02-04-035

COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
COMMITTEE ON JUDICIARY

In re: HB 1979 - 1989 Abortion Control Act

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Stenographic report of hearing held
in Room 140, Majority Caucus Room,
Main Capitol Building, Harrisburg

Friday,
October 13, 1989
9:00 a.m.

HON. THOMAS R. CALTAGIRONE, CHAIRMAN
Hon. Babette Josephs, Secretary
Hon. Gerard Kosinski, Subcommittee Chairman on Courts
Hon. Kevin Blaum, Subcommittee Chairman on Crime
and Corrections

MEMBERS OF COMMITTEE ON JUDICIARY

Hon. Michael Bortner	Hon. Nicholas B. Moehlmann
Hon. Lois S. Hagarty	Hon. Jeffrey Piccola
Hon. Richard Hayden	Hon. John Pressmann
Hon. David W. Heckler	Hon. Robert Reber
Hon. David Mayernik	Hon. Karen A. Ritter
Hon. Paul McHale	Hon. Michael Veon
Hon. Christopher McNally	

Also Present:

Hon. Stephen Freind
Hon. James Gallen
Hon. Allen Kukovich
David Krantz, Executive Director
William Andring, Majority Counsel
Katherine Manucci, Majority Staff
Galya Milohov, Staff writer
Mary Woolley, Minority Counsel
Mary Beth Marschik, Minority Research Analyst

Reported by:
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987 pages

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CHAIRMAN CALTAGIRONE: The House Judiciary Committee hearing will come to order. The purpose of the meeting today is a public hearing on House Bill 1979. I'd like to read a brief statement, then we'll have the introduction of the members and then there's going to be a presentation of some testimony.

Good morning, ladies and gentlemen, members. At this special hearing concerning the abortion legislation that's before the House Judiciary Committee, we are exercising the democratic right of free speech. The debate concerning abortion has been brought from the streets, the churches, the clinics, and wherever people gather to our legislative halls as testimony to the reverence we hold for the right of every person to have a voice in our democratic process. Representatives of the two opposing sides of this heated issue will give voice to their concerns in the names of their constituencies. Whether we are for the legislation being considered or against it, there are two things to be remembered as we hear testimony. One is that it is a fortuitous day when two dramatically opposing sides can get together to express their individual views within the same room. And secondly, I wish to assure you that every attempt has been made to give each side equal treatment.

In line with this, we will hear alternately from each of the two identifying sides on the abortion issue. I feel that I must remind you that due to the extraordinary volatility of the issue, there are rules of protocol which we must observe in this room. Order must be kept at all times. All attendees must remain seated during the testimony and there will be no outbursts at any time during the proceedings, nor will applause be an acceptable form of comment to the arguments and testimony to be presented.

At this time, I would like the members of the House Judiciary Committee to introduce themselves. I am State Representative Tom Caltagirone from Reading, chairman, and my co-chair is to my right.

REPRESENTATIVE MOEHLMANN: Representative Nick Moehlmann, Lebanon and Lancaster Counties, minority chairman of the committee.

CHAIRMAN CALTAGIRONE: Staff on either side

MS. WOOLLEY: Mary Woolley, Republican Counsel to the committee.

MR. ANDRING: Bill Andring, Democratic Counsel to the committee.

CHAIRMAN CALTAGIRONE: And if we could start at the left with the members and just go right down so that everybody can be introduced.

REPRESENTATIVE VEON: Representative Mike Veon, Beaver County.

REPRESENTATIVE HAYDEN: Representative Dick Hayden, Philadelphia County.

REPRESENTATIVE PICCOLA: Representative Jeff Piccola, Dauphin County.

REPRESENTATIVE McNALLY: Representative Chris McNally, Allegheny County.

REPRESENTATIVE RITTER: Representative Karen Ritter, Lehigh County.

REPRESENTATIVE HECKLER: Representative Dave Heckler, Bucks County.

REPRESENTATIVE HAGARTY: Representative Lois Hagarty, Montgomery County.

REPRESENTATIVE REBER: Montgomery County, Representative Reber.

REPRESENTATIVE JOSEPHS: Babette Josephs, Philadelphia County.

REPRESENTATIVE BLAUM: Kevin Blaum, city of Wilkes-Barre.

CHAIRMAN CALTAGIRONE: At this time, Representative Babette Josephs has a packet of letters that she would like to present to the committee and we will accept them at this time. She has a statement to make.

REPRESENTATIVE JOSEPHS: Thank you very much.

I have, I think, about 900 letters that were signed in Philadelphia in the course of a couple of hours at our Super Sunday urging us to oppose this act and also talking to us about taking our time looking at this act carefully and having respect for the democratic process while we do this. I'm happy that we're having this hearing in response to this type of sentiment and I would like to give these to the chairman. It's a pretty big package, and thank you very much for accepting them on behalf of the committee.

CHAIRMAN CALTAGIRONE: Thank you.

At this time, we'll start off with the first witness, Carol Everett. If you have prepared testimony, and we do have other written statements from people that have been distributed to the members, we'll accept the written testimony and have it disseminated amongst the members.

You may proceed.

MS. EVERETT: Mr. Chairman, members of the committee, I appreciate the opportunity to be with you today. I am Carol Everett. I do reside in Dallas, Texas, however my testimony will be substantiated by reports given to you by Suzi Dewing. This testimony will support

the post-abortion syndrome that I'll be testifying about.

After my personal abortion in 1973, I instantly knew that I murdered my own son and found that though I couldn't share that abortion experience, I could tell other women how great it would be for them, and the easiest way for me to do this was to sell abortions. I found it a very easy product to sell. Of course, I was in the sales field and my commission for abortions was $25 each. I was working on a strike commission and made no money if I didn't sell abortions. The last month I was in the abortion industry we did 545 abortions, which means my income for that month was $13,625, and that was a bad month in the abortion industry. I actually planned in 1983 to make somewhere between $250,000 to $260,000, and our expansion plans for 1984 called for opening three more clinics. At that time we would have done 40,000 abortions, and my income would be a million a year.

I was a hands-on operator and I was involved in all the employee training and we rotated eight doctors through our clinics on a 7-day-a-week schedule. Sunday was our most profitable day. We used an unlicensed doctor to do our sonograms and laminaria insertions because he was cheaper than an M.D. He was called doctor and did operate as a doctor inside the clinic.

The telephone counselors were trained by me

with a sales background to sell abortions to the women. Our patients' demographic information such as age, address, area, marital status, referral source, income range, date appointment was booked, date abortion was completed, gestational age, no show statistics, if she was not pregnant or if she was too far along, were all kept on a computer. The percentages were very accurately reported monthly for each employee answering the phone. In other words, their compensation depended entirely upon their percentage of completed abortions.

These statistics clearly reflected that the sooner an abortion appointment was made, the higher the ratio of completed abortions was. That means if she called today and we could get her in today, we knew we could complete her today, but if she booked two days from now, she might have time to think about it and she might back out, and that was very clearly reflected. The conclusion, of course, was that the shorter the period of time a woman had to consider abortion, the more likely she was to have an abortion, and of course the next statement just supports what I've just said, that the shorter timeframe gave the woman less time to discuss her decision with family and friends, which resulted in a decision made hastily to actually hide her pregnancy from her support system.

Since the consent of the spouse was not considered relevant to marketing techniques, we did not keep that statistic, however, I personally remember many women's concern of how to keep the abortion procedure a secret from their husbands.

Our counseling sessions were actually to calm the woman down, soothe her fears, and not to actually offer any alternatives but abortion. I personally trained the counselors to sell our product, and we only sold one product. I might tell you that we did not offer moneys for a woman to continue her pregnancy in any way. We had no maternity sources, no maternity homes. We didn't take her into our home. We did not offer anything but abortion.

We asked each woman why she was choosing abortion and then agreed with her that this was the best choice for her. If she started to move away from that abortion decision we reminded her, your husband will find out, using the very fear that we found out from her, and you don't really want to deal with your husband finding that out, and moved her back to the abortion decision.

Every woman asked at least two questions, and the first question was, always consistently, is it a baby? Even though the clinic personnel called it a glob of tissue, two tablespoons of matter, a blood clot, or a

piece of tissue, I believe women instinctively know, as I did, that they are pregnant. Their body is making changes to accommodate that pregnancy, and it's a crisis pregnancy. We want to believe that it's nothing. We want with all our heart to believe that it's the microwave popcorn answer to a problem pregnancy. We certainly don't want to believe it's a baby, and the pregnancy expert -- remember, the abortion counselor is the pregnancy expert at that time -- says, no, it's not a baby, it is a glob of tissue, it is a product of conception. I've never been aware, and I've worked with chains of clinics across this country from New York to California, from Canada to Texas, and I have never known an abortion counselor to ever tell a woman that it was baby.

I worked in the procedure area and cleaned the instruments after the abortion. I've held those little babies' broken bodies in my hands. Specifically, every single one of those babies had organs. Not one of them was hollow. And I know this sounds terrible to you, but I must say that the intestines, even though they might be threadlike, were what I remember most vividly. They were always there.

As early as an abortion can be done we had to check, the doctor or someone had to check, to be sure that all of the body parts were there. As early as an

abortion can be done. At six weeks a tissue check had to be completed.

As a post-abortive mother, I wish I had been told that at 10 weeks my son was completely formed, heart beating at 18 days after conception, with brain waves 42 days after conception. I wouldn't have had that abortion.

And the second question is, does it hurt? Our answer is, your uterus is a muscle, it's a cramp to open it, a cramp to close it, and they hold their hand up like this (indicating) and actually give them a visual aid on this one so they can see that it looks like it's nothing. The truth of the matter is, an abortion is excruciatingly painful. Women were commonly told that abortion is safer than child birth and 10 times easier, even though we knew that child birth and abortion statistics are reported together so it's impossible to really say that abortion is safer than delivery.

My personal experience in the abortion industry is that the last 18 months of my involvement, we experienced one major complication, or one death. One out of every 500 patients. Now, let me define a major complication - death, hysterectomy because of perforation to the uterus, colostomy because their uterus has been perforated and her bowel has been pulled from her vagina. Of course, that has to be repaired by colostomy.

Perforation of the uterus and cutting or injury to the urinary tract, which can be repaired. Not always do you have an ileostomy in that case.

Although the records were not -- oh, let me back up. Not one of those was ever reported to the National Abortion Federation or to the CDC as a complication. Not one single one, not even our death. Not one was reported to the newspaper. We always transported them to a hospital that would take care of us, not to the closest hospital, in my car because an ambulance is terrible advertisement in front of an abortion clinic, so we took them across town to the hospital that would take care of the doctor. You see, it was actually economics even there because you take a patient to a hospital where a doctor is a high producer, and they know how much their doctors put on their books, they will tend to look the other way, and that's precisely what we did. Not one of those ever filed a lawsuit. We always told the woman it was her fault. Actually, the truth of the matter is some of the records were falsified.

Although the records were not kept to separate them by gestation, over 75 percent of the major complications were for women 24 weeks or over. And you know, there's even a built-in cover-up because the woman is dealing with her problem, she is now facing the people

that she was trying to keep this secret from. She doesn't call the media. There's a built-in cover-up.

With two of the physicians, my job was to hold the baby still for the second and third trimester abortions, and you do that by putting your hand at the back of the baby and you push this baby forward and you say the hands are here, the foot is here, the head's here and you push it down (indicating). The head is the most difficult to get out. We used the D&E method, the dilation and evacuation, and what happens is they use large forceps called bearhawk forceps like this. They crush the baby inside the uterus, pull it out piece by piece. No live birth, no labor for the mother, and they reconstruct it outside of the uterus so they can be sure all the body parts are present. My job was to tell the doctor, of course, where the parts were. The head has to be deflated and usually you either use the suction machine to remove the brain and crush the head with large forceps. Psychologically, the doctor always sizes the baby at 24 weeks, even though I have seen babies that were almost full term. We did one abortion on a woman, the baby was so -- the muscle structure was so formed that the baby wouldn't come apart, and finally what happened is the baby's head came off its body. I saw many, many babies aborted that could have lived outside their mother's womb.

I can't even tell you how many.

We had a token R.N. on staff and L.D.N.'s, but you keep them out of the procedure areas specifically because, you know, R.N.'s and L.D.N.'s always want you to do all these procedures. They want you to completely clean the room, they want you to resterilize all the instruments, they want the doctor to wash his hands between cases and that slows things down, so keep your R.N.'s and your L.D.N.'s up front and out of the way.

Our staff was trained to adapt to each doctor, meeting the needs of that doctor regardless of the term of the pregnancy. Doctors have different ways that they like to do their abortions and you are expected to adapt to them. We routinely reused the curettes, gas sterilizing them, even though the sterile package clearly states, "STERILE - Use once and discard. Contents of unopened or undamaged package guaranteed sterile," and I believe there is supposed to be -- and there is an exhibit on the back showing this comes out of the curettes. This is a sample of it. It shows very clearly it's a one-time use, yet this last week or a week before last a clinic was closed in Florida for reusing them 10 to 12 times. We did that, too.

The tubing, which is also supposed to be disposable for the suction machine, was reused from

patient to patient using only one tube per procedure room per day, even though it was designed for the one use.

On a busy day, we were rushing women through using two to three doctors. If you have 50 to 75 patients coming through, you got some problems. There is a 43 percent repeat rate in this nation and you know you want to keep that woman happy because she is going to be going out there coming back for an abortion and it doesn't matter, she's going to be post-abortive, and the first stage of post-abortion is relief and then denial, and in denial she will say one of two things: I could never have an abortion but it will be good for you; or, I had an abortion, it was the best thing that ever happened to me. Whatever, she's going to be selling abortions, so you want her to be happy.

We rushed these girls through. Instruments were only "flashed," a term which means that rather than maintaining the instruments at a temperature considered high enough to sterilize them for 20 minutes to insure sterilization, the autoclave was kept as hot as possible, not turning it off between autoclave use. The instruments were placed in, the temperature raised to the level considered high enough to sterilize for seven minutes only, steam released, instruments sometimes cooled in the refrigerator or given to the physician so hot that he had

to use a gauze sponge as a hot pad to dilate the woman's cervix to do the abortion, and that was routine on a Saturday.

In order to insure sterility, instruments should not even be touched when the wrapping paper is still wet from the steam. This was routinely violated in an effort to keep turning instruments so each doctor could do 10 to 12 first trimester abortions per hour. Second and third trimester abortions were considered to take 20 to 30 minutes each to remove all the body parts, placenta and blood.

In a hospital environment, a doctor writes orders for his patient, the room is completely scrubbed and cleaned between patients, all instruments are sterilized completely and complete new sets brought in for each case. The woman is sedated, prepped, anesthetized, and the physician is expected to cover his hair, mask, do a surgical scrub on his hands and forearms, gown with a sterile gown and sterile gloves. The physician completes the abortion procedure and then is expected to go to the recovery room, check his patient, write follow-up orders and speak with the patient's family while the operating room is recleaned and the entire procedure starts over. Time elapsed: Roughly one hour. In a freestanding abortion clinic, only the regulations the state, city, and

physician impose on personnel are followed, but because of the 40 percent repeat rate of abortions, again this is repetitive. I'm sorry. I didn't realize this was in here.

Thus, on a busy day, the two to three doctors working in the clinic, optimally two teams of two women with each doctor, team number one sets up girl number one in room number one and the doctor does that abortion while across the hall team number two sets up girl number two so that when the doctor finishes abortion number one, he can run across the hall to do abortion number two. While he's doing that abortion, team number one takes the girl to the recovery room, leaves her with that attendant, rushes back to turn the room. The table paper is pulled down, an underpad is put on the table, wipe only the visible blood off, take the baby in the bottle to Central Supply, put the baby in a strainer. We used one of those big common kitchen strainers. You pour it in the strainer and you wash the blood out with water, put it on an underpad and number it 1 for the doctor to do that tissue check to be sure all the body parts are present. If a body part is missing, it is necessary to repeat the abortion procedure. The physician is responsible for the tissue check and only sends it out when he's questioning something in order to keep the costs

down because lab fees vary from $6 to $10 per procedure for tissue analysis and you want to keep your costs down if you can. And then again, we're going through, the blood is washed out of the bottle, the bottle is replaced in the machine and you're setting up a section, the rubber stopper is put in the bottle mouth, the tubing is put on, and the instruments used in the first procedure are replaced. Woman number three is brought in, placed on the table, and we allowed her counselor, usually the one who booked her abortion on the phone, to remain with her to keep her quiet. Our experience was that if one patient screamed it upset the entire day, so we strived to keep each patient as quiet as possible.

