MINUTES OF THE
MEETING OF THE SENATE COMMITTEE
ON HUMAN RESOURCES AND FACILITIES

SIXTY-FIRST SESSION
NEVADA STATE LEGISLATURE
June 2, 1981

The Senate Committee on Human Resources and Facilities was called to order by Chairman Joe Neal at 8:08 a.m., Tuesday, June 2, 1981 in Room 323 of the Legislative Building, Carson City, Nevada. Exhibit A is the Attendance Roster.

COMMITTEE MEMBERS PRESENT:

Senator Joe Neal, Chairman
Senator James N. Kosinski, Vice Chairman
Senator Richard E. Blakemore
Senator Wilbur Faiss
Senator Virgil M. Getto
Senator James H. Bilbray

GUEST LEGISLATORS:

Assemblyman Loni B. Chaney

STAFF MEMBERS PRESENT:

Connie S. Richards, Committee Secretary

ASSEMBLY BILL NUMBER 655

Dr. Lonnie Hammergren spoke in support of Assembly Bill No. 655. He provided material to the committee relative to the bill (see Exhibit B).

Mr. Patrick Pine, Representative, Clark County told the committee that the county did provide some drafting services for Dr. Hammergren in the drafting of the bill but this does not imply that the county is in total support of the bill. He noted the bill does apply to all counties. The fiscal impact of sections 2 and 3 could be very dramatic; in the case of Southern Nevada Memorial Hospital will expend roughly $650,000 more than today, this current fiscal year and this upcoming fiscal year will increase approximately $800,000 to pay for indigent care. He said the county does support the concept of financing for spinal cord injuries in section 1.

Assemblyman Loni B. Chaney spoke in support of Assembly Bill No. 655 which would still allow the county to receive federal funds.

ASSEMBLY BILL NUMBER 596

Dr. Eugene Glick spoke in opposition to Assembly Bill No. 596. He said the risk of abortion in all age groups is much less than natural childbirth. He provided statistics relative to the estimated annual mortality association with various methods of fertility control and with absence of control from the center of disease control as well as some additional information relative to abortions (See Exhibit C).

He told the committee that the 24 hour waiting period for an abortion increases the chances of death in the person receiving the abortion. He also pointed out that the 24 hour waiting period will require women to make two trips to the doctor and may cause them to miss an extra day of work. These problems are particularly pertinent to women living in the so-called "cow" counties of the state. He said the 24 hour provision may not be a danger to a women's life, but may very definitely be a danger to her health. He suggested the addition of the words "and health".

He said he did not feel that the notification of parents is always in a minor's best interest in some cases and that this should be better left to the doctor's discretion. He noted that in a review of his records he found that 9 out of 10 minors receiving abortions through his office did have parental consent. The other 1 out of the 10 is asked why and usually has a good reason for not notifying her parents.

Dr. Henry Davis, Carson City told the committee he has been in family practice for 12 years and his group serves about 4,000 families in the area and opposes the bill. He said many of the clinics offering abortions to patients do not wish to see patients after they have an abortion and subsequently have complications from that abortion. He said those women return to their regular physician to treat them for the complications and therefore statistics from such clinics are not accurate for the number of women with complications after abortion.

The Chairman asked Mr. Davis how this bill will help as informed consent is already in the law.

Dr. Davis replied that the new provisions for informed consent require that the physician performing the abortion is not entirely responsible for all counseling to be given to the patient. Such counseling (from the performing physician) may be incomplete or even incorrect.

Mr. Bill O'Mara, Attorney, Right To Life spoke in support of Assembly Bill No. 596. He pointed out that under current law, parents may be notified of a minor's impending abortion but has no veto-power to stop the abortion.

Mr. Patricia Glenn, Director, Lifeline a non-profit, volunteer agency offering alternatives to abortion. She said Lifeline has offered help at no charge to anyone faced with an unwanted pregnancey since 1974 by finding and referring the woman to agencies and organizations that can provide counseling, funding, or help in putting the child up for adoption as an alternative to abortion. She urged the committee to pass the bill.

Mr. John Barriage, American Civil Liberties Union spoke in opposition to section 4, lines 16 through 19 and section 5, lines 24 through 27 of the bill.

Mr. Charles F. Anderson, C.H.I.L.D. of God spoke in support of Assembly Bill No. 596. He told the committee of personal experience with abortion in his family and urged the committee to pass the bill out of committee.

Ms. Sally Zamora, Vice Chairman, Pro-Family, Fallon, Nevada spoke in support of Assembly Bill No. 596.

Mr. David Anderson, Pastor, Stewart Community Baptist Church spoke in opposition to Assembly Bill No. 596. He told the committee the bill will encourage young girls who cannot speak to their parents about an abortion to go to illegal abortion mills rather than having their parents informed of such action. He told the committee he was on the staff of a church in an urban area before abortions were legalized. During a period of five months, he held eight funerals for girls who had died of a result of illegal abortions. He said since the legalization of abortions, he has had no funerals for girls resulting from illegal abortions because girls are now able to seek legal abortions where they will receive good medical care and not risk losing their confidentiality with their doctor because he is required to inform her parents. He said the problem stems from the fact that

families do not communicate well among themselves, particularly in matters relating to sex.

Ms. Vivian Freeman, Chairman, Women's political Caucus and a nurse spoke in opposition to Assembly Bill No. 596. Specifically she opposed a woman being required to indicate her marital status and verify same in writing. She said this is an invasion of a woman's privacy. She noted that if women seeking abortions must be informed as to the dangers of abortion, she should also be informed of the dangers of pregnancy and carrying a child to term.

Ms. Freeman asked whether the phrase "secured a judicial declaration of paternity" in section 4, subsection 2 requires a woman to appear before a judge in order to receive an abortion without her husband's knowledge. She suggested that this is an invasion of privacy.

Ms. Freeman expressed a fear of undue governmental intervention into the lives of women and medicine throughout the bill.

Ms. Louise Bayard-De-Volo, Planned Parenthood spoke in opposition to Assembly Bill No. 596. She said Planned Parenthood helps people plan for a family and advocates a woman's right to choose, whether the choice be to have a child, not have a child, or to terminate an unwanted pregnancy. She said the organization provides information to women relative to pregnancy and family planning. She pointed out that minor children do need support of their families if they are seeking an abortion, but said not all familieis are willing to provide that support and may do damage to the minor, through guilt, verbal or physical abuse. She provided information relative to the 24-hour waiting period (see Exhibit D).

Ms. Rosa Matthews, Carson City Resident spoke in support of Assembly Bill No. 596. She said the bill is good for the "general good" of citizens of the state and urged its passage.

Ms. Courtney Jamison, Planned Parenthood spoke in opposition of Assembly Bill No. 596.

Senator Faiss said he feels that the issue of abortion as covered by Assembly Bill No. 596 is a serious matter and requires a great deal of thought. He said he has not yet

had a chance to assimilate all the facts presented and therefore cannot make an accurate decision at this time.

Senator Bilbray moved to "Do Pass" Assembly Bill No. 596.

Senator Getto seconded the motion.

Senator Kosinski said he supports the concept of counseling women on alternatives available to abortions and supports informing of a minor's parents when seeking abortions but feels that each individual case must be considered and some exceptions made in some cases. He suggested the physician have some discretion in such cases. He said he strongly opposes a mandate for the notification of the husband when a wife is seeking an abortion and does not feel that issue will be amended out of the bill on the floor, and therefore must vote against the bill.

The Chairman said provisions for criminal penalties in any issue give law enforcement agencies the right to review a case. He said he feels that this is an invasion of privacy in the case of women seeking abortion without her husband's knowledge particularly in cases in which the husband may not be the father of the child. He said as the law stands, it requires informed consent and also covers informing of parents in cases in which minors seek abortions. He said he cannot support the bill.

Senator Getto said he can see how women feel about the issue of informing her husband but feels the law should be passed as the informed consent will do more good than the bill will do bad.

Senator Bilbray said he feels a child is as much the father's as the mother's whether the mother carries the child or not and therefore the father has a right to know if the mother is seeking an abortion. He said he feels parents should be notified in cases of minors seeking abortions so that they may talk the decision over and make the correct decision.

The motion did not carry. (Senators Neal and Kosinski voted "No", Senator Faiss abstained from voting.)

There being no further business, the meeting adjourned at 10:40 a.m.

