Members Present:

Chairman Hayes
Vice Chairman Stewart
Mr. Banner
Mr. Brady
Mr. Coulter
Mr. Horn
Mr. Malone
Mr. Prengaman
Mr. Sena

Members Absent:

Mr. Fielding
Mr. Polish

Also Present:

Mrs. Westall, Primary Sponsor of A.J.R. 17

Chairman Hayes called the meeting to order at 6:08 p.m. in the chamber of the Las Vegas City Council.

ASSEMBLY JOINT RESOLUTION 17

Requests Congress to call a convention limited to proposing amendment to Constitution to restrict abortion.

Chairman Hayes outlined the rules of this hearing.

Ruth McGroarty, Director of Nevada Right to Life, presented a written statement (Exhibit A) to the Committee.

Dr. James Lyman, family physician in Clark County, presented a written statement (Exhibit B) to the Committee.

Lucille Lusk of the Pro-Family Coalition of Southern Nevada presented a written statement (Exhibit C) to the Committee.

Tom Miller, Director of the Catholic Welfare Bureau, said he wanted to relate two services of the bureau: a child care center and adoption services. He said that it would take him five years presently to fill the requests for adoptions.

Pat Barney, Director of L.D.S. Social Services, said that his agency offers an alternative to abortion and would like to indicate that a viable alternative is available. He outlined assistance which is available. This information was also indicated in written information he submitted to the Committee. (Exhibit D).

Dr. Samuel Davis said that he did not think the framers of the Constitution had intended for things like abortion to be legal. He said that much has been said about the right of a person to control his or her own body. He said that in this issue a woman does have a right to control her own body prior to conception. After conception, however, he said that a new life has been created that needs the protection of society.

Rev. Ted Cuveston, pastor of Greater Faith Missionary Baptist Church, said that he was opposed to any concept that deals with taking the lives of others whether born or unborn.

Carol Carlson, Director of the Pro-Family Coalition in Southern Nevada, said that since abortion has been legalized, there has been a destruction of Christian values. She said that young people are being taught that abortion is another means of contraception. She said she has been told that it would be too traumatic for children in school to see slides of aborted babies. She said that children are also encouraged not to discuss these matters with their parents.

Mrs. Carlson said that her group had determined to do everything in their power to support a resolution calling for a constitutional convention to restrict abortion. She said it was felt there would be no help from the courts. Further, she said there would be no help from Washington, D.C., and she said the word concerning abortion would have to come from the individual states.

Sandra Jolley of the Pro-Family Coalition presented a written statement (Exhibit E) to the Committee.

Adeline Bartlett, Southern Nevada Chairman of Stop ERA, presented a written statement (Exhibit F) to the Committee. She also stated that she hoped there would be mention made of medical experiments on babies that had been aborted alive.

Mr. Coulter asked Mrs. Bartlett her feelings regarding pregnancies that resulted from rape and incest. Mrs. Bartlett answered that she was against the idea of compounding the damage through aborting these types of pregnancies.

Donald Jaye of the Knights of Columbus stated that he would endorse what had been said by the organization at the hearing in Carson City. He also submitted the letter that had been submitted at the Carson City hearing (Exhibit G).

Tori Cornwall said that she saw no difference in Hitler, Herod, or the United States. She said there was no reason for abortion except for the protection of the life of the mother. She said that babies are not able to speak in their own defense in an abortion. She said that babies deserve the right to life and that killing babies is not right.

Neil Twitchell, an elementary school principal, said he had been the father of a mongoloid child that was the oldest of six children. He related the specialness of this child even though she was not normal compared to the standards of most individuals. He said that if he and his wife had chosen to take this child's life, they would have missed out on the happiness she has brought.

Dr. William Gordon of Nevada Right to Life said that data collection regarding long-term effects of abortion had begun. He said a recent survey showed that 40% of the new rise in suicides of children was directly related to abortion. He said that tearing of the cervix during abortion had caused further problems.

Dr. Gordon then showed a slide presentation regarding abortion.

This concluded the organized presentation of those favoring A.J.R. 17.

Dr. Vern Mattson presented a prepared statement (Exhibit H) to the Committee.

Jan Jenkins stated that she was a member of a religious group adamantly opposing abortion and the mother of an adopted child. She stated that she was against abortion, but she asked how those opposing abortion could shove their beliefs on other citizens. She said it was possible to lose some very precious rights if a constitutional convention was convened. She said that abortion will not stop even through passage of a law making it illegal.

Aileen O'Neill said that one of the rights of women is the freedom of choice. She stated that those opposing abortion should put more of their efforts into building facilities to take care of needy and unwed mothers. She said that perhaps those candidates for abortion would take advantage of such facilities. In the meantime, she felt that women should have the choice of terminating their pregnancies by abortion. She said that law has never stopped abortion, and she promised that it never would.

Naiomi Millisor of the Southern Nevada Chapter of the National Organization for Women stated that former Governor Laxalt had appointed a commission during his term to study ways of strengthening home life and to study problems confronting women in the late 1960's. She said that the first priority of that commission was the reproductive freedom of women. She said that this commission lobbied earnestly to allow abortions for women who were victims of rape or incest, as a change in the law that did not allow abortion in Nevada.

Ms. Millisor asked if Governor Laxalt's commission was wrong concerning freedom of choice in 1967.

Ms. Millisor stated that there had been a television advertisement regarding prisoners who had been battered children. She said that children are battered because they are unwanted, and they were born of immature, emotionally unstable parents who were unable to cope. She said it would appear that paying $150 to $250 for a safe therapeutic abortion would far outweigh the cost of thousands of dollars spent on the Nevada youth involved in the criminal justice system.

Ms. Millisor said that if abortion became illegal, the rate of abortions would not change. She said that it would only change the method.

Lisa Palmer stated that in the event she got pregnant she would want to be able to have the choice of having an abortion. She asked why she should damage her career when it is just beginning by having a child. She requested the Committee to not ask her to make a decision between having a baby or having an illegal abortion.

Stevie Carroll related that in 1968 she had become pregnant, and because she was "white and looked middle class", she was offered the name of a doctor in Mexico that would perform an abortion. She said she did not have that abortion, and her child from that pregnancy was present at this hearing. In the 1970's, she said her marriage was having problems, and she said her husband was practicing healing and studying extra-terrestrial beings. After her separation, she decided to go on welfare to be able to complete her education, when she found she was pregnant with a third child. She, at that time, decided to have an abortion rather than jeopardizing the lives of her other two children and herself.

Ms. Carroll said this type of decision is not easy to make, but she felt it should be a decision that is available. She stated that society in general does not look kindly on poor people or welfare mothers.

Peggy Lee of Clark County Welfare Rights said she was speaking in behalf of young black mothers. She said abortion was not an easy decision, but she asked why a mother should have another baby when she is already on welfare.

Saundra Phillips said that every women has the right to decide if she wants to have an abortion or not. She said every women should be the boss for herself in this matter.

Carla Caesar said that abortion is a hard decision, but she said it was one she would like to make for herself. She said it was not fair for her to raise an unwanted child, to give her an added burden, or to have her raise a child for juvenile institutions. She said her child would not have the parental

care it would need because she would have to work. Then, she said when it came time to lay off some employees, she would be the first to go because she was black. She suggested that the Committee, since they had seen the slides of aborted babies, consider hungry children, problem children, and children who lived in homes that were either too hot or cold because of the inability to provide utilities for temperature adjustments.

Kim L. Hansen presented his prepared statement (Exhibit I) to the Committee.

Susan Whitney said that if an amendment to the Constitution regarding abortion was adopted, the most personal details of her life would be laid bare. She said that things that could happen were that the Federal government would set up a monitoring system for pregnancies, institute a registration and reporting system on all types of health care and procedures, intrude into doctor-patient relationships, and monitor pharmacy files.

Ms. Whitney said that until there is a 100% effective means of contraception, there should be the option for abortion. She said it was a waste of money to continue to debate the issue. She suggested that something meaningful be done to eradicate the need for abortion.

Cynthia Cunningham, past Moderator of the Presbytery of Nevada, presented a prepared statement (Exhibit J) to the Committee.

Bea Levinson of the League of Women Voters presented a prepared statement (Exhibit K) to the Committee.

E. J. LeTourneau presented a prepared statement (Exhibit L) to the Committee.

Penelope Duckworth, a campus minister, said she believed it was the mission of all people to help others have life. She related other things in life besides abortion that are taking the lives of people today. She said that to be truly pro-life, one must first consider the living. She said that the place for an amendment such as being considered would not be the U.S. Constitution, but rather a change of the human heart.

Evan Wallach, Chairman of the B'nai Brith Anti-Defamation League, presented a prepared statement (Exhibit M) to the Committee.

This concluded the organized presentation of those opposing A.J.R. 17.

John Shipp, government teacher at Las Vegas High School, said that he would see problems with the enforcement of this type of amendment to the Constitution.

Julie Taggert presented a short satire on repealing laws regarding rape, drugs, and murder because these types of activities still occur even though these are crimes in the law now.

She further noted that states that have lowered the drinking age are trying to reverse those laws. She said that people should become more educated regarding sex.

David Katzman presented a prepared statement (Exhibit N) to the Committee.

Rex B. Purcell stated that he felt women that take part in sexual activities forfeit the right to the second right of terminating the life that may result from that union. He said that the present U.S. Supreme Court had discovered an alleged right in the 14th Amendment to the Constitution that had not been seen for over 100 years by other U.S. Supreme Courts during those years. He said that if it takes an amendment to the U.S. Constitution to say what to moral persons is obvious, he would urge other states to add their support to a constitutional convention call.

Helen Myers presented a statement and information (Exhibit O) regarding Tay-Sachs Disease in Jewish people.

Penny Taylor, Nevada Young Mother of the Year, said that hazards of abortion had not been considered. She asked if it would not be better to allow a mother to go a full term of her pregnancy and nurse a child to its death if it had a disease such as Tay-Sachs Disease. This would allow the mother a greater chance of success on a successive pregnancy.

In regard to the argument that more children would be on welfare in abortions were not allowed, Mrs. Taylor asked if the children presently on welfare should be annihilated for the same reason.

Dean Breeze, President of the State Board of the American Civil Liberties Union of Nevada, said he was opposed to a constitutional convention for any reason short of a dire national crisis. He said that such a convention could get out of hand causing loss of many of the civil liberties enjoyed by Americans now. He said that criminalization of abortion was contrary to the principles of liberty and privacy which he espoused.

Larry Bear said it is a shame that action such as this needs to be taken in regard to a problem that should have been taken care of years ago. He said that young men and women were not so dumb as to not know what caused pregnancy. He said there should be better education. He said he supported the amendment because the country has not been able to regulate their own actions to be able to take care of this problem.

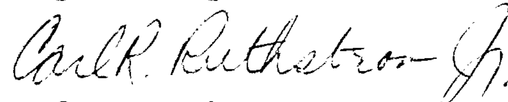
Thomas Ford Matthews said that this resolution would be placing women at the level of a chattel. He said the government should not be involved with what goes on inside the bodies of women.

James Singer said that presently in this country, people do not want to be responsible for their actions. He said that people in general had been accused of "playing God", and he asked how much more the taking of a life would be playing God.

Elder B. Carlson said he had worked with Indians and had seen the unhappiness that abortion had caused in the lives of Indian women.

Chairman Hayes adjourned the meeting at 9:00 p.m.

Respectfully submitted,



Carl R. Ruthstrom, Jr.
Secretary

TESTIMONY OF RUTH MCGROARTY
ASSEMBLY COMMITTEE ON JUDICIARY
APRIL 1, 1979

My name is Ruth McGroarty. I have been involved in the Right to Life movement in Nevada since 1968 and am now the director of the Nevada Right to Life and a board member of the National Right to Life. We regret that the Senate Judiciary Committee was unable to attend to hear our testimony from their constituents in Southern Nevada, but we hope you will pass our thoughts on to them for their consideration.

Our testimony this evening was to have started with a reading of a poem by our Nevada Right to Life poet, Dorothy Rue. However, she is ill and has asked me to relate her feelings which she has written down in poetry. This poem is very timely, this being the start of the Easter Season. It is entitled, "I Wonder."

> I wonder when a mother aborts, does her heart ache with the loss
> Such as another mother felt as she knelt at the foot of a cross.
> I wonder, does her heart ever hear how her unborn cried
> And feel the agony the other mother felt as she watched her only Son die?
> And God the Father must have felt sorrow that his only Son
> Had to suffer so much hell on this earth for the sins that we have done.
> I wonder, is a certain "seven" feeling guilty that they played God, instead of "men"
> By signing away an unborn's life, then "autograph" on paper with a pen.
> I wonder, do those doctors with their bloody knives
> Compare themselves to the soldiers that took our Savior's life?
> I wonder, on this Easter Day as we kneel in church to pray
> If Mary would have aborted her little seed
> Who would there be to fulfill our need?

We thank Dorothy Rue for her beautiful words and say, Yes, Dorothy, "We too wonder."

Opponents say this is an emotional issue. Think about it for a moment. If someone were to try to kill you or a loved one, wouldn't you be emotional. Probably not only emotional, but hysterical and would fight back. So, the killing of the most discriminated against and abused class of human beings, or the helpless unborn child, is emotional and because these victims cannot fight back, we of the Right to Life movement,

with a national membership of more than 11 million strong, international in scope, are speaking out for them, fighting for them and shall use every available legal means within our grasp to protect the right to life of all human beings from the moment of conception to a natural death regardless of age, place of residency, or incapacitation.

The advocates of abortion state many reasons for legalized abortion, a few of which I shall cover. The pro-abortionist states he is pro-choice. Now if pro-choice means allowing a woman the choice to bear or not to bear children, we are in total agreement. If their pro-choice means that a woman has the right to control her own body, we again are in total agreement, but they forget to add one other statement. A woman not only has a right to control her own body, but she also has the total obligation to control her own body from the moment she awakens and is in the presence of another human being. She cannot drive down the street at 90 miles an hour. She must control herself. She cannot commit assault and battery against another. She cannot rob or kill anyone else who has had the privilege of being born as there are laws that prevent her from doing what she pleases with her body. And, when a woman loses control of the reproductive system of her body, it again is her obligation to accept total responsibility of her action. However, our organization offers life solutions for problem pregnancies--assisting the woman through her pregnancy to keep the baby or give it up for adoption. So as a judge once told a young lady in court, "Your right to swing your arm ends at my nose." Now, if pro-choice means that the woman has a freedom of choice to kill her unwanted baby, we are in total disagreement. In a sound society we cannot give the individual the choice of a private right to kill. There is no basis for this right. If a woman is allowed to kill the unborn, through choice, then why not give her the same right and choice to kill other unwanteds--her children born defective--which is now happening. I saw a film on a mongoloid child who was left to die in a hospital because the parents refused to give permission for an operation that would keep this child alive. What happened? The child was starved to death. On the crib was a sign, "Nothing by Mouth." This child struggled for 14 days while nurses and doctors passed by, and then died. It is my own personal feeling that the parents should have been forced to take this child home and there let the parents let the child starve to death. What would have been the consequences? The incident would have been called murder, but in the hospital no charges were filed. It is said by the advocates of abortion that defective children are better off aborted than to live a less than meaningful life. By whose standards and where do they draw the line? It was called an act of mercy

killing. What's in a name--Everything. How merciful can we get before we call it by its right name--murder? No, ladies and gentlemen, there is no private right to a pro-choice to kill an innocent human being. To my knowledge, there is no law in all the world enacted to punish the innocent. There has to be a crime involved before a person can be condemned. So what crime did the innocent victims of the abortions killings commit to be condemned to death. We have thousands of years of tradition that holds that it is not right to kill. The very foundation of our American society today is based on the premise that everyone is innocent until proven guilty and is entitled to due process of law. Most of our laws are based on the Ten Commandments, making them moral laws, the most important of which is, "Thou shall not kill." No one on this earth is entitled to decide who of the innocent shall live or die? So just who is imposing their morality on whom? The religious--one certain religion is trying to force their morality on us is always used in a controversial issue when there is no merit to what they advocate, or just a smoke-screen which the majority of the people are just not buying.

So, we are in total disagreement on the pro-choice interpretation of a woman's right of pro-choice to take the life of an unborn child. However, we would like to point out that a woman has a freedom of two choices--contraceptives of her moral choice or the simple word, "No." Just as the pro-abortionists say that no woman is forced to have an abortion, so we say no woman is forced to become pregnant.

The advocates of abortions insist that we spend our tax money to pay for abortions for the poor based on a cost benefit analysis. This cost benefit analysis of the worth of a human life is completely utilitarian and establishes a frightening precedent for accepting death as a solution for other social problems--the mentally retarded, physically handicapped, terminally ill, the elderly, and on and on. The fact that a woman has been "temporarily" given a so-called right to an abortion does not imply that she has an additional right to a free abortion at taxpayers' expense. The implication is that poor women do not have the pro-choice to bear children nor do the unborn poor children have the pro-choice right to life. This, in itself, could have eliminated many of the greatest leaders of our nation--or perhaps even some of our legislators. Think about it. Can you afford your children now, in the future? Our opponents have even suggested as a social control of population that stock certificate type permits be issued to bear children. Confine childbearing to only a limited number of adults. Compulsory sterilization of all who have two children except for a few who would be allowed three. Fertility control agents in water supply. Payments to encourage abortion. Abortion and sterilization on

demand. More contraception truly available and accessible to all (I have to assume there is no age limit as none is stated and that this will also include abortion as a backup of failures). Improve maternal health care with family planning as a core element (if only they would stick with this issue as it is stated there would be no disagreement). All of these measures and more are outlined from a family planning perspective special supplement, Planned Parenthood, World Population, entitled "Five Year Plan for Population Research and Family Planning Services." At least 80% of all this type of research is done with grants of our tax money. All these measures were supposedly proposed to reduce population. Ladies and gentlemen, there is no population explosion in America. Replacement level is 2.2 and according to our national statistics, we are today at a level of 1.7 which is dangerously below replacement level. What will be the result? A nation of old people with not enough young taxpayers to care for the old people. And then what will be the cost benefit analysis answer. Euthanasia for those who are a burden to society? Think about it because you may become the victim.

Now, I ask all parents here today. Do you always know where your minor daughters are? There are two times you will know when they have had an abortion without your knowledge. One, when she has had complications and you are called to pick her up at the hospital and pay the bill or a call to pick her up for burial. This situation is critical and must be corrected. Parents are entitled to be notified when their daughters seek an abortion. Parents' rights are slowly but surely being usurped in many areas. After the U.S. Supreme Court decision of January 22, 1973, which legalized abortion on demand to the day of birth, the U.S. Supreme Court added insult to injury on July 1, 1976, just three days before our "Freedom for All" Bicentennial birthday, they handed down another one of their infamous decisions in the case of Planned Parenthood of Central Missouri vs. Danforth, 44 U.S.L.W. 5197 with the following regulations:

a) The states can no longer require the husband's consent for an abortion of his child.

b) The states can no longer ban the tragic saline abortion (Ironically, Japan after 20 years experience with the tragic results of abortion, banned the saline abortion as it was considered too dangerous for the mother). Thus the Supreme Court is not concerned with the life of the mother.

c) The states can no longer require that the doctor provide his medical skills to save the life of a baby aborted alive. In other words, let it die. The doctor is no longer required to live up to his Hippocratic Oath to preserve life.

d) The final decision is a direct attack on the parent-child relationship. The states can no longer require parental consent for abortions for a minor child. This is a total denial of the legal and moral rights of parents. It is contradictory and ludicrous that doctors may not treat minors in a general fashion--give them blood transfusions or innoculations, or as in Boston, even pierce a minor's ears without parental consent, but doctors may now legally destroy the life of a minor's unborn child and subject the minor to medical or surgical procedures that can and do result in dangerous and traumatic complications without parental consent or knowledge.

Are we to bear children, love, feed and clothe them only to have our parental rights taken from us by the Government? A mere child is not thoughtmature enough to vote, sign contracts or perform other adult acts, but is allowed the privilege of making the greatest, most traumatic decision in her entire life--to kill or not to kill another human being which she carries in her womb.

So what has been accomplished since 1973, since legalized abortion? Women are still dying from legal abortions. Babies are being killed by the millions for social whims. Population is now at a dangerous replacement level. We have gone from abortion, the killing of the baby in the womb, which is fetal euthanasia, to infanticide, killing the born defective unwanted babies. Some abortion mills turn out an assembly line type of slaughtering as recently uncovered in Chicago which pictures animal slaughter houses as more sanitary. The doctors continue to defy the Hippocratic Oath to preserve life and not destroy it. Women are still being exploited and are suffering at the hands of back-alley butchers who are just up-front now in the plush offices. The number of abortions ranks second only to tonsillectomy operations. Illegal abortions are still being performed. These are the horrible true facts. From all this I do not see that we have helped the young pregnant girl with a problem pregnancy but rather we have placed her health and even her life in jeopardy. If you in this audience today believe that the unborn child is a human being, then you must agree that we can educate. We can have alternatives but the real positive approach to stop this American holocaust is through a Human Life Amendment to protect the right to life of not just the unborn but all innocent human beings.

Our Legislature has passed a constitutional convention bill for budgeting our taxes. We feel that they should also pass our constitutional convention bill for a human life amendment. After all, our first priority should be to safeguard the right to life of all.

We ask the legislators to make 'life' their number one priority. We shall continue to elect legislators on a one-issue basis and rightly so as we do not feel secure with those who would deny the right to life to any class of human beings because you or I may be included in the next class destined for extermination simply by a legislator pushing a button. Do not accept, "I am personally opposed," because there are only two buttons--one for yes and one for no. There is no "but" button and we want a definite answer as to which button they intend to push.

Today we are only asking for a vote for life over the only alternative, which is death. A vote for the weak over oppression by the strong. A vote for the most basic right of all civil liberties--that of life itself. This is guaranteed in the Bill of Rights. We want it reconfirmed in the United States Constitution.

This is not a religious issue. It is a civil human rights issue. Let's put an end to this American holocaust and get back to the traditional American way of life of love of God, country, and the family unit.

Thank you for allowing us to be here today to give this testimony. You are to be commended.

Ruth McGroarty
Director of Nevada Right to Life

LIFELETTER '78 #17

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December 8, 1978

IT EXPLODED IN CHICAGO ON SUNDAY MORNING, NOVEMBER 12, 1978 -- a journalistic Neutron Bomb that leaves the abortion mills standing but has vaporized all notion of "safe legal abortion." And the radiation will surely spread across the nation.

The bomb-launcher was a surprise. The Sun-Times has been consistently and loudly pro-abortion (a bias it shares with virtually every other big-city newspaper) and regularly attacks Henry Hyde (who represents suburban Oak Park) for his anti-abortion views -- e.g., the S-T endorsed his opponent this year, and, last year, charged Hyde with "Legislating pain" in an editorial (June 6, '77) that said about abortion: "A woman who wants one will get it -- in a clean, equipped medical facility or with coat hangers in a dirty room. But she will get it." The front-page series that began Nov. 12 (and dominated the S-T's pages for almost three weeks) confirms that women are indeed getting it, some (at least a dozen) fatally, in dirty rooms "behind the Tiffany tinsel and Gucci glitter" of Chicago's swish Michigan Ave. "Miracle Mile," where the "abortion business is booming."

CHICAGO **Sunday Sun-Times** ★★★★ Final

• 1978 by Field Enterprises, Inc. November 12, 1978. 60¢

The Abortion Profiteers

Making a killing in Michigan Av. clinics

By Pamela Zekman and Pamela Warrick

Copyright, 1978, The Chicago Sun-Times

Behind the Tiffany tinsel and Gucci glitter, the abortion business is booming on the Magnificent Mile.

In the shadows of shoppers bustling from store to store, anxious, desperate women make their way to appointments at Michigan Av. abortion mills.

Some are pregnant; some are not. It doesn't matter. Most of them will be sold abortions.

For the abortion profiteers, there is money to be made and no time to waste.

The women don't know it yet, but they are about to put their lives on the abortion assembly line.

FIVE MONTHS AGO, The Sun-Times and the Better Government Assn. began the first in-depth investigation of Chicago's thriving abortion business since the U.S. Supreme Court legalized abortion on Jan. 22, 1973. We found:

• Dozens of abortion procedures performed on women who were not pregnant and others illegally performed on women more than 12 weeks pregnant.

• An alarming number of women who, because of unsterile conditions and haphazard clinic care, suffered debilitating cramps, massive infections and such severe internal damage that all their reproductive organs had to be removed.