When the doctor finishes abortion number two he runs across the hall to do abortion number three. The physicians in our clinics did not routinely scrub their hands. We did not have a scrub station, and I've worked, again, in abortion clinics all over the nation and I have never seen a scrub -- I have seen a scrub station in one. I have seen a scrub station in one.

The physician in our clinics did not routinely scrub their hands and forearms before the next abortion procedure. The physician does re-glove using sterile gloves, inserts the speculum designed to hold the vagina open so he can see to work, cleans the cervix off

with Betadine, a pre-surgical scrub, numbs the cervix with Xylocaine, similar to the Novacaine the dentist uses to numb your gums when your teeth are worked on, and then dilates the cervix starting with very small dilators, slowly graduating in size until the cervix is large enough to accommodate the cannula. This is pretty important because this goes back to the coat hanger abortion myth. You know, prior to Roe v. Wade, an abortion was done with a hollow spoon-shaped knife. It was called a curet, and they still use them in Ob/G and surgery, what happened was it's the uterus -- the uterus is a muscle and it's the uterus, placenta, the fluid, and the baby. And now, in order to remove this, you have to tear out all the products of conception so you've got to remove the placenta and the baby, and they did that then with this curet which scraped the baby off the wall of the uterus, and then they had to use tissue forceps to remove the parts and then go back and scrape to be sure it was all gone.

After Roe v. Wade, this marvelous little curet was developed, the cannula, and it's shaped like this (indicating), and these are the little edges which start the tear in the placenta and this is the suction, and it depends on the machine and the way it's done as to how strong the suction is, the way you set it, but what

happens is this tears the placenta off and the baby is pulled piece by piece, and you've seen those movies, and this is what they're doing (indicating). They're doing it like this, and it's just one fell swoop around. The doctor does it all around the uterus and it's over. The baby's dead. It's very fast. And when I was in the abortion industry, those things sold for 93 to 99 cents a piece, and when we started hearing the coat hanger myth again I decided to go buy some, and the law of supply and demand has already kicked in. They were $3.40 each then, and I understand that the next group that I buy will be $5 because they're already being stockpiled, I believe.

Each doctor, unless something was unusual about the pregnancy, the doctor saw the patient for the first time in the abortion room. Each doctor said hello in different way, but the main thing was not to use her name or ask her how she felt about the abortion because then he had to listen. So they used terms of endearment such as baby, hon, dear. The counselor's job was to tell her what was going to happen and to keep her quiet.

You know, I didn't put this in here but I've got to say it. One of the things that I saw in the abortion industry commonly was a woman would get to the abortion table and then decide that she no longer wanted to have an abortion. She would say, "Stop, I don't want

to have this." But you know, something very important had happened by that time. She had signed her consent form and she had paid her money. The doctor was on a commission, I was on a commission, the people working were on a commission, and we held those women down on that table, gave them Valium, and did their abortion. Unfortunately, I have to tell you I've done that many times.

Operative procedure notes are made in the charts when the doctor has time between cases, and let me go back to that. What that says to me is if she had time to wait, if she had an hour, if she had 24 hours, those women wouldn't choose abortion.

Operative procedure notes are made in the charts when the doctor has time between cases or when the recovery nurse is ready to dismiss the patient.

Using the above technique, the physician can accomplish 10 to 12 abortions per hour and makes approximately one-third to one-half of the fee charged, depending on his negotiated arrangement with the clinic. Now, an abortion in the United States can cost you right now, depending on if you have coupons or whatever, from $200 to $2,500, because you know that there are doctors doing abortions into the ninth month of pregnancy in the United States. If a physician does 10 abortions per hour

and the minimum fee is just $75, and that's conservative, the physician can make $750 an hour.

Our physicians were paid in cash. We didn't want any part of the responsibility of his malpractice insurance so we wanted to be completely independent of the doctors. The doctor's fee was collected separately from the clinic fee and we kept no records of the doctor's income, okay, or our collecting their money. Since the doctor was not an employee of the clinic and the clinic did not show that we collected his fee, the doctors were paid in cash, no records were kept for Internal Revenue Service. Reporting of that income was left entirely to the discretion of each doctor.

Physicians have no overhead in the abortion clinic if they're not owners and do not have to wait for the insurance to pay. Abortion charges are paid for before the procedure in cash, even if the woman files an insurance claim it's her responsibility.

The recovery room nurse monitors patients for at least one-half hour and does birth control counseling designed to help the woman choose a method of contraception. The woman is dismissed upon the discretion of the recovery room nurse unless something unusual demands the physician's attention. What I'm saying to you there is the doctor does not control anything in the

abortion clinic except the abortion itself. He does not determine when that woman leaves the clinic. He may be her doctor but he is not acting in the capacity of the doctor unless there's something unusual.

In July of 1983, Channel 4, the CBS affiliate in the Dallas area, ran a five-day expose on abortion clinics doing abortions on women who were not pregnant. They focussed on our clinics. One of our clinics was caught red-handed trying to do abortions on nonpregnant women and allowing an unlicensed doctor to practice medicine. Channel 4 sent women in dressed in jeans looking very innocent wired for sound to see if we'd do an abortion on a nonpregnant woman, and we did. The expose clearly showed me walking in and out of the clinic with sketches of how we sold abortions to nonpregnant women with a tape playing in the background, "Yup, Babe, you're pregnant. Got your money? Why don't we just do it today?"

Even as I held those babies' broken bodies in my hand I always told myself that I was helping a woman. Her choice to have a safe, legal abortion. That's what I believed. Slowly, painfully I had to admit that we were killing and maiming women, as well as killing a baby in each abortion. We weren't helping women.

Abortion is not a choice women make.

Abortion is a skillfully marketed product sold to a woman at crisis time in her life. She needs help. She tries the product and when she realizes it's defective, it's too late to return it for a refund. Her baby is dead.

CHAIRMAN CALTAGIRONE: Thank you.

There have been several additional members that have joined us and for the official record, I'd like to have them introduce themselves and the county of origin. If we would start over here.

REPRESENTATIVE MAYERNIK: Representative Dave Mayernik from Allegheny County.

REPRESENTATIVE KOSINSKI: Representative Jerry Kosinski from Philadelphia County.

REPRESENTATIVE PRESSMANN: Representative John Pressmann, Lehigh County.

REPRESENTATIVE BORTNER: Representative Mike Bortner from York.

CHAIRMAN CALTAGIRONE: Thank you.

Now, questions from the members.

Representative Hagarty.

REPRESENTATIVE HAGARTY: Thank you, Mr. Chairman.

BY REPRESENTATIVE HAGARTY: (Of Ms. Everett)

Q. Ma'am, what abortion clinic did you work for?

A. I was employed in the Dallas-Fort Worth area. Dallas Medical Ladies' Clinic, Women's Clinic of Mesquite, South Lake Women's Clinic, and North Dallas Women's Clinic. Four abortion clinics that I was employed in.

Q. Was this one business chain?

A. No, there were two business chains.

Q. So you worked for two separate chains?

A. Yes.

Q. And during what period of time?

A. '77 through 1983.

Q. You worked there for 13 years?

A. '77 through '83. Six years.

Q. Oh, six years. When the expose was done, were there arrests made?

A. Unfortunately, there were no arrests.

Q. And why was that?

A. I don't know. The cover-up, we knew this was being done. We were aware that they were investigating us and we started our cover-up before it even happened, so we want to NAF, the National Abortion Federation, called them in and had them help us get us straight, and I left before it was completed so I don't know what happened.

Q. You were never criminally charged yourself

with any of this allegedly criminal conduct?

A. No. No one was ever charged. Not one person was ever charged in any of those things.

Q. Were these doctors sued for malpractice on any occasion?

A. As long as I was in the abortion clinic business we never had a lawsuit. These were Ob/Gyns who were closet abortionists. They rotated through, had their private practice and rotated through on afternoons and evenings. No malpractice was ever brought.

Q. Were these doctors' licenses taken?

A. None of those doctors' licenses were taken. Every one of them are still doing business, and some of them are still doing abortions.

Q. Did you bring this to the attention of the doctor's licensing board in the State of Texas?

A. I have repeatedly, as late as last year, been to the Texas Medical Society and talked to them about that, asked them to investigate these doctors, but nothing ever happens.

Q. Is your position that an investigation was never done despite the extensive news coverage that you claim occurred?

A. There's no claim. You can get the tapes. There was never an investigation, and I have repeatedly,

year after year, month after month tried to get the Texas Medical Association to do something and it falls on deaf ears. They have helped.

Q. How many instances did you observe of abortions occurring after the second trimester?

A. I don't have good statistics, but probably -- and that was one of our specialties. We probably did 150 to 200 second trimester and third trimester abortions a month, but you've got to remember that we didn't separate them. We called them all 24 weeks because psychologically the doctor won't go over 24 weeks, but there were a huge number of those babies who were over 24 weeks and were viable.

Q. Were you aware at the time you were doing it this was an illegal practice?

A. It is not illegal. It's legal to have an abortion until the moment of birth.

Q. It's not my understanding of the law now or then, let alone--

A. They are still doing abortions in the second and third trimester in the United States all over, and third trimester abortions are commonly done.

Q. Have you ever observed an abortion clinic in Pennsylvania?

A. No, I have not. There will be follow-up

testimony about women who have been in abortion clinics in Pennsylvania. Consumers, I should say, of abortion, and there will be one -- I'm not sure, but there will be consumers of abortion, women who have been in abortion clinics in Pennsylvania.

Q. I didn't understand why after you concluded that you had murdered your own son you then went into an abortion business.

A. I'm glad you asked that question. Post-abortion syndrome is a delayed stress disorder similar to rape or incest or even the Vietnam experience and women don't normally deal with their own abortion experience for 5 to 10 years down the road, and I was, as most women are, very heavily into denial. The first thing was even though I thought I killed my son I had to believe it was right, and so it was complete denial. And I had the typical post-abortion statistics. I was -- I became involved in drinking, I had never taken drugs before but I became involved in abusing prescription drugs. I was a workaholic. Other things which happen to pop into those categories are promiscuity, workaholism, suicide attempts or completions, eating disorders, and on and on, an average of 5 to 10 years before the woman actually says, I killed my baby, and starts her grieving healing process. She's self-destructive all those years. My own experience

was 13 years. I only three years ago admitted that I killed my son. It's a subconscious thing and it's so bad that we can't admit that we killed our child and we can't tell anyone that we were that bad.

Q. Did you have psychological problems before you became pregnant?

A. Had never seen a psychiatrist, psychologist, had never been involved in any problem until I had that abortion, and I have been seeing a counselor since just a few months after that.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Representative Heckler.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

BY REPRESENTATIVE HECKLER: (Of Ms. Everett)

Q. What is your medical training?

A. Oh, I don't have any. I'm an operating room technician, but that's the very thing. Abortion is the largest unregulated industry in the United States today, and I can still open an abortion clinic. Now, I don't know if I can do it in Pennsylvania. You may have to have a license, but in many States I can open an abortion clinic right in this room.

Q. Okay. So when you say you're an operating

room technician, is that then by virtue of some training that you've had?

A. Yes. You learn to -- you're an operating room assistant in the operating room and what you're qualified to do is scrub with the doctor, pass instruments to him and assist him in surgery.

Q. Well, what you're telling us then is you did attend some school to receive some degree?

A. (Indicating in the negative.)

Q. How did you come to be--

A. I was trained in a hospital by a physician I worked for.

Q. Okay. Were you licensed by the State of Texas--

A. No, sir.

Q. --in any capacity?

A. (Indicating in the negative.)

Q. So that the term "operating room technician" has no particular significance in terms of being recognized by somebody as being either licensed or having achieved some particular recognized degree of expertise?

A. That's correct.

Q. Okay, so that when you give us either medical testimony or various conclusions, that's based simply on your experience?

A. It's based on my experience and my training in the medical field as an operating room technician in the State of Texas.

Q. Okay. Could you tell us, you mentioned four clinics in the Dallas area, I believe, that you worked in. What other abortion clinics have you worked in?

A. I have visited other abortion clinics but I have not actually participated in abortions outside of the State of Texas. I have visited others and watched procedures so when we were learning how to do the second and third trimester abortions it was necessary to observe them being done, and even though I didn't participate, we had to watch the procedures.

Q. I see. Well, could you tell us where you were?

A. Dr. Hochomovitch from New York has a chain of clinics, 12 clinics across from New York to California. He has two in New York, some in California, some in Dallas.

Q. Where did you personally go, since you didn't work in any clinics outside of the Dallas-Fort Worth area, where did you go to do these observations?

A. I just told you, to New York. We actually looked at other doctors who were performing these abortions, who were doing the second and third trimester

abortions who had experience with the second and third trimester abortions because we were learning how to do a D&E. We didn't know how to do a dilation and evacuation, so we observed.

Q. Okay, so that you observed abortions being done in is this New York City somewhere?

A. Yes.

Q. Also in California?

A. Yes. He had--

Q. I'm asking where you were present during some abortion procedure.

A. I was not in the room in California.

Q. Okay.

A. We were learning how to do second and third trimester abortions.

Q. Okay, and this was training that you got when you first became involved in the abortion clinic?

A. No, this was when the D&E method started coming out. You see, the first, second and third trimester abortions were done with a saline procedure and a prostaglandin procedure, and when it was necessary to stop the live births and the labor for the mother, then another type of procedure was necessary, and that's when the D&E came into effect, and we started to do D&Es probably '80 or '81 is when we got into the D&Es.

Q. Um-hum. Now, perhaps I misheard you but I thought that you testified during your prepared remarks that you had worked in abortion clinics all over the nation. I take it that is not correct?

A. I have worked in four clinics in Dallas. I have been involved with chains across the nation.

Let me tell you what I mean by working. Let me define that. You don't have many people you can call when you're in an industry like this to say, how did you cover up your last death? But you have to have friends that you can talk to, and the friends that you talk to are chains of abortion clinic operators who operate the same sort of facilities that you do. So you deal with these people so you can learn from them, and when I say "working with," that's the kind of relationship I'm talking about. A networking to work with them and literally, you know, one of my friends in a clinic in Houston had a live birth. Who could she call and say, what do you do? Well, she called me. I called her when we had a death and said, "We had a death. How do we do this? How do we cover it up? What do we do?"

Q. Now, you're saying the death of a woman?

A. A woman, a 32-year-old woman with a 2-year-old and a 17-year-old living child and she died of an abortion.

Q. And were any criminal charges or malpractice action brought as a result of that death?

A. No, but I'd like to go through that with you so you understand, because there should have been.

Q. Well, what you're saying is that you participated in a cover-up, prevented this woman's family and the legal authorities from discovering the true facts associated with her death?

A. Yes, sir, I am. I am telling you that the coroner found that she died as a result of a cervical tear to the cervix which could have been sutured had the doctor had time, but he had a date and had to leave and she died, and I was part of that. I am emptying out my heart, telling you the dirty parts of me. Yes, I am.

Q. And you're saying now, you indicate that the coroner made those findings. Were there facts which were concealed from the coroner?

A. Yes, sir.

Q. Let's hear about that.

A. The doctor called me and asked me to go in the clinic and to change the chart and I said, "Let me tell you something. I'm pretty bad but I'm not that bad, and I am not going to do that." And so I don't know, I can only -- I didn't see this but I know it happened. The doctor and his girlfriend went in the clinic, changed the

chart, and when I got there the chart was gone. And I said, "Where's her chart?" And I was given her chart and it was dropped under all my files in my drawer so our employees could never find it. But all of her blood pressures and her vital signs had been changed. When the coroner asked for a copy of those records, he received false information from Dallas Medical Ladies Clinic.

Q. And the true information was hiding under your files?

A. No, sir. The falsified information that the doctor gave me when I came in on Monday and asked for her chart was hiding under my files. He went in on Sunday and he changed it and no one ever knew but the doctor, his girlfriend, and me.

Q. And you never volunteered that information to any of the legal authorities who were investigating this matter?

A. Not at the time, but you've got to remember where I was. At the time I was scared. I was scared for my life, I was scared for what would happen to me, and I was implicated.

Q. This occurred in what year?

A. This was January the 16th, 1981.

Q. And you have -- have you since revealed this information to the authorities?

A. I have talked to the medical examiners in the Dallas County. I have talked to the medical examiners in Austin, Texas, our capital, and nothing has been done.

Q. When you say you've talked--

A. I have specifically told them there were deaths, there were multiple complications. I told them of the cover-ups by several doctors and absolutely no investigation has been started.