Respectfully submitted:

Connie S. Richards

Connie S. Richards, Committee Secretary

APPROVED BY:

Senator Joe Neal, Chairman

DATE: June 4, 1981

ATTENDANCE ROSTER FOR COMMITTEE MEETINGS

SENATE COMMITTEE ON HUMAN RESOURCES AND FACILITIES

DATE: May 2, 1981

EXHIBIT A

PLEASE PRINT NAME	PLEASE PRINT ORGANIZATION & ADDRESS	PLEASE PRINT	PLEASE PRINT TELEPHONE
HENRY F DAVIS MD.	FAMILY MEDICAL CENTER.		
Patricia Glenn	Right to Life		826-1404
Bill O'Brien	"		
Elaine Angelo	"		
Gene Glick MD	- Medical Doctor		329-0616
JANNIE HAMMARGREN M.D.			451-8444
CHARLES F. "ANDY" ANDERSON.	CHILD [illegible]		786-7917
Lonna Turner	Nev Nurses Ass		-
Louise Bayard-de-Volo	Planned Parenthood		329-1781
John B Jeffries	ACLU		359-4476
Joseph Patrick Shea	LAS VEGAS NEV RIGHT-TO-LIFE		
David L. Anderson	STEWART COMMUNITY BAPTIST CHURCH 534 SNYDER AVE Carson City		882-0627
Patrick Pine	CLARK COUNTY		
Sally Zamora	Pro-Family Dallas		423-3665
Vivien Freeman	Women's Political Caucus		
Ross Mathews	———		882-8731

EXHIBIT B

insight

Las Vegas SUN
EDITOR AND PUBLISHER ... H.M. Greenspun
EXECUTIVE VICE PRESIDENT ... Mike O'Callaghan
GENERAL MANAGER ... Burt Buy
ADVERTISING DIRECTOR ... Harold Blatt

technical know-how.

Treating Spinal Injuries

Nevada leads the world in the incidence of people suffering paralysis from neck and back spinal cord injuries.

If treatment and rehabilitation begin immediately, those unfortunate victims with crippling injuries may return to productive lives. But the treatment must be initiated early.

Assembly Bill 655 has been introduced at this session of the legislature. Known as the spinal cord injury bill, it would cut red tape to allow patients access to treatment.

However, legislators are hesitant to commit $1.5 million of state general funds for catastrophic care. Perhaps lawmakers could approve the bill with less money, if they cannot support the full amount.

Outreach Clinic Picked

In Clark County, Southern Nevada Memorial Hospital has been designated the outreach clinic of Good Samaritan Hospital in Phoenix, part of the National Spinal Cord Injury program. Washoe County Hospital contributes similar services with a San Jose, Calif. hospital.

Immediate care, doctors say, contributes to prevention of long hospitalization and lessens the injury.

Surely, this bill would provide relief for a state with more crippling back injuries than any other place in the world.

ASSEMBLY BILL NO. 655—COMMITTEE ON HEALTH AND WELFARE

MAY 12, 1981

Referred to Committee on Health and Welfare

SUMMARY—Broadens provisions for state medical aid. (BDR 38-1956)
FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: Contains Appropriation.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to state medical aid; establishing a program of financial assistance for spinal cord injuries; removing prohibition against making payment for treatment of indigents to private physicians; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. Chapter 428 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. There is hereby established a state plan of financial assistance to persons who incur injury to their spinal cords for rehabilitation services not eligible for reimbursement under Title XIX of the Social Security Act (42 U.S.C. § 1396–1396d).

2. The state board of examiners shall by regulation adopt standards of eligibility for assistance and procedures for filing and evaluating claims in light of the guidelines of the National Spinal Cord Injury Program.

3. The welfare division of the department of human resources shall administer the plan of assistance for spinal cord injuries in accordance with the regulations of the state board of examiners.

SEC. 2. NRS 353.264 is hereby amended to read as follows:

353.264 1. The reserve for statutory contingency fund is hereby created as a trust fund.

2. The reserve for statutory contingency fund [shall] *must* be administered by the state board of examiners, and the money in the fund may be expended only for:

(a) The payment of claims which are obligations of the state under NRS 41.03435, 41.0347, 41.0349, 41.037, 176.485, 179.310, 212.040, 212.050, 212.070, 214.040, 282.290, 282.315, 293.253, 293.405, 298.155, 353.120, 353.262, 412.154, *section 1 of this act* and 475.240; and

(b) The payment of claims which are obligations of the state under

NRS 7.125, 176.228, 177.345, 179.225, 213.153 and subsection 4 of NRS 361.055, but such claims must be approved for the respective purposes listed in this paragraph only when the money otherwise appropriated for those purposes has been exhausted.

Sec. 3. NRS 450.180 is hereby amended to read as follows:

450.180 The board of hospital trustees [shall have the power:

1. To appoint] *may:*

1. Appoint a suitable superintendent or matron, or both, and necessary assistants, and to fix their compensations.

2. [To employ] *Employ* physicians and interns, either full-time or part-time, as the board determines necessary, and to fix their compensations.

3. [To remove] *Remove* those appointees and employees.

4. [To control] *Control* the admission of physicians and interns to the staff by promulgating appropriate rules, regulations and standards governing those appointments.

5. [To contract] *Contract* with individual physicians or private medical associations for the provision of certain medical services as may be required by the hospital. [The compensation provided for in the contract must not include compensation to the physician for services rendered to indigent patients.]

Sec. 4. NRS 450.440 is hereby amended to read as follows:

450.440 1. The board of hospital trustees shall organize a staff of physicians composed of every regular practicing physician and dentist in the county in which the hospital is located who requests staff membership and meets the standards fixed by the regulations laid down by the board of hospital trustees.

2. The staff shall organize in a manner prescribed by the board so that there is a rotation of service among the members of the staff to give proper medical and surgical attention and service to the indigent sick, injured or maimed who may be admitted to the hospital for treatment.

3. [No member of the staff nor any other physician who attends an indigent patient may receive any compensation for his services except as otherwise provided in NRS 450.180 or to the extent that medical care is paid for by any governmental authority or any private medical care program.

4.] The board of hospital trustees or the board of county commissioners may offer the following assistance to members of the staff in order to attract and retain them:

(a) Establishment of clinic or group practice;

(b) Malpractice insurance coverage under the hospital's policy of professional liability insurance;

(c) Professional fee billing; and

(d) The opportunity to rent office space in facilities owned or operated by the hospital, as the space is available, if this opportunity is offered to all members of the staff on the same terms and conditions.

Sec. 5. 1. There is hereby appropriated from the state general fund to the reserve for statutory contingency fund created pursuant to NRS 353.264 the sum of $1,500,000 for the purposes specified in section 1 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 1983, and reverts to the state general fund as soon as all payments of money committed have been made.

SPINAL INJURY PROGRAM OF NEVADA

Affiliate, National Spinal Cord Program
Good Samaritan Hospital, Phoenix, Arizona

Mailing Address
2196 Maryland Parkway, #106
Las Vegas, Nevada 89109

Out-Reach Office:
1508 North Jones
Las Vegas, Nevada 89108

Benefits and Privileges for Paraplegic and Quadriplegic Persons

General Provisions

429.005 Policy of state concerning persons who are victims of spinal column injuries.

It is the policy of the state:

1. To provide financial medical assistance to persons suffering such injuries. Assistance is to cover all medical costs, not covered by private or other insurance or by Title XIX, from the time of emergency treatment until the assumption of medical costs by Title XIX.

2. To fund rehabilitation treatment costs not covered by Title XIX for up to two years. Such costs to include the procurement of and training in the use of electrical wheelchairs and environmental assistive controls in order to maximize the promotion of self sufficiency.

429.101 Purposes of this Chapter. The purposes of this Chapter are:

1. To relieve paraplegics and quadriplegics of the catastrophic burden of costs resulting from spinal cord injuries.

2. To assist persons suffering from spinal cord injuries to become more self sufficient and self supporting.

FUNDING

429.100 State Grant

1. The Legislature hereby appropriates $1,500,000 from the state general fund to reserve for statutory contingency fund for the purposes of this chapter.

2. Additional funding is to be provided as needed.

ADMINISTRATION

429.200 Application and eligibility requirements.

1. The state board of examiners shall adopt, repeal, and amend regulations prescribing the procedures to be followed in the filing of applications and proceedings under this chapter and for such other matters as the state board of examiners deems appropriate. These regulations shall be in accord with the guidelines of the National Spinal Cord Injury Program

2. Upon approval of the application by the state board of examiners, the state controller shall draw his warrant for the payment thereof and the state treasurer shall pay the warrant from the reserve for that purpose in the statutary contingency fund.

CLARK COUNTY MEDICAL SOCIETY
4700 BRUSSELS AVENUE • LAS VEGAS, NEVADA 89109 • 737-8099

March 19, 1981

Lonnie Hammargren, MD
3196 Maryland Parkway, Suite 106
Las Vegas, Nevada 89109

Dear Doctor Hammargren:

The Council of the Clark County Medical Society at its March 17th meeting supported your position that the State of Nevada should provide catastrophic insurance for patients with spinal cord injuries. The Council further supports your recommedation that the Nevada Industrial Commission Rehabilitation Center lease some of its excess space and therapy capacity to non-work related rehabilitation treatment programs.