• Incompetent and unqualified doctors, including moonlighting residents, medical apprentices and at least one physician who has lost his license in one state and faces revocation here.

• Doctors who callously perform abortions in an excruciating 2 minutes, when they should properly take 10 to 15 minutes, and doctors who don't even wait for pain-killing anesthetics to take effect.

• Referral services that, for a fee, send women to a disreputable Detroit abortionist, whose dog, to one couple's horror, accompanied the nurse into the operating room and lapped blood from the floor.

• Clinics that either fail to order critical postoperative pathology reports, ignore the results or mix up the specimens.

• Dangerously shoddy record keeping by aides who falsify records of patients' vital signs and who scramble or lose results of crucial lab tests.

• Counselors who are paid not to counsel

Turn to Page 4

Grand jury probe starts

Other officials scramble to react

Page 5

Some are pregnant; some are not. Most will be sold abortions."

•The two women reporters who wrote the series (Pamela Zekman and Pamela Warrick) summarize the main points up front: the S-T and Chicago's Better Government Association spent five months on "the first in-depth investigation of Chicago's thriving abortion business since the U.S. Supreme Court legalized abortion on Jan. 22, 1973." Given what they found, it is reasonable to assume that tens of thousands of local women (and presumably millions more nationwide) wish they hadn't waited so long. Just the listed "highlights" are gut-wrenching enough: for "the abortion profiteers, there is money to be made and no time to waste"; they perform "abortions" on un-pregnant women (investigators submitted male urine specimens and usually got "positive" results -- nothing new, the New York Daily News ran that kind of expose years ago!) and illegal abortions on women more than 12 weeks along; an "alarming number" of victims suffer "massive infections and such severe internal damage that all their reproductive organs had to be removed" because of "unsterile conditions and haphazard clinic care"; "Incompetent and unqualified doctors, including moonlighting residents" and "medical apprentices" perform abortions, often "in an excruciating 2 minutes" because they "don't even wait for pain-killing anesthetics to take effect."

•But even such ghastly "highlights" pale when illuminated by the massive accumulation of bloody detail: truly, this series is impossible to describe -- it must be seen to be believed. It is a throwback to the heyday of William Randolph Hearst; not since Watergate consumed the Washington Post has an investigation so dominated a newspaper (perhaps prophetically: this one could easily be the "Abortiongate" revelation that irrevocably tips

(over, please)

Chicago Tribune

Midwest Edition

Friday, November 17, 1978

44 Pages 2 Sections 20¢

Michigan Avenue clinic blamed in abortion death

the scales against legalized abortion) -- it even held its own through the fantastic Jim Jones "Cult" horror that dominated the rest of the nation's media (e.g., see the near-equal coverage in the Nov. 20 S-T). Even the august Chicago Tribune (which used to style itself "The World's Greatest Newspaper" and still feels that way vis a vis the tabloid S-T) succumbed to the explosive effect, running blaring front-page headlines that followed the S-T lead (see illustration). But the original defies imitation: day after day the S-T kept up the barrage, with screaming headlines, front-page pictures -- especially mug-shots of the most notorious profiteers -- and even special "cartoons" depicting blood-soaked doctors and operating tables, some stark with gore, others adding the open-mouthed-in-agony "mother" (the S-T remains, through it all, pro-abortion -- you won't find anything here about the primary victims, those tiny causes of these sensational effects).

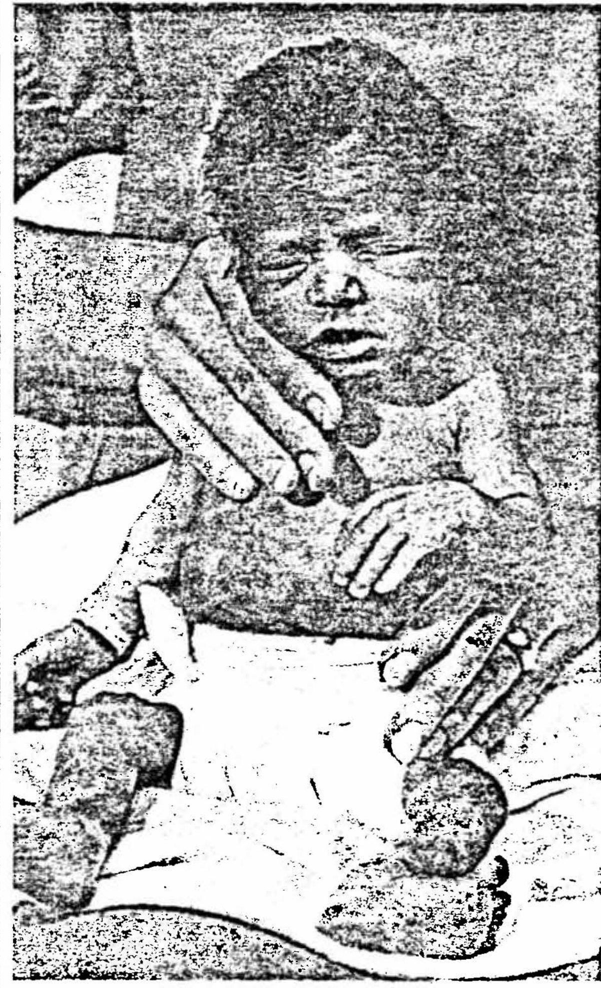
•Column after column, the stories read like a catalogue of all the "hysterical" charges the "right-to-lifers" have been making for years: money (not "safe" or "legal" much less "humane") is the operative word; a "counselor" is one who sells abortions -- hustles them on commission, $5 per at the "better" so-called "referral agencies," which do nothing more than take $50-60 dollars a head (womb?) in return for directing victims to "friendly" (i.e., agreeing to the kickbacks) mills. One fast-working guy who offers cut-rate jobs at only $125 has a "Bargain Wednesday" for just $110! Cash only, of course (well, maybe sometimes Master Charge or Visa ...). Records are routinely falsified; vital medical indicators are ignored (one headline reads: "Nurse to Aide: 'Fake that pulse!'"); the "products of conception" are dumped in garbage cans (by law, they are supposed to be sent to labs, so that technicians can determine if there was a complete -- or any -- abortion, and/or whether the woman is in danger, etc. -- but of course any such follow-up would cost more, expose phony operations, and otherwise complicate the only "clean" part of the process, i.e., fee paid, job done, that's it); "recovery rooms" can mean five minutes on a straight-backed wooden chair, after which a "You've been here long enough" ushers the still-groggy "patient" to the door (one almost bled to death on the bus home). The horror stories are done in detailed "true confession" style (here, however, many of the actors are plainly identified) -- and the packed columns graphically hyped up with big boxed quotes (e.g., re referrals: "Look, no matter how you put it, we're in the business of selling abortions."; from victims: "He didn't wait five minutes. He started right in. I was screaming, and squirming all over the table. I asked him to stop until the anesthetic took effect ..."; re the profitmakers: "The doctors race each other. Especially on Saturdays, they compete to see who can get the most patients done."). In one sense the stories are much the same -- these human butcher shops seem to have a brutality "norm" -- yet as a whole they portray a distinct phenomenon, different from more familiar prototypes like Buchenwald or My Lai. There is no race hatred or blood-lust here; the passion is purely economic, e.g., they don't use one-time plastic utensils again and again to maim or kill, just to cut costs. Ditto speed: another fee can be earned in the time it would take to wipe up the blood. And so on, and on.

THE U.S. SUPREME COURT HAS RULED IT'S LEGAL TO KILL A BABY...

of this age
8 WEEK LIVE BABY IN SAC.

or this age
14 WEEK LIVE BABY IN SAC.

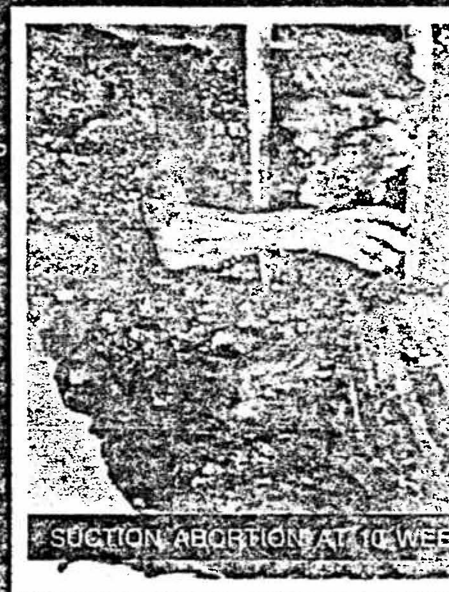
or this age
28 WEEK LIVE BABY



The only requirement is that:
— the baby still lives inside the mother.
— the mother wants the baby killed.
— the doctor is willing to do the killing.

The killing is done in different ways:

SUCTION ABORTION AT 10 WEEKS


SUCTION ABORTION AT 10 WEE

Some suction abortions do as thorough a job as your kitchen blender. There isn't much left to recognize.

Other suction abortions at the sa

SALT POISONED BABIES 18 TO 30 WEEKS

For older ones a poisonous salt is injected. This takes at least an hour to kil the baby and also burns off the outer layer of the baby's skin.

EXHIBIT A - Page 10 of 16

It is now legal for any physician to kill a baby while the mother is in labor and not commit a crime.

How? The U. S. Supreme Court in its January 22, 1973 decision (ROE v. WADE) on abortion ruled that:

A state is forbidden to "proscribe" (forbid) abortion anytime prio to birth if in the opinion of "one licensed physician" an abortion i necessary to preserve "the life or health" of the mother. (ROE v. WA

Her life? — few would argue.

Her health? — what did they mean by health?

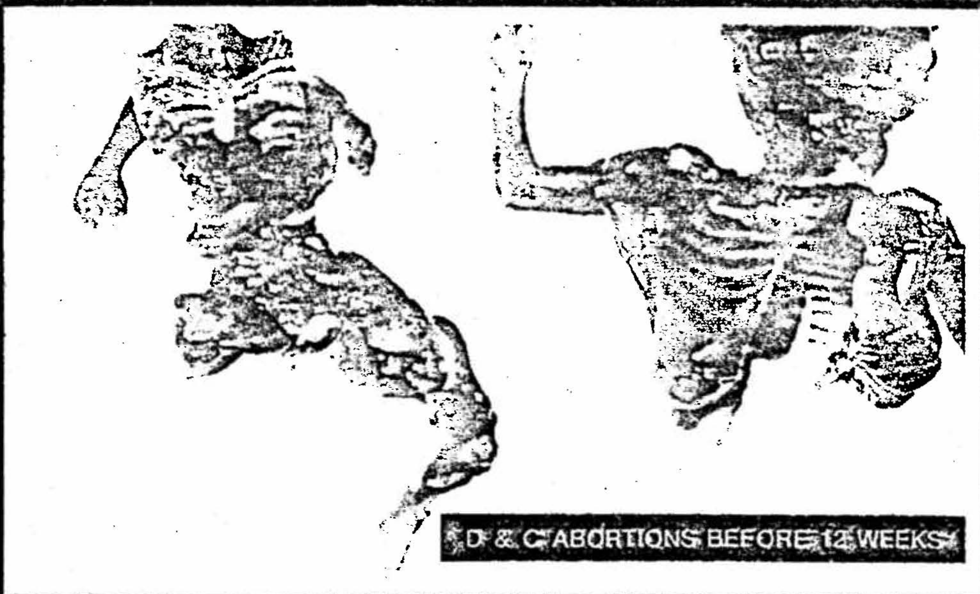
These are not medical reason

IT IS NOW LEGAL FOR A PHYSICIA FOR SOCIAL REA

©1973, Dr. and Mrs. J. C. Willke

The legal word for human life is "perso

...leave very recognizable parts.



Some abortions just slice the baby up and remove the parts.

The Hysterotomy and Prostaglandin type abortions deliver live normal babies that are left to, or encouraged to die.

EXHIBIT A - Page 11 of 16

For her "health." By the Court's own definition, the word "health" means:

... "The medical judgment may be exercised in the light of all factors — physical, emotional, psychological, familial, and the woman's age — relevant to the well-being of the patient. All these factors may relate to health." (DOE v. BOLTON)

It includes when a pregnancy would:

"Force upon a woman a distressful life and future."

Produce "psychological harm."

"Will tax mental and physical health by child care."

Will bring the distress "associated with the unwanted child."

Will "bring a child into a family already unable psychologically or otherwise to care for it."

Will bring the "continuing difficulties and stigma of unwed motherhood." (ROE v. WADE)

. these are social reasons.

TO KILL A BABY

SONS AT ANY TIME PRIOR TO BIRTH

"The use of the word [person] is such that it has application only postnatally." (ROE v. WADE)

Have we ever, in a civilized society given to one person (the mother) the complete legal right to kill another (the baby) in order to solve that first person's personal problem?

The U. S. Supreme Court has excluded an entire age group of humans from legal personhood and with it their right to life.

They used as partial justification for allowing this killing, the argument that the unborn is not yet capable of "meaningful life," were not "persons in the whole sense." (Roe v. Wade). It is no coincidence that euthanasia is being recommended for those who no longer have "meaningful existence."

How long will it be before other groups of humans will be defined out of legal existence when it has been decided that they too have become socially burdensome?

SENIOR CITIZENS BEWARE
MINORITY RACES BEWARE
CRIPPLED CHILDREN BEWARE

Once the decision has been made that *all* human life is no longer an unalienable right, but that some can be killed because they are a social burden, then the senile, the weak, the physically and mentally inadequate and perhaps someday even the politically troublesome are in danger.

It did happen once before in this century you know. Remember Germany?

ARE YOU GOING TO STAND FOR THIS?
HOW CAN YOU CHANGE IT?
THE ONLY WAY IS TO PASS A CONSTITUTIONAL AMENDMENT

Write one letter a week until it passes to your Senator, Congressman, newspaper, radio and TV station, etc. Join your Right to Life group. Give it your time, energy and support.

SUPPORT A HUMAN LIFE AMENDMENT

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by Dr. & Mrs. J. C. Willke

available from

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2 cassettes, 2 hours, filmstrip....$15.95
1 cassette, 32 min., 24 slides with manual..*English or Spanish*....$14.95
1 cassette, 32 min., filmstrip with manual..*English or Spanish*....$12.95

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1,000 copies...@ 7.5¢ each plus post.
25,000 copies...@ 5.5¢ each plus post.
L or D in *Spanish, French, German, Dutch, Italian, Norwegian, Hungarian, Portuguese*

ARE YOU [redacted]CT?????
WILL YOU ALWAYS BE PERFECT?????
WHO WILL JUDGE YOUR PERFECTION

Young man [redacted]hallenges right of "no[redacted]mal" society to judge value of retarded

Veterans Beware!

Euthanasia group tries to give living will to VA hospitals

NRTL News 6/76

•Now it's the disabled veterans who are under the euthanasists' gun and on a cost-benefit basis at that.

During recent hearings on bills in the Maryland legislature, it was revealed that the Florida-based American Euthanasia Foundation has urged the White House to permit the distribution of "living wills" to terminally ill veterans in hospitals of the U.S. Veterans Administration.

The bills, H.B. 764 and S.B. 596, providing for passive euthanasia by means of a living will and for immunity from civil damages or criminal proceedings for doctors, were unanimously rejected in both senate and house committees.

In his testimony before the house judiciary committee, Joseph Mauro, state pro-life chairman of the Maryland Knights of Columbus, read extracts from a letter from Dr. Richard F. Kuhn, national surgeon, Disabled American Veterans, to the Veterans Administration:

"I further noted in a letter Mr. (Vincent) Sullivan, Executive director, American Euthanasia Foundation, Florida, directed to the White House, he stated there were some 50,000 veterans in our VA hospitals who had no desire to live and the VA was blocking their organization from going into the VA so that the 'human wrecks' could be permitted death with dignity through their 'living will,' and perhaps the most disturbing part of this letter . . . was to equate life in the terms of dollars. Mr. Sullivan indicates that if these 50,000 no-hope veterans, as he refers to them, were permitted to die, it would save the government $2 billion annually, and eliminate overcrowding and inadequate treatment of our veterans. It was further stated that such action would be, indeed, the government's finest hour."

Mauro read from the Veterans Administration's rejection of the American Euthanasia Foundation's request, characterizing the administration's answer as expressing a "very succinct humanitarian and pro-life policy:"

"Your letter to the President about euthanasia and distribution of a 'mercy will' has been referred to me for reply . . . there are social, psychological, religious and legal factors that must be taken into consideration," the letter from the VA said. "From the purely medical point of view, our opinions are at variance with yours. Technological and scientific advances are being made and reported daily in the treatment of a variety of illnesses. Such procedures as open heart surgery, cardiac pacemakers, organ transplants and newly developed antibiotics, to name but a few, have done more than merely save or prolong life. People have been restored to useful and productive living who a year ago would have been considered hopelessly ill or dying. In other instances, the natural course of the disease process has reversed itself, and patients have recovered from apparently incurable afflictions.

"To have followed the course that you recommended would have condemned such individuals to death and their families to needless tragedy. I must therefore regretfully reject the policy you have proposed. I also question the validity of your figures. In the fiscal year ending June 30, 1974, the average daily census in all VA hospitals was 81,453. Your statement would imply that on any given day, over one-half of all patients were terminal, and kept alive by 'artificial' means. This is obviously untrue."

In introducing S.B. 596 for the second consecutive year, State Senator Julian L. Lapides, Baltimore, changed the title from "Euthanasia" to "Death Without Indignity." When he was asked last year whether the bill would provide a wide-open door for mercy killing in the future, he replied, according to Mauro's testimony, "Well, not a wide-open door, but maybe it opens it a crack."

Sackett's bill is defeated again

TALLAHASSEE, Fla. — A death with dignity bill introduced perennially by Rep. Walter Sackett was killed for this session April 15 when the measure was defeated in committee 8-7.

There was no motion to reconsider, so the bill is dead for this legislative session, according to informed sources here.

The bill, which has been sponsored by Sackett each legislative session since 1968, generated much public controversy in the state. A standing-room-only crowd was on hand for the final committee action on the bill.

Sackett, visibly upset as the committee hearings closed, quoted from polls which, he said, showed most Floridians favored his legislation. He argued that similar bills have been introduced in 18 other states. There are 50,000 terminal cases in Veterans' Administration hospitals "who need this legislation," Sackett said.

By JIM OSTERBERG

First and foremost for me the question of abortion is a question of spiritual morality. I believe that God made man, and only God can take away life. A mother, in this instance, is only a vehicle through which God can do his work. I realize that this point cannot really be argued. It is a question of personal morals, and I have just stated mine.

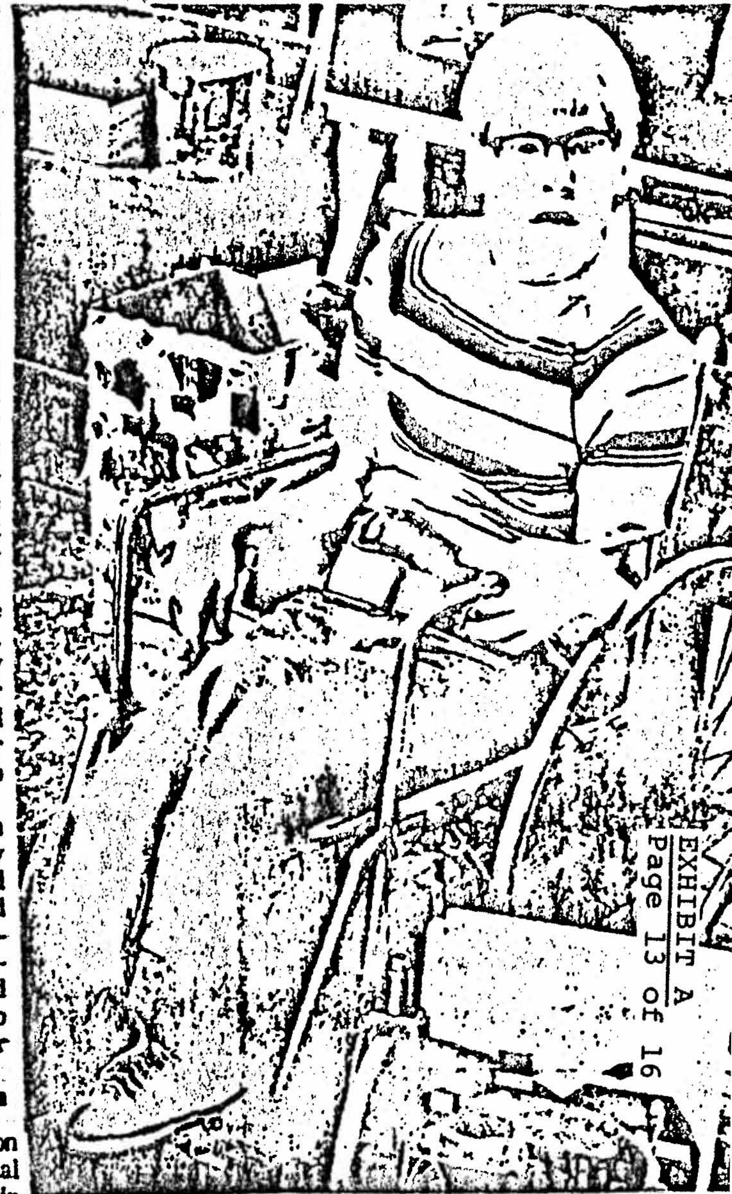
There are other aspects to the question of abortion of the retarded that do bear some debate and consideration. There is a certain beauty about being alive; a certain essence that everyone can appreciate, handicapped or not. Retarded people go about living their lives as best they can and most of them very happily. They judge achievement and success by their own standards. What gives the "normal" society the right to pass judgment on the "retarded" society and impose their standards on them?

I have had the opportunity to experience warmth and love from so many people. These experiences have made me a very happy person. The same cannot be said for many so-called "normal" individuals, and yet no one is proposing a prenatal test for happiness and aborting all those who probably won't be happy.

Our society has put a negative connotation on anything or any person that strays away from normal — including the physically and mentally retarded. Perhaps people should take a closer look at this judgment and re-evaluate it. The retarded are not undesirables. They love and feel and give and even enable some normal individuals to wake up to their own handicaps and their own strengths.

Lastly, it must be asked if abortion is a question of convenience and selfishness on the part of the society and the individual parents. Can we allow selfishness to get in the way of life?

God made man. Don't deny anyone the experience of being alive.



Jim Osterberg is a cerebral palsy victim For most of his 22 years he has been confined to a wheelchair.

Pro-Life...1648 Ottawa Drive, Las Vegas, Nevada 89109

INSTANT REPLAY

SLAVERY 1857	ABORTION 1973	EUTHANASIA 19 ? 1983 ?
Although he may have a heart and a brain and he may be a human life biologically, a slave is not a *legal* person. The Dred Scott decision by the U. S. Supreme Court has made that clear.	*Although he may have a heart and a brain, and he may be a human life biologically, an unborn baby is not a legal person* Our U.S. Supreme Court made this clear on January 22, 1973 when they legalized abortion.	Although he may have a heart and brain and he may be a human life biologically, the incapacitated and aged are not legal persons. (OUR COURTS WILL SOON TRY TO LEGALIZE EUTHANASIA AS THEY HAVE LEGALIZED ABORTION.)
A black man only becomes a *legal* person when he is set free. Before that time, we should not concern ourselves about him because he has no legal rights.	*A baby only becomes a* legal *person when he is born. Before that time, we should not concern ourselves about him because he has no legal rights.*	The aged and incapacitated are only legal persons when they are mentally and physically perfect. When their life becomes meaningless and of no concern to the government or society, they have no legal rights.
If you think that slavery is wrong, then nobody is forcing you to be a slave-owner. But don't impose your morality on somebody else!	*If you think abortion is wrong, then nobody is forcing you to have one. But don't impose your morality on somebody else!*	If you think the aged and incapacitated do not have their right to life, don't impose your morality on them.
A man has a right to do what he wants with his own property.	*A woman has a right to do what she wants with her own body.*	The government has a right to do what it wants with the aged and incapacitated.
Isn't slavery really something merciful? After all, every black man has a right to be protected. Isn't it better never to be set free than to be sent unprepared, and ill-equipped, into a cruel world? (*Spoken by someone already free*)	*Isn't abortion really something merciful? After all, every baby has a right to be wanted. Isn't it better never to be born than to be sent alone and unloved into a cruel world?* (Spoken by someone already born)	Isn't Euthanasia really something merciful? After all, every person has a right to be wanted. Isn't it better to be put to death than to be unwanted because you are aged or physically or mentally imperfect rather than to be left alone and unloved in a cruel world? (SPOKEN BY SOMEONE WHO IS YOUNG AND PERFECT.)