Q. Now, it is also your testimony that you have held women down who, women who verbally communicated to you that they wished to revoke any consent that they had given and that they did not wish an abortion and you have held them down while the procedure took place? Is that your testimony?

A. Unfortunately, that is my testimony.

Q. How many times did that occur?

A. I don't know, but certainly more than once. You don't sit around and count those things. I can tell you this, you're believing that you're helping a woman. She signed the form. You think she's just freaked out at the last minute and you tell yourself you're keeping her from a fate worse than death. You're helping her because this is what she really wants.

Q. Well, did any of these women after the fact bring criminal charges or at least make a complaint to the

medical licensing authorities?

A. No, unfortunately, but I do have one that I work with in Texas now that said that the reason she didn't do anything was because she was so devastated by what we had done that she couldn't tell anybody, and she was post-abortive and couldn't deal with it.

Q. How were clients referred to these clinics in which you worked?

A. Well, one of the big referrals, of course, was word of mouth because you keep your patients so happy you hope they'll come back, and then of course you know the 40 percent repeat rate. The largest number of abortions I ever saw one woman have was nine, but, you know, they keep coming back because you're encouraging that, you're reselling abortions. But the major source of referral was, I suppose, Yellow Pages, and then we also put out discount coupons and we advertised in the newspaper.

Q. Okay, so that you advertised commercially or your clinics did advertise commercial?

A. Oh, very definitely.

Q. And that's principally where your patients came from.

Now, when Representative Hagarty asked you whether you had reported the conduct of these physicians,

which would seem to me to be very clearly malpractice, as you describe it in your testimony, you said that you had conversations with the Texas Medical Society. That's a private organization, I assume, like the Pennsylvania Medical Society is.

A. No.

Q. And I'm sure in Texas, I know in Pennsylvania there is a separate State agency which issues a doctor his or her license to practice and which is charged with the responsibility of revoking those licenses where appropriate. Have you ever had any formal communication with that State agency or authority?

A. That is the agency I'm talking about. The agency that licenses physicians in the State of Texas is the agency I have contacted repeatedly and nothing has been done.

Q. Have you ever spoken with the district attorney in the jurisdiction?

A. Yes, sir, I have.

Q. And?

A. Nothing's happened.

Q. And evidently--

A. And let me further say, I've had a lot of help with this. I didn't just do this all on my own. I've had some people working with me. We have not been

successful.

Q. Okay. Have any of them indicated to you that they find your testimony not to be credible?

A. No. They always tell me they're going to do something about it and then we never hear from them and when you call them back, they don't return your phone calls.

Q. Well, I suppose the final question I would have for you, have you reviewed the legislation, House Bill 1979, which is the subject of this hearing?

A. I have not read word-for-word, but I am in support of the Abortion Control Act of 1989, and there's several things in there of course that I could speak to, the spousal consent, because we did see many woman come in without spousal consent.

Q. Well, if I could, I'm specifically interested in this because your testimony in large measure focuses on what appears to me to be terrible malpractice in the clinics in which you worked. Nothing in this bill, as I read it at any rate, deals with regulation of abortion clinics. That is covered in existing Pennsylvania law. And I'm just wondering what -- how the conditions, if we assumed that this kind of conduct were going on in Pennsylvania, I'm wondering what House Bill 1979 would do about that?

A. Well, I am specifically concerned about the 24-hour waiting period. I think that would be very advantageous to the women because I am very pro-woman and I believe that the women would be helped by that. And I also believe the spousal consent would certainly speak -- would be very, very informative. I will agree, I will tell you that many of the things that I went through and I will tell you, and I don't know what page it's on, but one of the major things we talked about was the 24 weeks, and I wanted you to know about the complication rate we saw in 24 weeks and over, and that was on my page 2 at the bottom, the last paragraph, and I think we're speaking there. And the reason I went through the counseling and some of the problems there is I believe that the counseling is very important and you, as lawmakers, have an opportunity to work toward controlling that in some measure.

Some of the things that women were told, that childbirth is more risky than abortion and all those things. I think also one of the reasons that I went through some of these things, for instance the R.N., that you could require that as in a hospital facility that perhaps you would have the same techniques and the same measures as any hospital rather than the freestanding unregulated clinics. And there was one other thing that I

was specifically -- I'd really like to see you do something about the reuse of equipment because that was routinely done, and we just found a clinic in Florida closed down for reusing equipment. We have also found 22 unlicensed clinics this week in the State of Florida. I think licensing is very important.

I think that these things tell us that this is probably not limited to the State of Texas. The physicians and their payment method and the fact that they are not required, that they can be independent employees, should, I think, be something of a concern to you as a lawmaker.

Q. Well, Ma'am, thank you. Again, now you're getting into areas which I believe are addressed by present law.

I was wrong. I do have an additional question.

You mention in your testimony that a CBS affiliate took a film of you specifically being involved in the conduct of, I guess, counseling and having a woman who was not pregnant participate in what was apparently a sham abortion to defraud her of her money, is that correct?

A. This is supposed to say, and I hope it does, that they showed me walking in and out of the clinic. All

they showed was me entering the clinic and leaving the clinic, with sketches of how we sold abortions to nonpregnant women, which I was not involved in because I had warned the nine doctors that worked for us that they were doing exposes specifically not to do abortions on any women that weren't pregnant during this period of time, but you can't control nine greedy abortionists and they caught us red-handed, my clinic, and I was not personally involved but I was involved in the clinic and it was certainly my responsibility. And I take full responsibility for that.

Q. Well, are you telling me then -- let's put aside the expose. Are you telling me that as a part during the years when you were working at these clinics that you knowingly participated in defrauding women of their money by having them participate in what were essentially sham operations, knowing that they weren't pregnant?

A. Let's walk through that in two parts.

Q. Okay.

A. I knew abortions were being done on nonpregnant women.

Q. Okay.

A. I did not know which ones because a doctor doesn't come up and say, "Hey, guess what, Carol. I just

did an abortion on one that wasn't pregnant." First of all, he's doing it for the money, I'm doing it for the money, and unfortunately, we're both on a straight commission and we're working together. Now, he is the doctor and he is in charge of the medical procedure. My job is to get them in there and get them ready for him. He is in charge of the operation and I did not know which women weren't pregnant. I had no control over that because I am not a physician.

Q. Well, certainly you must have known after the fact. You've described to us the trauma of dealing with this reconstruction of the fetal tissue. You certainly knew after the fact that a given, quote, "abortion" hadn't in fact aborted anything, right?

A. Sir, my testimony clearly states that the doctor was responsible for doing the tissue check, not me. The doctor was responsible. He is the only one that knew he did an abortion on a nonpregnant woman.

Q. Maybe I completely misunderstood your earlier testimony, but isn't one of the things you told us that you personally handled this fetal tissue?

A. I could not handle 545 babies. I did not handle every one. I handled an occasional one when there was a need for me to go back to Central Supply, but it was bottled up. But the doctor -- I clearly told you in my

testimony that the baby is checked, washed, put on a pad and numbered for the doctor to check.

Q. And you're telling us now that only on a very rare occasion was it your responsibility to do that?

A. As in my testimony, it was never my responsibility to do that. Occasionally I went back and cleaned the instruments after that. The doctor's responsibility was to do the tissue check. My responsibility was to make sure the instruments were cleaned, and if there were parts of those babies' broken bodies in there, then I picked them up. But it was the doctor's responsibility and it was never at any time mine or any other nonmedical personnel, not even the nurse's responsibility to do the tissue check. Doctors only, because you were saving money by making them do it.

Q. Well, I suspect that the authorities in Texas have made the same conclusions about your credibility that I have and have acted accordingly.

REPRESENTATIVE HECKLER: I have no other questions, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you.

Representative Reber.

REPRESENTATIVE REBER: Thank you, Mr. Chairman.

BY REPRESENTATIVE REBER: (Of Ms. Everett)

Q. Just briefly and as a follow-up to some of the questioning of Representative Heckler, Ms. Everett, I note that you've submitted to us an affidavit. Do you have the original of that affidavit or does the Chairman?

A. I don't have the original right here. This is a copy also.

Q. Okay. On at least two occasions I can recall during the course of your testimony and during the course of your dialogue with some of the other questioners you made reference to the statement saying that, "It's supposed to be in here," or "I believe it's in here." Is this in fact a statement prepared totally by you as it appears to have been sworn by you on or about October 3, 1989 before a notary here in the Commonwealth of Pennsylvania?

A. This is my statement and when I say I believe, I mean it's in there. If I said "I believe," I meant to say "it's in here," and there is no question in my mind that anything I said to you today or to Mr. Heckler or to the woman prior to him is not in here, and if you would like to review those things, I would love to go over them.

Q. No, I'm just questioning--

A. This is my personal statement, every word of it.

Q. You dictated this?

A. I dictated this over the telephone to my secretary in Dallas, Texas, who typed it up and Federal Expressed it here.

Q. Okay. Were you personally present before the notary?

A. This morning I was. This morning right here in town. I went to an attorney's office right here at 8:10 this morning.

Q. Okay, and that is the 13th then day of October. On the copy I have it appears to be--

A. It's today. This morning. Today's Friday the 13th, isn't it?

Q. Unfortunately, it is.

A. It is. Isn't this going to be fun? It's not unfortunate.

Q. So then I assume that it's fair that everything that you have in this written document you still stand on as being true and correct, is that correct?

A. As I stood on it in the prior cross-examination I still stand on it.

Q. Thank you.

REPRESENTATIVE REBER: Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you.

Are there any other questions from members?

Representative Ritter.

REPRESENTATIVE RITTER: Yes.

BY REPRESENTATIVE RITTER: (Of Ms. Everett)

Q. I would just like to go over this one point again. You said that from 1977 to 1983 you worked in these clinics?

A. I can barely hear you. I'm sorry.

Q. Okay. And you said that during that time you falsified records, you lied to patients, you reused medical supplies that were supposed to be thrown away, you didn't follow adequate sanitary procedures, and then in 1983 sometime you had a conversion and a revelation that said that this was not the proper thing to do. Did this conversion occur before or after the July of '83 expose by the CBS affiliate?

A. If you'll look at the last page of my testimony it says "Slowly, painfully, I had to admit we were killing and maiming women, as well as killing a baby in each abortion - not helping women." This happened. And there is another place in here where I refer to the last 18 months of my involvement in the abortion industry that we maimed or killed one woman a month, and it started January the 16th, 1981. It was a very slow and painful thing for me, and it ended July 27, 1983. I had to admit

we were killing women and babies and destroying women's lives.

Q. So that was after the TV cameras got you on tape?

A. No, it started January 16, 1981.

Q. But you said--

A. And it ended after. It was already done. The last one as May the 31st, a 21-year-old model who danced in and asked us to take care of her problem. She was just a little older than my son and I had my hand on that baby and the doctor went in with those big forceps and he pulled out placenta and the second time he perforated her uterus and he pulled her bowel through her vagina and May 31, 1983 it was over for me, May 31, 1983.

Q. But the point is, as of July of '83, according to your testimony, you took this woman into the clinic and told her she was pregnant and asked her if she had her money and all of these other things. I would think that if a conversion had been proceeding at that point that you wouldn't have been involved in that kind of activity, and my question is simply the timing of all of this and why suddenly you left this clinic and you said that you quit the clinic?

A. I walked out.

Q. Um-hum.

A. My testimony very clearly says that I was not involved in selling those abortions to those women personally, but I was responsible. It very clearly said--

Q. I would say that you were responsible.

A. --as the operator of that clinic I responsible.

Q. Absolutely.

A. And it very clearly says, if you will read it, the last page.

Q. I have read it.

A. Okay. It says that I walked in the clinic, walked out of the clinic, and then it showed sketches of how we sold abortions to nonpregnant women with a tape playing in the background, and I submit to you that this is not the only clinic in the United States that has been caught doing this. As a matter of fact, the Chicago Sun Times found them--

Q. But the point is, there are laws--

A. --and there was a lawsuit filed out of that.

Q. All of those activities are already illegal and there's nothing that I see in House Bill 1979 that will change anything that happened in your clinics because all of the things that were done were illegal already, so that there's really nothing in this bill that would be required to change anything that happened in your clinic

or to prevent the same thing from happening in Pennsylvania.

REPRESENTATIVE RITTER: That's all I want to say, Mr. Chairman.

MS. EVERETT: May I respond to that, Mr. Chairman?

REPRESENTATIVE RITTER: No.

CHAIRMAN CALTAGIRONE: Yes.

REPRESENTATIVE RITTER: No.

MS. EVERETT: Mr. Chairman, my testimony--

CHAIRMAN CALTAGIRONE: No, I'm sorry, I want to be fair to everybody and I think that--

REPRESENTATIVE RITTER: Well, I don't have any more questions for her.

REPRESENTATIVE KOSINSKI: Mr. Chairman--

CHAIRMAN CALTAGIRONE: Excuse me.

As chairman of this committee, I am trying my level-headed best to be fair with everybody. I think she is due her response, and as chairman I would like to listen to your response.

MS. EVERETT: Mr. Chairman, I appreciate that.

With my experience in the abortion industry, I believe it is necessary anywhere I have an opportunity to tell what I saw inside the abortion industry. I can

assure you it is not fun coming out here and opening your whole life and just spreading yourself out to this vulnerability to people and to these cameras. I am not patting myself on the back but I am telling you that I am speaking to you because I believe that should be included in my testimony. Specifically today I am here to speak to you in support of the 1989 Abortion Control Act, specifically the 24-hour waiting period which I think should been in effect in this State, and the spousal consent. I would like to see you also address the 24-week and over limit. Those are the three things that specifically I would like to touch today.

CHAIRMAN CALTAGIRONE: Okay. If we can, there are several members. I will get back to you, I promise you.

Representative Kosinski.

REPRESENTATIVE KOSINSKI: Just a comment. I think this is one of the reasons we need the current jurisdiction with the Attorney General in investigating abortion clinics because we found out in Philadelphia there has been a lack of cooperation with the district attorney there and in other counties in Philadelphia. The situation is such that the current jurisdiction is needed, and that's all I have to say about this matter here.

CHAIRMAN CALTAGIRONE: Representative

Pressmann.

BY REPRESENTATIVE PRESSMANN: (Of Ms. Everett)

Q. Ms. Everett, behind the cameras.

Since you stopped working at the abortion clinics, what do you do for a living?

A. I am now full-time in a post-abortion ministry called Let Me Live, and we counsel with the victims of abortion - the mothers, the fathers, the siblings.

Q. That's your occupation now?

A. That is my full-time occupation.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Representative Bortner.

REPRESENTATIVE BORTNER: Thank you, Mr. Chairman.

BY REPRESENTATIVE BORTNER: (Of Ms. Everett)

Q. Ma'am, what were your reasons for having an abortion in 1973?

A. That is a very good question and I wish they were good, but it was just simply not convenient to have another baby. I had two children, I had a good job. You know, my husband -- and I was married. We just didn't want a third child. And after all, we were told very clearly, I called my physician, my authority, he told me

that there was nothing there, there was nothing to be concerned about. It was a glob of tissue. And so I had this safe, simple, easy procedure February 19, 1973 right after Roe v. Wade.

Q. And at what stage of your pregnancy did you have the procedure?

A. I was 10 weeks pregnant.

Q. Okay.

REPRESENTATIVE BORTNER: Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Representative Ritter.

BY REPRESENTATIVE RITTER: (Of Ms. Everett)

Q. The only point that I wanted to make again is that there's nothing in House Bill 1979 which would prevent any of the activities that went on in your clinic or that you said went on in your clinic. There's no protection here, and it doesn't seem to be necessary in Pennsylvania. We haven't seen evidence of this type of activity going on in the clinics in Pennsylvania. They are performing abortions in a safe and legal way and medically appropriate ways, and counseling is appropriate. People are not falsifying records, and so there's nothing in this law, in this bill, that would prevent any of those things that happened.

A. Mrs. Ritter, I appreciate very much your comments but I am sure if you are in support of abortion, which I believe you probably are, that you would like to know everything that might have happened anywhere so you could protect the women of Pennsylvania, and that is why--

Q. Well, I certainly want to prevent you from having a license to run an abortion clinic in Pennsylvania.

A. That is why I submit this to you. I submit my soul, myself, again, because I want you to know what happened and I want you to offer protection. Please don't misunderstand me. I believe every abortion clinic in Pennsylvania should be closed, but the least you can do as a lawmaker is make certain if abortions are being offered that they are not being performed in this way.