By copy of this letter, we are informing the Legislative Chairman of the Nevada State Medical Association of our action and asking for the support and cooperation of the NSMA in your efforts to effect suitable legislation.

Sincerely,

William G. Findorff, MD
President

WGF:kr

cc: H. Treat Cafferata, MD
Legislative Chairman, NSMA
3660 Baker Lane
Reno, Nevada 89509

UNIVERSITY OF NEVADA . RENO

SCHOOL OF MEDICAL SCIENCES
DEPARTMENT OF SURGERY
WASHOE MEDICAL CENTER
. .77 Pringle Way
Reno. NV 89520
(702) 785-6165

December 11, 1980

Lonnie L. Hammargren, M.D.
3196 Maryland Parkway
Suite #106
Las Vegas, Nevada 89109

Dear Dr. Hammargren:

Sometime back and throughout the past six months, I, with the support of the University have been keenly interested in developing a spinal cord program at Southern Nevada Memorial Hospital. It is my belief that a spinal cord injury center is desperatly needed in Nevada, especially in Southern Nevada and further feel that such an entity could be a real contribution to the area. It has been my hope that formation of such a unit could be instigated in the next few months evolving around a core of interested physicians willing to participate on a team basis in the management and care of the spinal cord injured patient. It is my feeling that each and every spinal cord injured patient should be treated essentially on a protocol basis to guarantee and assure consistency in treatment with members of the team all involved from the beginning in order to assure quality and the best possible eventual outcome.

Individually I have talked to each of you concering participation on such a team. The purpose of thisletter is to institute a program, establish a protocol, and formulate a meaningful concept for the care and management of the spine injured patient. We have been told by the people at Good Samaritan Hospital in Phoenix, Arizona National Spinal Cord Injury Center that they will be happy to participate with us and will work on an out-reach basis allowing us to transfer our patients readily into their system for the long-term rehabilitatic as necessary. This, of course, requires long term follow-up records, regular visitations, and above all, a systemitized approach.

Joanne Toadvine of the Help Them Walk Again Program has volunteered space on the west side of Las Vegas which can be transformed into an out-patient unit acceptable and adaptable for spinal cord injured patients. This space has been seen by Dr. Dugan of the Good Sam Spinal Cord Injury Center who believes that such is quite adequate and recommends that we proceed forward in a positive direction.

I am writing this letter for purposes of seeking your help and support in establishing a spinal cord injury program here in Las Vegas.

Sincerely,

DONALD R. OLSON, M.D.

DRO/klp

cc: see over

SPINAL INJURY PROGRAM OF NEVADA

Affiliate, National Spinal Cord Program
Good Samaritan Hospital, Phoenix, Arizona

Mailing Address:
3186 Maryland Parkway, #106
Las Vegas, Nevada 89109

So. Nevada Memorial Hospital
Rehab Unit
1800 W. Charleston
Las Vegas, Nevada 89102
(702) 383-2312

Out-Reach Office:
1508 North Jones
Las Vegas, Nevada 89108
(702) 878-8360

ACUTE REHABILITATION CARE COSTS

* DONALD BECKER.....$44,036.00

GARLAND GOODLOW.....$32,476.00

** ABNER HEATHMAN.....$11,253.00

* This charge was for care at Southern Nevada Memorial Hospital Rehabilitation Unit only. This does not include care in the acute emergency period prior to his transfer and admission to the rehab unit. He was discharged on 6/27/80. SAMI was billed in August of 1980, and as of March 1981, SAMI has not paid on Don's account.

** Abner Heathman is a high C4 quadreplegic who needed special assistive devices in order to be trained toward independent home environment living. Utilization review for SAMI refused to give prior authorization for these special devices. Since the rehab unit could not document improvement without these special assistive devices, Utilization review determined that Abner would have to be discharged. At the present time. Abner, 24 years of age, is totally dependent upon care at home by public home health nurses and still awaiting SAMI assistance.

JIM SANTINI
NEVADA

WASHINGTON OFFICE:
1007 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-5965

DISTRICT OFFICES:
SUITE 4-620 FEDERAL BUILDING
300 LAS VEGAS BOULEVARD SOUTH
LAS VEGAS, NEVADA 89101
TELEPHONE: (702) 385-6324

1139 FEDERAL BUILDING
300 SOUTH STREET
RENO, NEVADA 89509
TELEPHONE: (702) 784-5697

RURAL OFFICE:
TELEPHONE: (702) 784-5697

Congress of the United States
House of Representatives
Washington, D.C. 20515

COMMITTEES:
INTERIOR AND INSULAR AFFAIRS
SUBCOMMITTEES:
CHAIRMAN, MINES AND MINING
OVERSIGHT AND SPECIAL INVESTIGATIONS
PUBLIC LANDS

INTERSTATE AND FOREIGN COMMERCE
SUBCOMMITTEES:
TRANSPORTATION AND TOURISM
OVERSIGHT AND INVESTIGATIONS

SELECT COMMITTEE ON AGING
SUBCOMMITTEE:
HOUSING AND CONSUMER INTERESTS

May 27, 1981

MEMBER OF NEVADA STATE
LEGISLATURE

I am writing in regards to the Spinal Injury Program of Nevada and particularly, the Spinal Cord Injury Bill.

Unfortunately, injuries to the neck and spine are quite common in Nevada. It has been demonstrated though, that early treatment and rehabilitation does, in fact, maximize the return of these individuals to productive lives.

The treatment and rehabilitation program offered by the Spinal Injury Program of Nevada opens the doors for treatment to those who are in need. I hope you will give their program all due consideration.

Sincerely,

Jim Santini

JAMES D. SANTINI
Member of Congress

JDS/js

1729

SPINAL INJURY PROGRAM OF NEVADA

Affiliate, National Spinal Cord Program
Good Samaritan Hospital, Phoenix, Arizona

Mailing Address:
[illegible]6 Maryland Parkway, #106
Las Vegas, Nevada 89109

So. Nevada Memorial Hospital
Rehab Unit
1800 W. Charleston
Las Vegas, Nevada 89102
(702) 383-2312

Out-Reach Office:
1508 North Jones
Las Vegas, Nevada 89108
(702) 878-8360

Dear Senator

I am a physician practicing privately in Las Vegas specializing in neurosurgery. I request the passage of a bill authorizing catastrophic health care for patients with spinal cord injuries.

Care for these devastating injuries should be immediately available as soon as the diagnosis is made. Primary care should be in the hospital in which the patient is first seen, if they are able to provide it. When the patient is stable, one to three weeks after injury, he would be transferred to a rehabilitation center which has special capacity to return these people to independent living as soon as possible.

In southern Nevada, the Southern Nevada Memorial Hospital has been designated as an Outreach Clinic of the Good Samaritan Hospital in Phoenix. This is a part of the National Spinal Cord Injury Program. In northern Nevada, Washoe County Hospital is an Outreach Clinic of Valley Medical Center, San Jose, California which is part of the federal program.

Spinal cord injuries are designated the highest priority in rehabilitation efforts, as in the long run, the cost effectiveness of intensive early rehabilitation will prevent long hospitalizations which end up ultimately to be more expensive. President Reagan has designated this the year of the handicapped and federal funds to supplement this program are available immediately upon implementation of the state program.

Please pass AB655 to help us treat our spinal cord injured patients. The actual numbers are small but we have more per capita than any other place in the world.

Sincerely,

Lon L. Hammargren

LLH:lem

1730

EXHIBIT C

ESTIMATED ANNUAL MORTALITY ASSOCIATED WITH VARIOUS METHODS OF FERTILITY CONTROL, AND WITH ABSENCE OF CONTROL*

A Service of Wyeth Laboratories

*Adapted from Tietze, C., New estimates of mortality associated with fertility control, Fam. Plan. Perspect. 9:74-76, 1977.