Will the unborn baby become the modern Dred Scott?
Or will our country use its great resources to respect every human life
. . . black or white . . . poor or rich . . . woman or man . . .
unborn baby or octogenarian or incapacitated!

In the above INSTANT REPLAY it took an Amendment to the U. S. Constitution to declare the slave a 'legal person'. Now for the second time in the history of America it will take another Amendment to the U. S. Constitution to declare the UNBORN a 'legal person'. And, with the ratification of this Amendment we will once and for all establish that all human beings have a 'right to life' from conception to death...not just certain groups!

COMMENT. . .WRITE TO YOUR UNITED STATES PRESIDENT, SENATORS, AND CONGRESSMAN. ASK THEM TO USE THEIR INFLUENCE TO FORCE A HEARING ON A HUMAN LIFE AMENDMENT. ASK THEM TO SUPPORT THIS AMENDMENT TO THE UNITED STATES CONSTITUTION.

"We hold these truths to be self-evident, [illegible] men are created equal, that they are endowed by th[illegible]eator with certain unalienable Rights, that among these are Life, Liberty and the Pursuit of Happiness."

UNITED NATIONS – Declaration of the Rights of the Child

". . .the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth."

PHYSICAL LIFE – International Conference on Abortion, 1967, Washington, D. C.

"From the present available data, we can only conclude that *human life begins at conception. . . .*"

SENSITIVITY TO LIFE – Dr. Hymie Gordon, Chief of Genetic Consulting Service, Mayo Clinic, Rochester, Minnesota

"Too much emphasis is being placed on destructive procedures . . .particularly on the destruction of unborn babies. I will not destroy any human life at any time after its conception even if there is the possibility that the individual will be less than perfect mentally and physically . . ."

MENTAL LIFE – Dr. Arnold Gesell, Founder, Clinic of Child Development, Yale University.

"Even in the limb bud stage, there is evidence of behavior patterning. . .all of this development, detectable as early as the fourth week, is mental growth."

JUDAIC LAW – Rabbi David B. Hollander, Vice President, Rabbinical Alliance of America

"Judaism, except where it is necessary to save the life of the mother, strongly prohibits abortion, and places it in the category of the taking of human life, however 'noble' the motivation. Even those who say that while they oppose abortion, they feel it is a private matter and the law should not interfere, are simply not facing the fact that *the law always does and should interfere where human life is the issue.* Thus the law forbids suicide, refusal to submit to medical treatment, or the mistreatment of children, the sick and the helpless. The law forbids the abandonment of children by parents. Is there a greater 'abandonment' than abortion?"

CANADIAN BILL OF RIGHTS

"It is hereby recognized and declared that in Canada there have existed and shall continue to exist, without discrimination. . . the following human rights. . .namely, the right of the individual to life, liberty, security of the person, and enjoyment of property, and the right not to be deprived thereof except by due process of law."

By George F. Will

Discretionary Killing

It is neither surprising nor regrettable that the abortion epidemic alarms many thoughtful people. Last year there were a million legal abortions in the U.S. and 50 million worldwide. The killing of fetuses on this scale is a revolution against the judgment of generations. And this revolution in favor of discretionary killing has not run its course.

That life begins at conception is not disputable. The dispute concerns when, if ever, abortion is a *victimless* act. A nine-week-old fetus has a brain, organs, palm creases, fingerprints. But when, if ever, does a fetus acquire another human attribute, the right to life?

The Supreme Court has decreed that *at no point* are fetuses "persons in the whole sense." The constitutional status of fetuses is different in the third trimester of pregnancy. States constitutionally can, but need not, prohibit the killing of fetuses after "viability" (24 to 28 weeks), which the Court says is when a fetus can lead a "meaningful" life outside the womb. (The Court has not revealed its criterion of "meaningfulness.") But states cannot ban the killing of a viable fetus when that is necessary to protect a woman's health from harm, which can be construed broadly to include "distress." The essence of the Court's position is that the "right to privacy" means a mother (interestingly, that is how the Court refers to a woman carrying a fetus) may deny a fetus life in order that she may lead the life she prefers.

Most abortions kill fetuses that were accidentally conceived. Abortion also is used by couples who want a child, but not the one gestating. Chromosome studies of fetal cells taken from amniotic fluid enable prenatal diagnosis of genetic defects and diseases that produce physical and mental handicaps. Some couples, especially those who already have handicapped children, use such diagnosis to screen pregnancies.

ABORTION AS ALTERNATIVE

New diagnostic techniques should give pause to persons who would use a constitutional amendment to codify their blanket opposition to abortion. About fourteen weeks after conception expectant parents can know with virtual certainty that their child, if born, will die by age 4 of Tay-Sachs disease, having become deaf, blind and paralyzed. Other comparably dreadful afflictions can be detected near the end of the first trimester or early in the second. When such suffering is the alternative to abortion, abortion is not obviously the greater evil.

Unfortunately, morals often follow technologies, and new diagnostic and manipulative skills will stimulate some diseased dreams. Geneticist Bentley Glass, in a presidential address to the American Association for the Advancement of Science, looked forward to the day when government may require what science makes possible: "No parents will in that future time have a right to burden society with a malformed or a mentally incompetent child."

WHO MUST DIE?

At a 1972 conference some eminent scientists argued that infants with Down's syndrome are a social burden and should be killed, when possible, by "negative euthanasia," the denial of aid needed for survival. It was the morally deformed condemning the genetically defective. Who will they condemn next? Old people, although easier to abandon, can be more inconvenient than unwanted children. Scientific advances against degenerative diseases will enable old people to (as will be said) "exist" longer. The argument for the discretionary killing of these burdensome folks will be that "mere" existence, not "meaningful" life, would be ended by euthanasia.

The day is coming when an infertile woman will be able to have a laboratory-grown embryo implanted in her uterus. Then there will be the "surplus embryo problem." Dr. Donald Gould, a British science writer, wonders: "What happens to the embryos which are discarded at the end of the day—washed down the sink?" Dr. Leon R. Kass, a University of Chicago biologist, wonders: "Who decides what are the grounds for discard? What if there is another recipient available who wishes to have the otherwise unwanted embryo? Whose embryos are they? The woman's? The couple's? The geneticist's? The obstetrician's? The Ford Foundation's?... Shall we say that discarding laboratory-grown embryos is a matter solely between a doctor and his plumber?"

But for now the issue is abortion, and it is being trivialized by cant about "a woman's right to control her body." Dr. Kass notes that "the fetus simply is not a mere part of a woman's body. One need only consider whether a woman can ethically take thalidomide while pregnant to see that this is so." Dr. Kass is especially impatient with the argument that a fetus with a heartbeat and brain activity "is indistinguishable from a tumor in the uterus, a wart on the nose, or a hamburger in the stomach." But that argument is necessary to justify discretionary killing of fetuses on the current scale, and some of the experiments that some scientists want to perform on live fetuses.

Abortion advocates have speech quirks that may betray qualms. Homeowners kill crabgrass. Abortionists kill fetuses. Homeowners do not speak of "terminating" crabgrass. But Planned Parenthood of New York City, which evidently regards abortion as just another form of birth control, has published an abortion guide that uses the word "kill" only twice, once to say what some women did to themselves before legalized abortion, and once to describe what some contraceptives do to sperm. But when referring to the killing of fetuses, the book, like abortion advocates generally, uses only euphemisms, like "termination of potential life."

Abortion advocates become interestingly indignant when opponents display photographs of the well-formed feet and hands of a nine-week-old fetus. People avoid correct words and object to accurate photographs because they are uneasy about saying and seeing what abortion is. It is *not* the "termination" of a hamburger in the stomach.

THE DEGRADATION OF MAN

And the casual manipulation of life is not harmless. As Dr. Kass says: "We have paid some high prices for the technological conquest of nature, but none so high as the intellectual and spiritual costs of seeing nature as mere material for our manipulation, exploitation and transformation. With the powers for biological engineering now gathering, there will be splendid new opportunities for a similar degradation of our view of man. Indeed, we are already witnessing the erosion of our idea of man as something splendid or divine, as a creature with freedom and dignity. And clearly, if we come to see ourselves as meat, then meat we shall become."

Politics has paved the way for this degradation. Meat we already have become, at Ypres and Verdun, Dresden and Hiroshima, Auschwitz and the Gulag. Is it a coincidence that this century, which is distinguished for science and war and totalitarianism, also is the dawn of the abortion age?

Idea of life without value not new in western world

By CLARE BOOTHE LUCE

(Reprinted from the Honolulu Advertiser)

Many arguments for abortion have been advanced in letters to the editor of The Advertiser. Some have been intellectually more plausible than others. But a pro-abortion argument made last week was so, well, crazy, that I cannot forbear commenting on it.

The writer (whose name I charitably refrain from mentioning), argued the following case for abortion: Every child is entitled, at birth, not only to mother-love, but to adequate food, clothing and shelter; and, therefore, an unborn child who may be deprived of these birthrights by an unloving or impoverished mother should be aborted. In short (he argued), A should be killed because if A lives, B may deny A the things to which A is entitled.

The writer who propounded this travesty of justice was, of course, groping toward an idea that has long been familiar to Europeans, but is still new to most Americans, namely, that human beings lose their right to life when (a) their relatives or society feel they would be "better off dead"; and (b) when their relatives or society would be economically better off without them.

This utilitarian idea first made its appearance in 1920 in the democratic Republic of Germany, with the publication of a book called, "The Release of the Destruction of Life Devoid of Value." The authors were Dr. Alfred Hoche, a distinguished pyschiatrist, and Karl Binding, a highly respected jurist.

In "Life Devoid of Value," the learned judge and the brilliant doctor persuasively developed the concept of "worthless human beings," such as the hopelessly crippled, deformed, and insane. They stressed the misery and futility of such unfortunate lives, and the cruel economic burden they represented to their relatives and society.

German "intellectuals" quickly bought the idea as being both humane and socially practical, possibly because at that time, the "good German folk" were staggering under the blows of the post-World War I inflation-depression.

The medical program began with the abortion of women, and sterilization of both sexes with "hereditary" diseases, among which German doctors listed imbecility, insanity, deafness, dumbness, blindness, epilepsy, and alcoholism. But the program was soon enlarged to permit "mercy killings" as a "final solution" to the problem of humans "devoid of value."

In the beginning, only seriously deformed or mentally retarded children were "put out of their misery." Later, children born with any imperfections, such as hare-lips, club feet, crooked spines, and children who showed withdrawn or hysterical behavior were dispatched to their careless Creator.

Most of these children were from poor families, or were war orphans.

By the time Hitler came on the scene, the concept of taking lives "devoid of value" had made enourmous progress. Hospital records show that by 1935, 375,000 innocent Germans had been sterilized, and more than 250,000 had been "mercifully killed"—among them many World War I amputees and basket cases.

The German medical and legal professions had become so accustomed to expansions of the euthanasia program that when the Fuehrer discovered that Jews were also "devoid of value," and parasites on the German economy, there was very little public protest.

Easy, you see, does it. Moreover, these things are done so quietly, so scientifically, so mercifully, in the hospitals that few but the doctors and the victims ever know much about them.

Launched in the 1920s as a humane undertaking, the "life devoid of value" program ended in the 1940s with the slaughter of 6 million Jews.

And easy may do it, too, in America.

For the first time in American history, the Supreme Court has now used its judicial power to decree that a human being who is innocent of any crime may be killed with impunity.

In its 1973 Roe-Doe decisions, the Supreme Court denied the right of the unborn child to life on grounds that a child who cannot live outside the womb is not (in the language of the court) "fully human," or "capable of meaningful life." And it turned the right to kill any unborn child, unwanted by the mother, over to the medical profession. Since the Supreme Court decision, American doctors have sucked, scraped and cut 3 million unwanted babies from the wombs of their mothers.

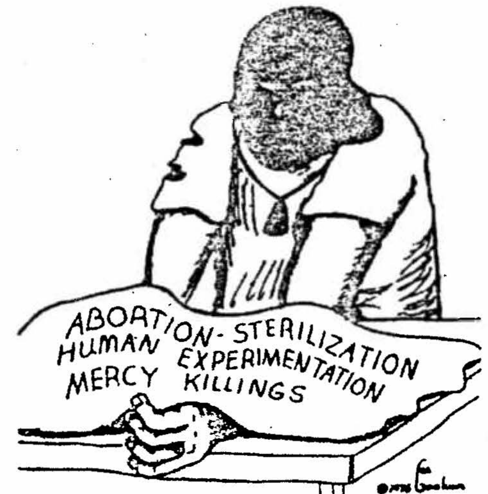
All jurists now agree that the court's abortion decisions have laid the foundation for the legalization of euthanasia, or the killing of people medically judged to be "incapable of meaningful life," such as mongoloid idiots, imbeciles, the terminally ill, senile melancholics, stroke victims living like "vegetables," and — well, what sort of people, besides unwanted babies, do you think, dear reader, would be "better off dead.."

Be patient: Euthanasia is coming. And as political tensions increase, and the economic demands of the people in a declining economy grow fiercer, and taxes for supporting the "unwanted" grow higher, the list of the legally wasteable will grow longer.

And who knows? One day you may find yourself on it.

(Clare Boothe Luce, who lives in Honolulu, is an author, playwright, former diplomat and one-time member of Congress.)

October, 1976
NATIONAL RIGHT TO LIFE NEWS



Hitler's Crimes Alive and Well in the U.S.A.

(For information, call Pro-Life/Right to Life 735-8216 or 735-1746)

Powerful forces are now at work trying to legalize euthanasia, the "mercy" killing of the elderly, the ill, the handicapped, and the unwanted. Every day these forces grow stronger— and your chances of dying a natural death grow smaller.

THE 'ALETHEA DOCUMENT' . . .

Secret Strategy For Euthanasia By 1983

— the "Alethea document" is no laughing matter. It is a polished, sophisticated "game plan" for legalized mercy killing (euthanasia). Already it is moving faster than predicted. Unless vigorous sustained action is taken now, the slaughter of the old and the infirm may easily surpass the current butchery of our unborn children. Hitler must be smiling in his grave! And 1984 will have arrived one year early.

TESTIMONY OF DR. JAMES LYMAN
ASSEMBLY COMMITTEE ON JUDICIARY
APRIL 1, 1979

Chairman Hayes, members of the Judiciary Committee:

I am Dr. James Lyman, a local family physician here in Clark County, Nevada. I appreciate this opportunity to speak to you in favor of A.J.R. 17. After reviewing previous testimony opposing the resolution, I am struck with the fact that no one denies the horrendous state of affairs existing in our American society today as a result of the rampant increase in sexual promiscuity during the last decade. The opponents, however, state that the overriding issue is one of freedom of choice which must be protected at all costs. I would remind them that this was the same argument used by the purveyors of pornography--and which ultimately has ended in an avalanche of filth and rot, the likes of which this country has never seen, and which is, in large part, responsible for the predicament in which we find ourselves today.

By the same argument, I should also be allowed to freely advocate the violent overthrow of the U.S. Government which, as we all know, is pure unadulterated treason. I submit that the assault on the integrity of the American home by the proponents of abortion and the like is no less a threat to our way of life than the treasonable act just mentioned.

Much has been said concerning the statistics of the decline of illegal abortion rates, morbidity mortality rates and so forth. However, I feel that this committee should be aware of the long-range effects of abortion, particularly on our young teenage children. To do this I will quote from the recent study of Dr. J. K. Russell and reported in the Clinics of Obstetrics and Gynecology, Vol. 3, No. 3, December, 1974, in which he examines the medical and social history of 62 pregnant teenage girls.

1 had a spontaneous abortion (miscarriage)
11 carried their pregnancy to term
50 had a therapeutic abortion

It is the fate of these 50 young girls that we should examine after their abortion. I will quote directly from Dr. Russell.

(Dr. Lyman quoted from the materials that follow as part of this same exhibit).

newborn. *American*
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ervical abnormalities
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Sexual Activity and its Consequences in the Teenager

J. K. RUSSELL

Elizabeth Manners (1971) has written of the young in contemporary society with considerable insight and great sensitivity. Drawing on thirty years' experience of teaching in a wide variety of schools she portrays in *The Vulnerable Generation* a disturbing picture of adolescents almost tragic in their vulnerability, exposed to the twin onslaughts of materialism and commercial exploitation. Miss Manners is rightly critical of the present strong undertone of contempt for standards and values which have long bound families together and have contributed to the stability of society—discipline, truth, service to the community, gentleness and consideration for others, a sense of responsibility and chastity before and fidelity after marriage.

It is, of course, difficult to establish how much of youth's apparent disenchantment with so much of what they find in today's world is real and how much reflects the views and attitudes of editors, writers, producers and others associated with the press, magazines, publishing, television, the cinema and the theatre. It is very likely that the majority of young people today are as concerned as their elders over falling standards of personal behaviour and are preparing themselves reasonably and adequately for an adult role in society. But the bizarre behaviour of a slowly increasing minority of youngsters is creating problems for themselves, anxieties for their parents and is a disruptive, unproductive feature of life in many communities.

Among several examples of this disturbing development none is better documented than the immediate and long-term results of sexual liberty among young teenagers. Whilst the apparent advantages of unrestrained sexual activity are widely presented, the personal and family tragedies that frequently stem from these relationships are seldom portrayed. In the United Kingdom, as in other advanced countries, the number of unwanted pregnancies among young girls has been rising steadily over the past twenty years. Apart from immediate obstetric and social problems, there is mounting evidence of other serious consequences of sexual activity at this early age—the hazard of venereal disease, the increased risk of cervical malignancy in later life and, where therapeutic abortion is performed, the chance that this may prejudice the girl's subsequent reproductive career.

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PREGNANCY IN YOUNG TEENAGE GIRLS

In England and Wales between 1948 and 1955, the Registrar General's Annual Reports show that around 200 girls aged 15 years delivered viable babies beyond the 28th week of pregnancy. From 1956 the number has increased steadily and reached 1267 in 1971 (Figure 1). There has been a similar

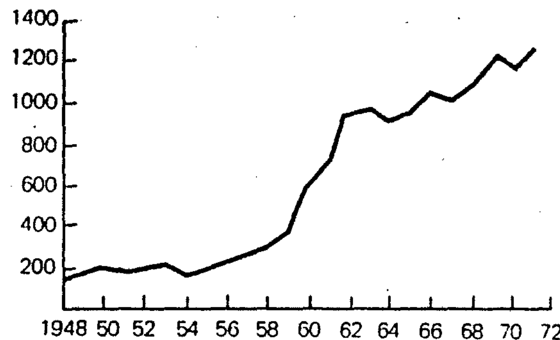

Figure 1. Number of pregnancies (beyond 28 weeks) per year in girls aged 15 years in England and Wales, 1948–1971.

increase (though the numbers are smaller) in the number of viable pregnancies in girls under the age of 15 years. Not only have the numbers increased but also the proportion of girls aged 15 years who have babies has risen from 0·8 to 3·8 per 1000 (girls aged 15 years) over the period 1956 to 1971 (Figure 2). There is no precise information about the number of thera-

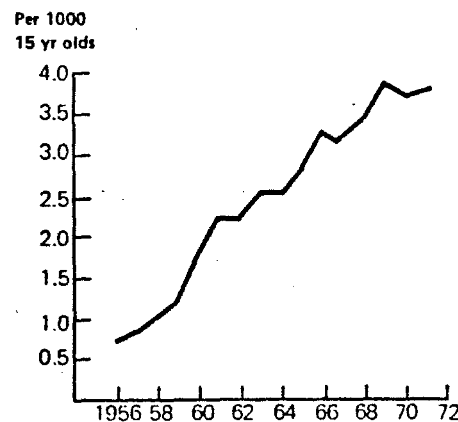

Figure 2. Proportion of 15-year-old girls in England and Wales with pregnancies beyond 28 weeks, 1956–1971.

peutic abortions carried out on girls aged 15 years prior to the Abortion Act (1967) but this information is available from April 1968 onwards. Table I

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Table 1. *Therapeutic abortion in girls aged 15 in England and Wales 1968–1971*[a]

Year	Number of abortions
1968	363
1969	848
1970	1233
1971	1671

[a]From the Registrar General's *Annual Statistical Review. Supplement on Abortion.*

shows the number of therapeutic abortions carried out on girls aged 15 years from the inception of the Abortion Act until the end of 1971. In effect, these figures for legal abortion show that in this age group one pregnancy is terminated for every one allowed to proceed to viability. The effect of therapeutic abortion in keeping down the number of viable pregnancies in girls aged 15 years is shown very clearly in Figure 3. Were it not for therapeutic abortion the number of babies born to girls aged 15 years would continue to rise sharply. This pattern of reproductive behaviour in the young is different

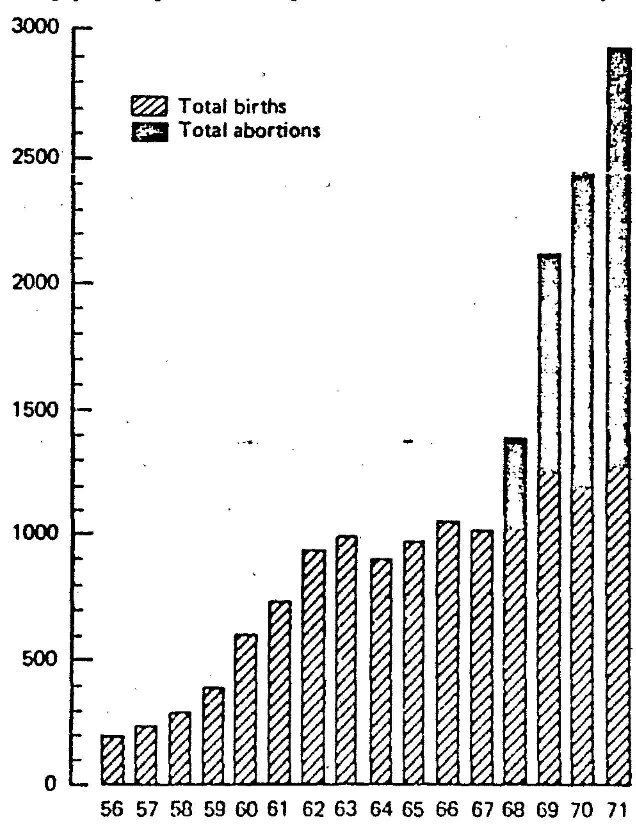


Figure 3. Total births and therapeutic abortions per year in girls aged 15 years in England and Wales, 1956–1971.

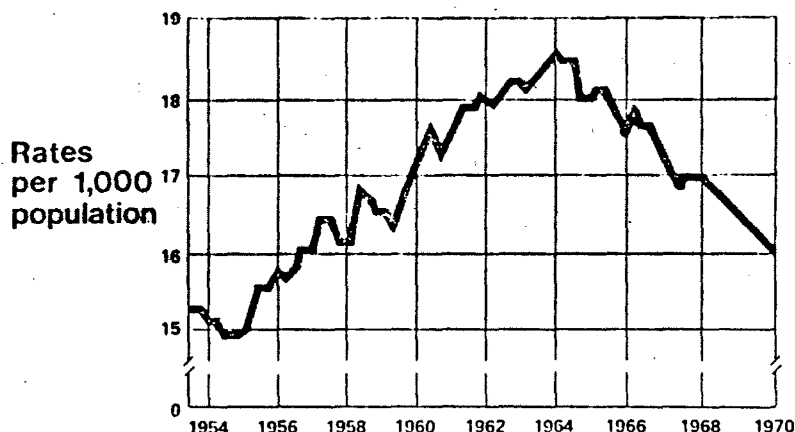


Figure 4. Crude birth rate for England and Wales, 1954–1970.

from that found among older women. In England and Wales the crude birth rate has been falling steadily since 1964 (Figure 4) and is around 16 per 1000 total population at the moment. When these births are divided into legitimate and illegitimate components the trends are seen to be different (Figure 5).