Q. And that's what we have already done. The law already provides that and I appreciate having your name so that we can be sure that you don't perpetrate these same crimes on the women of Pennsylvania that you did in Texas.

CHAIRMAN CALTAGIRONE: Chief Counsel, Bill Andring.

BY MR. ANDRING: (Of Ms. Everett)

Q. I just have one question. You state in your testimony and you refer several times that psychologically

the doctors always size the baby at 24 weeks. Who's psychological benefit was that for? Could you elaborate on that a little?

A. I appreciate that and I will clarify that. It was the doctor's psychological benefit. The doctors did not want to do an abortion over six months because of a 24-week line in their mind, and what we saw was that they would get the sonogram picture so that it looked -- and you can adjust those sonograms. They would get the sonogram so that it looked like it was 24 weeks, and the measurement of the baby's head was six months or less, and then they would be willing to do an abortion on anything.

CHAIRMAN CALTAGIRONE: Are there any other questions?

(No response.)

CHAIRMAN CALTAGIRONE: I want to thank you very much for your testimony.

MS. EVERETT: Thank you.

CHAIRMAN CALTAGIRONE: Dr. Roselle will testify next. She's not a doctor. Sue Roselle will testify next. We will come back to Thomas Zemaitis. This is an agreed-to change in testimony.

If you would state who you are for the record.

MS. ROSELLE My name is Sue Roselle,

R-O-S-E-L-L-E.

CHAIRMAN CALTAGIRONE: You may proceed.

MS. ROSELLE: I'm Executive Director of Women's Health Services, Incorporated, in Pittsburgh, and on behalf of our board of directors, I would like to express appreciation for this opportunity to testify before the House of Representatives Judiciary Committee regarding the proposed amendments to the Abortion Control Act.

Women's Health Services is a not-for-profit corporation governed by a voluntary board of directors approved by the Commonwealth's Department of Health to operate a freestanding abortion clinic. Women's Health Services also provides comprehensive gynecological services including contraceptive care and clinical services, individual and couple counseling, sex therapy, PMS treatment, and community education. I have been employed as director for three years. I brought to this position over 10 years of experience in health administration. I hold an undergraduate degree in family studies from Penn State and Master's degrees in social work from the University of Illinois and in business administration from Robert Morris College.

I consider myself very fortunate to be involved in reproductive health care in Pennsylvania

because the illegal and unethical activities that were described to you in Texas are not found here nor could they be found here.

Women's Health Services was recently inspected by the Pennsylvania Department of Health for compliance with the rules and regulations of the Abortion Control Act. No deficiencies were found. As a non-for-profit agency, Women's Health Services has always been in compliance with not only the rules and regulations of the Commonwealth but also with the standards for abortion practice established by the National Abortion Federation. These patient care standards are rigorous because they were established by the providers themselves. We have a complication rate of less than 1 percent. These complications are reported both to the National Abortion Federation and to the Commonwealth.

Women's Health Services would support regulations which are designed to protect the health of the woman and which do not impede her right to choose. Women's Health Services cannot and does not support laws and regulations which only serve to increase the cost of care without a result in increase in the quality of care. The only conclusion one can draw is that the proposed law is designed to reduce access. This would be accomplished by either increasing the price of care or by making it

more difficult for the patient to receive care because she and/or the provider must comply with meaningless requirements or face criminal penalties. This is especially true of the proposed informed consent section, particularly the 24-hour waiting period.

As the largest provider in the State, Women's Health Services performed approximately 7,000 procedures in 1988. Only a small portion of these women were referred by a physician. Many women choose not to consult with their private physician because of their fear of being criticized. Most often the decision is discussed within the confines of her family, with those who love her and can provide her support. Therefore, without a referring physician, the performing physician must provide the consent interview 24 hours in advance of the procedure simply to comply with the law.

Even in cases where a referring physician conducted the advance consent interview, the performing physician must still be involved in the consent process to comply with the standard of care within the Commonwealth. This standard created by civil law cannot be ignored. The Abortion Control Act as it is written will not take precedence over this body of case law. For example, if there is a civil lawsuit against a performing physician claiming lack of informed consent under the statute, the

physician should be able to defend the case upon proof that the referring physician conducted the interview 24 hours in advance of the procedure. The bill does not provide for such protection. Therefore, in order to protect him or herself from a malpractice suit, the performing physician should conduct a second advance interview. This would again add to the burden and the expensive care but add nothing medically.

For a large not-for-profit clinic like Women's Health Services, an advance interview with the performing physician will be a costly, extremely difficult requirement to meet. Women's Health Services has contracts with 11 physicians, all of whom are residency trained in obstetrics and gynecology, and none of whom are paid by the procedure, by the way. All are either eligible or certified by the examining board of the American College of Obstetrics and Gynecology. However, through our own internal credentialing process, not all physicians are approved to perform all types of care. For example, not all physicians perform second trimester procedures. With as many as four physicians seeing patients on a given day, it is virtually impossible to determine 24 hours in advance who the performing physician will be. Therefore, we would have to schedule sessions when women would come to the clinic in advance to receive

the required counseling and the exam. The physician who conducts this session would then become the referring physician. On the day of the procedure, the consent process would be repeated by the performing physician to be consistent with the standard of care relating to informed consent. And I have attached our consent form at the end of my testimony for your review.

The cost of the additional visit would be passed on to all patients through an increase in fees. Women's Health Services is not in a position to provide this additional counseling session without increasing our fees. We already provide $10,000 a month in uncompensated care to poor women which results in an annual operating deficit. Our annual operating deficit for the fiscal year ending March 31, 1989 was $145,000, and I have our tax return with me to verify that.

Having duplicate consent interviews with two physicians has an opportunity cost as well as direct cost. While the physician is meeting with the patient during the advanced interview, his or her talents will be denied to other women who need care. Because the number of hours a physician is available is limited, we will have to eliminate our entire gynecological program which requires the services of a physician so we can allow for two visits by abortion patients. This means that women who have been

patients at Women's Health Services for 16 years would have to find another provider. There is a shortage of gynecological care in the Pittsburgh area, especially for poor women. It is inappropriate to further overburden the system simply to erect a barrier to abortion services.

The 24-hour waiting period requirement presumes that when given certain information, women will choose not to have an abortion. At this time, abortion appointments are made more than 24 hours in advance. During the telephone interview, options were explored and the length of the pregnancy by date is discussed. The women are given information about the procedure. Approximately 20 percent of women who make appointments do not keep them. Another 10 percent of the women who actually come to the clinic do not have an abortion for various reasons, including their own ambivalence or that they were being coerced. These women are referred to counseling and prenatal care.

The existing system already provides a 24-hour waiting period. The women who are going to change their minds do so.

The final additional cost flowing from the 24-hour waiting period is the cost of transportation and/or lodging for the women who live out of easy driving distance to a clinic. Please remember that the majority

of counties in the Commonwealth do not have a provider who will schedule appointments for women who are not ongoing patients. Women's Health Service serves women from 34 counties within Pennsylvania plus counties from 3 adjoining States. In 1988, over 700 women traveled in excess of 100 miles one way to reach our clinic. Again, most of these women were not referred by a physician. Therefore, they would be required to make two appointments at the clinic - one for counseling and the consent interview, and one for the procedure. This would require either two trips or an overnight stay in the city. Again, if the sole purpose of the waiting period is to create barriers and increase costs, it will be successful. It certainly will not improve the quality of care.

The impact of the proposed amendments of the Abortion Control Act in general is to turn the providers into the keepers of the gate. Rather than being able to focus totally on the fiscal and emotional needs of the women who come to us, we would have to use resources to verify her age and ascertain the circumstances under which the pregnancy occurred. I envision this scenario: Are you married? If so, is the pregnancy to your husband? If so, has he been informed of your decision to have an abortion? If not, just sign this form, or please sign this form. And then this form becomes part of her medical

record. Please remember that medical records in Pennsylvania can be subpoenaed. The confidentiality of the information on the spousal notification form, just like the medical record itself, is not guaranteed. This form could easily become ammunition in a divorce proceeding. Again, the woman becomes the victim.

I would like to end by sharing the situations of two women who came to Women's Health Services. Darlene was 14 when she was referred by a physician in a small town. When Darlene became pregnant, her parents kicked her out. She went to live with her unmarried 19-year-old sister and her sister's baby. The sister told Darlene that she could continue to live there as long as Darlene continued the pregnancy. Darlene's 15-year-old boyfriend had been forbidden by his parents to see her. After two weeks with the sister, Darlene decided she wanted to have an abortion. Finally, the boyfriend disobeyed his parents. He and Darlene went to see a physician in a clinic about 95 miles from Pittsburgh. The physician turned to Women's Health Services. We agreed to provide a grant to pay for Darlene's procedure. The next problem was transportation. Although pregnant and going to be parents, neither Darlene nor her boyfriend were old enough to drive. Darlene prevailed upon her 16-year-old brother to make his first trip into the city to drive her

to the clinic. By the time they arrived, the chain of communication with her mother had begun to open up again and she has been accepted back into her household.

And then I would ask you what advice you would give to the married, unemployed mother of five children whose nose was broken by her husband in the hallway in the clinic in front of me because she refused to have an abortion. Women have enough barriers to receiving the care that they need in making the reproductive decisions that are important to them. It certainly does not seem necessary for the Pennsylvania legislature to add to them.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you.

Representative Hagarty.

REPRESENTATIVE HAGARTY: Thank you, Mr. Chairman.

BY REPRESENTATIVE HAGARTY: (Of Ms. Roselle)

Q. With regard to counseling, when a woman comes to your clinic in person, what type of counseling is given to them then and by whom?

A. We have two types of counselors. We have care professional counselors who are trained to counsel women during the consent process prior to seeing the physician and to ascertain their decisionmaking. That

counseling can last from 10 minutes to one hour. If during -- and the longer counseling is usually reserved for women who are very young, who are going to have their first pelvic exam, who are completely unaware of what has occurred. The other type of counseling we have is professional counseling that's performed by psychotherapists who have Master's degrees at a minimum and five years' experience in family therapy. We have several of the counselors who also have their Ph.D.s. This counseling is reserved for women who are very ambivalent, who are having psychological problems. Whatever type of care that is necessary. And there are no charge for any of the counseling that we provide, so whatever the woman's needs are is the type of counseling she receives.

Q. What type of information with regard to her pregnancy are women given in this counseling session?

A. Well, the length of the pregnancy is discussed. Now, the actual length of the pregnancy is determined prior to the abortion by exam. It's given to her by dates if she's sure of her dates and whatever information she wants about the pregnancy. If she requests the -- a description of the fetus, she is provided that. If she wants to see pictures of fetal development she's provided that. Whatever it is that she

requests for information. Also, it's very important that we do talk options. Has the woman considered the possibility of adoption and what adoption means and what services, what adoption services are available in the community? And also looking at what barriers there are that are preventing her from continuing the pregnancy and keeping the child.

Q. If this counseling session concludes and the trained counselor believes that further counseling is necessary, what is done?

A. She's referred internally to a therapist and if further counseling is necessary, we have it available here, we have it available at the clinic, ongoing counseling. Anytime it's a problem pregnancy counseling there is no charge for it no matter how long it goes on. If the woman is feeling uncomfortable or that she wants further information about adoption, say, we would refer her to a licensed adoption agency for further counseling.

Q. What is your view regarding a doctor's ability to counsel a woman as contrasted to a Master's level psychologist?

A. Well, we make the distinction because we feel that physicians are best at giving medical care and we do not ask our therapists to do medical care. So we do have a distinction in roles.

Q. Is any information given to a woman with regard to birth control either before or after the abortion procedure?

A. Before the procedure, the type of contraception the woman has been using is explored and why it was not appropriate for her. We have found that 50 percent of the patients that we see have been using some form of contraception during the month that conception occurred. So that is in anticipation. That information is recorded so that we can help her choose a method of contraception for the future that is more appropriate. During the discharge interview, the woman, every woman who leaves Women's Health Services leaves with a method of contraception.

Q. Is there a follow-up to the discharge, follow-up visit by the woman?

A. In six to eight weeks, as part of the fee that she's paid for the abortion, a woman is invited and is encouraged to come back for a follow-up check up. Since we serve a wide area, we see primarily the women who live within the greater Pittsburgh area. What we do is we provide her medical records to her -- to a physician in her home community or most likely a family planning clinic for her follow-up visit.

Q. How many second trimesters percentage wise

do you do?

A. About 5 percent, I believe. That's the last time I looked, and it has been a few months.

Q. And can you describe to us the reasons for second trimester abortions?

A. The primary reason for second trimester abortions, there are threefold. Ambivalence on the part of the woman, denial that she is pregnant, and looking for money to try to pay.

Q. Do you do any second trimester abortions as a result of testing in which the woman determines that the baby may be a carrier, for example, of a fatal disease?

A. We have done second trimester abortions for fetal anomalies.

Q. Do you do any abortions post 24 weeks?

A. No. Our upper limit is 17 weeks.

Q. And who determines the gestational age?

A. The physician, preceded by sonar.

Q. Are you aware of any clinics that do abortions post 24 weeks?

A. Not in Pennsylvania.

Q. Let me ask you, I know you've reviewed this legislation we have before us today. Have you determined what you would do if a woman came in for an abortion and indicated that her husband would not sign the

notification?

A. Well, it's my understanding he does not have to sign the notification. She just has to make him aware of it. And if she has not -- if she says, I have not told him and I don't plan to tell him it is his and would not be -- she felt she would not be in danger, then we would have to turn her away. We could not risk doing something administratively that would cause the physician's license to be suspended because these physicians have private practices, which would mean hundreds of women that they're providing prenatal care to would not be able to receive that care.

Q. Do you have any sense of how many women now inform their spouse that they are pregnant?

A. No, I don't know. I do know that our waiting room is full of partners every time we have a clinic.

Q. Is the counseling done with the woman or with the partner also?

A. It's done with the woman. If she chooses to have her partner in to the counseling, he is included in the counseling after the decisionmaking part of the counseling occurs, because we're really concerned that the woman is making this decision in an unbiased manner, that this is her decision.

Q. Do you have women after counseling who decide not to have an abortion and to continue with the pregnancy?

A. Every day.

Q. Are your -- do you believe your counselors are trained to provide in a neutral manner the options as they describe options?

A. Our counselors know that as a nonprofit it doesn't matter to us whether or not someone has an abortion. None of us are paid in any way that would influence them influencing a patient.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Representative Kosinski.

REPRESENTATIVE KOSINSKI: Thank you. A few questions.

BY REPRESENTATIVE KOSINSKI: (Of Ms. Roselle)

Q. So I would infer -- I don't want to put words in your mouth, of course, but you would not be against the 24-week prohibition of abortions?

A. I'm saying that Women's Health Services does not do abortions after 17 weeks.

Q. And why would you be against -- would you be against the 24 week ban?

A. I have not looked at that particular section

of the law. We have made referrals to a very small number of referrals to other States for gestations greater than 24 weeks.

Q. Are you aware of the numbers of abortions in Pennsylvania done after the 17th week?

A. No, I'm not.

Q. Okay. From the Pennsylvania Induced Abortion Report, January to December 1988, there were over a thousand induced abortions from the 18th week on and you're not familiar with any clinics in Pennsylvania that perform such abortions?

A. No, I'm not. Most of us have the same insurance carrier and we can't be insured for above 17 weeks, very simply.

Q. Okay. There is another thing that somewhat bothers me or I'd like you to explain. You talked about the 24-hour waiting period being unreasonable and you're against the 24-hour waiting period?

A. My testimony stated that it's already there.

Q. Then why be against it?

A. Because right now we're not required by law and do not face criminal penalties for not having two visits. Women are not required to make two visits and I would not have to shut down our gynecology program where we're doing an enormous service to the community,

including cancer detection and saving women's lives, by having these women come in twice for an abortion appointment.

Q. Basically a cost matter then?

A. No, I'm saying that there's an opportunity cost meaning that there are thousands of women that Women's Health Services would not be able to provide gynecology services to if we had to provide 7,000 women 2 visits in order for them to have abortions.

Q. Let's get back to the cost factor. Do your doctors get a per person rate for performing abortions?

A. I already testified that they do not.

Q. They're paid a salary?

A. That's correct.

Q. Now, with your particular service, you talk about cost, you talk about being not for profit. Can I have a salary range from the top to the bottom, if possible?