ESTIMATED ANNUAL NUMBER OF DEATHS PER 100,000 NONSTERILE WOMEN*

Age

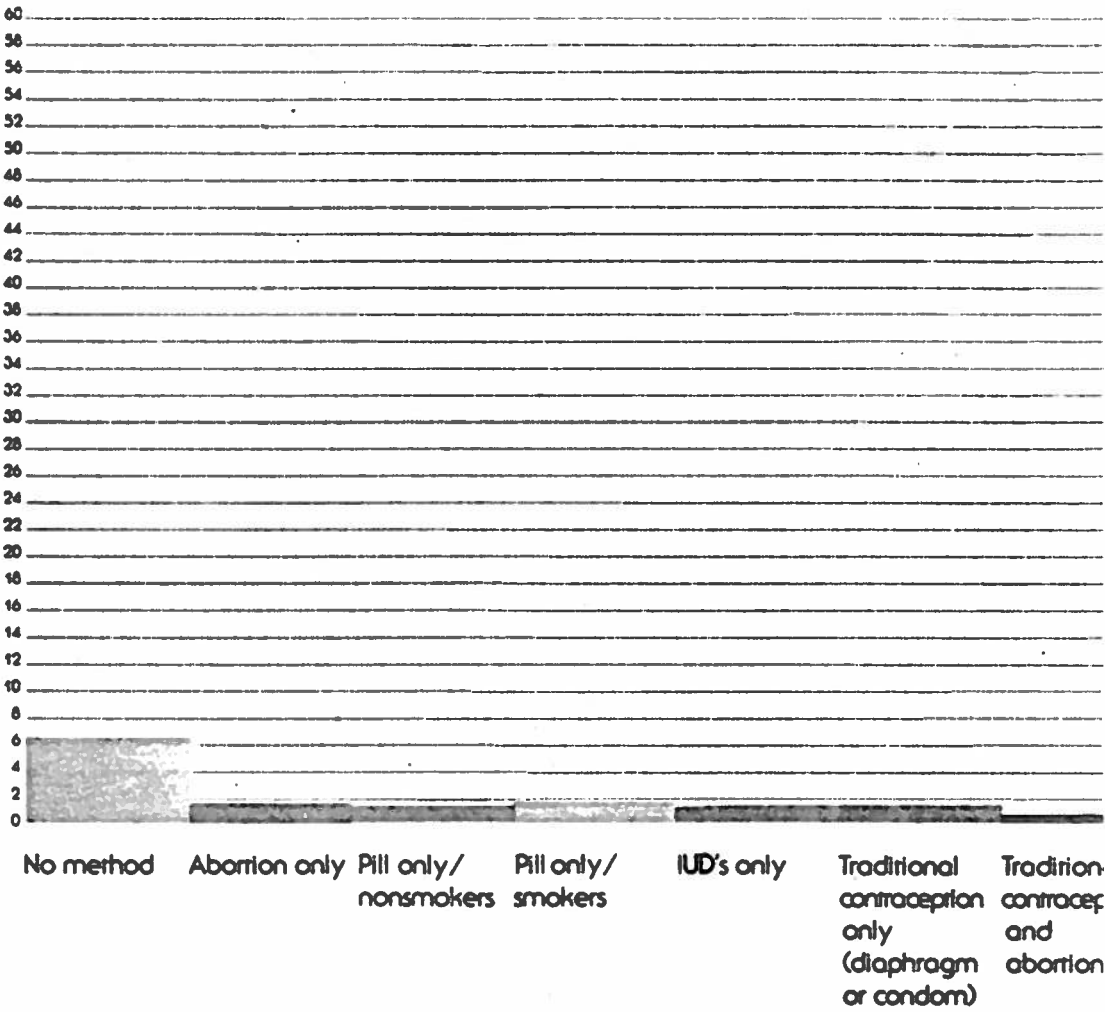
15-19

*See Accompanying Full Prescribing Information

ESTIMATED ANNUAL NUMBER OF DEATHS PER 100,000 NONSTERILE WOMEN*

Age

20-24



15-19 / 20-24

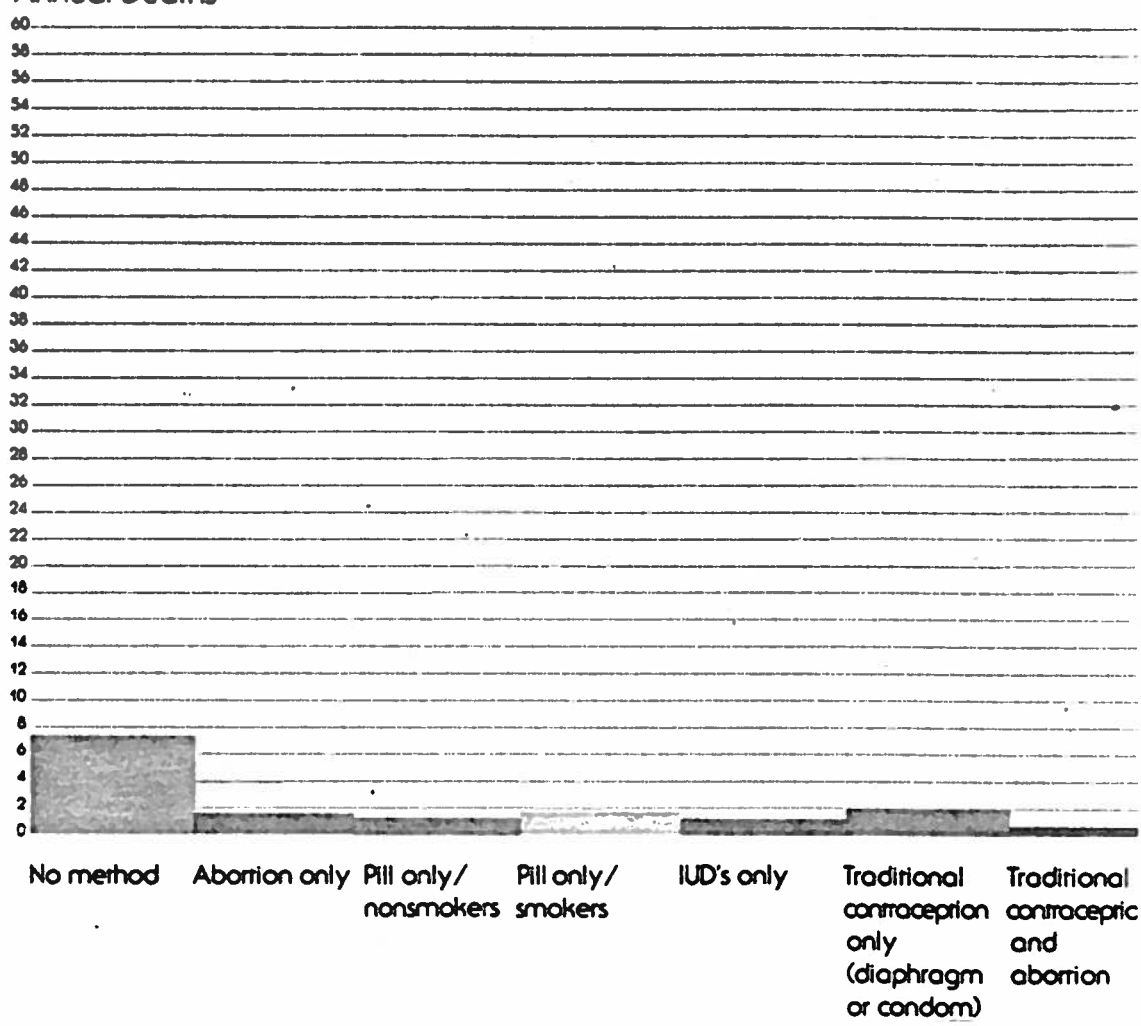
25-29 / 30-34

35-39 / 40-44

ESTIMATED ANNUAL NUMBER OF DEATHS PER 100,000 NONSTERILE WOMEN*

Age

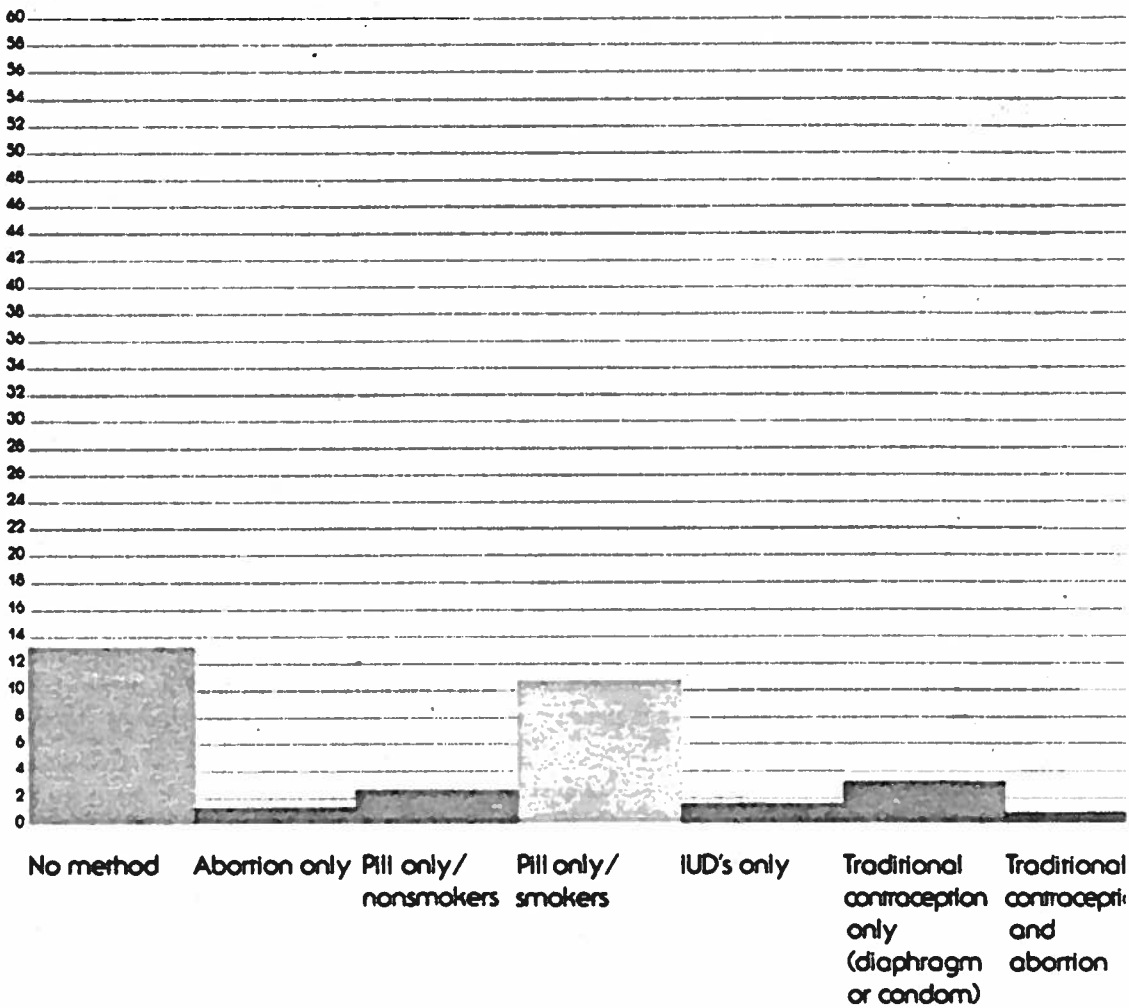
25-29



ESTIMATED ANNUAL NUMBER OF DEATHS PER 100,000 NONSTERILE WOMEN*

Age

30-34



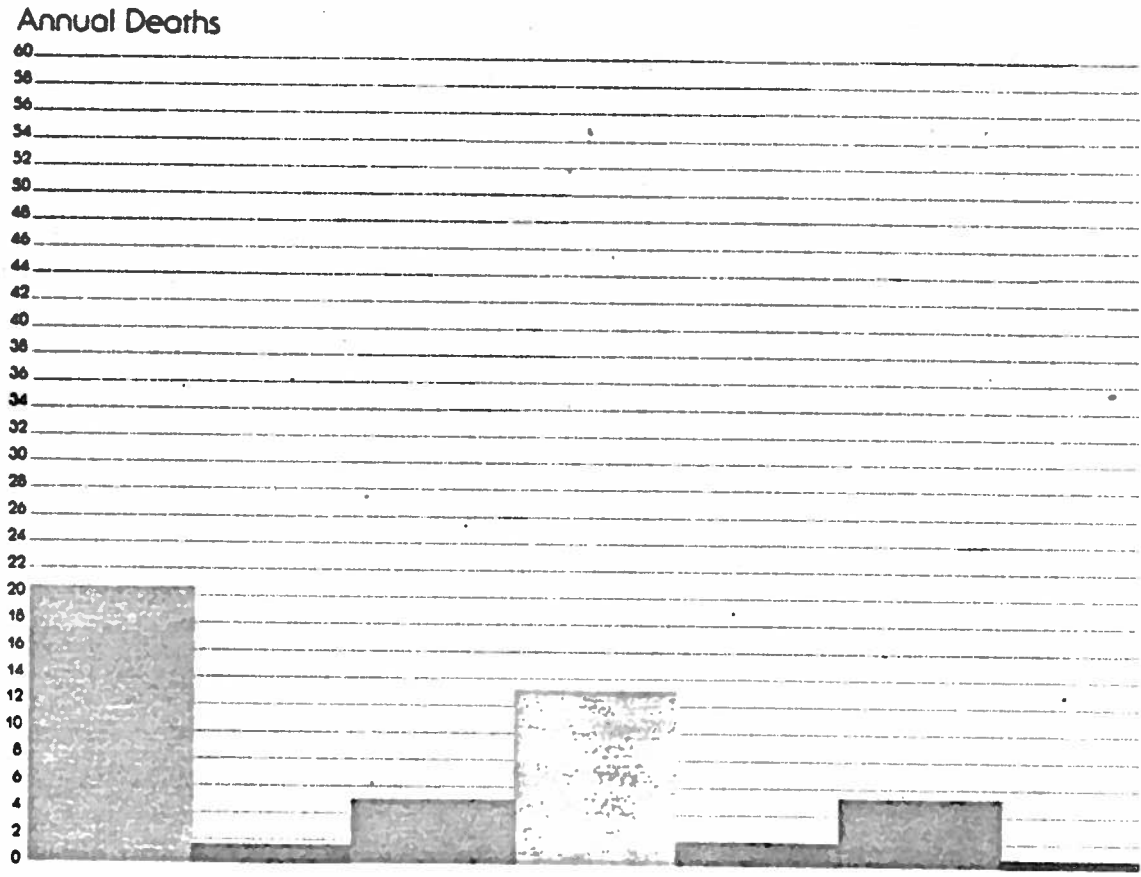
25-29 / 30-34

35-39 / 40-44

ESTIMATED ANNUAL NUMBER OF DEATHS PER 100,000 NONSTERILE WOMEN*

Age

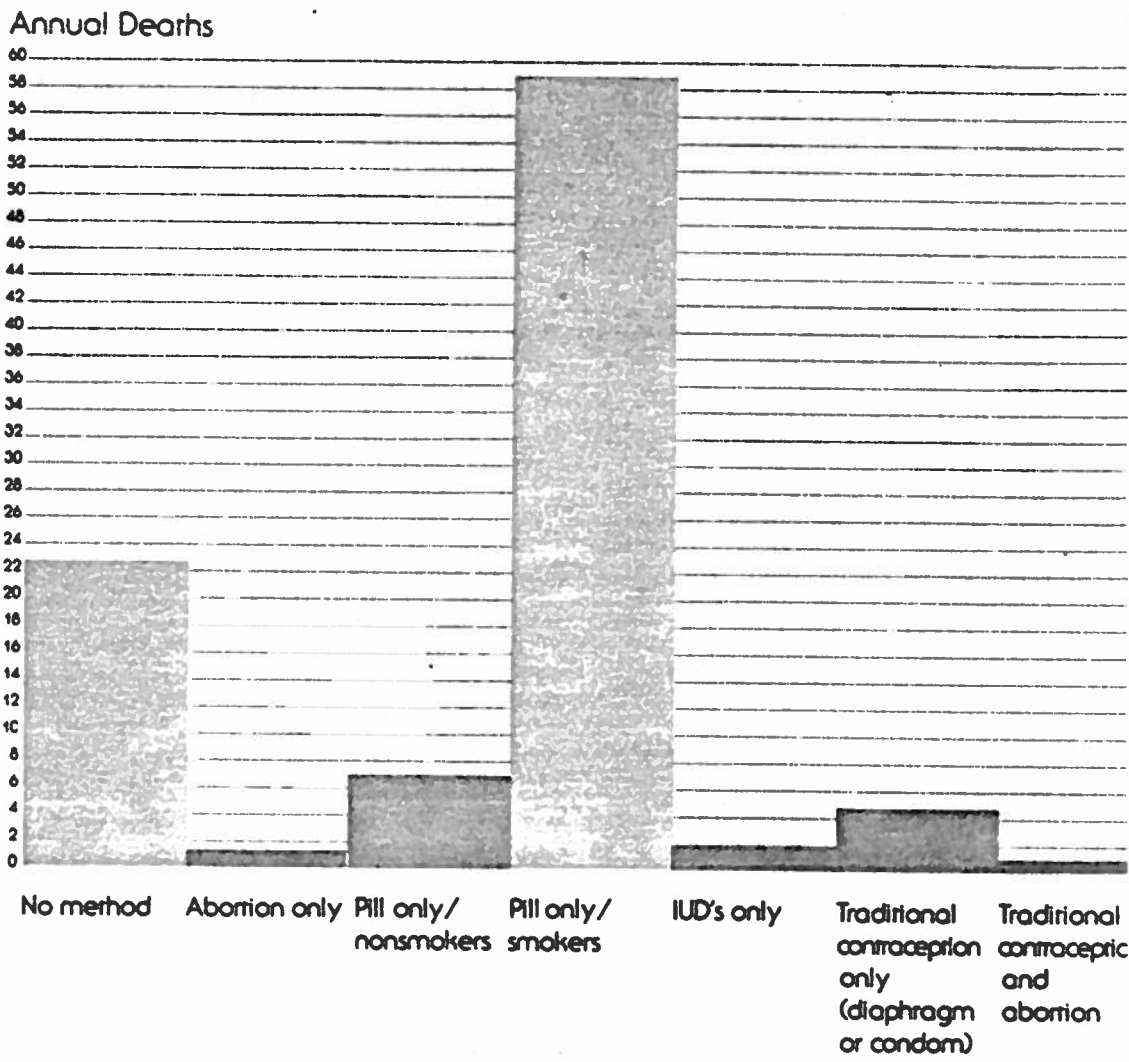
35-39



ESTIMATED ANNUAL NUMBER OF DEATHS PER 100,000 NONSTERILE WOMEN*

Age

40-44



Have you ever been hospitalized or had surgery? No ____ Yes ____

Explain: _____

_____

_____

List all medications or drugs you are presently taking:

_____

Do you smoke? ☐ No ☐ Yes: Pkg. per day _____ . Alcohol? ☐ Never ☐ Occasionally ☐ Frequently

Have you ever had any reaction to the following drugs? Circle

Penicillin Ampicillin Tetracycline Carbocaine Valium Tranxene Darvon Codeine Methergine Betadine

Other Antibiotic _____ Any other medications _____

_____

CONSENT FOR THERAPEUTIC ABORTION BY VACUUM ASPIRATION

I hereby direct and request Eugene Glick, M.D., and/or his associates to perform an operation called an abortion in order to terminate my pregnancy.

I understand that this abortion procedure is to be done by vacuum aspiration of the uterus, sharp curettage (scraping the wall of the uterus) and removal of the larger contents with other instruments. I understand that a paracervical anesthetic (local) is injected around the cervix, and that sedative drugs may be used for my comfort. Other medications that the doctor feels may be necessary may also be given.