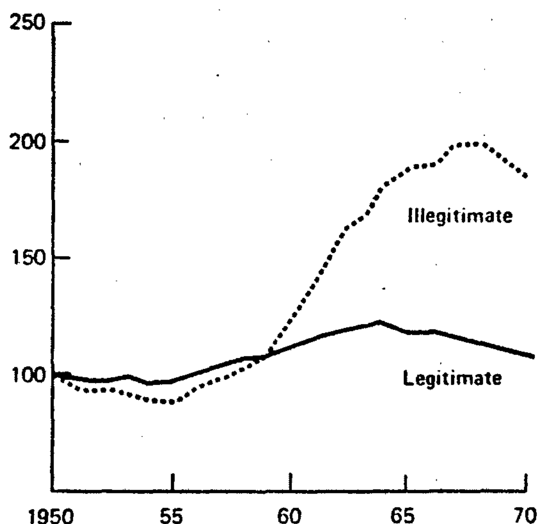
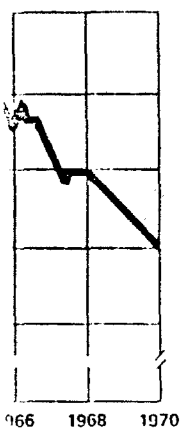


Figure 5. Number of legitimate and illegitimate pregnancies in England and Wales, 1950–1970, expressed as a percentage of the number in 1950.

Whereas the legitimate births reached a peak in 1964 and have been falling since then the illegitimate births continued to rise sharply and are only now beginning to fall, due in part to the Abortion Act. When the trend in illegitimate births since 1950 is analysed by age groups (Figure 6) it is seen that there has been little, if any, increase in the number of babies born to mothers aged



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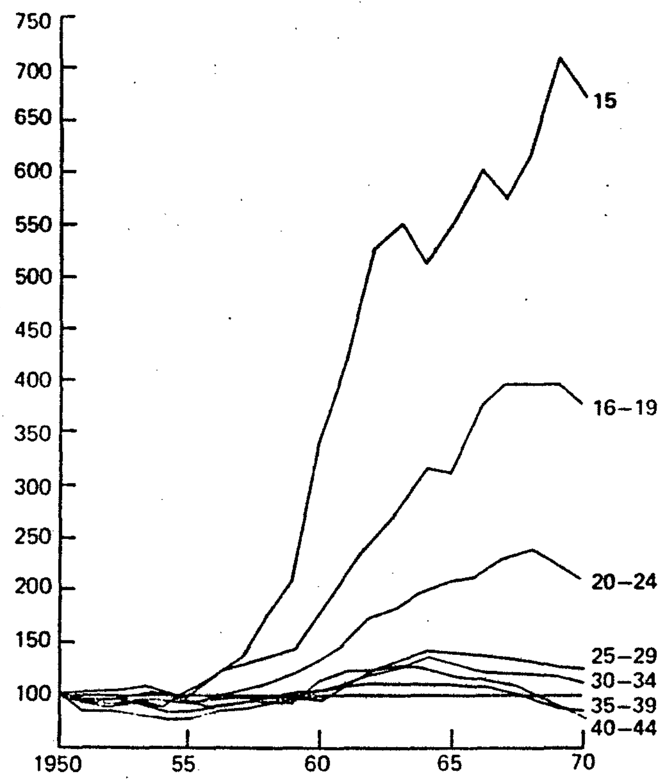

Figure 6. Number of illegitimate births in England and Wales, 1950–1970, by age of mother expressed as a percentage of 1950 figures.

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25 and over. But as one looks at mothers in the younger age groups the increase in number of illegitimate births becomes progressively greater until there is more than a sixfold increase in mothers aged 15. Birth rates follow precisely the same trends as numbers. Illsley and Gill (1968) in their careful study of extra-marital pregnancy in the United Kingdom, report that the upward trend in illegitimacy in recent years is especially associated with urban areas, younger unmarried girls and upper social groups. The trends in illegitimacy in Scotland, England and Wales are shown in Figure 7. The dramatic upward swing begun in 1957/1958 has almost reached the peak wartime level and to an increasing extent these mothers are young girls drawn from all social groups, particularly in large urban areas. And though it would seem from figures for the last two years that the illegitimacy rate in the United Kingdom has 'levelled off' this is due in considerable measure to the wider use of therapeutic abortion.

The same rising trend of pregnancies in young teenage girls is reported by Clark (1971) from the United States. In 1960 there were 4·2 million births in the U.S.A. and the number had fallen to 3·5 million by 1967. This steady decline in the total number of births is in sharp contrast to the dramatic rise

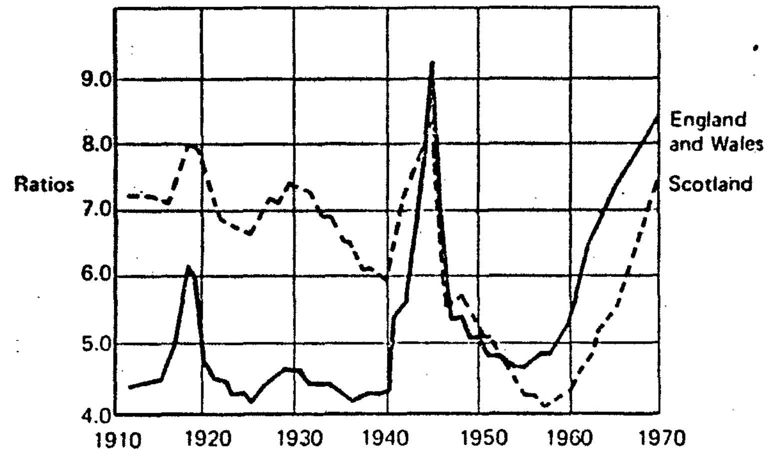


Figure 7. Illegitimacy ratios for Scotland and for England and Wales, 1911–1970.

in the number of births among girls aged 16 and under—a 36 per cent increase over the same 7-year period. In 1961, 14 per cent of all American births were to teenagers and this had risen to 17 per cent in 1971. Nearly half of all out-of-wedlock births in 1968 in the U.S.A. were to teenagers compared with 41 per cent in 1961 (*Vital Statistics of the United States*, 1961 and 1968). In America, as in England, the illegitimacy rates for all age groups, apart from 15 to 19 year olds have declined slightly over the past few years.

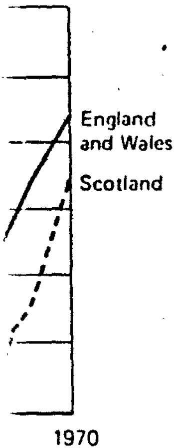
Pregnancy Complications in Young Teenagers

Most textbooks on obstetrics either ignore the particular problems of pregnancy in young teenagers or give the subject scant attention. But evidence has accumulated steadily over the past ten years of increased risks for these young mothers and of significant hazards for their babies. The threat to the lives and wellbeing of these mothers and their babies is sufficiently serious to warrant their receiving special care during pregnancy and the neonatal period.

Maternity mortality

In England the series of confidential reports on maternal deaths mentions very briefly the risk to the lives of teenage mothers as the number of such maternal deaths is very small in any 3-year period. But it is acknowledged that the available figures suggest a higher risk of mortality in the age group 15 and younger.

In America, as in the United Kingdom, maternal mortality rates have declined steadily over the past fifty years and all age groups have contributed to the fall in the number of deaths. Shapiro (1968) has reported the percentage fall by age group and has shown that, although mortality rates for women under 20 years of age declined more rapidly from 1929 to 1961 than for any other age group, the mortality rate is still higher for women under 20 than it is



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Ballard and Gold (1971) record that many special studies from centres in the United States report no maternal deaths in teenage pregnancies. But it is evident from the national figures for mortality among young mothers that there must be many other centres, probably with less effective maternity care programmes, where a number of pregnant young teenagers lose their lives. These centres obviously do not publish their results in the medical press.

Obstetric complications

The complications of pregnancy commonly associated with young adolescents are pre-eclampsia, anaemia, low birthweight babies and higher perinatal mortality rates. Where there is disagreement about the incidence and significance of the various complications, the reason generally is that there are differences in definitions of the various disorders and in the groups of adolescents under study—differences in age, socio-economic and ethnic group, nutritional status, etc. But there is quite wide agreement on the higher incidence of pre-eclampsia. Battaglia, Frazier and Hellegers (1963) have noted higher rates of toxaemia in the youngest adolescents—29·2 per cent among patients less than 15 years of age compared with 21·1 per cent in the 15 to 19 year olds. Even here, however, it must be conceded that youngsters drawn very often from the poorest and most deprived sections of the community will secure for themselves a very indifferent standard of ante-natal care and will more likely fail to accept medical advice offered to them—in a way they are victims of their own 'cultural lag' and thereby more likely to suffer from pre-eclampsia and other ante-natal complications. More often than not investigators report iron deficiency anaemia in pregnant adolescents. For example, Jovanovic (1972) reporting from the Chicago Lying-in Hospital on 1033 pregnant teenagers found anaemia to be a frequent clinical problem; the incidence of adolescents with haemoglobin levels lower than 10 g per 100 ml and haematocrit lower than 32 per cent was 14 per cent compared with 9·3 per cent in a control group of patients. These young teenage, pregnant girls probably represented the poorest section of the Chicago community and it is not surprising that a relatively high incidence of anaemia was found.

The incidence of low birthweight babies (under 2500 g) among young mothers is high. In the United States a Working Group on Pregnancy and Adolescence (1971) has reported that in 1965 18·7 per cent of low birthweight babies born alive in the United States were born to mothers under 15 years of age. With increasing maternal age the proportion of low birthweight infants decreased up to the age of 40. The lowest rate, 7·3 per cent, was found in the 25 to 29 age group. Jovanovic (1972) reports that 15·9 per cent of the babies born to teenage mothers in the Chicago Lying-in Hospital were below 2500 g compared with 9·8 per cent for the general population. These figures are similar to those given by other authors (Hassan and Falls, 1964; Wallace, 1965). One or two large studies have shown that death rates among babies born to young adolescents are higher than those found among mothers in their early twenties. In America the Working Party on Pregnancy and

Adolescence (1971), using data from the National Centre for Health Statistics, reports a matched study for the year 1960, showing that death rates were much higher for infants born to mothers under 15 years than for those born to older mothers; this applied to white and non-white infants. The differences were especially noticeable during the first 28 days of life. The neonatal mortality rate for infants born to white mothers (under 15) was 32·1 per thousand live births compared with 15·9 for those whose mothers were 20 to 24 years of age. The greater risk of death for babies born to very young mothers continued throughout the first year of life, though the difference was less marked than for the first month of life. In the national study of perinatal deaths reported by Butler and Alberman (1969) higher death rates were noted for babies born to mothers under the age of 20. When these deaths were analysed by cause it was found that toxaemia, congenital defects and prematurity of unknown origin were relatively more frequent causes of baby deaths in this group of young mothers.

Low birthweight is an important cause of death in these infants but equally important is the effect it may have on the development of those children who survive. Some studies link low birthweight with later development of epilepsy, cerebral palsy and mental retardation and to a greater risk of blindness and deafness (Lilienfeld and Pasamanick, 1954; Pasamanick and Lilienfeld, 1955; Vernon, 1967; Goldberg et al, 1967). Other studies relate low birthweight to poor motor development and to depression of the child's IQ (Weiner, 1970; Eaves et al, 1970; Drillien, 1969). These long-term associations are particularly significant in teenage pregnancy where low birthweight is a special problem. A further disturbing feature is the tendency for girls who have a first child at an early age to have a sequence of children at short intervals (Menken, 1972). In its turn this pattern of reproduction is associated with increased rates of perinatal mortality and infant deaths.

The belief that these young mothers are little upset by the experience of a pregnancy is challenged by several authors (Scher and Utian, 1970; Pugh et al, 1963; Whitlock and Edwards, 1968). Gabrielson et al (1970) reviewing the experience of a group of mothers under the age of 18 report that the risk of later suicide attempts is relatively high. Those girls who attempted to take their own lives had a higher rate of complications during their pregnancies and were more liable to suffer from venereal disease than other teenage mothers. Roman Catholics and girls from well-to-do areas were particularly at risk for suicide according to Gabrielson et al (1970). Brandon (1970) has noted that a poor relationship between mother and baby, baby battering and behaviour disturbances in childhood are closely related to early marriage.

In summary, a pregnancy at a very young age is an adolescent trap which leads to a vicious circle of medical and social problems from which the girl and her offspring can hardly escape (Ballard and Gold, 1971). Apart from the medical complications of early childbearing, the personal consequences can be very serious. Arthur Campbell (1968) has described very plainly and fairly what may flow from such a tragic beginning to a girl's reproductive career:

'The girl who has an illegitimate child at the age of 16 suddenly has 90 per cent of her life's script written for her. She will probably drop out of school even if someone else in her family helps to take care of the baby. She will

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probably not be able to find a steady job that pays enough to provide for herself and her child. She may feel impelled to marry someone she might not otherwise have chosen. Her life choices are few and most of them are bad. Had she been able to delay the first child, her prospects might have been quite different'.

But not all young girls want their pregnancies to continue. Where interruption of pregnancy is legally permitted, increasing numbers of teenagers request this alternative (Table 1). Currently in England and Wales the number of therapeutic abortions in girls aged 15 rather exceeds the number of pregnancies which carry on beyond 28 weeks.

These national figures draw attention in a general way to the growing importance, numerically, of pregnancy in young girls but tell nothing of the personal and family difficulties faced by these young girls and their families, not only at the time of pregnancy but afterwards. Between January 1960 and December 1971 I was involved in the management of 74 girls aged 16 or under who were pregnant and sought help. In many instances contact has been maintained with these girls and their families through subsequent attendance at ante-natal or gynaecological clinics. But I have also obtained a great deal of information from family doctors, medical social workers and other professional colleagues. As a result it has been possible to review in some detail the medical and personal histories of 62 of these girls. The longest period between the completion (or interruption) of the pregnancy and review was 12 years and the shortest 2 years. I have no reason to believe that the 12 girls whose subsequent reproductive careers and personal histories I have been unable to check differ in any significant way from those who were traced. The social and medical problems they and their families presented were substantially the same as found in the larger group. In most cases failure to obtain follow-up information was due to the girl having moved from the North East to another part of the country. A certain amount of information was obtained on three of the girls but it was inadequate for the purpose of the follow-up study.

Table 2. *Socio-economic status of families of 62 teenage girls*

Social Class I and II	8
Social Class III	28
Social Class IV and V	26

The socio-economic status of the parents of the 62 girls is shown in Table 2. They are reasonably representative of the surrounding community; there is no preponderance of any one social class over the others. In 37 out of the 62 there were obvious social or marital problems in the homes (Table 3). Irrespective of social class these girls tended to come from families where there was insecurity and instability.

The outcome of the original pregnancy in the 62 cases is shown in Table 4. One girl had a spontaneous abortion at ten weeks—the pregnancy had only been discovered when she began to have heavy vaginal bleeding and she was referred to see me on this account. In 11 cases the pregnancy, very largely because it was too advanced for termination, was allowed to continue and the

Table 3. *Social or marital problems in the families of the 62 girls*

Parents separated	11
Parents divorced	5
One or other parent known alcoholic	5
One or other parent in jail or been in jail	5
One or other parent known to have had illegitimate child	9
Child herself illegitimate	7
Child 'in care'	4
Child attending 'special school' because of low IQ	3

Some cases are included under more than one heading but in 37 out of the 62 families there was an obvious social problem.

patients remained under my care in the Princess Mary Maternity Hospital. Seven of these girls were aged 16 years at the time of the initial consultation, three were 15 years and one was 14 years of age. All produced live babies at or near term and the only noteworthy complication occurred in a girl aged 15 years. The circumstances of this pregnancy and labour have already been reported (Russell, 1970). The girl was known to have some transverse narrowing of the pelvis—true conjugate at inlet 11·4 cm; widest transverse diameter 11·9 cm. After a labour lasting 14 hours the fetal head was in the pelvis with the leading point just below the level of the ischial spine and the cervix fully dilated. A decision had to be made between caesarean section and forceps delivery; the vaginal route was chosen. The delivery was more difficult than had been anticipated and the baby responded slowly to resuscitation. The

Table 4. *Outcome of initial pregnancy in 62 teenage girls*

Spontaneous abortion	1
Pregnancy allowed to continue	11
Therapeutic abortion	50

birthweight was 8 lb 5 oz (3773 g) and the child showed signs of neurological disturbances during the neonatal period. Arrangements for adoption had to be cancelled. Two months after delivery there was still evidence of neurological disturbance but at nine months the paediatrician found no evidence of residual damage and arrangements were made for the child's adoption. The obvious lesson to be learned from this case is that where there are reasonable indications for caesarean section the very young age of the patient should not unduly influence the obstetrician to undertake a lesser procedure, namely forceps delivery, for this may aggravate an already difficult situation.

In 50 cases the decision was made to terminate the pregnancy by therapeutic abortion and the methods of termination are shown in Table 5. Of the 50 cases the gestational age was under 12 weeks in 38 cases, between 12 and 14 weeks in 9 and beyond 14 weeks in three instances. Over the years covered by this study the techniques in pregnancy termination have altered. In the early years the commonest method was cervical dilatation and curettage under general anaesthesia; where the pregnancy was beyond 14 weeks, hysterotomy was performed. In recent years the first choice has become

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Table 5. *Method of pregnancy termination in 50 cases*

Vacuum aspiration	30
Dilatation and curettage	16
Hysterotomy	2
Prostaglandin	2

suction curettage with either extra or intra amniotic prostaglandin if the pregnancy is too far advanced for termination from below. The operations are not without risk and the immediate complications in this personal series are set out in Table 6. By comparison the risk of trauma to the cervix through dilatation seems to be much less in older patients. There has been no example of cervical damage requiring suture in the last 50 primigravidae over the age of 20 years terminated following cervical dilatation by the same operator. The cervix of the young teenager, pregnant for the first time, is invariably small and tightly closed and especially liable to damage on dilatation.

Table 6. *Immediate complications associated with therapeutic abortion in 50 cases*

Complication	Number of cases	Comment
Laceration of cervix requiring suture	4	These cervical tears happened in spite of routine use of paracervical local anaesthesia and gentle dilatation with warmed dilators
Blood transfusion at time of operation or within 12 hours	4	
Retained products necessitating return to theatre for recurettage	2	
Significant infection with identified organisms requiring antibiotic therapy	3	
Other complications	1	Tip of acrilic suction curette broke off during curettage and was retrieved with difficulty. The cervix was split in the course of searching for the tip and two sutures had to be inserted

Thirty-seven of the 50 girls whose pregnancies were terminated have married and eight of these have separated from their husbands, ~~whilst~~ another three are divorced. Two further marriages are clearly in jeopardy—in the first the girl has had three spontaneous abortions since marriage and her husband is associating with another woman by whom he had had a child; in the second the girl has had four spontaneous abortions and her husband ~~(previously married and with two children)~~ is openly blaming the induced abortion for her present failure to have a successful pregnancy.

Outcome of Subsequent Pregnancies

Thirty-two out of the 37 married women have produced 45 pregnancies with the following results:

1. Three were terminated by therapeutic abortion.
2. Seventeen ended in (apparently) spontaneous abortion.
3. Seven ended in premature delivery between the 32nd and 36th weeks with the death of one baby at three days. Another was a got death at three months. Crib
4. Eighteen pregnancies went to term. One baby died shortly after a precipitate delivery; a second died of acute gastro-enteritis at three months; a third died of pneumonia at 18 months and a fourth died following a scalding accident in the home at the age of 2½ years.

Seven of the 13 unmarried girls have produced eight pregnancies since the original therapeutic abortion. Two of these ended in spontaneous abortion, three were terminated by therapeutic abortion, one resulted in a stillbirth at the 30th week and two live babies were born at or near term.

In summary, these girls, since the original therapeutic abortion, have had 53 pregnancies of which six have been terminated by therapeutic abortion. The outcome of the remaining 47 pregnancies where, ostensibly, there was no interference makes rather dismal reading. Nineteen ended in spontaneous abortion; one baby was stillborn at the 30th week and a further six died for various reasons between birth and 2½ years. There were 21 surviving children (December 1973) out of the 47 pregnancies.

Of the 11 girls whose initial pregnancies were allowed to continue (as opposed to therapeutic abortion), eight conceived during the period of the follow-up study and between them they have had nine pregnancies all of which went to term (or near term) and the babies have survived.

Pregnancy, perhaps the most obvious and certainly one of the most frequent consequences of sexual activity in the teenager, clearly carries medical hazards for the girl and her baby. But the full significance of these early pregnancies will only be established by carefully planned prospective studies involving several disciplines—obstetrics, paediatrics, psychiatry and sociology. Russell (1969, 1970) has given individual case histories to illustrate some of the personal and family problems that may arise in association with pregnancy in teenagers. He has stressed the following points:

1. Interference with the girl's education.
2. Tension and discord within the family, leading eventually in some cases to disruption of the whole family unit.
3. Breakdown of the girl's subsequent marriage when details of an earlier therapeutic abortion are kept from the husband and only divulged after marriage.
4. The tendency for the girl to link any subsequent unsuccessful pregnancy with an earlier therapeutic abortion and the strain this may place upon her and her marriage.

Inevitably the rising incidence of pregnancy among young teenagers raises the whole matter of sexual behaviour at this age and what should be done to reduce the number of unwanted pregnancies. Kantner and Zelnik (1973) have reported on the behaviour of some 3000 teenage, unmarried, white girls drawn from all parts of the United States. Socio-economic status was found to have little effect on the likelihood of sexual experience though, as might be expected, those girls who attended church regularly, came from a rural

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background or were in the habit of confiding in their parents, were less likely to have had intercourse. As age increased from 15 to 19 years, more of the girls used some form of contraception but not on every occasion. With increasing age the proportions who never used or who always used contraceptives diminished and the proportion who sometimes used contraceptives increased. Of the sexually active girls at the time of interview, 53 per cent had not used any kind of contraception the last time they had intercourse. A partial explanation for this 'chance-taking' is that a substantial number of the girls believed that they could not become pregnant either because they were too young, because they had sex too infrequently or because they had intercourse at the wrong time of the month. Rather similar findings were reported from a study of young female students in the University of Aberdeen (McCance and Hall, 1970).

It is likely that the greatest deterrent to the use of contraception among teenagers is the irregularity of intercourse. Were coitus to take place regularly they might better take suitable precautions to avoid pregnancy. When intercourse is unanticipated, prevention of pregnancy is a considerable problem. Another difficulty that faces these young girls is that the use of contraception increases the risk that their sexual activity will be discovered by their parents—at least when methods other than withdrawal or the safe period are used. In broad terms, there are two possible approaches to the problem of unwanted pregnancy in these young girls. The first is to mount an extensive, prolonged and carefully prepared national programme depicting the responsibilities that come with sexual activity and the personal and family problems that may well arise if intercourse is followed by pregnancy at this early age. The challenge is formidable but the rewards could be considerable. The alternative is to accept that widespread sexual activity among the very young is unavoidable, and to make certain that contraceptive methods are freely available and the young properly instructed in their use.

The present dilemma is obvious and it makes no sense that it should continue with increasing numbers of young girls suffering the indignity and traumatic experience of an unwanted pregnancy. Society must decide which of the alternatives is preferable and will the means to mount an effective programme likely, in time, to reverse the rising trend in teenage births.

VENEREAL DISEASE

Over many years it has been a recurring theme of the Chief Medical Officer's yearly report on the health of the nation that whereas most infectious diseases have proved increasingly susceptible to control, the venereal diseases have not; indeed the incidence of most types of venereal disease continues to rise steadily. This is hardly surprising in view of the nature of these diseases and the steady trend towards sexual permissiveness which has taken place since the mid 1950s. Most distressing, however, is the increasing representation of young teenagers among patients attending clinics for treatment, especially for gonorrhoea. The figures for England given by the Chief Medical Officer (*On the State of the Public Health, 1972*) in his most recent report are shown in Table 7. In 1972, in England, one third of the new cases of gonorrhoea

Table 7. *Gonorrhoea – new cases per 100 000 population seen at hospital clinics in England 1968–1972 (females)*

Disease	1968	1969	1970	1971	1972
Gonorrhoea (post-pubertal)					
Under 16	4·19	6·22	7·01	7·03	7·36
16 and 17	193·92	248·64	316·00	348·62	362·92

in females occurred before the age of 20. In America the trend is similar. Whilst the total reported incidence of gonorrhoea continues to rise at an increased rate each year, the number of cases of gonorrhoea in the youngest age group rises most rapidly. For example, for all age groups there was a rise of 14·7 per cent in 1968 over 1967 but for the 15 to 19 year age group the rise was 18·6 per cent (Wallace, 1971).