A. From -- what do you mean?

Q. The whole agency. The top salary down to the bottom salary. What's the salary range?

A. The salary range would be $5.94 an hour--

Q. Which would be paid to?

A. A clerical type of person. To around $100 an hour for a physician.

Q. Okay, and how about executive director? Is that hourly?

A. No, that's a salary. Are you asking me what my salary is, sir?

Q. If you would give it.

A. Okay, $46,200, and I have an MBA, thank you.

Q. Okay. That's fine.

CHAIRMAN CALTAGIRONE: Representative Kosinski, are you finished?

REPRESENTATIVE KOSINSKI: I'm finished.

CHAIRMAN CALTAGIRONE: Representative Bortner.

REPRESENTATIVE BORTNER: Thank you.

BY REPRESENTATIVE BORTNER: (Of Ms. Roselle)

Q. I just want to follow up on the point about abortions after 17 weeks. You're not testifying that those abortions -- that no abortions are performed in Pennsylvania after 17 weeks?

A. No, I'm not.

Q. I mean, those are typically done at a hospital, are they not?

A. When we see a woman that we cannot serve who is between 17 -- over 17 weeks but below 20 weeks, we refer her to a private physician who sees her in the local hospital.

Q. How long have you worked, and you may have testified to this, at your clinic?

A. Three years.

Q. Have you worked at other clinics prior to this?

A. No. I was Executive Director of the Emergency Medical Service Institute, which is the planning agency for EMS for 12 counties of southwestern Pennsylvania. Prior to that I was in administration in charge of all services other than nursing for a large hospital-based home health agency.

Q. Do you visit other clinics or have you engaged in a visit of other clinics in Pennsylvania?

A. Occasionally, but never to see their day-to-day operations.

Q. Were you present for the testimony that preceded yours?

A. Yes, I was.

Q. How would you compare your experience, either your clinic or other clinics you've visited, with the scenario or the circumstances that was testified to by the previous witness?

A. I was really shocked by her testimony, and as a health administrator, I ascribe to a certain standard of ethical practice. I'm also a member of the National

Association of Social Workers and a licensed social worker within the Commonwealth and another set of ethical principles. If I knew of that situation being repeated in Pennsylvania, I would work very hard to make sure that that clinic was closed down.

Q. And I'm asking your opinion now which you may feel free to give or not give, do you believe that that's typical of clinics that are operating either in Pennsylvania or across the country, understanding that you have not visited all of them?

A. No, I do not believe that. I do not believe that to be true.

REPRESENTATIVE BORTNER: Thank you, Mr. Chairman. Thank you.

CHAIRMAN CALTAGIRONE: Representative Josephs.

BY REPRESENTATIVE JOSEPHS: (Of Ms. Roselle)

Q. I'll try and talk loud enough. I don't have a mike.

Thank you, Ms. Roselle, for your testimony. I think I recall hearing or reading that recently your clinic had some problems with folks who self-styled themselves as rescuing your patients. Would you give us some details of that incident, please?

A. On September 30th, I assume you mean asking

me if I've gotten my feet out of tar to get to Harrisburg today. On September 30th, we had five people force their way into our clinic early in the morning behind an employee coming to work through a door that was clearly marked "Authorized Personnel Only," and they brought in with them 25 gallons of roofing tar in boxes and in containers and they positioned themselves standing against the wall with their feet or foot or feet, I haven't quite gotten that all clear yet, in buckets of roofing tar, which had been splashed around by that point in time, apparently, and then when the police arrived, rather than cooperate with being arrested, they all went limp, spilling the roofing tar around. It's difficult to describe what 25 gallons of roofing tar will do in a health care facility, so I brought these photographs for the committee's consideration.

(Ms. Roselle passed photographs to the committee members. See appendix for a copy of the photographs.)

At some points in the clinic in the patient care areas the tar was 2 inches deep. The police took the demonstrators out in laundry carts which were destroyed, which also cost $250 a piece, so that they would spread the tar as little as possible, but there's a lot of carpeting damage, too. But you're seeing the main area of

damage there. Our response was after the arrests were made were to talk to the women in the waiting room and the people who accompanied her. I spoke with them and I told them that they could be free to leave or that they could be referred to another clinic. They could be rescheduled with us if they were feeling particularly anxious. We had counselors available. This was a crisis, but there would be a short delay.

We placed cardboard over the tar. We were able to use five of our six rooms. We performed 58 abortions that day. The only woman who left was a gynecology appointment who was our first appointment of the day and she said, "Look, I can come back next week." Everyone else stayed. By Tuesday afternoon we had our first estimate of $25,000 worth of damage. On Tuesday of this week we had -- the perpetrators have been held over for trial under a variety of charges, including some felonies, and a clean-up has commenced. The cost of staff is somewhat higher. We've considered still having some critical incident stress related to this. The staff has been debriefed by professionals and we are continuing to function.

Please note that Women's Health Services was the second clinic within a month in Pittsburgh that was attacked. The entry way of a clinic in East Liberty was

destroyed about three weeks before ours was tarred.

Q. Thank you, Ms. Roselle.

REPRESENTATIVE JOSEPHS: I have no more questions.

CHAIRMAN CALTAGIRONE: Counselor Andring.

BY MR. ANDRING: (Of Ms. Roselle)

Q. I just have a couple of questions. This bill would require that a pregnant woman be told that the Department of Health publishes printed materials which describe the unborn child and provided with a list which offers alternatives to abortion and that she has a right to review these materials if she wishes. It requires that she be told that Medical Assistance benefits may be available for prenatal care, child birth, and neonatal care, and that printed materials are available and the bill requires that she be told that the father of the unborn child is liable to assist in the support of her child. Would a woman who comes to your clinic now be told those things in a counseling session?

A. Yes. Probably the only difference would be that the reality of women trying to collect support payments would also be added.

Q. Okay.

A. And that's not a -- that would be a statistic. I mean, we would tell her that more than 50

percent of women who are granted support awards do not receive them and the courts cannot enforce them.

Q. But you would consider these things then to be an essential part of any comprehensive counseling?

A. If the woman requests that information, it is provided to her, but again, you have to understand that at Women's Health Services we provide patient-driven care not criminally-avoidance-driven care.

Q. Well, do you have an objection to a requirement that a pregnant woman be informed of these three specific things that--

A. That they are available? I have no objection to that whatsoever, but I think that it should be done in a way of concern for women and what their needs are, not to be on the part of the clinic to be trying to avoid criminal charges.

Q. Okay. Now, the bill also requires that the woman be informed of the nature of the proposed procedure, treatment of risks and alternatives, that she be informed of the probable gestational age of the unborn child, that she be informed of the medical risks associated with carrying her child to term. Is that information currently provided to a woman through counseling, and do you object to the provision of that information?

A. I don't object, as I said, to the provision

of information. I did not say that in my testimony. And if you look at our informed consent, there is -- all of that information is covered in there.

Q. Okay. Let me follow this up. So you're saying that these three things I just mentioned would be part of the informed consent and the counseling process of the woman?

A. The counseling process, yes. Now, the consent does not include the medical risks of continuing the pregnancy because, very frankly, most women do not have abortions because of medical risks.

Q. Okay, now this bill would require that these last three things - the nature of the treatment and the alternatives, the probable gestational age, and the medical risks - that the information on those subjects be conveyed by a physician.

A. That's correct.

Q. Now, is that currently the practice in your clinic?

A. The current practice in the clinic is that information is provided by the para-professional counselor and then verified by the physician. The physician meets with the woman prior to the abortion and says, do you have any questions? Do you understand the procedure? And begins to explain the procedure to her, what the possible

complications are. But the extensive informed consent interview that lasts anywhere from 20 minutes to an hour is conducted by a counselor and verified and followed up by the physician.

Q. So that the information on the nature of the proposed procedure for treatment and the risks and alternatives to the procedure is being conveyed by a non-physician in most cases?

A. That's correct, and verified by the physician.

Q. Okay, so when you say "verified," you mean he says, "Have you been given the information?" And the patient will say--

A. By the physician, and the patient says, yes.

Q. Okay, and when is the consent form signed? Before or after the patient sees the physician?

A. It's signed before she sees the physician and then the physician signs it before the procedure is done, after he has had the conversation with her.

Q. Okay, so the patient signs it before she sees him. I'm sorry?

A. She signs the form with the counselor.

Q. Okay.

A. And it's witnessed by the counselor, and if additional consent is necessary it's obtained, such as

with a woman who is declared incompetent and has a guardian.

Q. Okay.

A. And that happens--

Q. But the consent form is signed by the patient before she sees the physician?

A. And then she sees the physician and he verifies and he talks with her about the complications and about the procedure and what is going to occur. And then he signs the consent form prior to the performance of the procedure.

Q. Okay. In your testimony on pages 3 and 4 you say, "On the day of the procedure, the consent process would be repeated by the performing physician to be consistent with the standard of care relating to informed consent."

A. That is correct.

Q. And then you go on to say, "having duplicate consent interviews with two physicians." From what you're telling me, the physician is truly not involved in the consent process in your clinic because the consent form is signed by the patient before she even sees the physician and the basic medical information is being provided by a non-physician to the patient.

A. And that is consistent with the law as it's

required and it is also consistent with the law within Pennsylvania that the information is -- the civil law in Pennsylvania that the information is all verified by the physician.

Q. Okay, it's consistent with the law but I don't think it's consistent with the implication your testimony tries to raise here.

A. No, I'm sorry. Every woman is given the complications and what is going to happen to her during the procedure by the physician. That happens. And I don't know what it is that I stated that made you feel that that's inconsistent.

Q. What percentage of the income of your organization comes from fees for services as opposed to contributions or for that type of thing?

A. I think 2 percent of our -- in the period of time to which I testified, about 2 percent of our income came from contributions.

Q. And 98 percent were from fees for services?

A. That's correct.

Q. Okay. On the first page of your testimony you list a number of services that you provide.

A. That's correct.

Q. Could you break down your income into the sources for the different services and specifically what

percentage of your income comes from abortion services?

A. Probably 90 percent of the income comes from abortion services.

Q. Okay, thank you.

BY CHAIRMAN CALTAGIRONE: (Of Ms. Roselle)

Q. I would just like to follow up on a comment that you had made about the number of women that are treated that are medically at risk.

A. Um-hum.

Q. Could you expand on that, please?

A. No, I can't, because I don't keep those statistics.

Q. Oh, you don't keep those statistics?

A. No, I don't.

Q. You had indicated though that the majority of women that you see--

A. That's common knowledge.

Q. --are not medically at risk.

A. That's common knowledge.

Q. Do you know of any of the clinics in this Commonwealth that do keep such statistics?

A. No, because it's not an important factor of why someone is having an abortion.

Q. Um-hum. No, but I mean in the consultation with the woman, if she's medically at risk, of course, you

would need to know that prior to her treatment.

A. Oh, that we do, but we don't keep hashmarks somewhere about that. We don't keep those statistics, but that certainly is part of the medical treatment that they receive.

Q. But you had indicated though that there seems to be a large number, whatever that number could be, that would not be medically at risk.

A. That's -- if you read the literature, that information is generally known.

CHAIRMAN CALTAGIRONE: Are there other questions from the members?

Representative Heckler.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

BY REPRESENTATIVE HECKLER: (Of Ms. Roselle)

Q. Just maybe a few questions additionally about the consent issue. Am I correct in sort of summarizing what we've developed that a nurse or some other clerical or counseling person -- okay, a counselor?

A. Yes.

Q. Reviews the various consent issues with the patient, has the consent form signed, then subsequently the doctor who is actually going to provide the services sits down with the patient, reviews the materials that are

legally required for him to review in order to be satisfied that valid consent has been given, and then he signs the release form in the presence of the patient?

A. That's correct.

Q. Okay. Are you familiar with procedures followed, say, at hospitals for other kinds of elective or non-elective surgery?

A. Yes, I am.

Q. Is that not consistent -- it's my impression, having been through more consents than I would have wanted to at Children's Hospital in the University of Pennsylvania, that that's about the way it works in all kinds of areas of medicine.

A. Well, yes, and that is correct. In fact, having had surgery recently and neurosurgery recently, the nurse practitioner took me through the consent and the physician never mentioned any possibility of risk to me, even though one of the risks that I knew was quadriplegic.

Q. Okay. So that this is consistent with your experience of practice--

A. Absolutely.

Q. --across the medical spectrum?

A. In fact stronger.

Q. Okay, thank you.

REPRESENTATIVE HECKLER: I have no further

questions.

BY CHAIRMAN CALTAGIRONE: (Of Ms. Roselle)

Q. I have one final question. Would you know the number of women that are admitted in either your clinics or Pennsylvania as a whole that have died in the clinics because of an abortion procedure?

A. There have been no reported deaths in Pennsylvania since abortion became legal from legal abortions.

Q. In any of the clinics?

A. In anywhere in Pennsylvania, hospitals or clinics. It just has not happened.

CHAIRMAN CALTAGIRONE: Okay. Representative Blaum.

REPRESENTATIVE BLAUM: Thank you, Mr. Chairman.

BY REPRESENTATIVE BLAUM: (Of Ms. Roselle)

Q. Ms. Roselle, in this legislation it would make it unlawful for any person to knowingly procure, sell, or use any tissue, organ or remains of an aborted child for the purposes of research, experimentation, or transplant. Is that something that in any way touches clinics such as yours or is that something that's left to the medical centers?

A. Our clinic treats the tissue and any other

products upon which surgical blood has touched as an infectious substance, as required by Federal and State law. And that is disposed of and incinerated in accordance with that law. And we have been inspected by and our process has been approved by the State Department of Environmental Resources.

Q. So to the extent that this would happen, it would, I assume, be done in medical centers or--

A. I have no ability to testify on that at all.

Q. Thank you.

BY CHAIRMAN CALTAGIRONE: (Of Ms. Roselle)

Q. Just as a follow-up to that, I happen to have a piece of legislation concerning anatomical gifts. You're saying then for the record that any part of the fetus or parts are not in fact used for any kind of medical purposes after the abortion has been completed?

A. I cannot speak to anyplace other than Women's Health Services. That's the only testimony that I can give, and I have told you what we -- how we comply.

CHAIRMAN CALTAGIRONE: Okay. Thank you for your testimony.

If we could, we'd like to continue with the proceedings, and the next witness will be Maggie D'Alesio. And I do want to recognize that Representative Paul McHale has joined us on the panel.

For the record, there were additional supplements that had been handed out to the members that are going to be added to the record.

MS. D'ALESIO: My name is Maggie D'Alesio. I'm a registered nurse and a certified emergency nurse. I'm here to testify on behalf of House Bill 1979, the 1989 Abortion Control Act. I'm going to start with just a brief outline of the development of a fetus.

In the second week, the a rudimentary heart is form.

In the third week, limbs appear as short buds.

CHAIRMAN CALTAGIRONE: Excuse me, I don't mean to interrupt you, but do you have prepared testimony to be handed out to the members?

MS. D'ALESIO: I did not Xerox it.

CHAIRMAN CALTAGIRONE: You did not?

MS. D'ALESIO: Um-um.

CHAIRMAN CALTAGIRONE: Okay. Do you have an extra copy?

MS. D'ALESIO: I'm sorry, I don't. Could I do that now? Would that help you?

CHAIRMAN CALTAGIRONE: Yes, we can do it right next door in the Speaker's office.

Some of the members have expressed the

desire that you proceed.

MS. D'ALESIO: In the fourth week, the heart separates into the right and left heart.

In the sixth week, the membranes of the nervous center, the bladder, the kidney, the tongue, the larynx, the thyroid body, and the germs of the teeth are apparent.

In the eighth week, the arm and the forearm, thigh and the leg distinction is apparent, and the two halves of the hard palate unite. Sympathetic nerves are discerned. Nerve fibers, both cerebrospinal and sympathetic systems, convey impressions of a two-fold kind. Sensory nerves transmit to the nervous centers impressions made upon peripheral extremities of the nerves, through the medium of the brain, and becomes conscious of external objections. Motor nerves transmit impressions and excite muscular contraction or influence the process of nutrition, growth, and secretion.

I just want to add right here at the 8th week that during an abortion, prior to the 12th week of pregnancy, the usual method is by a hollow curet or a suction catheter. Keep in mind that those babies have nerves at that point and can feel.

In the ninth week, phalanges appear. Phalanges are fingers.

In the third month, it's possible to distinguish male and female organs from each other. The eyelids, the hair, and the nails form.

In the fourth month, fat is first developed in the subcutaneous cellular tissue and the tonsils are seen.

In the fifth month, you have the eruption of hair on the head and differentiation between the uterus and the vagina become apparent.

In the sixth month, the free border of the nail projects from the corium of the dermis.

In the seventh month, the testicle passes into the vaginal process of the peritoneum.

