the confidentiality between the physician and patient and that they contradict United States Supreme Court decisions on the subject of abortion.

We believe that the clear intent of A-1155, which would require a physician to notify the parents or guardian of a pregnant, unemancipated minor of the intention to perform an abortion is to circumvent the purpose of New Jersey's consent statute N.J.S.A. 9:17A-1. That law, enacted in 1965, clearly gives the unmarried, pregnant minor the same powers and obligations as a person of legal age to consent to medical and surgical procedures related to her pregnancy. We believe mandatory parental notification would interfere with the minor's legally established right to consent.

A-1592, which would require a physician to gain and forward to the State Department of Health a patient's written acknowledgement that she has read and understands a state-prepared booklet detailing all medical facts pertinent to the abortion procedure, is an unwarranted interference with the physician-patient relationship. It treats informed consent for abortion differently from consent on any other medical procedure, even open heart surgery. We believe such a result is medically unnecessary and legally unsound. The State Department of Health already has the regulatory authority to address legitimate public health concerns. With these powers, the Department has adopted numerous regulations concerning abortion. A-1592 would force the Department to take an additional, unnecessary and intrusive step into the delicate and confidential area of the patient's relationship with the physician.

We ask the committee not to release either of these bills.

October, 1980

The New Jersey State Right To Life Committee is pleased to have this opportunity to address the crucial issues surrounding the vital area of informed consent. Because the health of women as affected by legal abortion is of prime concern to us, our medical research department has delved deeply into this matter.

Section 1. It is impossible, we submit, to promote or protect maternal health by providing abortion services because not enough is now known about the long-term physical and psychological effects, and much of what is known in the profession about immediate effects remains obscure to the general public and is unknown by the legislature.

Section 2. The Department of Health may find that "reasonably outlining" "all medical facts including any health risks associated with abortion" are two mutually exclusive ideals. Does the word "reasonably" give the Department the option of withholding information about complications they deem are not important enough or prevalent enough to include? Who sets the standard?

The word "any" implies the presumption that few if any health risks exist -- a fantasy popularized by abortion advocates and providers of abortion services. The Department of Health is apparently accountable to no one for thoroughness; what if they choose to list only 60 or 70 complications when medical literature has recorded at least 100 more than that? Will the booklet encourage the pregnant mother to complete her sexual cycle? Will it say that completing her sexual cycle can be a rewarding, enriching, maturing experience? Will it reinforce her dignity by reassuring her that no matter what the situation making this pregnancy a problem, she can cope with it competently? Or will Section 3 be effected by handing her just one more form to be signed, one more sterile formality necessary before she can take the quick way out?

This bill calls for the booklet to make a comparison between "health risks associated with abortion" and "risks of eventual childbirth." NO VALID COMPARISON CAN BE MADE BETWEEN THE RISKS OF ABORTION AND THE RISKS OF CHILDBIRTH. We will clarify this statement. This calls for a comparison of what can go wrong in the 6 or 8 weeks of an artificially terminated pregnancy and what can go wrong in the 40 weeks of a naturally terminated pregnancy; no one will dispute that more is likely to go wrong in 40 weeks than in 4 weeks. It would come as no surprise to see the Department espouse the theory that "abortion is safer than childbirth based on statistics." But we know that statistics can be very deceiving and while this is a highly effective advertising slogan, it is a poor representation of fact. What actually concerns the pregnant mother is what are her chances, individually, of being killed or injured by forced termination compared to natural termination? There is a distinct and

striking difference between these two unpleasant possibilities: the overwhelming majority of women who die from a legal abortion are perfectly healthy before their surgery; in carrying their pregnancies to term few -- if any -- would die. But those women who died in childbirth died from a disease process -- an abnormality in the pregnancy/childbirth experience which for some reason could not be adequately treated. NO VALID COMPARISON CAN BE MADE BETWEEN TWO SO ENTIRELY DIFFERENT CLASSES OF PREGNANT WOMEN: ONE GROUP HEALTHY AND THE OTHER GROUP DISEASED. The death of the healthy woman from a legal abortion is totally PREVENTABLE simply by not aborting; this also holds true for women with a condition complicating pregnancy as has been shown conclusively in medical literature. Unfortunately, the death from childbearing of that woman with a disorder is mostly UNPREVENTABLE due to medical inability to understand or control the disease process which takes her life. What this means to the individual pregnant mother is that allowing her pregnancy to follow its natural course is more healthful and more free of risk than unnatural, forceful, surgical intrusion into her body and its natural processes.