Although abortion is considered to be a safe medical procedure, I understand that there may be occasional serious complications which include: hemorrhage, serious infection and retained tissue. Perforation of the uterus, a very rare complication, may require abdominal surgery. Death may follow the above complications. On occasion, unexpected reactions to the drug or anesthetic may be serious or even fatal. Scar tissue (adhesions) may form in the uterus preventing the passage of menstrual flow. This may require dilation of the cervix and the breaking of the adhesions at some later date. Sterility (the inability to conceive) and prematurity (the delivery of a child before full term) may occur following an abortion. Other complications and unforseen things not listed above may also occur.

On occasion, the abortion itself may be incomplete requiring a second procedure. If the pregnancy is any place but in the uterus (e.g. in the fallopian tube) this surgery will not remove that pregnancy.

I realize that I have the option to continue this pregnancy and that no warranty or guarantee has been made as to the results of this procedure. I have read the above and discussed the procedure with a staff member. I understand fully the contents of each paragraph.

_____ ___/___/___ _____ a.m./p.m. Witness _____

Patient's Signature Date Time

FOR LAMINARIA

I have been instructed regarding the special procedure to be used for my abortion. I am aware that is done with the aid of laminaria (seaweed stems) inserted into the cervix (mouth of the womb) before the procedure. This is done in order to dilate (open up) the cervix gradually. Once the laminaria are inserted, I understand that I have committed myself to return as scheduled for the abortion or else face the probability of serious infection which may threaten my life.

_____ ___/___/___ _____ a.m./p.m. Witness _____

Patient's Signature Date Time