American (Deschin, 1969) and Danish (Ekstrom, 1970) studies of 600 and 300 teenagers suffering from venereal disease confirm that large numbers of these children (compared with the normal population) came from an unfavourable social background, have poor contact with their homes, frequently change their school or job, have many sexual partners, and are more liable to indictment for criminal offences such as stealing, prostitution and illegal abortion. Even at this early age alcoholism is a significant problem. All stress the need for perseverance with educational programmes in schools and other teaching institutions together with strengthening of family life. Essentially the problem is one of promiscuity and there are only two ways that the spread of infection can be checked. Firstly the rejection of promiscuity by a society which recognises the serious threat this poses for family life and for the community; secondly the tracing and treatment of sexual partners of every infected person. According to Sir George Godber (*On the State of the Public Health in England and Wales, 1972*) the first of these methods has been successfully adopted in the People's Republic of China, where responsible Chinese clinicians claim that primary syphilis, once common, is now rarely seen and the incidence of gonorrhoea has been greatly reduced. Unfortunately, the National Health Service cannot by itself bring about such a change in sexual mores nor can it initiate or direct the essentially educational activities which are needed for younger people. The contribution of the health sector must, for the present, continue to be an emphasis upon early diagnosis and the tracing and treatment of contacts.

CARCINOMA OF THE CERVIX

It is now beyond doubt that coitus plays a major role in the etiology of cervical cancer. In an authoritative article Rotkin (1967) reports that every single one of 416 patients with cervical cancer had had sexual intercourse. By comparison with controls four inter-related etiological factors were noted —age at first coitus, age at first marriage, number of husbands and total number of sexual partners. Sexual intercourse was the factor common to all. There is now convincing evidence that of all the coital factors, age at first intercourse is the most significant and that coitus during early adolescence

Deschin, C. S. (1969) *The Teenager and Venereal Disease*. New York: Richards Rosen Press.
Drillien, C. M. (1969) School disposal and performance for children of different birth weight 1953–1960. *Archives of Disease in Childhood*, **44**, 562–568.
Eaves, L. C., Nuttall, H., Klonoff, H. & Dunn, H. G. (1970) Developmental and psychological test scores in children of low birthweight. *Pediatrics*, **45**, 9–14.
Ekstrom, K. (1970) Patterns of sexual behaviour in relation to venereal disease. *British Journal of Venereal Diseases*, **46**, 93–95.
Gabrielson, I. W., Klerman, L. V., Currie, J. B., Tyler, N. C. & Jekel, J. F. (1970) Psychiatric considerations in pregnancy. *American Journal of Public Health and Nation's Health*, **60**, 2289–2295.
Goldberg, I. D., Goldstein, H., Quade, D. & Rogot, E. (1967) Association of perinatal factors with blindness in children. *Public Health Reports*, **82**, 519–531.
Hassan, M. H. & Falls, F. H. (1964) The young primipara—a clinical study. *American Journal of Obstetrics and Gynecology*, **88**, 256–269.
Illsley, R. & Gill, D. (1968) Changing trends in illegitimacy. *Social Science and Medicine*, **2**, 415–433.
Jovanovic, D. (1972) Pathology of pregnancy and labour in adolescent patient. *Journal of Reproductive Medicine*, **9**, 61–66.
Kanter, J. F. & Zelnik, M. (1973) Contraception and pregnancy. Experience of young unmarried women in the United States. *Family Planning Perspectives*, **5**, 21–35.
Lilienfeld, A. & Pasamanick, B. (1954) Study of association of factors of pregnancy and parturition with the development of cerebral palsy. *Journal of the American Medical Association*, **155**, 719–730.
Manners, E. (1971) *The Vulnerable Generation*. London: Cassell.
McCance, C. & Hall, D. J. (1972) Sexual behaviour and contraceptive practice of female undergraduates at Aberdeen University. *British Medical Journal*, **ii**, 694–700.
Menken, J. (1972) Health and social consequences of teenage childbearing. *Family Planning Perspectives*, **4**, 45–53.
On the State of the Public Health in England and Wales, 1972. London: H.M.S.O.
Pasamanick, B. & Lilienfeld, A. (1955) Association of maternal and fetal factors with the development of mental deficiency. *Journal of the American Medical Association*, **159**, 155–162.
Pugh, T. F., Jerath, B. K., Schmidt, W. M. & Reed, R. B. (1963) Mental disease and childbearing. *New England Journal of Medicine*, **268**, 1224–1229.
Reports on Confidential Enquiries into Maternal Deaths in England and Wales, 1952–1969. London: H.M.S.O.
Rotkin, I. D. (1967) Aetiological factors in cervical cancer. *Cancer Research*, **27**, 603–611.
Russell, J. K. (1969) Teenage pregnancy. *Lancet*, **i**, 365–366.
Russell, J. K. (1970) Pregnancy in the young teenager. *Practitioner*, **204**, 401–405.
Scher, J. & Utian, W. H. (1970) Teenage pregnancy. An inter racial study. *Journal of Obstetrics and Gynaecology of the British Commonwealth*, **77**, 259–262.
Shapiro, E. (1968) *Infant, Perinatal, Maternal and Childhood Mortality in the United States* Cambridge, Mass: Harvard University Press.
Vernon, M. (1967) Prematurity and deafness. *Exceptional Children*, **33**, 289–298.
Vital Statistics of the United States. Vol. 1. *Natality 1961*, Tables 2.9 and 2.12; Vol. 1. *Natality 1968*, Tables 1.26, 1.41 and 1.51.
Wallace, H. M. (1965) Teenage pregnancy. *American Journal of Obstetrics and Gynecology*, **92**, 1125–1131.
Wallace, H. M. (1971) Venereal disease in teenagers. *Clinical Obstetrics and Gynecology*, **4**, 432–441.
Weiner, G. (1970) Relationship of birth weight and gestation to intellectual development at 8 to 10 years. *Journal of Pediatrics*, **76**, 694–701.
Whitlock, F. A. & Edwards, J. E. (1968) Pregnancy and the risk of suicide. *Comprehensive Psychiatry*, **9**, 1–6.
Working Party Report on Pregnancy and Adolescence (1971) Relation of nutrition to pregnancy in adolescence. *Clinical Obstetrics and Gynecology*, **4**, 367–392.

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especially predisposes women to cervical cancer (Coppleson, 1969). Admittedly the age at first coitus is likely to be closely related to socio-economic status which is itself linked to such factors as nutrition, personal hygiene, number and spacing of children, ethnic group, etc. But the epidemiological evidence pointing to the paramount importance of age at first coitus (and the presumption of continuing coitus in early adolescence) is substantial. An interesting theory (Coppleson, 1969) based on careful colposcopic and histological studies on 300 girls between the ages of 12 and 13, is that the cervical epithelium in early adolescence is in a dynamic period of metaplasia and very susceptible to atypical patterns of metaplasia when exposed to the penis and semen. Possible carcinogens, under these circumstances, are listed by Coppleson—spermatozoa, viruses, protozoa, bacteria, smegma, chemical agents, mechanical irritation, hormonal stimulus and neural stimuli. Whatever the direct cause it must be accepted, on present evidence, that a predisposition to cervical cancer is one of the long-term consequences of sexual liberty in young, teenage girls.

CONCLUSIONS

These various consequences of sexual liberty among teenagers add nothing to the dignity or quality of life; rather the reverse. The tragedy is that so many youngsters are apparently quite unable to grasp the significance of their behaviour and especially the effect it may have upon their future lives. And some of the blame inevitably must rest upon the shoulders of those adults who, for one reason or another, are deeply admired by youngsters, yet set such poor examples of personal behaviour. Drug taking, promiscuity, selfishness, irresponsibility and inability to form deep and lasting relationships with the opposite sex are not the sort of attributes one looks for in leaders but, alas, these are common findings in contemporary society. The young tend to follow the example of adults who are in contact with them and for whom they have respect. The best hope for the future is that those adults in a position to influence the young will look afresh and with greater understanding at their own standards of behaviour. The greatest need is moral leadership.

REFERENCES

American Social Health Association (1970) *Today's Venereal Disease Control Problem.* New York: American Social Health Association.

Ballard, W. M. & Gold, E. M. (1971) Medical and health aspects of pregnancy in the adolescent. *Clinical Obstetrics and Gynecology,* 4, 338–366.

Battaglia, F. C., Frazier, T. M. & Hellegers, A. E. (1963) Obstetric and pediatric complications of teenage pregnancy. *Pediatrics,* 32, 902–910.

Brandon, S. (1970) Behaviour disturbances in childhood. *Journal of Psychosomatic Research,* 14, 253–257.

Butler, N. R. & Alberman, E. D. (1969) *Perinatal Problems. 2nd Report of the 1958 British Perinatal Mortality Survey.* London: Livingstone.

Campbell, A. (1968) The role of family planning in the reduction of poverty. *Journal of Marriage and the Family,* 30, 236–241.

Clark, J. F. J. (1971) Adolescent obstetrics—obstetric and sociologic implications. *Clinical Obstetrics and Gynecology,* 16, 1026–1036.

Coppleson, M. (1969) Epidemiology and aetiology of cervical cancer. *British Journal of Hospital Medicine,* 2, 961–980.

EXHIBIT C

Lucille Lusk
Pro-Family Coalition
of Southern Nevada

I wish to address the other half of this resolution - the call for a Constitutional Convention limited to the drafting of an amendment to protect human life by restricting abortion.

A Constitutional Convention is not to be taken lightly and we have not done so. We have studied the Philadelphia Convention of 1787 and analyzed Article 5 of the Constitution, read legal opinions and research texts, and obtained information on Senator Ervin's proposed legislation to establish guidelines for such a Convention. I have also read with interest the comments of Nevada's legislators as recorded in the daily journals, regarding a Constitutional Convention for balancing the budget.

A Convention is provided for in the Constitution as a safeguard for the people, so that when a situation of grave concern arises that the Federal Government will do nothing about, the States may by a vote of 2/3 of their legislatures, demand that action be taken. Article 5 also requires that 3/4 of the States, by legislatures or ratifying conventions, must ratify any amendment arising out of the Convention before it can become law. This is the safeguard of the Convention - not one line can become law without the approval of 3/4 of the States.

Competent legal opinion is that the scope of a Convention can be limited to the subject as defined in the calls for the Convention. You are aware that AJR 17 includes the clause limiting it to "proposing an amendment....to protect human life by restricting abortion." What could a Convention do in the area of right-to-life that is more dangerous, more devastating than the loss of life now occurring through virtually unrestricted abortions? The worst is happening now - the babies are dying. And no - Congress will not act on it's own; the Supreme Court will not act to save these lives. We already know what they will do. We, the people - the States....we are the only glimmer of hope the children have.

I am reminded of Germany - Auschwitz, Dachau, places of tears and terror and the stench of death. Are we better than the people who were there, who let it happen and did nothing?

The State of Nevada has already called for a Constitutional Convention for a balanced budget. 13 Senators and 31 Assemblymen - a handsome majority - thought it was worth the risk to save money! Will Nevada go on record as caring more for money than for lives?

We submit to you that the high instance of abortions is such a grievous situation that it cannot be ignored. More American lives have been lost in these few short years by abortion than by the combined wars of two centuries. If we could hear the cries of the unborn denied their opportunity for life, it would be such a hue and cry as has never been heard in this Nation! But we hear no cries - only silence - for they are dead. I will tell you that God hears them, and He listens, and He will not hold us guiltless if we value their lives less than we value our money.

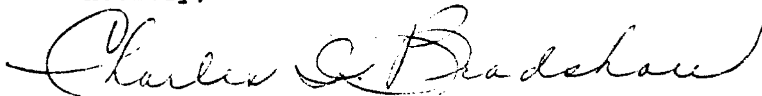
LDS Social Services - Nevada
1906 Santa Paula Drive
Las Vegas, Nevada 89105
(702) 735-1072

Because of our convictions as to the inappropriateness of abortion, we would like to offer an alternative. We also have concern that often a girl who has had an abortion experiences emotional trauma afterwards. We therefore, desire to make you aware of the services we, of LDS Social Services, have to offer in our Unwed Parent Program:

1. Social and Emotional Counseling.
2. Foster Homes for those who wish to live away from home temporarily during pregnancy.
3. Educational Assistance so that education may be continued.
4. Medical, Legal, Financial Assistance (each situation is considered individually).
5. Adoptive Placement of Child if desired.
6. Spiritual Guidance - each girl will be encouraged to seek the clergy of her faith for assistance in religious counseling.

We would appreciate your reviewing the enclosed materials and determine how we may help you in your area of responsibility. Also please consider how we may help those young women (regardless of religious preference) who may be in need of our services.

Sincerely,



Charles I. Bradshaw, Ph. D.

CIB/sh

LDS Social Services - Nevada
1906 Santa Paula Drive
Las Vegas, Nevada 89105
(702) 735-1072

Unwed Parents Services

LDS Social Services assists unwed parents through legally recognized agencies in the United States, Canada, New Zealand, and Australia. These agencies care for unwed parents and, when desirable, provide adoption and foster care placement. The privacy of those involved and the security of the child are protected by law.

Although professional counseling assists in their planning, final decisions regarding the future of the unborn child rest with the natural parents.

Those Served by LDS Social Services

1. An expectant, unwed female.

2. A mother of a child already born out of wedlock.

3. A legally married woman whose husband is not the father of the child.

4. An unwed mother who is going to keep her baby, but who needs counseling and guidance in planning for herself and her child.

5. The natural father of the unborn child.

6. The parents of the natural parents described in items above.

7. Married couples wishing to release their child or children for adoption.

8. Parents seeking an alternative to abortion.

9. A child born under any of these circumstances.

Although the majority of the clients served are LDS, consideration is given to all in need of this assistance.

How Services Are Secured

Unwed parents (or any of those listed) may request services by telephoning or personally visiting the agency. In addition, they may be referred by letter, telephone, or personal contact from Church leaders, doctors, attorneys, friends, relatives, or social welfare agencies.

Agency Services

1. *Treatment*
The unmarried mother, the unwed father, if possible, and their parents, if appropriate, are included in an individualized counseling program. Parents who decide to release the child are assured that the child will be placed in a home that meets the high standards the agency requires of adoptive applicants. Should the unwed mother decide to keep her child, the agency helps her prepare for motherhood.

2. *Medical care*
Prenatal, delivery, and postpartum care of the mother and routine care of the child are provided by local physicians.

3. *Care of the child*
Immediate adoption in an agency-approved adoptive home, or temporary boarding care, is available.

4. *Relinquishment of the child*
Arrangements are made by the agency on request from the mother or father.

5. *Housing of expectant mothers before and immediately after delivery.*
When needed, a foster home is carefully chosen and approved. Expectant mothers are to be treated as members of the foster family and to assume reasonable responsibilities in the home.

6. *Volunteer Services*
Important to the services are the women who are selected to provide a healthy example and an accepting relationship through which the mother can grow and develop, intellectually and spiritually.

If the mother has not completed high school, arrangements usually can be made for her to continue schooling.

Financial Policies

LDS Social Services encourages clients to provide for their own financial needs. When financial assistance is needed, planning is offered on an individual basis.

Confidentiality

Church and professional leaders would maintain appropriate confidentiality. Many mothers make tremendous personal progress through this service. Confidentiality frees them to maintain this progress.

Unwed parents need direction and counsel during an out-of-wedlock pregnancy. They would be given the opportunity to review their goals and values and receive guidance in looking at all possible alternatives and consequences.

How do you apply for service?

The person with the problem pregnancy may telephone or come in to one of the agencies listed on the back of this brochure.

An individual may be referred by a parent, bishop, minister, school counselor, doctor, attorney, or any interested party.

Information Regarding Services May Be Obtained at the Following Office :

Unwed Parent Services—

LDS SOCIAL SERVICES
Nevada Agency
1906 Santa Paula Drive
Las Vegas, Nevada 89105
735-1072

RENO OFFICE
William J. Nord
(702) 358-7465

Problem Pregnancy?

LDS Social Services Can Help!

Unwed Parent Program

What services are available?

- ***Counseling***

  Licensed counselors will help you consider alternatives. You can then make the best possible decision for all concerned.

- ***Housing***

  Temporary homes are available for girls who wish to live away from home during the pregnancy.

- ***Schooling***

  Arrangements can be made for a girl in junior or senior high school to continue her education.

- ***Medical, Legal, Financial***

  Needs will be considered individually.

Who may apply?

A girl pregnant and not married may apply, and so may the father of the baby.

A married or divorced couple who feel they need help may also make application.

Significant people involved in the lives of those experiencing problem pregnancies may seek consultation.

Do you know someone who needs this *confidential* service?

EXHIBIT E Sandra Jolley

TESTIMONY ON CONSTITUTIONAL CONVENTION-ABORTION

One of the rallying points of those who fear a Constitutional Convention to restrict abortion is that we must maintain a seperation of Church and State. This argument not only lacks proper understanding of this phrase, but has reduced it to trite rhetoric.

Seperation of Church and State does not and cannot mean the seperation of morality and the law. Until very recently educated men understood this and taught that a country is only as strong as the moral principles which it embraces. Such men include the crators of our Constitution. Those who gave birth to this nation believed in a God and in the importance of spiritual leadership. If they would have had the prophetic vision to foresee the sanction of abortion in American society, it is doubtless that they would have taken steps to remedy this atrocity in the first Constitutional Convention and saved us this most undesirable burden.

In the adulthood of this nation, however, we seem to have abandoned the religion of our forefathers. Instead "do your own thing", and "feeling good" have become religions of their own--A religion of hedonism, which simply means "the most physical pleasure for the most people." Your own convenience supersedes the importance of the unborn. Sex replaces love. If you doubt the truth of this I would tell you only to drop by the Planned Parenthood Office on 13th street and pick up some of their pamphlets they have out. Read "The Problems With Puberty" (the one for the boys is especially revealing), and "So You Don't Want To Be a Sex Object". Pure hedonism.

Our forefathers worshipped God. We worship ourselves. Our forefathers studied the Bible. We read pornography. Our forefathers built churches, and we are building abortion clinics.

In divorcing the spiritual from the political we proportionately increase the very ugly possibility of immoral law, illegal law, unconscionable law, and the possibility that self-interest groups can aim the cannon of the law toward that which they dislike--including and especially the unborn.

No one is calling for a theocracy. Just a return to the principles of morality that this country was founded upon, not the hedonistic philosophy that sexual freedom is where its at, and if you happen to become pregnant you can destroy the results.

A Constitutional Convention is the only way--The peoples way. From May until Nov. of last year I walked precints and spoke with people about many issues, abortion included. What I found was a large majority who do not want abortion sanctioned or subsidized by our government. I think it worthy of note that those same people who are telling us that the people of this state want abortion are thost same voices that told us we wanted the Equal Rights Amendment just a few short months ago. They were wrong then, and they're wrong now.

ABORTION & RAPE

RAPE is often put forth as an argument in favor of abortion - mainly because of its' emotional impact.

But - what are the facts concerning rape and pregnancy?

PREGNANCY RESULTING FROM RAPE IS EXTREMELY RARE

For example, at a meeting of obstetricians at a major midwest hospital several years ago, a poll, taken of the doctors, who had delivered over 19,000 babies, revealed that not one had delivered a bona fide forcible rape pregnancy. Other reports in various scientific and medical journals confirm the rarity of pregnancy following forcible rape.

WHY IS PREGNANCY FOLLOWING FORCIBLE RAPE SO RARE?

There are a number of reasons. Among them is the fact that most women are fertile, or at a point where they could conceive a child, only a few days out of the month. Another important factor is the evidence that severe emotional trauma, such as that experienced from a forcible rape, may prevent ovulation. (Emotional trauma can affect the body chemistry. For example, if you're suddenly scared, you get a strange feeling in the pit of your stomach - adrenalin is released in your system. Fear releases hormones in your body. If a woman is forcibly attacked, hormones are released and can set up a chemical barrier to her becoming pregnant.)

WHAT IS THE DIFFERENCE BETWEEN FORCIBLE RAPE AND STATUTORY RAPE?

Forcible rape occurs when a woman is actually attacked and forced to submit to intercourse against her will. Statutory rape occurs when a woman consents to intercourse but is under the legal "age of consent" (eighteen in most states). Often cases which receive newspaper publicity or are used in compiling statistics are actually statutory rape rather than forcible rape cases.

Also, a woman facing condemnation by a judgemental society may seek to explain her pregnancy by saying, "I was raped three months ago". Prior to legal abortion on demand, those states which passed laws allowing abortion following rape, saw a substantial increase in the number of alleged "rapes".

ANY WOMAN WHO IS ATTACKED SHOULD GO TO A DOCTOR OR HOSPITAL IMMEDIATELY.

Conception (fertilization) does not take place immediately after intercourse. There are treatments available for a doctor to use to prevent conception immediately following intercourse. The possibility of veneral disease is another reason for seeking immediate medical attention.

Thus, WE DO NOT NEED ABORTION ON DEMAND, which has STRIPPED ALL PROTECTION FROM MILLIONS OF INNOCENT UNBORN CHILDREN to AID THE VICTIM OF RAPE. We do need to EDUCATE WOMEN TO IMMEDIATELY SEEK MEDICAL ATTENTION if they are raped and see that COMPASSIONATE, COMPETENT AID IS AVAILABLE.

BUT, WHAT IF A GIRL DID BECOME PREGNANT?

Even if there is one case of one woman who becomes pregnant as a result of rape, we must be concerned for her welfare -- and for the life of the innocent child. The trauma of the rape has already occurred, and willfully adding a second tragedy cannot relieve the pain of the first. Rather than having to live with the memory of destroying her developing baby, a woman, given care and support, will ultimately be more at peace remembering that, in spite of becoming pregnant against her will, she nevertheless gave her child life and a home (possibly through adoption).

CONCERN BY SOCIETY FOR THE LIFE AND FUTURE OF BOTH HER AND HER CHILD, AND POSITIVE SUPPORT AND ASSISTANCE WITH WHATEVER PROBLEMS SHE MAY ENCOUNTER, IS THE MOST HUMANE SOLUTION FOR BOTH THE MOTHER AND CHILD.

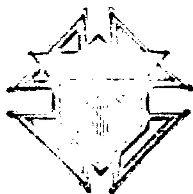
(In her beautiful autobiography, His Eye Is On The Sparrow, Ethel Waters reveals that she was conceived following the rape of her 13 year-old mother at a time when treatment and care were unavailable. Her mother's love and Ethel Waters' value to society were not diminished by the circumstances surrounding her birth.)

WHAT ABOUT ALLOWING ABORTION IN CASES OF INCEST?

An abortion will ultimately be more traumatic to a girl than competent, supportive and loving care to bring her through her pregnancy. (With proper medical care, girls old enough to conceive a child, can be brought through pregnancy very successfully.) Further study, done at Toronto General Hospital on a group of very young patients, found that one out of three suffered complications following abortions which might jeopardize their ability to ever have children again.

Incest means that a family situation exists where help is needed for all involved. Performing an abortion on the girl and returning her to the same environment will not solve her problem, and results in the death of an innocent child.

MCCL
A PRO-LIFE MOVEMENT
4803 Nicollet Avenue Minneapolis, Minnesota 55409
(612) 825-6831



Knights of Columbus

NEVADA STATE COUNCIL

March 26, 1979

TO: THE HONORABLE MEMBERS OF THE NEVADA STATE LEGISLATURE

RE: ABORTION AND A.J.R. 17

The Knights of Columbus of the State of Nevada strongly support the adoption of A.J.R. 17 requesting the Congress of the United States to propose an amendment to the Constitution of the United States to protect human life by restricting abortion. We accept the following:

1. The necessity of protecting innocent human life is one of the fundamental purposes of civilized law and government.

2. The beginning of pregnancy is the beginning of human life.

3. Abortion kills new life that has already begun.

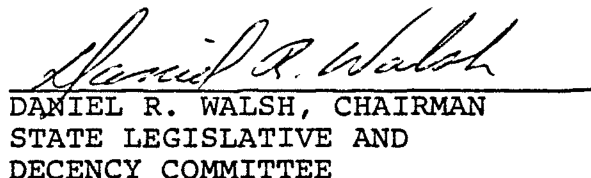
4. It is not a mother's right or freedom to kill or not to kill an innocent unborn child.

5. Permissive abortion laws represent a total rejection of the fundamental values of man.

The Knights of Columbus reject the notion that a human fetus is nothing more than a biological lump that can be disposed of for a variety of reasons--convenience, family planning, dislike of children, or the embarrassment of illegitimacy. We are unwilling to be directed by a moral policy based on individual convenience. We believe in the sacredness of human life from conception to the grave and respectfully urge that this legislature adopt A.J.R. 17 in recognition of these basic human values.