And in the ninth month, eyelids open and testicles descend into the scrotum.

I've brought along a manual that will give you an idea of what a fetus looks like at 28 days, 35 case, 60 days and 20 weeks so then when you see this picture you maybe can have a better idea of what I'm talking about when I give my testimony.

(Ms. D'Alesio handed a copy of Taber's Medical Cyclopedic Manual to the committee members. See Appendix for a copy of the picture presented.)

Five years ago, on September 12, 1984, I was at work in the Emergency Department of West Park Hospital

in Philadelphia. Approximately 9:30 that evening, Dr. Joseph Melnick developed a live baby girl during an elective abortion. This abortion was performed on a 13-year-old girl on the second floor of the hospital. Dr. Melnick placed Baby Girl Smith in a bedpan and she was carried to a nearby utility room. The baby was observed by several staff members attempting to breathe. Her heart rate was auscultated at 20 beats per minute by Pearl Resnick, R.N., the nursing supervisor. Mrs. Resnick began CPR. CPR was terminated shortly thereafter when three resident physicians were called to the utility room. They too observed the baby showing signs of life. Questioning Dr. Melnick as to how long the baby had been breathing like this, Dr. Melnick responded, "90 minutes."

The resident physicians were reluctant to resuscitate an infant who was breathing agonally for 90 minutes because they were concerned about probable brain damage due to anoxia. Mrs. Resnick then called Dr. Krane, the head of the Ob/Gyn at West Park Hospital. He advised them to resuscitate the infant and transport her to the nearest neonatal intensive care unit. Arrangements were made with nearby P.C.O.M. and the baby was carried by Mrs. Resnick to the E.R. An intravenous line was to be started via the umbilical vein and the baby was to be transported by ambulance to P.C.O.M. I observed the "chux", which is

the diaper-like cloth that the baby was swaddled in, move. I also heard a faint sound, most probably an exhalation, coming from the little baby. Mrs. Resnick then exclaimed, "My God, she's alive." We moved toward the stretcher and Mrs. Resnick unwrapped the covering. Baby Girl Smith appeared to be full term. I began to cry and asked to be excused to compose myself. As I returned five minutes later, Dr. Mike McDonald, a resident physician, told me that the baby had died and they were ready to pronounce her. It was 11:00 p.m. Baby Girl Smith was 32 weeks gestational age. She weighed 3 pounds, 8 ounces. She struggled for life for 90 minutes. She had agonal respirations and sustained a heart rate of 20 beats per minute. She survived for 90 minutes exposed to the cold, uncovered in a bedpan, without suctioning, without warmth, without the benefit of human touch. She lived. She existed.

The man who delivered her was found guilty of infanticide in June of 1989, but Joseph Melnick was never found guilty of illegal abortion. Judge Lynn Abraham found the existing Abortion Control Act too vague as to the definition of viability. She believed that Joseph Melnick, perhaps in gross negligence, did not determine correctly the gestational age of the fetus. Dr. Joseph Melnick did not employ ultrasound as a means of

measuring gestational age. I find it difficult to believe that a board certified Ob/Gyn on physical examination could not make the distinction between 17 weeks gestation and 32 weeks.

Thirty-seven years ago, on February 25, 1952, a baby boy was delivered at St. Agnes Hospital in Philadelphia. He was 30 weeks gestational age. He weighed 2 pounds. He was suctioned, he was swaddled in warm blankets. He struggled valiantly to live, and without the benefit of the technology we have today. Surely if this baby survived against all odds, a 24-week gestational age fetus with all the benefits of today's technology should be called viable and be protected from death by abortion under our laws. That little baby boy from St. Agnes is my husband, who's a police lieutenant in Upper Darby.

It is imperative that we have more stringent laws governing abortion in the second trimester. These babies are viable at 24 weeks. We must insist that physicians performing abortions utilize techniques that determine the gestational age of the fetus. I am emphasizing the need to ban all abortions after 24 weeks, except to save the life of the mother. A baby of 24 weeks can survive outside the womb.

I have witnessed firsthand the outcome of an

abortion performed on a viable baby. I assure you, the picture of that tiny baby will be before my eyes for the rest of my life. If I can do anything for her and the thousands of babies who will come after her, I will, and I will continue to beg and plead and fight for their lives. I pray that you join me.

I also have a printout here on late term abortions that I'd like to share with you. Recently published statistics compiled by the Pennsylvania Department of Health indicate that in 1988, 953 abortions were performed in Pennsylvania on unborn children 18 to 22 weeks gestation, and 128 abortions on children from 23 to 26 weeks gestation or more.

In order to fully understand the tragedy of late term abortions, it is important to understand the methods which are used. Late term abortions are performed by one of four methods. Hysterotomy, which is a mini-C-section, prostaglandins, which is what Dr. Melnick used, saline abortion, and dilation and evacuation, known as the D&E.

While the first two methods, hysterotomy and prostaglandins, can result in a live birth, D&E and saline abortions most often are effective in killing the child. Children who do survive saline abortion usually suffer complications such as blindness and gastrointestinal

injuries due to corrosive effects of the hypertonic salt solution.

D&E abortions involve dismemberment of the fetus and always result in the child's death. The fact that live birth is considered a complication by abortion providers was blatantly exposed by Dr. Robert Crist when he testified in Planned Parenthood v. Ashcroft in 1983. Dr. Crist testified that he had performed dismemberment procedures five times within two months prior to his testimony on unborn children of 24 weeks or more gestation. He said that he felt the best method of abortion on a fetus of 28 weeks gestation, which is 7 months, was by dismemberment because the woman has a right "not only to be rid of the growth, called a fetus, in her body but also has the right to a dead fetus."

In his how-to book, Abortion Practice, Dr. Warren Hern describes in detail the instruments and methods of performing dismemberment procedures on unborn children in his outpatient surgical facility. In discussing procedures used for late term abortions he states, "The procedure changes significantly at 21 weeks because the fetal tissues become much more cohesive and difficult to dismember...a long curved Mayo scissors may be necessary to decapitate and dismember the fetus."

That concludes my testimony.

CHAIRMAN CALTAGIRONE: Thank you.

Questions from the members?

Representative Hagarty.

REPRESENTATIVE HAGARTY: Thank you.

BY REPRESENTATIVE HAGARTY: (Of Ms. D'Alesio)

Q. First, let me say that I'm sure all of our hearts break with a tragic situation of a baby born alive who was not allowed to live and that this man, as I understand what you said, has been convicted in our courts in Pennsylvania. There is nothing to justify that conduct, surely. And you, and I'm sorry I missed as you went into your background, you worked as an emergency room nurse at West Park Hospital?

A. I did. I'm now employed at Delaware County Hospital in Drexel Hill.

Q. For how long were you a nurse there at West Park Hospital?

A. I worked in nursing school there as a nurse's assistant for two years and as a Registered Nurse for one year.

Q. And during those three years, I guess, did you at all at that time assist in obstetrical procedures or where were you positioned?

A. I was always -- as a nursing assistant, I was in the telemetry unit, which is hearts, and after I

became a Registered Nurse I was in the emergency department, so I never assisted in anything like that.

Q. Okay. Were you aware of any other viable -- any other viable babies being born mistakenly as this occurred at the hospital?

A. Not at the time, but afterwards I did find out from different people who worked in the operating room of the hospital and in the different floors of the hospital that this is not the first time that it happened. It was the first time it was reported.

Q. On the other occasions, was it this same doctor that--

A. I don't know, Ma'am.

Q. Okay, it could have been the same doctor who has been convicted of a crime in Pennsylvania then that did this on other occasions?

A. Yes.

Q. I'm curious, and I don't know if you know, I would think that we would all agree that -- I would think we would all agree -- that unless there was a real, I guess at the very least, that unless there was a real health risk to a mother that we should not be performing a late abortion. Are you -- and the question occurs to me that are there -- well, let me first ask you, my one concern about this post-24 weeks is the way this section

is phrased, you need three separate doctors to say that a woman will die before the abortion can occur. Are you aware of that?

A. No, I am not familiar with that.

Q. The way that it's written is that one doctor has to certify that the woman will die and two others must concur. Are you aware of any other medical procedure in which we need three doctors to save the life of a woman?

A. No, I'm not. I can tell you that the hospital that I work in I am vaguely familiar with Blue Cross and Blue Shield and I know that often they require a second opinion. That is the only --

Q. Did you ever hear of a third opinion?

A. Electively, not imposed upon by insurance agencies.

Q. Because while we've talked about it, and I think obviously late term abortions are difficult for us to discuss, and while we've talked about them, I guess what concerns me about this section is three doctors are necessary to say that a woman will die. Suppose three doctors aren't willing to say that, and I believe there are criminal penalties if they're wrong. Does that concern you at all, just with regard to the fact that you may actually have a woman in danger of death if something is not done?

A. Yeah. I could -- I can understand your concern and that would be a concern of mine also. I would think, although, I mean, in late term abortions she was probably more likely a woman was having some prenatal care and this would probably be detected much sooner than the last trimester.

Q. Let me just ask you, I mean, from when I know about pregnancy, I do believe the conditions can occur though. I would agree with you hopefully that would be known earlier. Cannot conditions occur or in fact perhaps as a result of the pregnancy which could be life-threatening to the woman late in her pregnancy?

A. I can think of one offhand, and again, I'm not a physician, I'm only a nurse. With a blood clot to the brain, a cerebral hemorrhage, that would be a condition where sometimes I think they feel that if the stress of the pregnancy was eliminated, then the mother would have a better chance of living. In that case, she would be under a neurologist's care, her medical doctor, and her gynecologist. You've got three right there.

Q. I would think in most instances that a woman who's life was in jeopardy or serious health was in jeopardy of course would want to try to save the baby. What procedure would be done in those instances?

A. Could you repeat that question?

Q. Well, I mean, I'm thinking that most of these women obviously would be trying to save the baby and the issue would be -- I mean, I'm concerned as to whether is the issue if you're trying to save the baby but perhaps the woman isn't actually in danger of death and so you perform a Cesarean but the baby doesn't live, could someone say it's an abortion because you performed it, you know, because you performed it at a late time when the woman wasn't really going to die?

A. I think you would probably have to ask an attorney that, but off the top of my head, I would say no, that, you know, you've attempted to save the life of a baby.

Q. But, of course, we're jeopardizing the baby by doing any procedure that's not allowing the baby to remain in the uterus to full term.

A. But we are also talking about third trimester abortions where babies, with today's technology, have a real good chance of surviving outside the womb.

Q. Oh, I agree with you. I just think we're talking about extraordinary circumstances. The law, as I understand it now, is that a woman's health or life must be jeopardized before an abortion is ever done on a baby that could be viable. Is that your understanding?

A. No.

Q. What is your understanding?

A. I didn't think that that was -- well, in Dr. Melnick's case, just that he aborted a 32-week fetus.

Q. But he was convicted of a criminal--

A. Right, but not of illegal abortion. That abortion was not illegal.

Q. I believe that the infanticide section under our criminal statute, we have counsel here, she has the statute, I believe it's actually under the Abortion Control Act, isn't that true?

A. Infanticide is.

Q. Well, didn't you indicate that he was convicted of infanticide?

A. Right, but he was not convicted of illegal abortion.

Q. He was -- well, let me just indicate that the infanticide section is under the Abortions After Viability section. It just seems clear to me that his illegal conduct, which I hope has been punished to the fullest extent of the law, was clearly provided for in the statute and that the man was clearly behaving illegally.

A. I would think so, but he was not convicted of illegal abortion. That charge was dropped.

Q. Okay. I think that what we're talking about, and I don't want to quibble over it, I believe that

there are a number of sections, as there are in any criminal case, in which a particular individual can be charged. I believe that he was convicted of the higher charge and that our law--

A. He was charged with abortion after viability and with infanticide. He was not convicted of abortion after viability.

Q. Well, all I'm indicating is that I believe, I don't have the penalties in front of me, but I believe that he was convicted of the greater offense.

A. Yes.

Q. And that infanticide is also an offense under the Abortion Control Act in this Commonwealth.

Thank you.

CHAIRMAN CALTAGIRONE: Representative McHale.

REPRESENTATIVE McHALE: Thank you, Mr. Chairman.

BY REPRESENTATIVE McHALE: (Of Ms. D'Alesio)

Q. I've been in the House for seven years now and throughout that period of time I have supported the woman's right to choose whether to continue or terminate her pregnancy when that decision is being made very early in the gestational period. I have my own moral views on the issue, but by and large, I've respected a woman's

right of privacy early in the pregnancy.

I've had a growing concern regarding the issue that you raised in your testimony today, and that is with regard to late term abortions. You presented a statistic that I appreciate because I had not seen it before. You indicated the recently published statistics compiled by the Pennsylvania Department of Health indicate that in 1988, 953 abortions were performed in Pennsylvania on unborn children 18 to 22 weeks gestation, and 128 abortions on children from 23 to 26 weeks gestation or more. I consider all of those to be late term abortions, and that number adds up to approximately 1,100 abortions performed after the 18th week of gestation. Following up on the questions that were raised by Representative Hagarty, do you have any idea how many of those 1,100 late term abortions were elective and how many involved, by contrast, a genuine threat to the mother's health or safety?

A. No, sir. I really don't know. I can't answer that.

Q. Do you know who would have that information? Representative Hagarty raised the significant issue of a late term abortion where the mother's health or indeed her life is directly threatened. I have a concern that I hope will be perhaps addressed in later testimony that the vast

majority of those 1,100 late term abortions were in fact elective in nature and did not relate to the very real problem voiced by Representative Hagarty, and that is a threat to the mother's life or physical health. Do you know where we could get that information?

A. I think that the Pro-Life Federation would probably be able to help you out with that information. Just let me give you an example. This 13-year-old girl that had the abortion in the Dr. Melnick case had been to at least two other doctors, one who did an ultrasound in August of 1984 and determined the gestational age and refused to do the abortion. Dr. Melnick was her third doctor. They did that abortion at West Park Hospital on the second floor of the hospital at 9:30 at night. She was 13 years old, it was her second abortion within one year and she had a seizure history which would then make her a high-risk patient, in any event. The only abortions I ever saw listed that were going to be done in West Park Hospital were listed under first trimester, and they were on the O.R. schedule. I never saw any second or third trimester abortions listed anywhere on the O.R. schedule at West Park Hospital in the years that I worked there. I think that that is significant that they hid that fact.

Q. I thank you for your information on this point because it's the first time I've seen the

compilation of statistics that indicate in terms of data how many late term abortions were performed last year in Pennsylvania, and I find that number, 1,100, to be very disturbing. I think that someone, and I'll close very briefly with this, I think that someone such as myself can, with sincerity, support a woman's right to choose, even if she chooses an option that we might not individually choose for ourselves or our own families, you can support a woman's right to choose when that decision is made early in the gestational period, but when you get to 18 weeks of pregnancy and the decision is made on an elective basis to terminate the pregnancy, I think that raises some very serious moral questions and I would like to know from later witnesses anyone else who might have the information of how many of those late term abortions were elective in nature and how many related to the mother's life or physical well-being.

REPRESENTATIVE McHALE: Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Representative Heckler.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman. I'll be very brief.

BY REPRESENTATIVE HECKLER: (Of Ms. D'Alesio)

Q. Representative McHale has really gotten to

the question that had occurred to me in some measure. I note that the material that is attached to your prepared testimony referring to late term abortions appears to be an extract from the submitted testimony of the Pennsylvania Pro-Life Federation?

A. That's correct.

Q. So you're relying on the data that they have provided you with regard to these late term abortion numbers?

A. That's true.

Q. And I presume that similar to your answer to Representative McHale's questions you are not, but I want to ask the question anyway, you're not aware of what number of these 18 to 22 week and 23 to 26 week abortions may have involved situations in which there was a fetal anomaly or fatal defect of the fetus detected by some medical procedure?

A. No, I'm not aware.

Q. Okay.

REPRESENTATIVE HECKLER: That's all I have, Mr. Chairman. Thank you.

CHAIRMAN CALTAGIRONE: Representative McNally.

BY REPRESENTATIVE McNALLY: (Of Ms. D'Alesio)

Q. Yes, Ma'am. In Dr. Melnick's case, would

you happen to know what sentence he received?

A. I was told he was going to be sentenced on September 19th. I have not heard that he has been. I don't know if he has been sentenced as of yet.

Q. Do you know what the range of sentences are for infanticide?

A. I think that -- I don't have it in front of me, but under the infanticide statute I think there is a mandatory three month -- I don't know. They take away your medical license for a certain period of time. As far as jail sentencing, I don't know. He can get up to seven years.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Representative Bortner.