Will this booklet say that for each death caused by a legally-induced abortion, hundreds of women suffer traumatic complications and thousands endure debilitating physical or psychological consequences -- all preventable simply by not performing this invasive and unnecessary surgery? Will it state plainly that, according to statistics from the Center For Disease Control, in every year since (and including) 1973 when abortion was legalized, more women have been killed by legal abortions than by illegal abortions?

We are concerned about the apparent inconsistency between the bill's call for a "complete listing of alternative services" and a well-known statement made by one of the sponsors about there being no alternative to abortion. The personal agony of many post-abortion women matters too much to be chided in this fashion; there are hundreds if not thousands of women who wish now that their pregnancies had been handled differently.

What recourse is there for a woman, an emergency pregnancy service, even for a legislative or regulatory body if the Department omits mention of a given agency that sees women through to natural termination? The bill leaves this matter open to the interpretation of the Department, which is accountable to no one.

We find the concept behind this bill good, but in its present form, inadequate to bring about the type of informed consent insurance which every woman is entitled to. Will the woman have time to read the book? What if she can't read? What if she can't read English? Who will explain its significance to her? The bill in its present form leaves these questions unanswered.

Let us assume that the Department of Health booklet enumerates for the pregnant mother's consideration the 180 or so known complications of legal abortion. Under this bill "before a physician performs any abortion he shall give" the woman a copy of the book "and answer any questions" she may have. HE shall give her the book? How long before the abortion? Shall he give it to her as she is coming into the surgery area, perhaps as he turns on the machine, and then glance at her and say "Any questions?" Most abortionists do not see their patients at all before the abortion; in effect, we forsee the receptionist -- a non-professional hired off the street -- giving the pregnant mother the booklet. Then who fields the questions? How many questions is the girl allowed to ask? Have you ever sat in a counselling session with a distraught pregnant woman or teen? We have! They can ask questions for hours! And they need to -- they need to be sure in their own minds that this is the right thing for them. What abortionist is going to limit the number of procedures he is able to do in a day by giving his wholehearted attention to such interminable interrogation? What kind of explanations are going to be given by the doctor who isn't getting paid any more to play Twenty Questions than he is getting for performing the abortion? Especially if he realizes that if he explains it too well, his client may get up and leave? What is his attitude going to be toward his "patient?" Will he be patient with her, or irritated and anxious to get on with it? Won't his attitude influence her to be brief? The bill provides insufficient regulation in this area.

Let us assume that, booklet in hand, the prospective client has been informed of the 180 or so fatal and non-fatal, immediate and long-term, debilitating and traumatic complications of legal abortion and has had them explained to her satisfaction. Armed with this plethora of new ideas, she marches off to.... where? Home, to mull it over? Or straight to the operating table? This bill is crippled by the lack of a 48 hour interval the woman will need to weigh the new information and to evaluate the advantages of completing her sexual cycle against the presumed benefits of invasive, possibly damaging surgery that is known to kill, maim and psychologically cripple thousands of women each year.

Of equal importance to women contemplating abortion is information about the preborn: his/her body, life and capabilities. This is vital, because embryology is one of those basic facts of life which all growing girls learn later, if not sooner. We know firsthand the consequences to girls who are not told this truth beforehand. We have witnessed their discovery that the preborn's body is perfectly formed at six weeks after conception, and we have heard their anguished cries "Why didn't anybody tell me?" We have held their shuddering bodies and tried to console them in their shock and grief, but we cannot answer the question "Why didn't anybody tell me?" Maybe the abortionists wanted to spare her that reality; maybe they just didn't care. But we know that countless girls suffer needlessly because nobody tells them the facts of life -- prenatal life. This bill, in its present form, will do nothing to prevent this tragedy from being repeated.

This bill needs to be amended before it is released from Committee and we believe that the booklet itself, in its final form, should be required to be reviewed by this Committee for clarity and thoroughness before approval for publishing is given. Thank you.