Respectfully submitted,

ADDISON A. MILLARD, STATE DEPUTY



DANIEL R. WALSH, CHAIRMAN
STATE LEGISLATIVE AND
DECENCY COMMITTEE

Historical Arguments Against the Proposed Anti-Abortion Amendment

The politics of moral behavior have a long history that has cut deep into the American experience. On numerous occasions Americans with a particular religious, moralistic outlook on the world, confronting a majority of Americans whose views differed from their own, have claimed the right to impose through law their particular moral values upon the entire society. In short, some Americans have attempted to devise mechanisms of control to make other people behave according to their particular conception of morality. The prohibition crusade and resulting prohibition amendment to the Constitution is the most well-known example of this kind of moral tyranny. The present-day drive to amend the United States Constitution to prohibit abortions throughout this land is a contemporary manifestation of this long-standing tendency for self- appointed spokesmen for the Almighty to present themselves as the guardians of their fellow citizens and the conscience of the nation. Like their prohibition predecessors, these contemporary fanatical crusaders try to control other people through precept and persuasion and, when their means fail, they turn to the power of the state. The right-to-life crusaders have tried to enforce their views on all Americans through the Congress, the Presidency, and the court system. Having failed to accomplish their objectives through these approaches, they now are determined to enforce their minority point of view upon the majority through a constitutional amendment.

This crusade to legislate morality must be resisted because:

1. In a pluralistic democracy such as ours in which we enjoy a separation of church and atate, a vocal, crusading religious minority has no right to force its views upon the whole population through legislative or constitutional mandates. Separation of church and state means freedom from the tyranny of politically enforced religious precepts.
2. Most reasonable citizens agree that national prohibition was a national fiasco because a)it encouraged illegal behavior; b)it was a study in what happens when a minority faction (the prohibitionists did not have the united support of all religious Americans, and neither do present day right-to-life leaders) within the American religious community is allowed to enforce its concept of what is acceptable behavior upon all Americans; c)it did not work; legal drinkers became illegal imbibers; d)it has become a symbol of moral tyranny and the ill-advisability of trying to enforce private morality through amendments of the Constitution; e)a majority of Americans never supported prohibition; it was forced on them by a crusading, emotional, single-minded minority; f)it made the mistake of defining the use of alcohol as a moral issue when in fact it was a much more complex issue; g)the prohibitionists did not believe that citizens could be trusted to exercise self-discipline and individual free choice; and h)it has become a symbol of how unworkable it is to enforce total abstinence by law.

   If the right-to-life crusaders are allowed to achieve their objective, the outcome will be a repetition of the prohibition fiasco. We must oppose this drive to prohibit abortion through a constitutional amendment for the same reasons that a vast majority of Americans repealed the ill-fated prohibition amendment in 1933. The prohibition experiment stands as a vivid historical reminder of the undesirability of allowing religious zealots to use the state to coerce other citizens to conform to certain moral and behavioral expectations.

3. Rather than stopping abortions an amendment would force those desiring abortions to practice illegal abortions.
4. Such an amendment would give the Federal Government unwarranted power to interfere in the personal lives of American citizens. It is interesting that some of the same people who have argued against the Equal Rights Amendment on the ground that it would encourage federal intervention are arguing now in favor of massive federal intervention when it serves their purposes.
5. The proposed anti-abortion amendment is being presented as a moral and religious issue; religious and moral issues cannot be enforced by legal mandates.
6. Such an amendment would ignore the economic and social dimensions of the abortion issue which are as or more important than the religious and moral issues and make the proposed amendment totally unacceptable.
7. Such an amendment would be a study in inequitable, class legialation. Just as the prohibition movement discriminated primarily against the poor and lower middle classes who could not afford the illegal speakeasies, an anti-abortion amendment would primarily affect those in the lower third of the income bracket.

TESTIMONY OF KIM L. HANSEN, EXECUTIVE DIRECTOR OF PLANNED PARENTHOOD OF SOUTHERN NEVADA, INC. BEFORE THE NEVADA STATE ASSEMBLY JUDICIARY COMMITTEE, APRIL 1, 1979, IN LAS VEGAS.

Aside from the divisive religious, moral, ethical and legal implications of AJR 17, there remains an imposing economic implication if this nation adopts a constitutional amendment banning abortion as a result of the convention called for in AJR 17.

Last Thursday the Alan Guttmacher Institute released a study examining in detail the impact of the Hyde Amendment upon public funding for abortions in this country. The Guttmacher study gives us the opportunity to assess and project the potential impact of a total ban of all abortions in the U.S. and Nevada particularly, based upon the experience of America's poor, who are denied access to abortions under the Hyde Amendment.

In 1977, 1.3 million abortions were performed in the U.S., 295,000 paid for by Medicaid for $87 million. In Nevada in 1977, 4,200 abortions were performed, 400 paid for by Medicaid for $157,000.

During 1978 an estimated 205,000 poor women in the U.S. were denied abortions due to the Hyde Amendment. Terminations for these women would have cost the American taxpayers $58.5 million. Instead, the Hyde Amendment forced these women to bear unwanted children at a cost to the people of $342 million.

The situation in Nevada in 1978 was no better. I estimate that 500 indigent Nevadans were forced to bear children against their will in 1978. Terminations for these women would have cost Nevada approximately $131,000. Forced child-bearing by these women cost Nevada taxpayers a projected $1.53 million.

As bad as the situation now exists, with only the poor denied access to abortion in Nevada, the situation will become intolerable if all women are denied freedom of choice. If a constitutional amendment were adopted effective in 1980 to ban all abortions in the U.S., the impact upon Nevada would be devastating. I estimate that under such an amendment a minimum of 6,000 Nevadans would be forced to bear unwanted children in 1980. Over 4,000 of these women (indigents, teenagers and young adults) would be forced by economic necessity to join the Nevada welfare roles. At a projected $3,671 unit cost for prenatal care, delivery and one year of public support, the cost of these unwanted children to Nevada taxpayers would be $14.7 million, and that is only the first year's cost. Support for additional years could cost Nevada hundreds of millions of dollars in unnecessary expenditures. I do not believe that the taxpayers of this state or any other will stand for such expenditures.

Many of our opponents will stress to you that you cannot place a price upon a potential human life. I ask the committee: How can you place a price upon the devastated lives of those women whom you are forcing to bear unwanted children or of the disrupted lives of the unwanted children themselves.

Thank you.

TO THE JUDICIARY COMMITTEES OF THE NEVADA LEGISLATURE EXHIBIT J
4/17/79

I am Cynthia Cunningham, a 25 year resident of Las Vegas and immediate past moderator of the Presbytery of Nevada. I come to suggest that freedom from compulsory pregnancy is not the only question before you. The basic question is the constitutional question of freedom from compulsory religion.

Changing the Constitution of the United States is not a light matter. Opponents of change often refer to it as a divinely inspired document. Certainly it was the product of some of the most creative and courageous minds ever on this Continent. But we must remember that it was also the product of a revolution. The 1776 declaration that all men are created equal was radical. To understand the intent of our founders in declaring liberty and equality as inalienable rights given by God, we must remember our history as a nation.

Our first settlers came to escape religious intolerance in England. Unfortunately, the Puritans in Massachusetts established a theocracy as oppressive to non-believers as the country they had left. The arrogant oppressiveness of intolerant religious domination was a lesson not lost on those who shaped our freedom documents.

The First Amendment guarantee--"Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof"--was intended to grant freedom from any established religion. People are to be free to worship as they choose or to practice no religion at all. To impose on any woman a restriction based on a theological belief not her own is to deny her the most basic freedom granted by those inspired fathers of our country, the freedom to make decisions based on her own religious values.

No one in this room advocates the choice of terminating pregnancy for anyone whose religious belief forbids it. We only ask the same right of private conscience for ourselves.

The Roman Catholic Church condemns abortion. The President of the LDS Church has again reiterated that abortion is a crime next to murder except when the mother's life is in danger. We respect these positions for members of those faiths. But a majority of Americans do not ascribe to the theology of either. What we fiercely resist is placing a restriction of freedom in our Constitution based on a doctrine we do not believe. Such an amendment would prohibit the free exercise of religion.

Many Americans would agree with the Rev. Richard Thompson of Oklahoma City who wrote:

> "If God's greatest concern about a pregnancy is that the human situtation touched by that birth be the most loving and optimal for all involved. . .abortion might be the most moral (though always regrettable) choice.. . I cannot and will not second guess what the will of God is for someone as they struggle with that situation."
> (Source of quotation: Missionscope, a publication of the United Presbyterian Church, U.S.A., January, 1979.)

LEAGUE OF WOMEN VOTERS OF NEVADA
STATEMENT ON A.J.R. 17, MARCH 31, 1979

In 1973, the League of Women Voters of Nevada studied the issue of abortion and reached the following consensus:

Every effort should be made by educators, religious leaders, legislators and parents to equip young people with alternatives to abortion. Since human nature does not seem to take kindly to abstinence, people should have access to information about safe and effective methods of birth control and be able to make use of them to prevent pregnancy. The community should make a concerted effort to inform young people about the serious results of promiscuity since neither the pill nor abortion prevent the incredible rise in venereal disease that Nevada currently faces.

Abortion should not be considered as a method of birth control. However, the League Consensus states that "abortion is a medical matter between the patient and her physician." The League of Women Voters in the United States, The Nevada League, and the League of Women Voters of Las Vegas Valley in all their "humanistic" positions have stressed the quality of life. Unwanted children are frequently abused children and as recent studies have indicated, abused children generally grow up to become child abusers -- creating a tragic circle, which should be considered seriously by responsible people.

Eliminating legal abortion will not solve the problem of unwanted pregnancies and will not stop abortions. It will allow all the illegal abortion clinics formerly run by untrained "butchers" and organized crime to flourish again in the United States.

Although the League has no formal position on Constitutional Conventions, we would like to point out that there are no guarantees that a convention convened to discuss one issue only can be limited to that one issue. Article V of the Constitution which deals with methods of amending the Constitution gives no

direction on how a Constitutional Convention is to be organized and sets no limits on the authority of a Constitutional Convention. No set of rules drawn up by one Congress is binding on another Congress, or on a Constitutional Convention. The only Convention since the original writing of the Constitution was convened in 1787 to change some of the Articles of Confederation. Instead, the Convention threw out the original Articles of Confederation and wrote a whole new charter. To quote Howard Jarvis (on the proposed Constitutional Convention to amend the Constitution to require a balanced budget), "It would put the Constitution back on the drawing board, where every radical crack-pot or special interest group would have the chance to write the supreme law of the land."

Also to be considered, is what has happened in the past when a Constitutional Amendment tried to legislate a "moral" issue: The 18th Amendment, which outlawed alcohol, proved to be unenforceable and was responsible in large part for the power that organized crime gained in the United States. Think of the Federal Bureaucracy that would develop in an effort to enforce a Constitutional Amendment prohibiting abortion. Every miscarriage, D&C, etc., would have to be monitored -- every gynecologist would be suspect -- where would the line be drawn? The Spanish Inquisition would look like child's play by comparison!

TESTIMONY OF E. J. LETOURNEAU
ASSEMBLY COMMITTEE ON JUDICIARY
APRIL 1, 1979

Constitutional Convention would be precedent setting and open our great Constitution to all varieties of alteration such as an amendment against gambling, birth control, sex education; an amendment for a State Church: Mormom, Lutheran, or Catholic, as the Church of England; a national holiday honoring Elvis Presley's birthday.

There are no guarantees against a myriad of amendments being effected through a convention. I object on these grounds and suggest careful consideration as well as rejection of this resolution which is a dangerous move.

Murder itself is not mentioned in the Constitution.

Don't open up the Constitution to specificity. Even though the ERA movement isn't specific, it is only specific in interpretation by its opponents.

If more births are an objective of this proposed amendment, I submit that the next step will be the outlawing of birth control so we can have even more unwanted, unhappy, hungry children uncared for and abused to adulthood. We already have millions of children uncared for, literally roaming the streets and unsupervised.

Our society does not care for these children. It grudgingly feeds them in school and discriminates against them. By race, color, and etc., and otherwise neglects them.

A Constitutional Convention won't solve our societal problems and our designed inflation is not solving them either.

Society is not as concerned with the life of the child as is claimed.

Women in trouble will thumb their nose at the Constitution, not their God. Teach, don't force.

Message from Jean Rambo: Freedom of choice is primary, and abortion should be between a woman and her doctor.

On abortion as an issue. This is an attempt to impose the church philosophies on an entire population, regardless of personal belief. In short--if you become pregnant, you will bear the child by law with no individual choice. We argue against this mandate.

We who oppose this issue of outlawing abortion want a freedom of choice. As a State, we go to Washington and argue state's rights forcefully, and then turn around and deny individual rights on this issue.

If the State or the church truly believes that a fetus of one or two months is an actual human being, why do we not announce the death in our vital statistics and have full church services and burial services for each miscarriage.

I know of deaths by abortion of the daughters of prominent local families. I'm sure they'd be against this resolution.

TESTIMONY OF EVAN WALLACH
ASSEMBLY COMMITTEE ON JUDICIARY
APRIL 1, 1979

I would like to summarily discuss two matters relevant to the convention call here at issue. The proposed convention is aimed at reversing decisions of the United States Supreme Court holding women have a constitutional right to abortion and contraception.

I will quickly review some reasons the Court reached those decisions and then will give some general thoughts about use of the proposed constitutional convention as a means to the end sought.

Before I approach those two points, though, I must express my suprise that among the proponents of this convention there appear so many persons who fought so bitterly against passage of the Equal Rights Amendment. Surprise, because back in November those people argued on two premises. 1) Stop Government Intervention--that ERA would give the Federal Government the power to regulate matters of personal morality; and, 2) That the proposed amendment was fine in principle--nobody, it seemed, was against women's rights,--but that it was too broadly worded. How could we vote for it, they asked, if we couldn't be sure what the effects would be?

As I understand it, the question under consideration is whether to call a Constitutional Convention to write an amendment to restrict abortion. To all those former strict constructionalists out there who opposed the wording of the ERA, I can only say there has either been an awfully rapid change in fundamental beliefs, or somebody is prevaricating.

I might also propound several questions of fundamental moral philosophy. As I understand the proponents of this convention they oppose anything that interferes with fetal development from the moment the sperm enters the egg. That is, I assume they oppose the so-called morning-after pill and other post-coital methods of contraception. Is there any moral difference between that position and opposition to all forms of contraception. They seem to stand for opposition to prevention of fertilization. I submit that attitude embodies the worst aspects of Victorian punitive philosophy and is at odds with reality on an overcrowded planet.

Reasons court reached abortion decision. 1927, Justice Brandeis 227U.S.438,478 observed the framers of the Constitution conferred:

> As against the Government, the right to be let alone--the most comprehensive of rights and the right most valued by civilized men. To protect that right, every unjustifiable intrusion by the Government upon the privacy of the individual, whatever the means employed, must be deemed a violation of the Fourth Amendment.

In Eisenstadt v. Baird, 405U.S.438(1972), the United States Supreme Court reasoned:

> If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.

A number of factors explain the evolution of the Supreme Court's present stance toward abortion and contraception. They include:

1) The belief that unwanted pregnancies and unwanted children pose an unreasonable limitation on a woman's personal liberty--possibly death.
2) A feeling that new life is not necessary the divinely ordained aftermath of sexual intercourse--religious thrust of pro arguments--Congress shall make no law respecting an establishment of religion.
3) The conviction that a doctor should not be threatened with criminal sanctions for performing a medical procedure believed to be in the patient's best interest.
4) The recognition that criminal prosecutions for abortion are seldom brought despite numerous violations of the law.
5) The fact that while affluent women manage to obtain safe abortions, poor women are often butchered by quacks.
6) The rising status of women and the increasing variety of non-procreative roles available to them.

Article V of the U.S. Constitution provides for Amendments. It requires Congress "on the Application of the Legislatures of two-thirds of the several states" to "call a Convention for proposing amendments."

I would point out that once the convention is called, it is not limited as to what it may propose.

Now that method exists. It is, I submit, a safety valve written into the Constitution for only the most dire circumstances. I say this for two reasons:

1) A convention has never been called in this manner, but more importantly,

2) It is a fundamental diversion from our system of government. The ready calling of such conventions to make societal changes on a case by case basis would convert us from a republic with representative government, to something much closer to a parliamentary democracy. You are political animals. The proponents of this bill feel you can be swayed by emotionalism, vocal theatrics, and political threats.

Think for a moment about President John F. Kennedy's historical essays - Profiles in Courage - where a legislator has had the courage to stand up for that which he or she believes.

I would remind this committee that the Nevada Constitution is also subject to the calling of a constitutional convention. Think about the effects on the system of state government if year by year legislative, judicial, and executive decisions were reworked on a constitutional basis.

For goodness sake, look before you leap.

TESTIMONY OF DAVID KATZMAN
ASSEMBLY COMMITTEE ON JUDICIARY
APRIL 1, 1979

My name is David Katzman. My family and I have lived in Las Vegas for 25 years. I am against the proposed legislation for two reasons: the first is that the bill, if enacted, will not eliminate abortion, which has been with us for centuries as a matter of fact. Rather it will again force those who can least afford it to go to midwives, hideaway abortionists who cannot be controlled, and just plain butchers. Once again, there will be many poor, unfortunate women who will die of hemmorhaging and blood poisoning, because they will have their abortions in the many unsanitary and unsafe places that used to abound before abortions became legal. If the proponents of the bill are pro-life, then they should be "pro" the life of the pregnant woman. Somehow she is not to be consulted. This is a bad bill and should be turned down.

The second reason for voting against the bill is that the State is getting into a realm in which it does not belong--namely the freedom of its citizens to make their own free choices. The State of Nevada has always been known as a free state, and should shy away from laws which cannot be enforced. The experience of the Prohibition Amendment should be warning enough. The issue is not Abortion vs. No Abortion. It is abortion under adequate and sanitary conditions and care. Against abortion done by hacks, charlatans, and butchers which endanger the life of the pregnant woman. I am not pro-abortion. I am for the right of a woman perhaps with the consultation of her family, religious leader, and her doctor to make the decision.

Thank you.

THERE ARE OVER 2,000 DISEASES OF KNOWN GENETIC ORIGIN THAT EFFECT 15 MILLION AMERICANS AND ACCOUNT FOR 40% OF ALL INFANT DEATHS. THE MOST WELL KNOWN ARE DOWN'S SYNDROME (MONGOLISM), CYSTIC FIBROSIS, HEMOPHILIA, MUSCULAR DYSTROPHY, TAY-SACHS DISEASE AND SICKLE CELL ANEMIA.

ONE IN 30 AMERICAN JEW IS A CARRIER OF TAY-SACHS DISEASE (TSD), A CRIPPLING AND ALWAYS FATAL DISEASE OF THE NERVOUS SYSTEM. WHILE THE CARRIERS THEMSELVES DO NOT SUFFER FROM TSD, IF THEY MARRY SOMEONE WHO IS ALSO A CARRIER, THEIR CHILDREN HAVE A 1-IN4 CHANCE OF HAVING AND DYING FROM, THE DISEASE. FORTUNATELY THERE IS A SIMPLE BLOOD TEST BY WHICH THE GENE FOR THIS DISEASE CAN -AND SHOULD- BE DETECTED. SCREENING PROGRAMS ARE GOING ON ALL OVER THE UNITED STATES TO IDENTIFY THESE CARRIERS. I COORDINATED THE SCREENING IN LAS VEGAS IN 1976. SEVERAL CARRIERS WERE IDENTIFIED.

IF BOTH PARENTS ARE "AT RISK" (CARRIERS), THERE ARE SEVERAL OPTIONS OPEN TO THEM. THEY ARE:

TAKE THEIR CHANCES
ARTIFICIAL INSEMINATION FROM A NON-CARRIER DONOR
NOT HAVE ANY CHILDREN OF THEIR OWN
ADOPTION
HAVE EACH PREGNANCY TESTED BY AMNIOCENTESIS

WHAT HAPPENS IN TAY-SACHS DISEASE?

MOST TAY-SACHS BABIES ARE BEAUTIFUL. THEY HAVE CLEAR, TRANSLUCENT SKIN WITH A PINK, DOLL-LIKE COLORING AND LONG EYELASHES. THEY APPEAR HEALTHY AT BIRTH AND DEVELOPE NORMALLY FOR THE FIRST THREE TO SIX MONTHS. GRADUALLY THE CENTRAL NERVOUS SYSTEM DEGENERATES BECAUSE OF THE PROGRESSIVE ACCUMULATION OF EXCESS FATTY SUBSTANCES IN THE BRAIN. BY THE TIME THE CHILD IS 8 TO12 MONTHS OLD, PHYSICAL AND MENTAL DETERIORATION IS OBVIOUS.

PARENTS NOTICE MILD MOTOR WEAKNESS AND AN INCREASE STARTLE RESPONSE TO SUDDEN SOUND. WITH IN A FEW MONTHS HE CAN NO LONGER SIT UNASSISTED; MUST BE PROPPED. HE DOES NOT FIX HIS EYES WELL DUE TO FAILING VISION. SOON THE INFANT CEASES TO SMILE, REACH OUT, RESPOND TO SOCIAL STIM-ULI. ULTIMATELY, BY 18 MONTHS USUALLY, THE CHILD BECOMES PARALYZED, BLIND AND DEAF.

MEDICAL MANAGEMENT BECOMES MORE DIFFICULT. THE CHILD MUST BE TUBE FED BECAUSE HE HAS DIFFICULTY IN SWALLOWING; HE MUST BE ASPIRATED OR CHOKE TO DEATH; HEMUST BE TURNED REGULARLY TO PREVENT BEDSORES; HE MAY BECOME CONSTIPATED AND REQUIRE MANUAL EVACUATION OR ENEMAS. EVENTUALLY HE DEVELOPES SEIZURES THAT MAY OCCUR AS OFTEN AS EVERY HOUR.

HOSPITALIZATION IS USUALLY BEGUN AFTER THE CHILD IS 16 MONTHS OF AGE. SOME PARENTS ARE ABLE TO KEEP THEIR CHILDREN HOME WITH A GREAT DEAL OF SUPPORT AND HELP. IN EITHER CASE, LONG-TERM INTENSIVE CARE FOR TWO OR THREE YEARS IS REQUIRED. THE CHILDREN USUALLY DIE BETWEEN THE AGES OF THREE AND FIVE OF BRONCHOPNEUMONIA; THE AVERAGE IS 40 MONTHS.

APPROXIMATELY 50 BABIES ARE BORN EACH YEAR WITH TSD. TREATMENT VARIES BETWEEN $10,000 AND 50,000 PER YEAR PER CHILD.

WHAT CAN BE DONE FOR A BABY WITH TSD ?

NOTHING. THIS IS THE MOST HEART-BREAKING BUT THE MOST HONEST, ANSWER THAT MEDICINE CAN PRESENTLY OFFER. THERE IS NO CURE OR TREATMENT THAT WILL PREVENT THE DISEASE FROM RUNNING ITS DOWNWARD COURSE. THERE ARE NO EARLY PROSPECTS FOR A CURE.

UNTIL PRE-NATAL DIAGNOSIS BECAME A POSSIBILITY, FEW COUPLES DARED TO RISK THE BIRTH OF ANOTHER CHILD ONCE THEY HAD GONE THROUGH THE EXPERIENCE OF HAVING A TAY-SACHS BABY.

TODAY, EACH PREGNANCY CAN BE TESTED BY AMNIOCENTESIS. WHEN THE FETUS IS 12-14 WEEKS OLD, A TEST CAN BE MADE TO ASCERTAIN IF IT IS AFFLICTED. IF NOT - AND THE TEST HAS PROVED TO BE 100% ACCURATE- THE PARENTS ARE FREED OF THE EXCRUTIATING ANXIETY AND CAN CONTINUE THE PREGNANCY KNOWING THEIR CHILD WILL NOT BE AFFECTED.

A PREGNANCY IN WHICH A FETUS WITH TSD IS IDENTIFIED COULD BE ELECTIVELY TERMINATED IF THE COUPLE SO CHOOSES. IN THIS WAY COUPLES "AT RISK" MAY SELECTIVELY HAVE ONLY UNAFFECTED CHILDREN AND NOT FACE TSD IN THEIR OFFSPRING. WHAT WOULD YOU CHOOSE?