The *Chlamydia* Epidemic

King K. Holmes, MD, PhD

Dr Holmes is professor of medicine and chief of the Division of Infectious Diseases, Seattle Public Health Service Hospital, University of Washington School of Medicine, Seattle.

JAMA: What are the most important facts that practitioners should know about diseases caused by *Chlamydia trachomatis*?

Holmes: I believe that there are five crucial facts concerning chlamydial infections that practitioners should know.

1. Chlamydial infections are epidemic in this country, yet they are neither well recognized nor correctly treated in many instances.

2. Nationally, we are observing alarming increases in the number of cases of ectopic pregnancy and salpingitis, a large proportion of which may result from chlamydial infection. Since each of these ectopic pregnancies represents one fetal death, this constitutes an epidemic of fetal deaths.

3. Chlamydial infections during pregnancy should receive much greater attention. These infections may lead to postpartum endometritis in the mother and may be transmitted to the infant, causing pneumonia or eye infection. Our group has disturbing data showing that the fetuses of women who have chlamydial infections during pregnancy are at increased risk for premature birth, stillbirth, and neonatal death. However, these data concerning perinatal mortality have not yet been confirmed elsewhere, and the conclusions must be regarded as tentative.

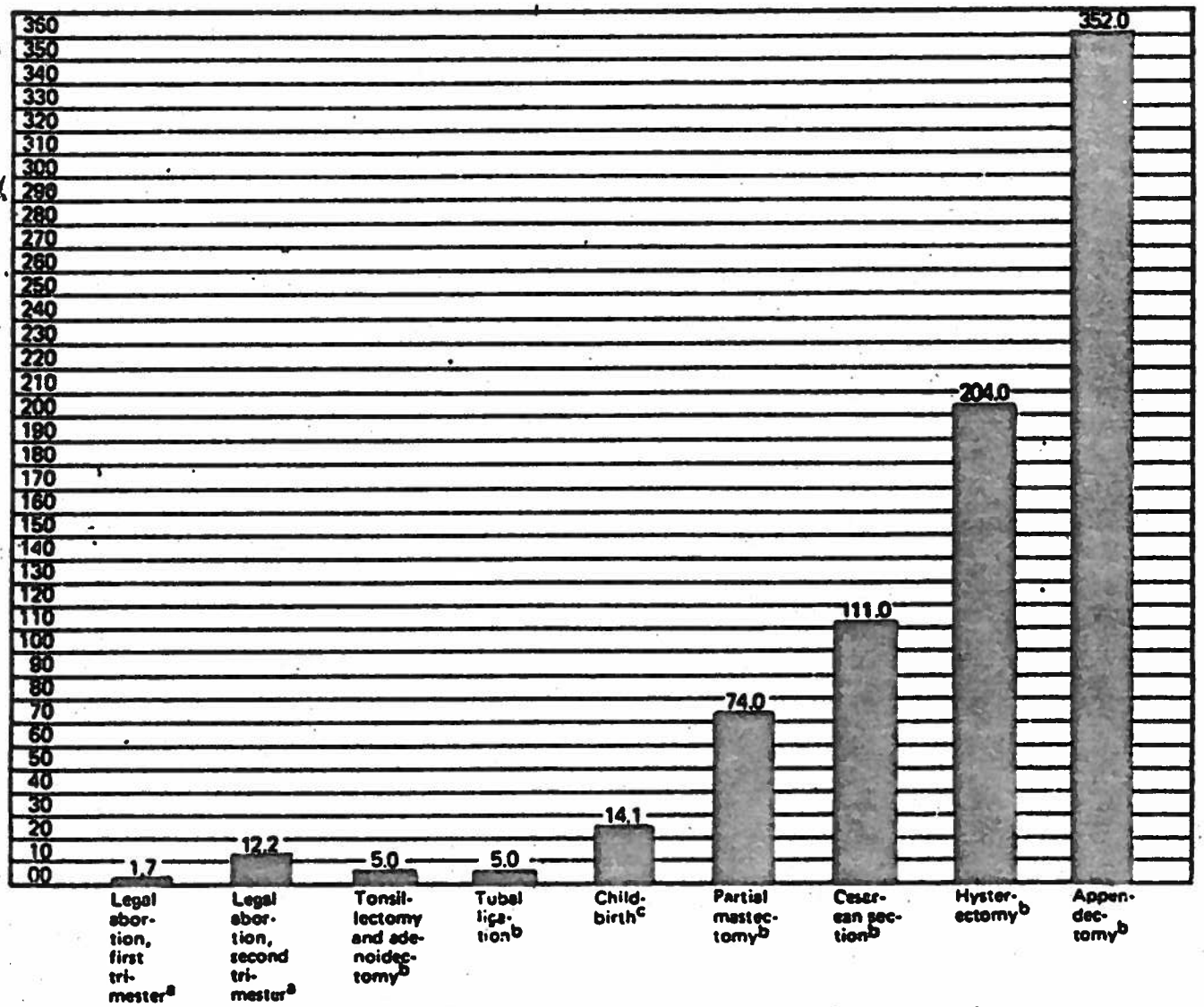
4. Current treatment failure rates following conventional ambulatory therapy for nongonococcal pelvic inflammatory disease [PID] are unacceptably high. I believe that we should be more conservative and hospitalize a higher percentage of women with nongonococcal PID, treating them with antimicrobials that cover the leading possible causes of the infection.