Respectfully Submitted,

Ann Saltenberger

Ann Saltenberger
Medical Researcher
New Jersey State Right To Life Committee

October 1, 1980
9 Laurel Avenue
Irvington, N.J.
07111

New Jersey State Assembly
Committee on Institutions,
Health and Welfare
Trenton, New Jersey

Dear Members of the Committee:

Enclosed please find a copy of the testimony that I was to have given before your Committee on October 1, 1980 in the Union County Administration Builging in Elizabeth, New Jersey. Because of some family and personal ma tters, I am unable to present this before you myself. Therefore, I am sending my testimony to you asking that it be admitted and considered in reference to A-1592. If I can further clarify any of my testimony or answer any questions you may have in reference to it, please do not hesitate to ask, my telephone number and address are enclosed.

Thank you,

(Mrs.) Margaret M. Bardes

Mrs. Margaret M.Bardes
9 Laurel Avenue
Irvington, N.J.07111

Members of the Committee, I thank you for the opportunity to speak before you today on Assembly Bill 1592. My name is Mrs. Margaret Bardes, I am a Welfare Mother from Essex County representing Women Exploited, and am opposed to the bill.

The first time I read A-1592 I thought "That's not so bad, sounds pretty good." Then I reread the bill and found it a bit vague on certain points. Each time I read it I found what a lawyer might consider a "loophole" or at the very least another way to "interpret" the meaning of the bill. It is for these reasons I cannot support the bill.

I am bothered by the wording in the first section of the bill that "some women have been or are suseptible to being victimized by a small number of medical practicioners and that greater protection a gainst this possibility may be necessary." To me this implies that this happens to such a small degree that the point of this bit of legislature is almost a "by-the -way" attitude. Since abortion has been advocated as an "answer" to "problem pregnancies" one would have to assume that any girl or woman seeking an abortion would be doing so because of emotional, social, physical, or mental "problems" and as such very vulnerable to exploitation especially by those health care providers who stand to profit monetarily by her decision. I feel if one case comes to surface where the girl or woman has been victimized in any way then 1) it's a safe bet that she's not the only case to be dealt with and 2) the utmost protection IS necessary.

The idea of a booklet being prepared is very good, but I am at a loss as to exactly what the Department of Health would put in the booklet. Many of the clinics hand out flyers or something similar "describing" the "painless" and "safe" methods of abortion that that particular clinic uses. Also these little bits of information

constantly have some reference to the acceptiblity of abortion by society which many times is a backup to the decision to have the abortion. Again in the wording- "including any health risks which may be associated with abortion and how these may compare with the risks of eventual childbirth." To me this implies the false statistics the clinics give out that abortion is anywhere from 9-14% safer than childbirth. I also feel that information should be given out concerning fetal development and the chances for the child's survival. This was an issue in the 1978 Abortion Regulative Bill; W.E. felt it a necessary point then and feel even more strongly now. In April of this year a friend's sister began running fevers and went into premature labor; she was at the end of her fourth month and beginning her fifth month of pregnancy. She was delivered of a boy weighing one-pound-nine-ounces. Today her child is home and, although smaller than most five-and-a-half month olds, is normal in every way. By the time he is two years old in all probability, no one would notice or find any difference between him and a full termed child of the same age. Our modern technology is truly wonderous! The smallest child ever to survive more than a few weeks was born only seventeen weeks after her mother's last menstrual period. She is a healthy, normal child today, almost two years of age, yet at birth, she weighed only seventeen ounces! Too often W.E. hears from girls and women who say they either were not told of the child's development or they were lied to concerning these facts.

A complete listing of alternative services available should be just that, a COMPLETE listing of agencies such as Birthright and other pro-life services with their services listed and a mention of the fact that Birthright's services for instance, are provided free. Agencies that do not provide abortion referral or contraceptive services or referral should not be denied listing.

W.E. feel there should be some waiting period between the time the girl/woman receives the booklet and subsequent information from the physician and the time the abortion is performed. Too often (and here I am not necessarily referring to abortion) especially with a young girl, who is frightened and unfamiliar with the personnel in the clinic, she may feel "obliged" to go through with the procedure

regardless of any second thoughts she may have. A waiting period would provide her with the opportunity to investigate and consider some of the alternative services available that maybe, 1) she had not considered, or, 2) she had previously been unaware of.