IN EVERY INSTANCE A TSD FETUS HAS BEEN DETECTED THE PARENTS HAVE CHOSEN ABORTION. TODAY ONLY UNINFORMED COUPLES NEED EVER SUFFER THE ANGUISH OF LEARNING THAT A SEEMINGLY HEALTHY CHILD IS DOOMED BECAUSE OF TSD.

A CONSTITUTIONAL AMENDMENT AGAINST ABORTION WOULD DENY THE PARENTS OF THESE AFFLICTED CHILDREN THEIR RIGHT TO CHOOSE THE QUALITY OF DEATH FOR THEIR CHILD.

I OPPOSE THE RESOLUTION REQUESTING A CONSTITUTIONAL CONVENTION TO CONSIDER SUCH A DISTRUCTIVE ACTION ON THE RIGHTS OF THE INDIVIDUAL.

HELEN MYERS
2304 WINDJAMMER WAY
LAS VEGAS, NEVADA 89107

EXHIBIT O
Page 4 of 15

Currently, some 943 dominantly inherited disorders have been catalogued. Examples include:

- achondroplasia—*a form of dwarfism*
- chronic simple glaucoma (some forms)— *a major cause of blindness if untreated*
- Huntington's disease— *progressive nervous system degeneration*
- hypercholesterolemia— *high blood cholesterol levels, propensity to heart disease*
- polydactyly—*extra fingers or toes*

Recessive inheritance—Both parents of an affected child appear essentially normal, but by chance, both carry the same harmful gene although neither may be aware of it.

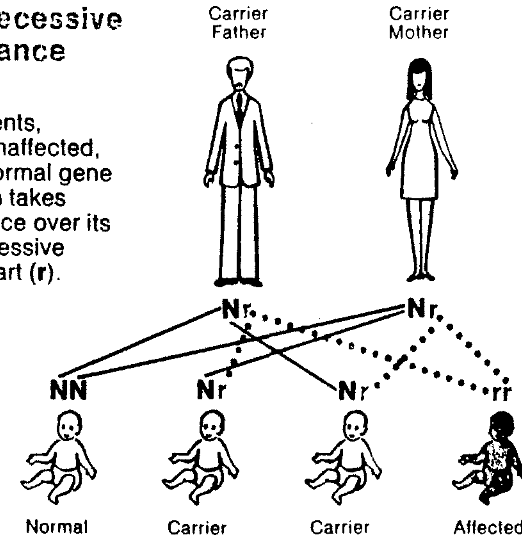
Unfortunately, the child who receives the defective gene from both parents may have a significant birth defect. As a rule, recessive abnormalities tend to be more severe than dominant ones, but they are also less likely to occur.

When both parents are carriers of a harmful recessive trait, each of their children will run a 25 per cent (1 in 4) risk of manifesting that genetic disease. Each child will also have a 25 per cent chance of *not* inheriting the gene from either parent; and each has a 50/50 chance of receiving only a single defective gene and becoming a carrier of the genetic trait like both parents. Should the carrier-child ultimately marry another carrier, he or she runs the same risk as his parents of transmitting the disease to the next generation.

Among 783 recessively inherited disorders catalogued are:

- cystic fibrosis— *disorder affecting function of mucus and sweat glands*
- galactosemia—*inability to metabolize milk sugar*
- phenylketonuria—*essential liver enzyme deficiency*
- sickle cell disease— *blood disorder primarily affecting blacks*
- thalassemia—*blood disorder primarily affecting persons of Mediterranean ancestry*

- Tay-Sachs disease— *fatal brain damage primarily affecting infants of East European Jewish ancestry*



The odds for each child are:
1. a 25% risk of inheriting a "double dose" of **r** genes which may cause a serious birth defect
2. a 25% chance of inheriting two **N**s, thus being unaffected
3. a 50% chance of being a carrier as both parents are

X-linked inheritance (sometimes called sex-linked)—Normal females have two X-chromosomes. Normal males have one X and one Y. The most common X-linked abnormalities occur when the mother carries a faulty gene on one of her X chromosomes. In such a case, each son has a 50/50 risk of inheriting that gene and manifesting the disorder. Each daughter has an equal chance of being a carrier like her mother, usually unaffected by the disease, but capable of transmitting it to her sons.

Tay-Sachs: Prototype for Prevention of Genetic Disease

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Tay-Sachs: Prototype for Prevention of Genetic Disease

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This most common of the sphingolipidoses can be effectively prevented if adult carriers of the recessive anomaly are detected and appropriate pregnancies monitored, followed by therapeutic abortion of homozygous fetuses. The authors describe the research through which an accurate, rapid assay for the enzyme defect was developed and the way in which the findings were applied in a program of mass screening for carriers.

One day in May 1971 some 1,800 men and women presented themselves at a Washington, D.C., synagogue as part of a pioneering experiment in the delivery of new medical knowledge. During a seven-hour period, three quarters of these people had blood drawn for a simple serum test to detect heterozygous carriers of the autosomal recessive disorder called Tay-Sachs disease.

It was the first voluntary community-based attempt at mass screening of adults for carriers of a genetic abnormality. It was remarkable for another reason as well. The enzyme deficiency responsible for Tay-Sachs disease had been identified only two years earlier. Since then the enzyme assay had been automated, making it possible to complete 300 serum assays per day. In addition, the organizational and educational action required for a mass screening program had been carried out. In only two years the basic scientific understanding of this uniformly fatal neurodegenerative childhood disorder had become available for large-scale application to the population.

Continuation of the screening program in the Ashkenazi Jewish population in the Washington-Baltimore area has led to the testing of nearly 10,000 individuals. It is known that Tay-Sachs disease occurs 100 times more frequently in Ashkenazi Jews than in other Jewish groups and non-Jewish populations. Similar community screening programs have begun or are being planned in at least 40 cities, not only in the United States but in Canada, England, Israel, South Africa, and other countries. The reasons for widespread interest in such programs is *not* that TSD is that common, even amongst Jews, but rather that a simple blood test allows for complete prevention of this tragic genetic disease and at the same time enables couples, even if genetically at risk, to have unaffected children. Blood testing can determine whether or not a couple are at risk for TSD in their offspring. The infrequent couples identified to be at risk can then elect to have their pregnancies monitored (by amniocentesis) and selectively complete only those pregnancies in which an unaffected fetus is identified. Since accurate antenatal detection of TSD became available, more than 100 pregnancies at risk for TSD have been monitored to date (predominantly in families that have previously had TSD children). Approximately one fourth of these pregnancies were terminated electively after the fetus was found to have Tay-Sachs disease. The remaining pregnancies have produced unaffected children, as predicted.

We believe that the basic procedures adopted for the screening programs in Washington and Baltimore provide a model for the prospective prevention of other autosomal recessive diseases. Prevention by therapeutic abortion, however, must be considered a temporary and imperfect alternative. It is to be hoped that continued research will result in the discovery of an effective treatment or a cure for Tay-Sachs disease. Until that happens, carrier identification, prenatal diagnosis, and abortion of affected fetuses can prevent the tragedy of the birth of a Tay-Sachs child.

In short, just as phenylketonuria represents a prototype for screening newborns for treatable genetic disease, Tay-Sachs provides a model for mass screening of adults to locate couples at risk for recessive disorders prior to the conception of affected offspring, thereby making prospective prevention possible. Since the prospects for effective treatment or cure are now remote, the need for the interim prevention program is likely to remain for some time.

Genetic or genetically related conditions account for a significant proportion, perhaps 10% to 20% of all pediatric

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The progression of Tay-Sachs disease is illustrated in this sequence of photos showing the same child. At left above, at age 3½ months, he is asymptomatic and appears to be developing normally. Although a month later he was able to sit with little or no help, by age 7 months (at right above), early regression was apparent and he could no longer sit alone. He also displayed

hospitalizations, with hereditary neurologic disorders being especially prominent. Of the 420 or so autosomal recessive conditions already known, many occur more frequently in specific populations where screening might be highly effective—for example, sickle cell anemia in blacks, thalassemia in Italians, and cystic fibrosis in Anglo-Saxons.

Mass screening is not something that can be embarked upon casually, however. The mere suggestion that an individual or a group may have "bad genes" can arouse significant anxieties. Clearly the screening test must be accurate, and experienced genetic counselors are required to guide individuals who are identified as carriers. A screening program should be able to offer those screened a positive course of action if they are shown to be at risk. It is our belief that if the program cannot offer an alternative of treatment, cure, or at least prevention without limitation of individual freedom of choice in mate selection or procreation, it should not be undertaken on a large scale. These matters will be discussed in more detail later.

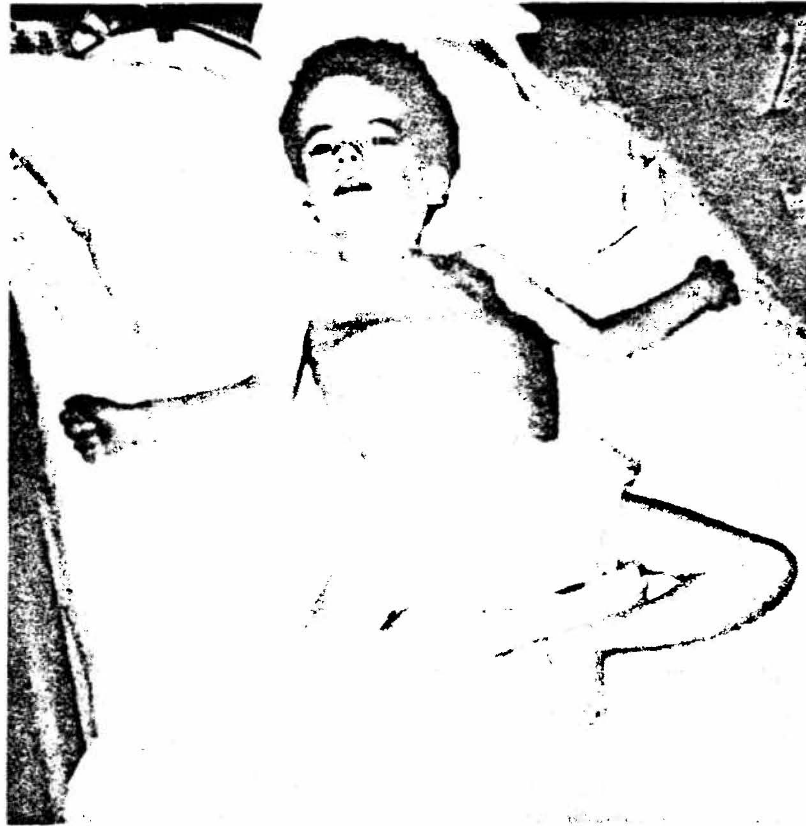
The Tay-Sachs Child

Tay-Sachs disease is the most common form of sphingolipidosis. Several thousand infants have died with this disease since it was recognized and characterized late in the 19th century. The typical course of a patient with the disease is illustrated in the photographs at the top of these pages. Most Tay-Sachs babies are beautiful. They have clear, translucent skin with pink, doll-like coloring and long eyelashes. They appear healthy at birth and develop normally for the first three to six months. Gradually, however, the central nervous system degenerates because of the progressive intraneuronal accumulation of excess amounts of the sphingolipid ganglioside G_{M2}. By the time the child is 8 to 12 months old, physical and mental deterioration is usually obvious.

Some of the first signs of deterioration noted by parents are mild motor weakness and an increased startle response to sudden sound. The child usually develops the ability to crawl and sit up unaided; he may even be able to pull to standing. But within a few months he can no longer sit unassisted and must be propped. The mother may also notice that he does not fix his gaze well; his eyes wander because of failing vision. Soon the infant ceases to smile or react to social stimuli. Ultimately, usually by 18 months, he becomes paralyzed and blind.

As the disease progresses, medical management becomes more difficult. The child must be tube fed because he has difficulty swallowing; secretions may pool in the bronchi and must be aspirated; he must be turned in bed regularly to avoid pressure sores; he may be constipated and require manual evacuation, enemas, or cathartics; eventually he develops seizures that may occur as often as once an hour. These respond initially to anticonvulsant therapy but later become refractory.

Diagnosis is generally made within



decreased muscle strength and coordination, was less interested in his environment, his eyes tended to wander, and he exhibited a striking startle response to minimal sounds. Hospitalization became necessary at 18 months. At left above, at 38 months, seizures, blindness, and severe retardation were present. Final photo was made at 42 months; the child died two months later.

9 to 12 months after birth. The children usually die between the ages of three and five, frequently because of bronchopneumonia; the average age at death is 40 months.

Hospitalization is usually begun after a child has reached the age of about 16 months. Some parents wish to keep their child at home and can care for the problems indicated above with support and help. In either hospital or home, long-term intensive care for two to three years is required. In some facilities, 24-hour nursing care may cost as much as $180 a day. Hospital costs – when suitable facilities can be found – vary between $10,000 and $50,000 a year. Until prenatal diagnosis became a possibility, few couples dared to risk the birth of another child once they had gone through the experience of having a Tay-Sachs infant.

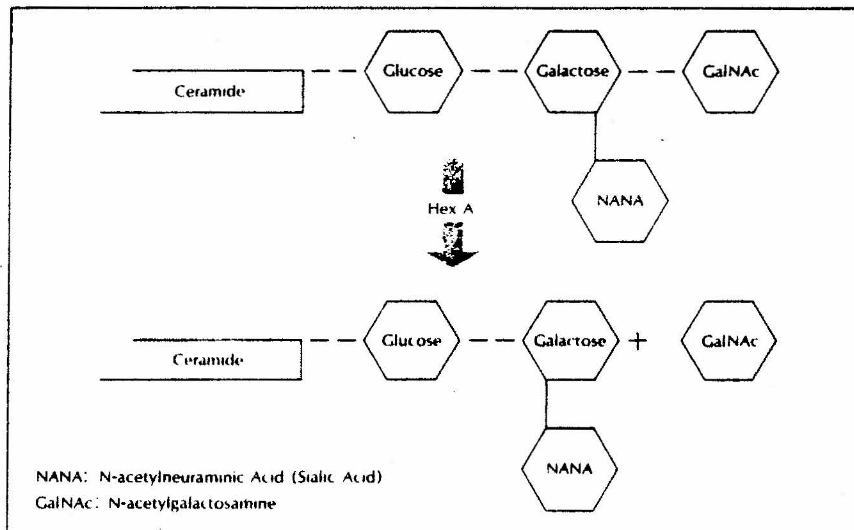
Early History and Genetics

Demographic studies by Stanley Aronson, Professor of Pathology at Downstate Medical Center, Brooklyn, and Ntinos Myrianthopoulos, at the National Institute of Neurological Diseases, demonstrated that the ancestors of the majority of Jewish cases of Tay-Sachs disease in the United States can be traced to the northeastern provinces of Poland, Western Russia, and those neighboring upon the Baltic Sea (Kovno, Suwalki, and Grodno). Very few originated in the Western Balkan zones or Germany. The reason for maintenance of the high gene frequency for TSD amongst Ashkenazi Jews is obscure. Such explanations as consanguinity, selective advantage for the heterozygote, founder effect, and genetic drift have all been invoked as contributing factors.

The modern history of the disorder began in 1881 when Warren Tay, a British ophthalmologist, described the first recorded case. He reported eyeground changes in a one-year-old child with pronounced muscular weakness. He also described one of the characteristic features of the disease, the so-called cherry-red spot (see the illustration on page 111), as follows: "In the region of the yellow spot in each eye a conspicuous, tolerably defined large white patch, and showing in its center a brownish-red, fairly circular spot, contrasting strongly with the white patch surrounding it."

The cherry-red spot is not diagnostic for Tay-Sachs disease. While almost all children with the disorder have this abnormality, there are at least half a dozen different storage disorders in which cherry-red spots occur. The spot can be seen as early as the first few days of life. The red spot is not in itself abnormal, since it represents the normal vasculature of the foveal retina; it is the accumulation of lipid in ganglion cells adjacent to the fovea, resulting in the white halo, that is pathologic.

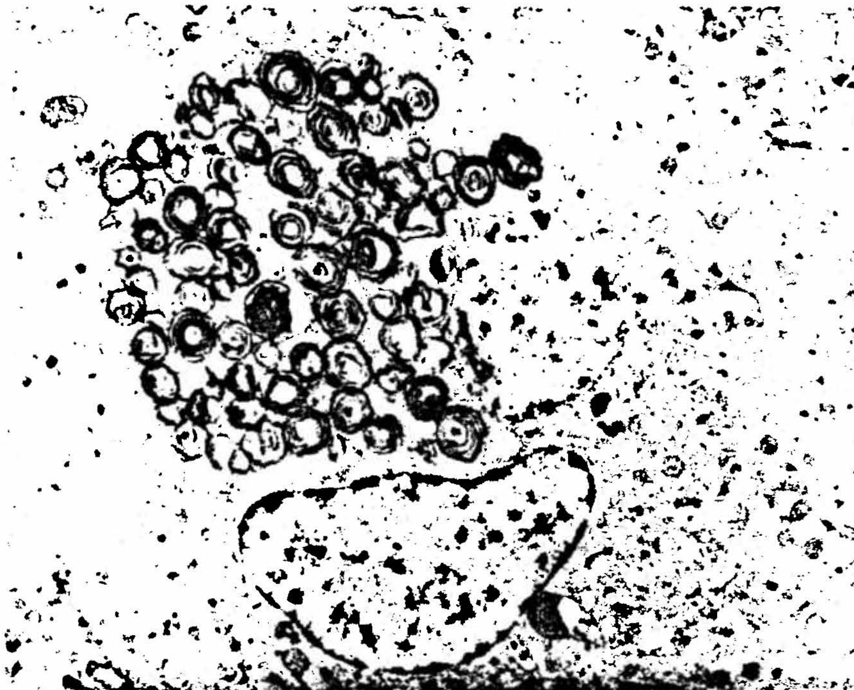
Tay subsequently saw two more children with similar symptoms in the same family, and another in a second family. Then, in 1887, the American neurologist Bernard Sachs gave the first pathologic description of the dis-



Hexosaminidase A (Hex A) is a lysosomal hydrolase, which, as illustrated above, acts to catalyze the cleavage of N-acetylgalactosamine (Gal NAc) from ganglioside G_{M2}.

ease after studying 19 cases from several families. By 1898, Sachs concluded that this was a hereditary degenerative disease characterized by three principal manifestations: the arrest of all mental processes, progressive weakening of the muscles terminating in general paralysis, and rapidly developing blindness associated with changes in the macula lutea, development of the cherry-red spot, and optic atrophy. Sachs also recognized that the disease was a lipidosis, since neurons in the nervous system – predominantly in the central nervous system but also in the periphery – were engorged with lipid material.

Tay-Sachs disease is transmitted as an autosomal recessive trait. Parents of affected children are clinically normal and both have hexosaminidase A function that is intermediate between those of patients and normal subjects. Sex ratios are nearly equal. Analysis of pedigrees, correcting for incomplete ascertainment of matings of two heterozygotes, gives ratios of approximately one affected child to every three unaffected children. In utero diagnosis of fetuses conceived from the matings of two heterozygotes demonstrated that in 39 instances 9, or 23%, were affected, a value close to that expected. Drs. Aronson and Myrianthopoulos have estimated, from mortality records, that in the United States as many as 1 out of every 30 Ashkenazi Jews is heterozygous for the trait. Using enzyme assays to detect heterozygotes, a frequency of 1 in 27 was found in the Washington Jewish population and 1 in 23 in Baltimore by Kaback and Zeiger. Among non-Jews or Sephardic or Oriental Jews, the heterozygote frequency is estimated at 1 in 300. Using overall statistics one can calculate that 50 children will be born with the disease in the United States this year, of whom 40 to 45 will be of Ashkenazi Jewish origin.



Electron micrograph of a neuron (x16,000) shows accumulations of lipid (ganglioside G_{M2}) in form of many concentrically arranged, membranous cytoplasmic bodies.

The Enzyme Defect

The biochemical history of Tay-Sachs disease began when the late Ernst Klenk, Professor of Chemistry at Cologne University, described a massive accumulation of gangliosides in brain tissue of affected children in 1942. Twenty years later Lars Svennerholm, Professor of Biochemistry at the University of Gothenburg, identified the specific lipid as ganglioside G_{M2} and characterized its structure. Ganglioside G_{M2} is one of seven or eight different gangliosides normally present in man's brain, but in Tay-Sachs disease it accumulates to levels 100 to 300 times normal.

The ganglioside accumulation could be explained by excess synthesis, diminished degradation, or both. Several pieces of evidence suggested decreased degradation as the most likely mechanism. First, ganglioside G_{M2} accumulates in structures that resemble altered lysosomes. Second, the normal brain contains lysosomal hydrolases capable of breaking down ganglioside G_{M2} by sequentially cleaving off sugar molecules. This made the deficiency of a lysosomal hydrolase a conceivable explanation for Tay-Sachs disease.

This hypothesis was strengthened by the findings of Dr. Roscoe Brady and his coworkers at the National Institutes of Health that in several other lipid storage diseases the absence of a specific degradative enzyme accounts for the accumulation.

When British workers in 1968 reported the existence of two hexosaminidases in normal human spleen tissue, Drs. Shintaro Okada and O'Brien, working at the University of California, San Diego, recognized that one or both of these enzymes could be involved in ganglioside G_{M2} degradation by cleaving the terminal beta-linked *N*-acetylgalactosamine (see illustration on page 110). When frozen tissue from Tay-Sachs children was examined, it was found that one of the enzymes, hexosaminidase A (Hex A), was missing. The absence of Hex A was demonstrated in freshly drawn serum and leukocytes from patients and in skin fibroblasts growing in tissue culture.

Okada and O'Brien also demonstrated that Hex A and B are found in normal human brain, liver, kidney, skin, leukocytes, serum, and cultured skin fibroblasts, and that Hex A is missing from all these tissues in patients with Tay-Sachs disease. They also established that both enzymes are present in cells cultured from amniotic fluid obtained during the second trimester of normal pregnancy and that parents of affected children have lower than normal levels of Hex A.

Funduscopic view of the eye in a child with Tay-Sachs disease shows the cherry-red spot (arrow) characteristic of this disorder and several other lipid storage conditions; typically a yellow ring surrounds the spot, first described by Tay.

Prenatal Diagnosis

These findings laid the foundation for both prenatal diagnosis and carrier detection. Just a few days after the first publication (in 1969) of Hex A data a woman telephoned O'Brien. She had borne a Tay-Sachs child eight years before and was 13 weeks pregnant. She said that if she could be confident that the baby would not have the disease she would continue the pregnancy because she and her husband wanted another child. If the answer was uncertain, she was considering terminating the pregnancy by therapeutic abortion, since she could not face the tragedy of another Tay-Sachs baby.

Fluid was obtained by amniocentesis and Hex A was found in both the amniotic fluid and the cells. O'Brien indicated that the baby very likely did not have Tay-Sachs. Five months later she delivered a baby girl. Serum assay of the umbilical cord blood showed normal Hex A activity. O'Brien examined the child when she was 14 months old and she was developing normally; serum Hex A assay demonstrated that she was heterozygous. Another laboratory in which the prenatal diagnosis for Tay-Sachs was carried out was that of Dr. Lawrence Schneck of Kingsbrook Medical Center in Brooklyn. All told, more than 100 pregnancies have been monitored for Tay-Sachs disease, 39 of them in O'Brien's laboratory alone. These are predominantly in couples who have previously had TSD children. Now, however, some at-risk pregnancies are being monitored in couples who have not had a TSD child but who have been identified in screening programs.

The fluorometric assay for serum developed by Okada and O'Brien was modified to permit assaying of Hex A in amniotic fluid, uncultured cells, and cultured amniotic cells. Amniocentesis for diagnosis of Tay-Sachs disease in utero is best carried out between the 14th and 16th gestational week. By this time there is enough fluid so an adequate sample can be obtained and yet there is still time for the cells to be cultured before the optimal time for an abortion has passed.

In laboratories with well-developed expertise in growing amniotic cells, the results of all three assays should be consistent. In our laboratories, for instance, we assay the fluid itself and cells sedimented from the fluid. We confirm the results of these two assays by assaying the cultured cells when they have grown out – in from 10 days to four weeks. The results on the cultured amniotic cells are the most reliable, since they produce a greater spread of values between affected and nonaffected individuals (heterozygotes and normal homozygotes).