5. Greater awareness, diagnosis, and treatment of chlamydial infections, as well as treatment of the sex partners of patients with chlamydial infections, by practicing physicians could begin to have a major impact on the epidemic.

JAMA: Are there good data on the incidence of chlamydial infection?

Holmes: In the United States neither chlamydial infections nor the conditions that *Chlamydia* causes are reportable diseases, but the United Kingdom requires that nongonococcal urethritis be reported, and this is caused by *Chlamydia* in 40% to 50% of cases. The incidence of nongonococcal urethritis has been increasing progressively during the past two decades. In the United States, nongonococcal urethritis is probably about three times as common as gonorrhea among men in many communities, including Seattle.

Reprint requests to the Department of Medicine, Division of Infectious Diseases, US Public Health Service Hospital, 1131 14th Ave S, Seattle, WA 98114 (Dr Holmes).



[a]Based on 1972-1973 data from the Center for Disease Control (US Department of Health, Education and Welfare)
[b]1969 data from C. G. Child III, "Surgical intervention," in *Life and Death and Medicine*, W. H. Freeman, San Francisco, 1973, p. 65.
[c]National Center for Health Statistics, DHEW, "Summary report: Final mortality statistics, 1973," *Monthly Vital Statistics Report*, Vol. 23, No. 11, Supplement (2), 1975.

Figure 15.8. Death rates (deaths per 100,000 procedures) for legal abortion and other selected operations, United States, 1972–73. (Population Reports, *Series E, No. 3, March 1976, E-27.)*

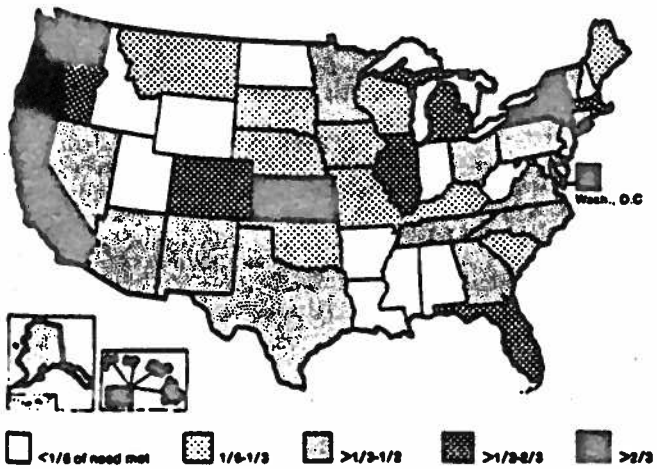


Figure 15.9. Proportion of needed abortion services actually provided, by state, 1974. [From Weinstock et al. (35).].

job of the physician is to preserve life—not to destroy it." Noted Arthur M. Sackler, publisher of the *Medical Tribune:* "There is guilt—the guilt of a society which permits a vicious manhunt against a physician performing his duties in accord with the rules of his hospital, the laws of the land, and the tenets of his conscience. There is guilt, and injustice, when an individual is unfairly singled out to be punished for an interpretation of law established only at his trial."

On appeal the Supreme Judicial Court of Massachusetts, December 17, 1976, quashed the verdict and acquitted Edelin, the justices finding, in a five to one decision, that his action had been neither "wanton" nor "reckless," as previously alleged. "We deal here," the court observed, "with the professional judgment of a qualified physician acting under stress at the operation table. The Supreme Court has cautioned in the abortion

The Effect of Abortion Method on the Outcome of Subsequent Pregnancy

Paul E. Slater, M.D., M.P.H.
A. Michael Davies, M.D.
Susan Harlap, M.B., B.S.

Infants born to women following a previous induced abortion, primarily by the D&C method, showed an excess of low birth weight. However, when women with medical illnesses were excluded, the excess was very slight. The data suggested that the greater the dilatation at D&C, the lower the birth weight. Women requiring induced abortions should have them as early as possible to minimize cervical damage and its consequences.

Delayed reproductive complications after induced abortion

Dalaker K, Lichtenberg SM, Økland G. *Acta Obstet Gynecol Scand* 58:491-494, 1979.

No above-normal rates of reproductive complications were found in a group of 619 women whose preceding pregnancies had ended in therapeutic abortion, as compared to 619 age- and parity-matched controls. The complication rate was 24.3% for the abortion group and 20.2% for controls. Such factors as spontaneous abortion before and after the 13th week, cervical incompetence and pre-term

(continued on overleaf)

Risk of spontaneous abortion following legally induced abortion

Obel EB. *Acta Obstet Gynecol Scand* 59:131-135, 1980.

This study of 3,042 pregnancies found no significantly increased risk of spontaneous abortion in women whose prior pregnancy had been terminated through legal abortion. These pregnancies comprised 1,667 deliveries, 210 spontaneous abortions, 17 extrauterine pregnancies, and 1,148 legal abortions. Using a decremental method, which calculated analysis from the date of conception, the cumulative risk

(continued on overleaf)

Pregnancy complications following legally induced abortion

Obel EB. *Acta Obstet Gynecol Scand* 58:485-490, 1979.

A study of four groups of pregnant women comprising 7,327 patients in matched pairs could find no pregnancy complications other than bleeding prior to the 28th gestational week and placenta or placental tissue retention as a result of induced abortion in the previous pregnancy. Other reports correlating a higher risk of low birth weight and/or shortened gestational age with a previous induced

(continued on overleaf)

A Prospective Study of Spontaneous Fetal Losses After Induced Abortion.
Hariap, S., Shiono, P., et al., N.E.J.M. 301, 677-681, September 1979
PROG 5-2, November 1979

907. ABORTION SPONTANEOUS FETAL LOSS AFTER INDUCED ABORTION

A study of 31,900 in California who were followed throughout their pregnancies. Six hundred sixty-one had spontaneous AB in the first trimester and 753 miscarried in the 2nd trimester. Nearly 11% of the total women had one or more induced abortions and the incidence of spontaneous abortion amongst these women was reviewed. Losses in first trimester were not significantly affected by previous induced abortion and spontaneous 2nd trimester loss was not increased among parous women having undergone induced abortion previously. However, there was an increase in the incidence of midtrimester loss among nulliparous women with previous induced abortion. The differences between nulliparous and parous women support hypothesis that risk is mediated through damage to cervix at time of induced abortion. Findings suggest that this risk in nulliparous women can be eliminated by use of Laminaria prior to abortion procedure. Authors conclude there is little or no risk of spontaneous abortion after induced abortion when performed by current techniques.

Rep.— Savitri Ramcharan, M.D., Contraceptive Drug Study, Kaiser-Permanente Medical Center, 1425 Manin St., Walnut Creek, CA 94596

Association of Induced Abortion with Subsequent Pregnancy Loss.
Levin, A., Schoenbaum, S.C., et al., JAMA 243, 2495-2499, June 27, 1980
PROG 5-11, August 1980

907. ABORTION ABORTION WITH SUBSEQUENT PREGNANCY LOSS

A comparison of pregnancy histories in 2 groups of women, multigravidas with pregnancy loss up to 28 weeks gestation (240 women) and multigravidas having a term delivery (1,072 women). When 2 or more prior induced abortions had occurred there was a two- to three-fold increase in risk of first trimester spontaneous abortion loss between 14 to 19 and 20 to 27 weeks. No increase in risk of pregnancy loss occurred after a single prior induced abortion.

Rep.— Dr. S.C. Schoenbaum, Peter Bent Brigham Hospital, 721 Huntington Ave., Boston, MA 02115

Pop at Risk - ? Not Same -
Truth - less likely - (Memory less likely)
2 previous AB's of OK

Role of Induced Abortion in Secondary Infertility

JANET R. DALING, PhD, LEON R. SPADONI, MD, AND IRVIN EMANUEL, MD

The medical histories of 105 patients with secondary infertility were studied to determine whether or not induced abortion contributes to the occurrence of secondary infertility. One hundred ninety-nine control cases were matched to these cases according to age, number of previous pregnancies, race, marital status, and socioeconomic status. It was found that women with a history of prior induced abortion did have a slightly higher risk (risk ratio = 1.31) of secondary infertility, but that the 95% confidence interval (0.71 to 2.43) was consistent with no association at all. When the analysis was restricted to women without ovulatory problems the risk was of similar magnitude. Prior spontaneous abortion was also found to be unrelated to secondary infertility in this series of women. ***(Obstet Gynecol 57:59, 1981)***

In 1976, close to 1 million induced abortions were reported to the Center for Disease Control.[1] Immediate complications, such as uterine injury and infection, that occur in a small percentage of women undergoing induced abortion[2] might occasionally be expected to result in scarring of the endometrium and/or fallopian tubes and thus to contribute to the occurrence of secondary infertility. As the relationship of induced abortion to secondary infertility in a series of American women had not yet been examined, this study, which uses a retrospective case-control approach, matching for relevant factors, was undertaken.