Also, the way I read this piece of legislation, it would be possible for the physician to give the girl/woman the booklet and answer any questions while she was being prepared for surgery, or as the abortionist scrubbed if facilities were available to do so in close proximity to where the abortion would be performed, thus further pressuring her into the abortion.

Not being a lawyer, I do not understand some of section four of the bill and will refrain from comment except to say there must be some way of reporting the actual data for the purposes of compiling statistics. If the necessary information is not permitted to be recorded because of loopholes which we now have, the Department of Health would not be able to "reflect any changes" or even be sure that satisfactory care was being provided to these girls and women seeking abortion.

Again, I thank you for the opportunity to make our views on this bill known to you.

Mrs. Margaret M. Bardes

ncjw

NATIONAL COUNCIL OF JEWISH WOMEN / GREATER ELIZABETH SECTION

October 8, 1980

Raymond Lesniak, Vice-Chairman
State House
Trenton, New Jersey

Dear Assemblyman Lesniak,

Inasmuch as we did not have the opportunity of presenting our viewpoint with regard to the Assembly Bills 1155 and 1592, we are acting upon the assurance that were it presented in writing our testimony would be incorporated into the record of the Public Hearing that was held on October 1st at the Union County Administration Building in Elizabeth.

We represent 9,500 women voters in the State of New Jersey; and the National Resolutions of our organization call upon us "to work to protect every woman's right to choose abortion as an individual right and to work to eliminate any obstacles that limit her reproductive freedom".

Though the legal aspects are of considerable importance we leave those arguments to those with legal expertise and wish to focus our attention on the human factors of this problem.

Re: Bill A1155- This bill fails to recognize that if open communication between the parents and the young woman did indeed exist, undoubtedly she would be inclined to go to her parents with her problem. It is the young woman who must of necessity make her own decision because of fear of her parents who is affected by this bill. This fear is often well founded as indicated by the epidemic proportions of child abuse. In many of our projects we see cases of child abuse as a direct result of an unwanted pregancy. This bill, while well intentioned, will further compound the problems. Not only will young women be afraid to go to a reliable qualified practitioner, but they will be forced to perpetuate the obscenity of using the "services" of an illegal abortion butcher -- all brought about by the interference of government. There are children who fear reporting to their parents that they have been raped much less are pregnant. And what of those pregnant due to incest?

NATIONAL COUNCIL OF JEWISH WOMEN / GREATER ELIZABETH SECTION

This bill postulates a family unit which no longer exists in a majority of situations. We cannot think in terms of the ideal family, one where there is a continuous exchange of ideas, thoughts, and feelings. In addition, even in a traditional family setting the fragility of this bill is apparent: suppose a parent is in frail health. Being confronted with such news by a physician could prove devestating. The physician is denied the use of his discretion by this bill.

In a word, the State has no right to manipulate the lives of its citizens.

Now, as to Bill A1592- It appears that only ivory tower thinking could have allowed a bill of this character to emerge. Do you honestly believe that every young girl (or, indeed, older woman) will actually read the material presented to her? Do you honestly believe that the busy physician will make certain that a woman has read the material, or will just take her word for it in the interests of protecting himself with a signed acknowledgement in his files.

This is one of our concerns with this bill. A law which is passed only to be disregarded diminishes respect for all laws. How will the reading of the material be enforced by the State? How can comprehension of the material be mandated by the State? We also have severe reservations concerning the maintaining of anonymity when there are reports to be filed.

We trust that your committee will give our statement serious consideration. We shall, of course, be happy to answer any questions you may have. Please address any inquiries to the National Council of Jewish Women, Greater Elizabeth Section, 132 Hillside Road, Elizabeth, New Jersey 07203.

Respectfully Yours,

Sue Marcus

Sue Marcus, President

Board of Chosen Freeholders
Union County

Elizabeth, N. J. 07207

OFFICE OF FREEHOLDER
JOHN K. MEEKER, JR.

RESIDENCE
25 STONELEIGH PARK
WESTFIELD, NEW JERSEY 07090

October 1, 1980

Assemblyman Raymond Lesniak
60 Prince Street
Elizabeth, New Jersey 07208

Dear Assemblyman Lesniak:

Please be advised that I wholeheartedly support Assembly Bill 1155, requiring parental notification prior to the performance of an abortion on a pregnant minor.

Sincerely,

JOHN K. MEEKER, JR.
FREEHOLDER

JKM:go