Among the 39 monitored pregnancies at the University of California, San Diego, there were nine fetuses deficient in Hex A. Eight of the pregnancies could be terminated safely, and were. Diagnosis of Tay-Sachs disease was confirmed in seven by means of electron microscopy, ganglioside analysis, and enzyme assays; one fetus was unavailable. On the average there was a 30-fold increase over normal levels in cerebral ganglioside G_{M2} levels in the affected fetuses. In the ninth affected pregnancy amniocentesis was

carried out too late to end the pregnancy artificially. The child is now over two years, has absent Hex A activity, and demonstrates the clinical manifestations of Tay-Sachs disease. In the remaining 30 pregnancies, enzyme assays indicated the children were not affected; and of the babies born to date, all have had adequate levels of Hex A and are free of the disease.

Amniocentesis for Tay-Sachs should not be attempted unless 1) an obstetrician experienced in midtrimester amniocentesis carries out the procedure, 2) the parents have been counseled concerning the procedure and its implications and risks by an experienced clinician, and 3) arrangements have been made for the determination of the enzyme in a laboratory with expertise in hexosaminidase A assays. Numerous pitfalls, which include an improperly done amniocentesis, an inadequate specimen, bacterial growth in the sample, and artifactual inactivation of the enzyme due to shipment problems or poor laboratory technique, can be avoided by careful planning so that the ultimate disaster of a false-positive or false-negative diagnosis will not occur. When these requirements have been met in the past, to our knowledge no errors in diagnosis have been made. Should there be any question about these matters, the mother should be referred to one of the major centers in the United States that are capable of providing these services.

To develop an effective therapy, many laboratories are now trying to characterize the basic molecular defect responsible for the Hex A deficiency, with the ultimate aim of trying to find a way to activate production of the missing enzyme or replace it. Intravenous administration of Hex A in matched plasma from normal donors has been attempted by O'Brien and others; however, dozens of infusions in patients at various stages of illness have produced no clinical improvement.

Carrier Detection

Unfortunately for the parents involved, Tay-Sachs disease is typical of other autosomal recessive diseases in that it occurs principally in families where it has not been known before. A study conducted 40 years ago by Slomé, involving 88 sibships and 130 cases of Tay-Sachs disease, revealed that 82% of the cases marked the first appearance of the condition on either side of the family. Thus, if one waits for proband cases to occur, only about 20% of the total cases are preventable. In order to detect the majority of the cases prenatally it is necessary to identify at-risk matings before they reproduce.

The fundamental procedure for carrier detection is the fluorometric assay devised by O'Brien et al, which estimates the activity of both Hex A and Hex B in serum. A slightly different version of the same assay is used for leukocyte analysis. The basic assay was modified somewhat by Kaback and his associates when he was at Johns Hopkins to permit the screening of serum from large numbers of individuals.

The assay of Hex A and B depends upon the difference between the heat stability of the two enzymes. Hex A activity is rapidly destroyed by heating, while that of Hex B is not. The serum assay is so sensitive it can be performed on a drop of blood from a heel stick in an infant, although collection of a larger sample is usually preferred so that multiple tests can be carried out. While the serum analysis is simple enough to be conducted in any hospital laboratory, it requires critical internal quality control to provide accurate, reproducible results.

As the assay is used in our laboratories, primary serum screening can positively identify 97% of those tested as either carriers or noncarriers of the Tay-Sachs gene. The remaining 3% fall into an inconclusive range, arbitrarily defined to avoid false-negative and false-positive results. These "inconclusive" subjects are retested with the more accurate leukocyte assay, which gives greater than 99% confidence in genotype designation. In noncarriers, 50% to 75% of their total hexosaminidase activity is heat labile (Hex A); in carriers, this value is 20% to 45%. To be classified as a carrier, a subject must have three consecutive duplicate serum determinations in the carrier range. Two consecutive determinations in the higher

Starch gel chromatographs of liver tissue obtained from four aborted TSD fetuses (numbered) and two normal (N) aborted fetuses show that while Hex B is present in both groups, Hex A activity is missing in the livers of the affected fetuses.

range are sufficient for noncarrier designation.

Hex A activity in the serum may reflect many factors extraneous to the Tay-Sachs gene, such as medications, pregnancy, and systemic illnesses, e.g., diabetes and hepatitis, which may give unreliable data regarding carrier status. For example, the serum assay in pregnant women after the fourth week of pregnancy or in some women taking birth control medications may falsely indicate carrier Hex A levels. However, the leukocyte assay remains accurate in both instances. Although the leukocyte method is more accurate it is also more laborious and costly, making it less desirable as a screening test.

Approximately 350 individuals out of the first 10,000 screened in the Washington-Baltimore program were "inconclusive" after initial serum testing. Leukocyte assays on over 300 of these subjects allowed all but four to be accurately genotyped. These four probably represent genetic variants for Hex A, since other members of their families also had inconclusive serum and leukocyte Hex A levels. In any couple in which both partners are found to be carriers by serum assay, confirmatory leukocyte assays should be carried out and family studies conducted in order to corroborate these findings.

Mass Screening

Three criteria that make prospective prevention of TSD feasible are: 1) it occurs principally in a defined population group so that selective screening is possible; 2) there is a simple, accurate, and inexpensive carrier detection test; and 3) the condition can be detected in an affected fetus early enough in pregnancy to permit selective abortion if the parents so desire, and to enable at-risk couples to have unaffected offspring.

If mass screening can be justified because it provides a positive alternative, it still must be undertaken with human values foremost in mind. Careless planning, premature announcements, incorrect information, or improperly delivered results can have disastrous effects on those who are supposed to be helped by the program.

Those planning a voluntary community-based screening program should first determine which of two basic strategies to employ: to attempt to reach a major share of the population at risk or to make a service available on a limited scale to those who happen to learn of the service and come in spontaneously. The choice will depend not only on a given community's needs but also on the resources available. If voluntary community-wide screening is decided upon, the planners will have to be prepared for a detailed organizational effort, with carefully planned public education.

The planners should also decide just who will be screened. Because facilities and personnel were limited and because of potentially greater psychologic problems and misunderstandings in teenagers, the Washington-Baltimore testings were confined to men and women of childbearing age, and principally to married or engaged individuals. If a woman was more than four and a half months pregnant neither she nor her husband was tested because time would be inadequate to carry out the required procedures and for the information to be useful in that pregnancy. If the woman was less than four and a half months pregnant, only her husband ("pregnant husband") was tested, since her *serum* test would be likely to give a spurious result. If his serum test indicated he was a carrier or if it was inconclusive, both man and wife were immediately asked to come to the hospital for leukocyte and repeat serum assays. Serum screening of "pregnant husbands" was given priority to minimize "deadline" problems.

If the target population is sufficiently large, a community-wide program is a rational way to bring genetic screening and counseling to those who need it. This sort of program requires long and complex preparation, however, and should not be attempted unless the planners are thoroughly committed to meeting the responsibilities it will eventually generate. The strategy and planning sequence of the Washington-Baltimore program is illustrated on page 114.

One of the major foundations of a large screening project should be a strategically planned educational program. This must start many months in advance of the screening itself. In the project at Johns Hopkins, 14 months of planning and education preceded public announcements of the first screening session. The only technical work done during this period of time was development of the automated assay and trials of the technique in parents of affected children and with hospital personnel.

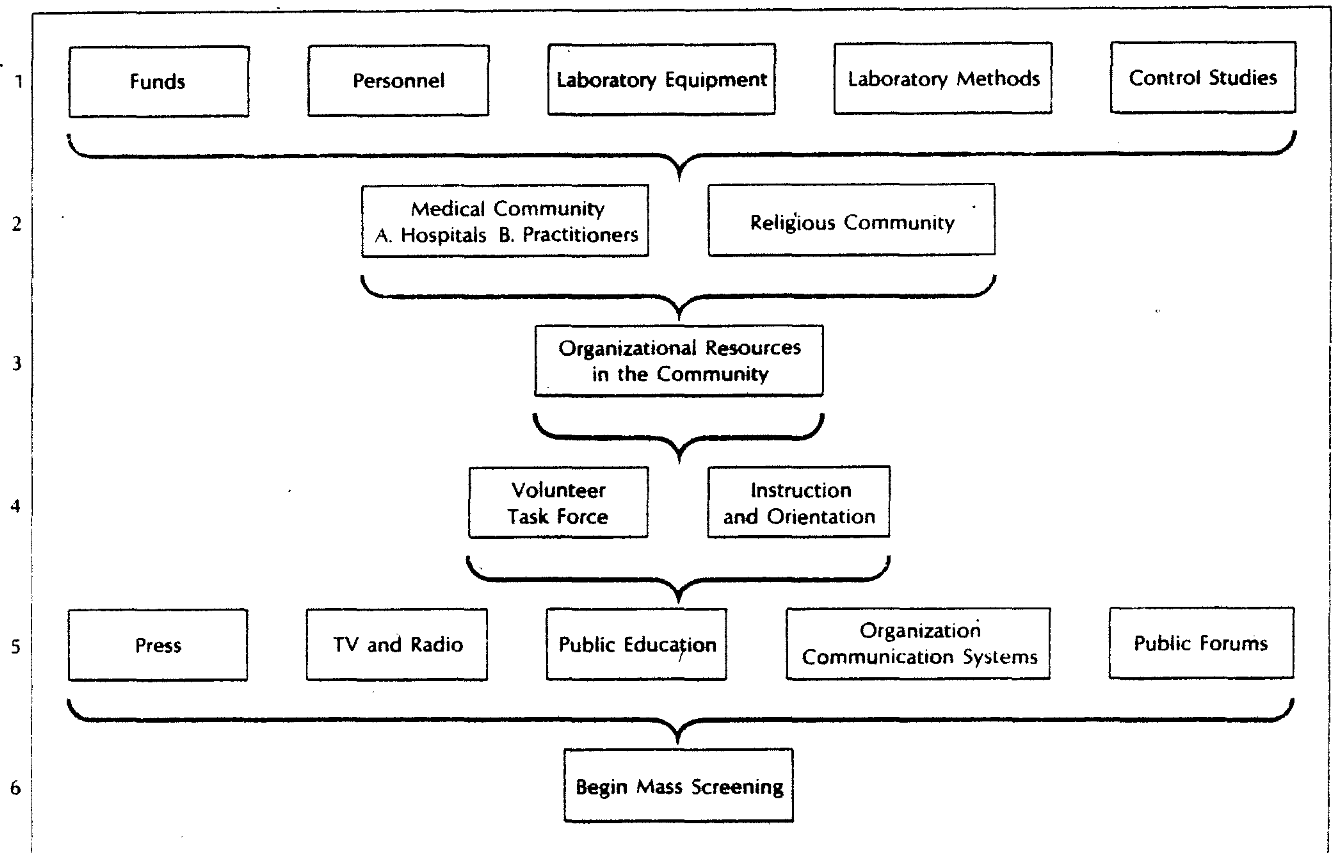
Prenatal Diagnosis of Tay-Sachs Disease: Experience at University of California, San Diego (to January 1973)

Pregnancies monitored (both parents heterozygous)			39
Fetuses homozygous			9
Aborted		8	
Analyzed and confirmed	7		
Unavailable	1		
Born		1	
Diagnosis at 27 weeks of gestation has clinical TSD (now age 2)			
Fetuses heterozygous			30
Born		28	
(All have adequate Hex A)			
In utero		1	
Aborted		1	
(Chromosomal abnormality)			

Perhaps the first step in education is to reach the medical community. Most practicing physicians are unfamiliar with rare genetic conditions such as Tay-Sachs disease and unlikely to know of the latest advances associated with them. This is understandable, since only 10 years ago less than one quarter of the medical schools in the United States offered any formal course work in medical genetics.

If a physician is informed, he can support the screening effort when one of his patients asks about it: "Yes, it's a rare disease and the chances are remote that it will affect you. But I believe you should consider being tested since the information is helpful however the results come out." A doctor who is uninformed, on the other hand, may dismiss the program as wasted effort on the part of ivory tower scientists.

A second audience that needs to be reached in any screening project involving minority populations is the



The strategy of a voluntary, community-wide screening program aimed at prevention of a genetic disease requires a carefully staged sequence of efforts, as indicated above. Without the basic knowledge and funds (stage 1) the necessary educational work (2) cannot be undertaken; similarly, the mobilization of volunteers and media of public communication should be delayed until their immediately preceding stages are completed. Hence, the mass screening may not be able to begin for many months.

leadership of the religious community. This is certainly true for Tay-Sachs disease. The rabbinate in Washington and Baltimore was approached months before any public announcement was made. The rabbis gave the screening effort their active as well as moral support. They delivered sermons on the topic and counseled couples and individuals. They also have a major responsibility for continuation of the program as they have the opportunity to provide educational material regarding the screening to young couples prior to marriage.

The third step in education is to reach a corps of community volunteers who can disseminate accurate program information, help generate interest when screening gets under way, and man the facilities when testings are conducted. On the order of 1,000 such volunteers, recruited from religious and community organizations, were trained in Washington-Baltimore. Through lectures and workshops they learned the basic facts about Tay-Sachs disease and then communicated them to organizations and friends at various community gatherings. Screening could not have succeeded without these volunteers. Two facts convince us this is so. First, the staff was prepared at the initial session to offer counseling to individuals who were confused or did not understand the program. But in fact little counseling was required because the volunteers had done an outstanding job of communicating what the project was all about. Second, the volunteers made it physically possible for the technicians and physicians to handle the large numbers of people who came to be screened. They took care of marking the test tubes and recording names and addresses. It is a real testimonial to the conscientiousness of these volunteers that only four tubes were mislabeled or misplaced during the screening of about 10,000 persons.

Only after this firm foundation of knowledge and volunteer support had been laid was the screening program publicly announced, approximately four to six weeks before the first community testing. Small task forces of 10 to 20 people started calling members of their parent organizations and distributing flyers and letters while the newspapers and broadcast media carried announcements of the screening data. The timing of these steps in the program was indispensable to its effectiveness; one should not start talking publicly about testing until preparations are close to final. Otherwise the interest generated will be dissipated, frustrated, and wasted.

All mass screening efforts in the Washington-Baltimore area were carried out in community facilities such as synagogues, schools, or community centers. This seemed far more appropriate than hospitals, which are not set up to deal rapidly with hundreds of "patients." These other facilities

could accommodate large numbers and were also more accessible. A schematic diagram of the layout for a typical session is shown on page 115.

To initiate the Washington-Baltimore program, approximately $65,000 was required for equipment, laboratory and office personnel, and supplies. This sum was raised chiefly from the private community, the John F. Kennedy Institute in Baltimore, and the Maryland State Department of Health and Mental Hygiene. The program was made self-supporting thereafter by charging a voluntary fee of $5 for each individual given the serum test. This fee slightly exceeded the actual cost of the test but the difference covered the expenses of the few people who did not pay. Physicians who participated in screening sessions volunteered their time.

Genetic Counseling

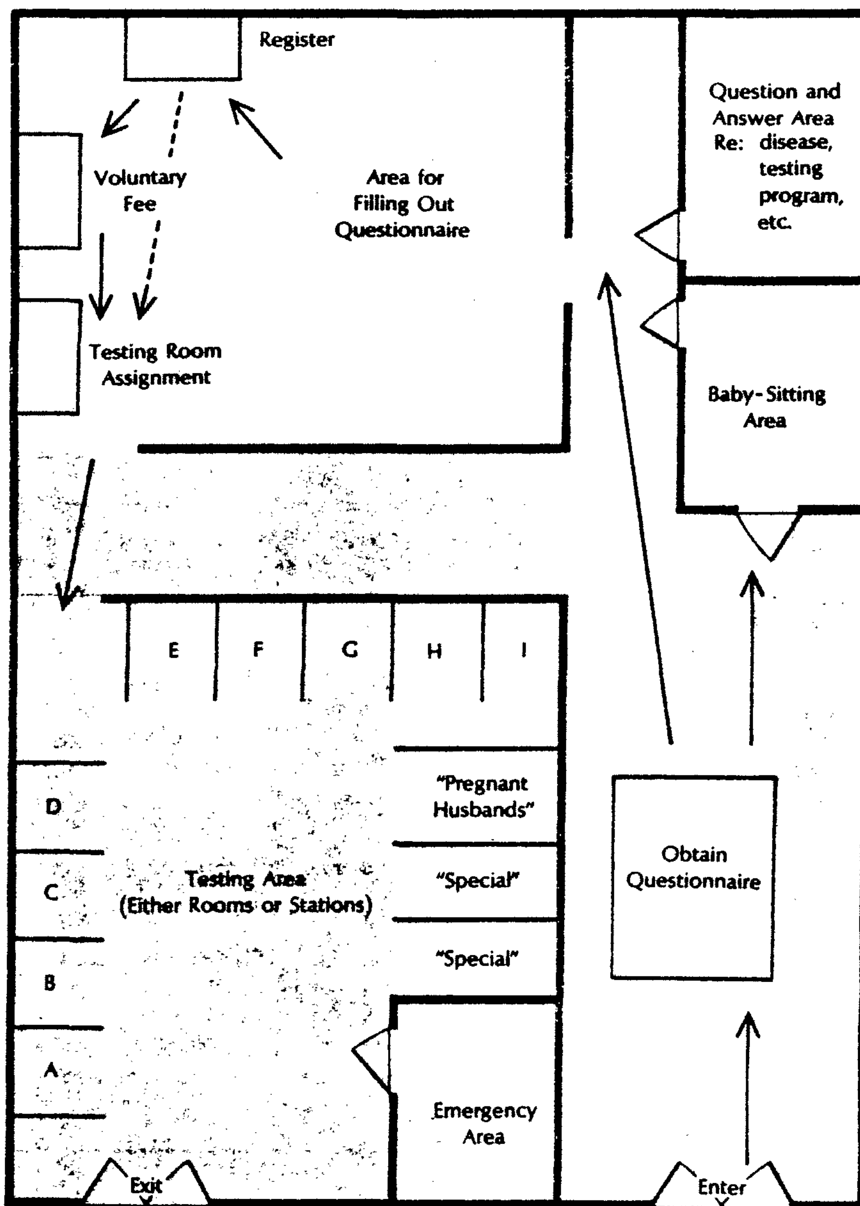
Once the technologic problems of screening for a genetic disease are solved, the question remains of helping people use the information obtained to make voluntary decisions of the highest personal importance.

Test results must be delivered in a careful and sensitive way. When there is clearly no carrier in the family a form letter will do. But in almost every other circumstance at least a telephone call from the genetic counselor is required. For example, two of the couples found at risk in the Washington-Baltimore screening had children at home under one year of age. A letter giving them the test results would have been frightening. A phone call, some verbal reassurance, and immediate testing of their children were able to allay their anxieties.

Working with members of the public under these circumstances requires a special commitment. Even before an individual or a couple is screened the mere idea of testing can be threatening. "You're going to tell me whether I have bad genes," is the general idea. Our experience suggests that intensive counseling will overcome the fears of the few couples who have serious questions before testing. And all couples in whom possible or proved risk exists must have direct contact with the counselor. Discussion must be shaped to the individuals involved. Some require more factual data, others more emotional reassurance. But this is the interface at which a screening program will succeed or fail.

Complete privacy in the delivery of results is of course essential. We have received calls from inquiring relatives of screenees, for instance. "My son-in-law was tested. Is he a carrier? I need to know because my daughter hasn't been tested." Our results are delivered only to those screened. In a program involving adults voluntarily seeking this service, we believe we are able to maintain confidentiality better than might be possible in a mandatory situation involving people of all ages or in a commercial testing setup coordinated through physicians' offices.

Once a carrier of the Tay-Sachs gene is identified, another question arises: How far should the physician go in trying to identify other carriers in the same family? We believe there is an obligation to try to do this as far as possible. In our program this is done through the identified carrier, who is provided with educational material to send or give to his appropriate relatives. This information instructs those relatives to contact the center if



Community facility, in preference to a hospital, may provide an optimal setting for mass screening programs in genetic disease prevention. Layout shown above is based on Washington-Baltimore program for Tay-Sachs disease; parking space is also needed.

they wish to be tested or obtain further information. Arrangements are then made with physicians of out-of-town relatives to have appropriate samples sent for testing. To reduce the volume of work we begin (when possible) by testing the carrier's parents to determine which side of the family carries the gene, since in most cases both are not heterozygotes.

In all of our studies of Tay-Sachs carriers (more than 250 in the East and 75 in California), we have always been able to identify at least one parent in the previous generation as a heterozygote. In fact, three older couples were found in Washington and Baltimore in which both partners carried it, but fortunately none had had a Tay-Sachs child. In the Washington-Baltimore screening program 11 couples have been identified in which both man and wife carry the Tay-Sachs gene. There was no previous history of the disease in their immediate families. Every one of these 22 individuals has been confirmed as a carrier by leukocyte assay, and at least one parent in the preceding generation has also been found to have comparable serum and leukocyte enzyme levels. Thus it is evident (short of their having a TSD child) that these couples are at risk.

Within one year of being identified, five of these couples conceived. All elected to monitor their pregnancies. One of the five showed no Hex A in amniotic fluid and cultured cells. The pregnancy was terminated and the fetal diagnosis was confirmed in post-abortive tissues.

While we believe that genetic screening as described here is fully justified in human terms, the question of its cost is bound to be raised. Several estimates of cost effectiveness have been made that indicate it would cost only one fifth to one third as much to screen the entire Ashkenazi Jewish population in the United States as to care for the affected children that would be born without a preventive program. Because the gene is so much less frequent outside the Jewish population, it would be economically unrealistic to screen the entire nation.

Implications for Other Genetic Diseases

Obviously our experience with Tay-Sachs disease has many implications for dealing with other autosomal recessive conditions once suitable carrier and fetal detection procedures have been developed. In considering the long-term effects of genetic screening, two broad areas are of concern – the impact on the gene pool, and the possible psychologic effects of mass education and genetic counseling.

One must make a large number of assumptions to arrive at even very rough calculations of the genetic impact of a preventive program such as that for Tay-Sachs disease. Carrier detection as such is not likely to alter the frequency of the Tay-Sachs gene in the Jewish population. One reason is that the overwhelming majority of carriers in the population result from the matings of heterozygotes with noncarrier homozygotes and these matings are likely not to be affected by the preventive program. Long before any significant effect on the frequency of the gene could be observed, medical science should have developed a superior approach for dealing with Tay-Sachs disease.

With respect to the psychologic impact of a screening program, our experience suggests that those couples established to be at risk have responded well to intensive counseling. To evaluate those impressions, and to assess the impact of carrier identification, interviews are now being conducted in the screened population to see how effectively information was transmitted and to evaluate whether significant stigmatization is felt by identified heterozygotes. In addition, other studies are being conducted to investigate other psychosocial considerations in mass genetic screening of this type.

A final point concerns the virtues of voluntary genetic screening as contrasted with a legally mandated form. We have been impressed with the effectiveness of the voluntary approach and we believe that the psychologic, political, and moral dangers of legislating human genetic testing far outweigh the potential medical benefits.

As a practical matter, legislation alone cannot solve genetic problems. The public must be educated for any program to work, and voluntary learning based upon enlightened self-interest is inherently more effective than coerced learning. There is also the matter of financial support. Each genetic disease program will require a substantial investment in backup services to be sure it benefits all segments of the population. Although amniocentesis has been a medically accepted procedure for some time, it is still primarily a service available to those well-off enough to pay for it. The government cannot require education about genetic disease without providing the related services.

We do not believe that every Jewish person of childbearing age should be *required* to have a Tay-Sachs enzyme assay. We do believe that every Jewish person of childbearing age should know about the disease, should know what can be done about it, and should be free to make his or her own decision whether or not to be tested. Education and individual choice is a mechanism far superior to legislation with regard to genetic programs of this sort in any population. It is hoped that the information and experience gained in Tay-Sachs screening will facilitate future implementation of preventive programs for other genetic conditions. □

Selected Reading

O'Brien JS: Ganglioside storage diseases. Advances in Human Genetics, Vol 3, Harris H, Hirschhorn K, Eds. Plenum Publishing Co., New York, 1972, pp 39-98

Kaback MM, Zeiger RS: Heterozygote detection in Tay-Sachs disease: a prototype community screening program. Advances in Experimental Medicine and Biology, Vol. 19, Volk BW, Aronson SW, Eds. Plenum Publishing Co., New York, 1972, pp 613-632

Kaback MM, Zieger RS: The John F. Kennedy Institute Tay-Sachs Program: practical and ethical issues in an adult genetic screening program. Ethical Issues in Genetic Counseling and the Use of Genetic Knowledge, Harris M, Ed. Plenum Publishing Co., New York, 1971