Materials and Methods

The records of all patients diagnosed as having secondary infertility at the Endocrine and Infertility Clinic, University of Washington Hospital, during the years 1976 through 1978 were reviewed. Patients eligible for inclusion in the study were married; the husbands had a normal semen analysis; and all had been trying to become pregnant for at least 1 year following the legalization of abortion in Washington State in November 1970. To adjust for possible differences due to socioeconomic status, all patients and controls selected had some form of private medical insurance.

Of 152 women potentially eligible for the study, 39 were eliminated for the following reasons: no semen analysis (17 cases); abnormal semen analysis (10 cases); no husband (3 cases); duration of infertility inappropriate (7 cases); and no form of private medical insurance (2 cases).

The mean age of the patients was 30 years at the time of consultation. Seventy percent of these women had experienced only 1 previous pregnancy; 22% had experienced 2. Twenty percent (23) of the women with secondary infertility admitted to having had a previous induced abortion. Only 1 woman had had more than 1 previous induced abortion.

The sampling frame for controls consisted of women seeking prenatal care and delivery at the University of Washington Hospital during the years 1972 through 1978 who had private health insurance. Complete pregnancy histories were collected for all cases and controls. A computer program was used to access the control pool randomly, matching for the following factors:

1. The year of last menstrual period matched to year the patient started trying to become pregnant. (This controlled for the fact that a woman would not have been a candidate for an induced abortion during any time when she was infertile.)
2. Age: 3-year age groupings.
3. Race: caucasian (108 cases), black (5 cases).
4. Pregnancy order: cases with n pregnancies were matched to controls with n + 1 pregnancies. Hence the current pregnancy was used as an indication that the control had remained fertile after n pregnancies.
5. Marital status: all married.

Results

Two controls were matched to each of 94 cases; 1 control was matched with each of 11 cases. An estimate of relative risk was derived using a matched analysis, al-

From the Departments of Epidemiology and of Obstetrics and Gynecology, University of Washington, Seattle, Washington.
Submitted for publication May 15, 1980.

0029-7844/81/010059-03$02.50

Planned Parenthood

EXHIBIT D
May 20, 1981

Dear Senator:

Before you vote on AB 596 (abortion bill), please read the attached article summary on mandatory waiting periods for abortion. Note the number of states in which laws requiring waits have been overturned or enjoined (10), and that in the one state in which the waiting period was upheld (Ohio), this decision is being appealed. The summary also reports views of over 400 patients regarding the effects of a waiting period on them. (Copying costs prevented reproduction of the full article; please call if you would like a complete copy.)

Also, as physicians testified before the Assembly Jucidiary Committee on May 15, informed consent is standard medical practice and is regulated already through negligence law and internal controls within the medical community. There is no need to legislate informed consent. It is not legislated for any other medical procedure.

Before approving any parental notification requirements, it is important to have clarification of the Utah decision by the U.S. Supreme Court this year (M.L. v. Matheson). The notification requirement upheld in this decision covered only a very narrow group of immature, unemancipated minors who cannot prove that notification would not be in their best interests (five of the nine justices supported this view, one did not, and three would not give opinions).

Amended versions of AB 596 share many of the defects of the original bill. There is no need for a bill of this type. If you would like any background information regarding abortion issues and related court decisions, please contact me.

Very truly,

Louise Bayard-de-Volo, Ed.D.
Executive Director

Enclosure

406 ELM STREET ☐ RENO, NEVADA 89503 ☐ PHONE: (702) 329-1781

How Patients View Mandatory Waiting Periods for Abortion

By Michael Lupfer and Bohne Goldfarb Silber

Summary

In recent years, various legislatures have enacted laws and ordinances mandating a waiting period for women seeking to obtain abortions. Legal challenges to such statutes have been successful, except in one instance (Akron, Ohio), and a federal judge in Tennessee recently struck down a waiting period statute.

As part of the appeal against the Tennessee law, two surveys were made of some 400 women who experienced such a delay to probe their opinions about the benefits and drawbacks of the mandated waiting period. More than seven in 10 women were unable to name a single benefit to be derived from waiting, and six in 10 pointed to one or more problems they had experienced, including extra expense, missed work or school, experiencing some discomfort and entering the second trimester of pregnancy, among others. About $7,600 in extra expenses were incurred by about 200 of the women (with a median of $24 per woman), adding about 48 percent to the costs for the typical low-income woman and 14 percent for the typical higher income woman. The cost of the second visit increased in direct proportion to the distance a woman lived from the family planning clinic and to the number of hours she was employed per week. The typical woman was found to hold a negative view of the statute. Women who were surveyed before and after the waiting period said that they actually realized fewer benefits and experienced more problems from the waiting period than they had anticipated.

Seven in 10 women required to go through a waiting period prior to obtaining an abortion said that they disapproved of such a delay. Waiting periods raised the cost of the procedure for typical low-income women by at least 48 percent and for higher income women by 14 percent.

Introduction

Laws requiring waiting periods have been overturned or enjoined in Illinois, Louisiana, Maine, Massachusetts, Missouri, Nebraska, North Dakota and Rhode Island.[1] There have been conflicting opinions in Kentucky about the constitutionality of waiting periods. In 1976, the U.S. Court of Appeals for the Sixth Circuit upheld the constitutionality of a 24-hour waiting period imposed by a 1974 Kentucky law.[2] In December 1980, however, a federal district court struck down that law. In doing so, the district court pointed out that unlike the plaintiffs in the case being heard, the plaintiffs in the earlier sixth circuit case did not present any evidence that the waiting period "would, in effect, impose increased health risks or increased financial burdens upon pregnant women seeking an abortion."[3] A waiting period requirement has been upheld in Akron, Ohio, and is being appealed; a similar law had been in effect in Tennessee,[4] but was struck down on March 23 by the federal court in which the case had been pending.[5] The court held that the waiting period imposed an undue burden on the women.

The Tennessee statute, originally adopted in March 1976, required that a woman seeking an abortion, after being examined by her physician and informed of the "benefits and risks . . . attendant either to continued pregnancy and childbirth or to abortion,"[6] must wait at least two days before having an abortion. The penalty for ignoring the waiting period was one to three years' imprisonment of the physician who performed the abortion.

Efforts to challenge the Tennessee law began as soon as it went into effect in September 1979; although the issue has been resolved in that state, the effort to impose mandatory waiting periods may continue in other jurisdictions. One aspect of the Tennessee case is, therefore, of special interest. Attorneys for the plaintiffs, reviewing similar cases elsewhere, noted that no attempt had been made to evaluate systematically and empirically the impact of the law, i.e., to gauge the effect of the mandatory waiting period on women seeking abortion. We were commissioned to assess the law's impact, by conducting two surveys of women who were candidates for abortions at clinics in Memphis and Knoxville from October 1979 through January 1980.*

The surveys were designed to measure the benefits and costs of the waiting period for abortion candidates: What benefits did the women believe they derived by waiting? What problems did the waiting period create for them? What costs, if any, did they incur by having to return to the clinic a second time? In addition, we wanted to determine whether the women favored or opposed the required waiting period.

The first survey focused on women who had already completed the waiting period. The second survey, identical in content to the first, questioned women both before and

Michael Lupfer is Professor of Psychology and Bohne Goldfarb Silber is a doctoral student in the Department of Psychology, Memphis State University, Memphis.

The authors acknowledge the assistance of the staffs of the Memphis Association for Planned Parenthood, the Memphis Center for Reproductive Health and the Knoxville Center for Reproductive Health in conducting the surveys reported in this article. In addition, they are indebted to Gail O. Mathes, counsel for the Memphis Association for Planned Parenthood, and C. Philip Arnold and Thomas M. Daniel, attorneys for the West Tennessee American Civil Liberties Union, who served as the plaintiff's legal team. A different version of this article was submitted as an exhibit in the case of *Planned Parenthood of Memphis et al. v. Alexander et al.*, Case No. C-78-2310, U.S.D.C. W.D. Tenn. (1978).

*The surveys were commissioned by the Memphis Association for Planned Parenthood

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