BY REPRESENTATIVE BORTNER: (Of Ms. D'Alesio)

Q. Yes, Ma'am. I'd like to follow up on your exchange with Representative McHale's questions concerning late term abortions in particular, his observation that many of these would be elective. And I'm searching for some reason why a woman would wait until the very end of her pregnancy to have an elective abortion when it obviously greatly increases her own health risks and when she had an opportunity to have that earlier. And to the extent that you could provide me any inside insight into

that, I would appreciate it.

A. I think that the doctor who testified earlier answered that question by saying denial, looking for the money to be able to afford an abortion, much more expensive in the last trimester. Just, say, perhaps she didn't find out until she was four or five months pregnant. And another one is that they're just plain stupid.

Q. You used statistics to indicate the number of pregnancies, the reported pregnancies that occur in the Commonwealth of Pennsylvania over that same period of time that the late term abortions occur--

A. I'm sorry?

Q. Do you understand the question?

A. I couldn't hear you.

Q. Do you have statistics or do your statistics also indicate the number of pregnancies that occurred over that same period of time?

A. I do not have them with me, no.

Q. Thank you.

CHAIRMAN CALTAGIRONE: As a brief follow-up to that, if you have that information that you could access for us and provide it to the committee, we would be deeply appreciative of that.

Are there other questions from the members?

(No response.)

CHAIRMAN CALTAGIRONE: If not, thank you.

MS. D'ALESIO: Thank you.

CHAIRMAN CALTAGIRONE: We'll turn next to Dr. Dratman.

DR. DRATMAN: I'm Cathy Dratman, a board certified obstetrician gynecologist. I'm a graduate of Hahnemann Medical College and served an internship and residency at Pennsylvania Hospital in Philadelphia. This is one of the busiest, high-risk obstetrical centers in the State. During these years, I provided care to many women, including those with severe medical problems, those with wanted but genetically or developmentally abnormal pregnancies. During that time, I also performed many first and second trimester abortions. I have had a private Ob/Gyn practice and I'm presently the Medical Director of Planned Parenthoods of Southeastern Pennsylvania and of Chester County. Both organizations provide reproductive health services including pregnancy testing, options counseling, sexually transmitted disease services, and contraception. Planned Parenthood Southeastern Pennsylvania also provides first trimester abortions.

I appreciate this opportunity to explain the impact this House Bill will have on women such as those I

have cared for and on practicing physicians. I ask you to consider the effect this legislation will have in the real world of doctors and their patients, and with that understanding, I hope that you will protect the lives and health of Pennsylvania's women by recommending defeat of this bill.

I've analyzed this bill and I'm deeply troubled by many of its provisions. There's no doubt that the combined burdens imposed by this bill will seriously endanger the lives and health of women seeking abortions in Pennsylvania. Many of these provisions will cause delays in obtaining a medically safe abortion. Such delays will make the procedure more hazardous. For each week of delay after the 12th week gestation, there's a 15- to 30-percent increase in the complication rate, and a 50-percent increase in the mortality rate. In effect, this bill will cause later, less safe abortions to be performed. Other provisions interfere with my ability as a physician to exercise my clinical discretion so as to provide the safest care possible for the pregnant woman. This will discourage doctors from performing abortions by expanding their liability and impose unnecessary investigatory and informational requirements.

Finally, new obstacles, such as spousal notice, coupled with this likely decrease in the

availability of abortions because people will stop performing abortions because this bill is so unclear will make it more likely that some women will resort to illegal and unsafe abortions.. The lives and health of these women will tragically and unnecessarily be placed in severe jeopardy.

I'd like to begin with Section 3211 because it's most disturbing. This prohibits physicians from performing an abortion after 24 weeks except where necessary to prevent the death of the mother. In addition, those abortions are permissible only if two other physicians concur and the abortion is performed in the manner most likely to produce fetal survival. This section is apparently motivated by the mistaken belief that abortions are frequently and cavalierly performed in the late stages of pregnancy. This is just not true. Dr. Melnick's case is really an aberration. I cannot remember hearing or seeing of such a thing in the years that I've been in practice, and I've been involved in at least five hospitals during my training from the time I was a medical student through the time that I was in practice. 94 percent of abortions in Pennsylvania do take place in the first trimester. Nationally, fewer than .01 percent of abortions are performed after 24 weeks.

The way the statistics are reported in

Pennsylvania, the ability to poll that figure for Pennsylvania is very difficult. I have the Induced Abortion Report from January to December of '88. I'm sure we can get it copied if you want it. That figure of 953 abortions from 18 to 22 weeks that's been discussed at length here is really very misleading. All of those fetuses cannot possibly be viable. It's not until at least 24 weeks gestation that the fetus has even the amount of lung tissue that's necessary for it to be able to breathe. And there are plenty of other situations in which a fetus with that amount of lung tissue is still not viable, and I'll explain that to you in a few minutes.

You should also know that the denominator of that equation is 50,786. So for the State of Pennsylvania, the number of abortions performed after 18 weeks is 2 percent. After 23 weeks, it's only 128, or 0.2 percent. Now, you must understand that these are not elective abortions. Again, Dr. Melnick's case is an anomaly. It was wrong, he's been punished. But what this bill will do is punish the physicians and the patients who have severe medical problems and the physicians who have the difficulty of trying to help them with this problem. Did you know that amniocentesis results are not available until at least 18 weeks of pregnancy? Therefore, for most women in this State who have amniocentesis, their chance

of finding out if they have a severely abnormal child doesn't occur until after 18 weeks. I would venture to say that most of that figure that's been bandied around represents those women with abnormal pregnancies whose babies, even if they went to 38, 40 weeks, which is full term, 42 weeks, would not survive because they are not able to survive with the genetic make up that they have.

Also, there are plenty of medical conditions, such as lupus erythematosus, renal disease, diabetes that can be exacerbated during the pregnancy that can be definitely followed, as was stated in previous testimony, under prenatal care, but prenatal care does not guarantee a favorable outcome. If these diseases begin to produce effects that cannot be taken care of during a pregnancy, if the diabetic's renal disease from the diabetes or her eye problems begin to get severe, she may not be able to continue that pregnancy without losing her kidneys or her eyesight. This bill, the way it's written, is going insure that that happens to her because her physician is liable for a felony if he delivers her.

You should also know that it's very unclear in this section what delivery is and what abortion is. Because if I have a woman who has an infection, who has toxemia of pregnancy at 24 weeks, sometimes delivering her by Cesarean section, which would probably be the best

thing in terms of fetal survival, is the worst thing for her in terms of her own survival and her own health. So what this bill does is forcing me to put her life and her health in jeopardy to save a fetus that probably will not survive.

There's also no provision in this bill for the genetically or developmentally abnormal fetus that will not survive. The way it's written, I am liable for a felony unless I put my maternal patient at risk of death in order to save that fetus.

You should also know that in terms of concurrence with the necessity for termination based on the risk of maternal death, there are 27 counties in this State that do not have 3 gynecologists. So there aren't going to be people around to give this information. There are also eight counties in this State that have no pediatricians. Who's going to resuscitate that 24-weeker? If the woman is ill enough or becomes ill enough that she can't be transferred to a perinatal center, she may have to be delivered in a community hospital in Elk County or Fulton County and there's not going to be anybody there who can help that baby. You have to think about the real world when you're looking at this bill.

You have also must know that 24 weeks does not equal viability. That is the point at which,

according to the literature, it is possible for a fetus to survive because of lung development. You have to take the other things into account. What was the mother's health at the time of the delivery? What medical problems did she have? How was the fetus developing inside? Was it getting enough blood through the placenta or was there a problem there? Were they infected? Was the mother on drugs? What is the genetic and anatomic makeup of that fetus? All of these things have to be taken into consideration in the medical decision about viability. It's a very complex thing to try and do clinically. And it's so complex that I don't understand how you, as lay people, are going to make a rule that will be on the law books that will tell all of us in the hot seat what we must do and still protect our patients.

We recognize that we have two patients, but the mother is walking around and talking to us, and if we have to jeopardize her health in order to save somebody who won't survive, this is forced malpractice, ladies and gentlemen. You're going to drive some obstetricians out of practice if you pass this, and you know that there are enough places in this State that don't have good medical coverage already.

The 24-hour waiting period that's already been discussed I'm not going to belabor because Ms.

Roselle already told you a lot of the pertinent facts. Again, let me emphasize that this is going to increase the delays in the procedure, and anything that increases delays is going to increase complications. Abortion is a medically safe procedure but we know that medically it gets more difficult to do and therefore there are more complications the longer people wait. It may even put some people from first trimester into the second trimester by the time they see somebody who can give them informed consent and then can make the appointment, and into second trimester we know that the risks increase, as I've just told you.

There was also a question about women who are medically at risk in having abortions performed in a clinic such as Ms. Roselle's. You should know that there are plenty of women who have medical problems who come for terminations both elective and non-elective. We have very strict regulations for outpatient freestanding abortion centers about who may be done safely, and women are screened for these problems over the phone when they make the appointment. They are screened again by the counselors and the physicians before a procedure is done, and if they evidence a problem that could not be cared for safely in an abortion facility such as Ms. Roselle's and my Planned Parenthoods, they are referred for a hospital

abortion. And that is why the question that was asked doesn't cover the whole ground of what actually happens in the real world.

Ms. Roselle also discussed the requirement for the physician to give informed consent. I would maintain to you besides her points that trained counselors can do much better with options counseling than physicians can because they are very often much more in tune with the psychological and the psycho-social problems of the patient and can much better discuss these with her. Very often a woman will open up to a counselor about these things that she may not talk about with physicians.

And, for instance, this requires giving information about alternatives to women. 90 percent of women, when they make the abortion appointment, know what they need to do. If that additional 10 percent needs additional counseling, they are referred, the abortion is not done. We do not hold people down on the table and perform an abortion. It just does not happen in this State.

On the other hand, if, for instance, the woman presenting is a victim of rape or incest and she knows that she needs to have an abortion for her own peace of mind, for her own sanity, to force her to listen to the risks of continuing to term and where other alternative

help for the pregnancy can come from I think is cruel.

Also, there is no -- nothing in this bill that talks about regulation of that list of alternative providers that the Department of Health is supposed to provide. Planned Parenthood provides such a list to its patients who request them. We screen those providers for adequacy of services. There's nothing like that required in this bill. Will that list therefore include such agencies as the Montgomery County Center in which a pregnancy test patient was physically restrained and forced to watch an anti-abortion film before her pregnancy test was done? What about the Philadelphia agency that promised postpartum assistance to one of our patients and delivered one box of diapers and one case of formula? Will this list also include the real world information that there are few adoptive homes for non-white, handicapped, AIDS or drug-infected or older than newborn children? If somebody is considering her options, she has to know that.

The informed consent provision also requires that the patient be given information about the availability of Medical Assistance benefits and the liability of the father to assist in child support. In some cases, this is totally inappropriate. First of all, it bears no relationship to the medical risks of abortion,

so if it's appropriate at all, it belongs in options counseling and not in informed consent counseling. Moreover, this is very complex legal information that's far beyond the scope of certainly a physician's expertise, probably of the counselor's expertise, and far beyond the scope of any simple printed materials that would be produced by the Department of Health. It certainly takes a lot longer than 24 hours to find out if somebody is eligible for Medical Assistance. And an abbreviated presentation of this information could confuse and mislead the patient.

The inclusion of this information also is particularly offensive to me as an obstetrician in light of the reality that child support and Medical Assistance available to poor women is inadequate at best. If you see fit to further restrict abortion, you must provide better benefits for the poor women who will be bearing children they would otherwise not have had. Some city hospitals are considering closing their obstetrical clinic services because the cost of providing that care is totally beyond our State's allocation for it. There's also currently no State funding for contraception. We have to have funds to prevent these unwanted pregnancies before we have to deal with them as abortions.

There's also no provision for increasing

child care benefits to realistic levels or for increasing allocations for the social services that these mothers and children will require. This bill's written as if life ends at delivery.

And this requirement for spousal notification is very disturbing. Women are going to lie. And when they lie, they disturb, because you will have told them to, the information passage that's absolutely required between the patient and the doctor in order for the doctor to provide the safest care for that patient. In most cases, women involve their husbands in the decision, but in troubled marriages, women may have very good reasons for not involving their husbands. And there's no justification for the State to force these women to choose between notifying their husbands and admitting to infidelity or that they're rape victims in signed statements which remain in the medical chart. Ms. Roselle alluded to this. What happens to that medical chart? It can be subpoenaed. If the chart is copied because the records are requested, does that slip of paper go with those records? Who has access to it and what's the penalty for disclosure? There's nothing about that in there. Are we setting a double standard here? You know, according to the American couples studied, 21 percent of wives admit infidelity, 26 percent of husbands admit

infidelity. Are you going to make the husbands write down that they've been unfaithful, too? Come on.

Also, have I violated this act if I require proof, the proof says the woman is not married, I do the abortion, and then the husband comes in and says, you aborted my wife? There is several penalties in here that I think might apply to that situation. There are criminal penalties in here that might also apply to that situation. How much proof must I demand before performing an abortion?

The section on requiring determination of gestational age before performing an abortion apparently is applicable throughout pregnancy. I'm troubled by this provision because it invades the discretion of the physicians by requiring them to perform those tests and examinations necessary to make an accurate diagnosis of gestational age. Dr. Melnick's case aside, what's an accurate diagnosis? How accurate is accurate? For whose purposes? What determinations are required? Does accurate imply ultrasound in all cases? If so, this would add unnecessary delay and extremely unnecessary costs. Particularly to the cost of a first trimester abortion, and again remember there is 94 percent of abortions done. Ultrasound is a sophisticated, expensive test that's not medically required in many cases. Performing it only in

order to comply with this statute is clearly harassment and interference with clinical judgment. And again, gestational age does not equal viability at 24 weeks.

There is also the limitation on the physician's discretion in performing an abortion regarding the sex of the fetus. Did you know that there are approximately 200 X-linked diseases that fetuses can have that will produce severe physical or mental anomalies, most of which will end in early death? Take Duchenne's muscular dystrophy, for instance. Until very, very recently, we had no test other than amniocentesis to find out if the fetus was male to find out whether or not that baby would be affected by Duchenne's.

CHAIRMAN CALTAGIRONE: Please speak up. Some of us are having a difficult time hearing.

DR. DRATMAN: I'm sorry. Okay.

If this statute goes through as written, does this make it impossible for a woman with a family history of Duchenne's muscular dystrophy who knows that her fetus is male and therefore probably affected? Does this mean that she may not abort that fetus?

Also, in terms of the ban on fetal experimentation, 3216, there's presently law regulating this area. This section though bans the use of tissue from an aborted fetus for research or experimentation

purposes and also prohibits the performance of non-therapeutic medical procedures on the fetus for experimentation purposes. This provision is very dangerous, and its inclusion in a bill ostensibly designed to protect children is particularly ironic. You have to know that most, if not all, of the therapies that are now in common practice began as experiments. The only way one can perfect a procedure to know whether it's going to be a therapy is to experiment with it. And very often, you need to do it in a situation where the outcome, the safety of the procedure is not the first line. You have to get the technology down first. Yes, you do this in animal models, but there reaches a point in most technology where it must be tried on a human model.

In Philadelphia presently, researchers are trying a new technique of fluid breathing on fetuses whom they know will not survive. The purpose of this research is to develop the technique which, when perfected, will improve the chances of survival for premature babies with immature lungs. Under this bill, such procedures might be banned, and with them the possible later salvage of other neonates.

Experimentation with human fetal tissue was essential to development of the Salk polio vaccine to understanding of how the Rubella vaccine and the Rubella

virus affect fetuses. These are clearly all things that are helpful to today's children. Currently, fetal tissue research is essential in studying the genetics of retinoblastoma, which is a life-threatening cancer of children. Studying the differentiation of cells like leukemias, of respiratory distress syndrome, of a chicken pox vaccine, of transplant rejection, sickle cell anemia, and some AIDS questions.

Fetal transplantation research which is showing promising results involved implantation of fetal cells into Parkinson's patients and into diabetics. Such fetal transplantation is the medically preferred treatment for DiGeorge's Syndrome, which is a congenital fatal loss of immune function.

I would ask you to think carefully before denying the people of Pennsylvania the opportunity to participate with unethical guidelines in similar important research or to benefit from techniques currently under development in this State that require fetal experimentation. Denying the possibility of such research may case the State to lose numbers of its best medical researchers and delay furtherance of their techniques and of their technique's potential benefits.

Thank you for your attention to these issues. In your deliberations, please consider the real

world impact of this proposed legislation on the health and welfare of Pennsylvanians. This legislation endangers the State's women and children. You must protect their lives and their rights and their health. The courts can no longer be counted on to do it for you.

CHAIRMAN CALTAGIRONE: Thank you.

Representative Heckler.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

Dr. Dratman, I just have a few observations. One, when you questioned the rationale for the required notification under all circumstances of husbands, you obviously overlooked the paternal procreational rights which the sponsors of this bill have concluded, have discovered and concluded, that I and other members of my sex have.

DR. DRATMAN: Congratulations.

REPRESENTATIVE HECKLER: And I don't ask for any response to that. I'm not sure that one could refrain.

Secondly, Mr. Chairman, I'd just like to make the observation that we engage all too often in this legislature in exercises which utterly ignore the outside world and the fact that the people of Pennsylvania are actually going to have to live one day, day-in and

day-out, with what we do. Dr. Dratman, I thank you for your testimony. I only wish that you would be permitted to introduce the same element of reality to the consideration of this matter which will take place on the floor of the House of Representatives.

And, Mr. Chairman, I'd like to thank you for having this hearing. I have heard in the press that it has been suggested that this is a meaningless exercise of no significance, and I would certainly suggest that having both sides have the opportunity to let us know what the real impact of our actions in this regard will be is of the greatest importance, and I thank the Chair for scheduling this hearing. Thank you.

CHAIRMAN CALTAGIRONE: Thank you, Representative Heckler.

Representative Hagarty.

REPRESENTATIVE HAGARTY: Thank you, Mr. Chairman.

BY REPRESENTATIVE HAGARTY: (Of Dr. Dratman)

Q. I, too, thank you for sharing with us the real world of women's health and pregnancy issues. I have some other questions that I hope will further enlighten those who may not be about how women's health and lives may be affected.

First, let me ask you, as an obstetrician in

dealing with pregnant women, do you find that most women are familiar with fetal development and what the fetus looks like during development?

A. In general, they are not. If they ask us, we tell them. We refer them to resources. And in general, the women who want to know and who need to know do ask and find out.

Q. Have you ever talked to a woman who chose to have an abortion purely because the sex of the baby was not their preference at that time?

A. I have had a number of patients discuss it with me, but I have had no patients who have actually had such an abortion performed.

Q. How many weeks pregnant would a woman be before this determination of the sex of the baby was known?

A. It depends what technique is used. There are currently two which will define the genetic makeup and therefore the sex of the baby. At eight weeks gestation a technique called chorionic villus sampling can be performed which will tell the sex. This technique is a very good one, it's very accurate, but it's not available in most parts of the State. It's only in academic centers that this is available. For most women to find out the sex of the fetus requires amniocentesis, which cannot be

safely and reliably performed until at least the 16th week of pregnancy. It takes at least two weeks for the fetal cells which are harvested from the fluids taken out during amniocentesis to grow, so it's not until at least the 18th, more usually around the 19th, week that such results are available to the woman.

Q. Isn't the risk of the earlier procedure of miscarriage also greater than amniocentesis?

A. It was thought so initially, but there's just been a large multi-center study published, in which Jefferson Hospital participated, by the way, that shows no increase over baseline in miscarriage.

Q. Oh, I'm glad to hear that.

A. Yes.

Q. The last I heard, it was.

Let me ask you, what is the reason that a woman does undergo the procedure of amniocentesis?

A. Most of the time it's done because she is concerned that her fetus may be anomalous and many -- I can't really give you a percentage, but many of those women are over 35 and therefore at some risk for a fetus with Down's Syndrome.

Q. Would a woman also who had given birth or miscarried a baby of a congenital abnormality undergo an amniocentesis?

A. It depends on the abnormality. If it is something that can be found out by genetic testing or by testing of the fluid from around the baby, yes, she probably would.

Q. Is this a pleasant procedure that you think women would undertake normally just to determine the sex of the baby?

A. No.

Q. Would you describe what the technique is?

A. Yes. It requires an ultrasound examination, then injection of local anesthesia into the skin of the abdomen and then the placing of a large bore needle through the abdominal wall, through the wall of the uterus into the fluid cavity where the baby is, and the ultrasound is used so that the placenta, or the afterbirth, and the fetus and the umbilical cord are missed by this needle. We do use the local anesthesia, but very often women do experience some discomfort and some cramping afterwards.

Q. The abnormalities that amniocentesis detects, are some of them fatal so that baby will not live to term anyway?

A. Absolutely.

Q. Could you give me an idea of some of those diseases that would sadly result in that baby not being

born alive?

A. Well, the best examples are some of the other trisomies, similar to Down's Syndrome but a different chromosome has one extra one. These babies uniformly die.

Q. Will the result then of this bill be in large part causing women to carry to term babies which will not live and which will die intrauterine?

A. It's entirely possible. The bill is so unclear, the penalties are so unclear and the procedures are so unclear that I would bet that many obstetricians will not deliver, abort, whatever term you want to use, such fetuses for fear that somebody in the back room is going to say, that's an abortion on a viable fetus.

Q. Do you find that in late abortions that are health related, as you've indicated most of them are other than the abnormalities, that those women wish to have a live baby?

A. They definitely do. Most of them have actually risked their lives and their health to try for a conception. Many of them will have been in the hospital for a number of weeks in an attempt to alleviate the medical problem that might cause the need for the delivery.

Q. And do you believe that this bill is clear

enough that a physician would attempt in saving that woman's life or health or eyesight or some other bodily function proceed to deliver the baby?

A. Well, if he or she wants to take the risk of doing a Cesarean section in such an instance when it might be very harmful to the mother, yes. To save the mother's life probably, yes, because that's in here, but to save the mother's health, to save her eyesight, to save her kidneys, to prevent her from having seizures, she's toxemic, no.

Q. Is a Cesarean section major surgery?

A. Absolutely it is. And in some of these instances, it is very risky major surgery. Particularly in an instance where the mother and the fetus are infected, possibly from ruptured membranes, the mother could become septic, meaning infected throughout her whole body, because of a Cesarean.

Q. Can you tell us, a carrier of a sex-linked disease, if the male, say, exhibits the traits or has the disease, in what percentage of those cases in which the mother is carrying the male will that sex-linked disease occur?

A. That's a hard question because it depends on the disease and it depends on the penetrance within that woman's family. In other words, some of these diseases

seem to be expressed in different percentages of the males within a given family as opposed to the percentage of males within another given family. But in some of them, like Duchenne's, a large percentage of males will be affected. Actually, all of those will have to be affected. But the way an X-linked chromosomal disease is transmitted is on the chromosome that there are two of in women, there were two X's, so in most of these, the normal X chromosome protects this person, who happens to be a woman, from having the disease that's carried on the other chromosome. In a male, there's only one X and then there's a Y. So the abnormality on that X chromosome will be expressed, will be seen, in a male rather than a female.

Q. Would an amniocentesis, would that trait be detectable independently of the sex of the baby by an amniocentesis?

A. Not in many instances. There is a test for Duchenne's muscular dystrophy that has just been started in just a few centers across the country, but that's the only one that I'm aware of. I can get you more information about that, if you wish.

Q. No. I know that amniocentesis does not and cannot detect many abnormalities. I just wanted to make that clear to the other members of the committee.

What percentage of abnormalities would you indicate could actually be determined by an amniocentesis?

A. I can't really give you a figure on that, but that's not the only way you can tell. A limb reduction defect, for instance, if arms are missing or if legs are missing, can't be told by amniocentesis. We don't know what chromosomes produce that defect. So doing an amniocentesis on a fetus like that, you might get perfectly normal chromosomes but the fetus is clearly abnormal. Those things can be told under ultrasound. There are also abnormalities that cannot be told by amniocentesis or ultrasound and the fetus is abnormal.

Q. If the woman is carrying a baby that she knows has a fatal defect, how long might she continue carrying that baby knowing that that baby will die?

A. That depends on her. I've had patients who requested termination as soon as they found out.

Q. Well, I mean physically.

A. I've also had a patient who was, because of the tenets of her religious belief, carried a known abnormal fetus for months.

Q. I mean, my question is though that the body will continue to carry for several months--

A. Oh yes.

Q. --a baby even though it's clear that that

baby has an absolutely fatal disease?

A. Right.

Q. Do you think that this legislation will prohibit a late term abortion of a baby that will die?

A. Yes.

Q. Have you ever seen a piece of legislation that will put in greater jeopardy the lives and health of women in this Commonwealth?

A. Only the other abortion control acts.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Representative Reber.

REPRESENTATIVE REBER: Thank you, Mr. Chairman.

BY REPRESENTATIVE REBER: (Of Dr. Dratman)

Q. Doctor, first of all, I want to thank you for, in essence, taking some of the earlier testimony and commenting on that and interrelating that into your testimony. I, like Representative McHale earlier, had some concerns with the aspect of the numbers and the induced abortions, the 953 subsequent to the 18-week period, and I shared many of the concerns that were expressed and I think, at least from my perspective, you have factually, pragmatically, unemotionally, and professionally attempted to give what I consider to be a very good analysis as to how those figures should be

interpreted, and I thank you for doing that.

A. You're welcome.

Q. Unfortunately, your testimony in one area took a concern and arranged in my mind a lack of fear for that concern, but you did bring up something that I find very troublesome as I sit here and have been listening, and frankly have been sitting here with bated breath to discuss with you, and that's the Section 3211 and the language with the additional two physicians and your comments on that and getting the additional two physicians' certification, et cetera, et cetera.

A. Um-hum.

Q. I was really troubled by the fact that you referenced in the Commonwealth of Pennsylvania in many counties, and I think it was 28 or some odd counties, do not even have certain specialized professionals. Is that correct?

A. That's correct.

Q. Building on that, as I sit here and look at this legislation, let me ask you this: Do you think that just any licensed physician, any licensed physician, is sufficiently professionally qualified to be making the kinds of determination in this specialized area that the act is calling for such licensed physicians to do?

A. No, sir, I do not.

Q. Pretty straightforward answer. That's my conclusion also.

A. Many of these decisions are really difficult obstetrical decisions weighing risks and benefits to both patients. That's the training that obstetrician gynecologists have.

Q. So the, you know, take-your-temperature-take-two-aspirin-and-call-me-back-in-three-days general practitioner really isn't the kind of person that you would even want to go up, and with all due respect to that G.P., request him to be involved in this because in my mind, he could be subjecting himself to a very serious malpractice situation in being involved in the so-called statutorily mandated deliberative process that he's brought into play. Is that a fair statement?

A. In most cases, yes. Now, there are certainly some cases, when a woman is in heart failure, for instance, and must be delivered, when any physician would know that she needs to be delivered in order to save her life because her heart can't take care of what's going on in her body. But in some of the other instances that I've mentioned, no.

Q. In your opinion, would licensed physicians, and again, I emphasize that because that's the language set forth in the statute or the proposed statute, would

certain licensed physicians in the Commonwealth, in your professional opinion, not be qualified to professionally analyze all of the types of tests and test results that you in your specialized area do to come to such a deliberative fashion? In essence, if you drop those in the front of a G.P. in Elk County, is he going to be able to read those and understand those and apply those to a particular case?

A. Probably not.

Q. Now, if what you said is correct that there are a number of counties in the Commonwealth of Pennsylvania that have no one in the professional areas and if our dialogue is even closely correct that we're now having, not only aren't there professional specialists in those counties, there probably are not going to be licensed physicians at all in those counties that would be qualified to carry out the mandates of this act, Is that correct?

A. That's correct. Neither to deliver nor to resuscitate the infant.

Q. Thank you, doctor, and thank you for bearing with me on that.

REPRESENTATIVE REBER: Let me just say this in closing, Mr. Chairman. This particular concern, I think, is exhibited of a number of areas that I, at least,

have been hearing today that even though there is well intention and well meaning in some of the things and I'm sure in the mind of some people in all of the things that are set forth here in the act, I think there is no doubt that professionally, medically, technically, legally pragmatically, however you want to characterize the particular instance, there are certain areas in this act that are so fatally flawed that I think this committee has a responsibility in some way, shape, or form, if we are given the opportunity, to at least let the full membership of the House know that there certainly has to be amendatory action to at least portions of the bill.

I think the best example, or one of the examples, I should say, is in this particular area that we were just talking about, and I'm not sure where the testimony is ultimately going to go from this hearing and I'm not sure exactly where the procedural avenues of this particular issue and/or this legislation is going to go, but I do think and I do have a significant concern that the more we listen to discussions on the context of this bill in one total form, House Bill 1979 or its progeny that may appear in the amendment process, again, in its total context, really, really is not, in all fairness, the way that anyone in the House, Senate, or the Governor, for that matter, should be called upon to look at this, having

arrived in this totalitarian fashion that so many times Abortion Control Act documents do go through these so-called hallowed halls. And I think we have to make abundantly clear to the membership that there are concerns, there is remediation, at least, that has to be done, and I'll let it to the other members to determine how far that remediation has to go.

Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you, Representative Reber.

Representative Pressmann.

REPRESENTATIVE PRESSMANN: Thank you.

BY REPRESENTATIVE PRESSMANN: (Of Dr. Dratman)

Q. Doctor, where do researchers get fetuses and fetal tissue for experimentation?

A. It depends on what it is they need. Sometimes the tissue is from miscarriage specimens, but those tissues aren't good for a lot of these types of research because some of the cells are already dead. Sometimes they are from aborted fetuses.

Q. And I'm going to ask you to step away. You're a board- certified Ob/Gyn?

A. (Indicating in the affirmative.)

Q. And are you board certified in any other--

A. No, sir, I'm not.

Q. Okay. So I'm going to ask you to do what we may be asking doctors to do under this act, and that is that maybe in your area you would be sketchy. A pregnant woman is diagnosed with a type of cancer that would require chemotherapy to give her a chance for survival. What would be the effect of chemotherapy on a pregnant woman's fetus if the fetus were brought to term?

A. You're right, that's beyond my expertise, but I can tell you in general that it depends where in the pregnancy the chemotherapy is contemplated, whether it's early in the pregnancy, late in the pregnancy, how close to the time the fetus could be delivered to get it sort of out of the way before chemotherapy. That's a very, very complicated question and it really depends on the particular type of cancer and the particular agents that would be used.

Q. During an early pregnancy, two months, three months, if chemotherapy was used, what would be the risks of the fetus developing various cancers because of the chemotherapy?

A. It probably wouldn't develop cancers but it might develop abnormally. And again, it depends on the particular agents that are used.

Q. Is it your experience that a delay in chemotherapy for a pregnant woman if she decided to bring

her baby to term and delay her cancer treatment would be endangering her life?

A. It might.

Q. I don't think you have the knowledge of where I'm going with this question.

A. Well, I'm hedging on this because the literature is -- when you say cancer, what you're talking about is something that's the same as saying infections, and there are a list of them as long as my arm, all of which require different treatments. I did a little research in some of my textbooks about this question before I prepared my testimony, and in many cases the fetus would not be harmed by particular agents, but in some cases it would be. And in some cases, termination of the pregnancy is advised so that the chemotherapy can proceed. In some cases it's all right to wait until the pregnancy at least reaches the point at which the fetus is viable, can then be delivered, and then the chemotherapy given. So it's a long, incomplete answer to a very complicated question.

Q. To put a different spin on this, if under the section of the act that Representative Reber was discussing with you, if that act were to be transferred into another area, say that in order to have chemotherapy that you would have to have three doctors sign off and an

oncologist were to come to you as an Ob/Gyn and say, I think this person should have chemotherapy and I want your agreement that that should happen, would you feel totally inadequate to make that decision whether a person should have chemotherapy?

A. I would, and I would also feel totally, totally inadequate to discuss which agents should be used, and that's the analogy to which method of delivery.

Q. Okay. Thank you.

REPRESENTATIVE PRESSMANN: With that, one of the concerns, and I guess I'm addressing the whole community, everyone, on this is that one of the big discussions we've had since I've been in the legislature over the last five years is the exposure of the medical profession to malpractice, and we've routinely heard testimony, particularly from doctors from your profession, about their exposure to malpractice. It would seem to me under this act that we are creating more opportunities for malpractice probably in a very unreasonable way, particularly if in the situation where there is not a readily available three Ob/Gyns to make a decision, where the only people that are available are, say, a neurosurgeon or an oncologist, then who would give consent, that would open them up to malpractice.

Also, with my discussions with doctors is

that I'm constantly hearing that you're practicing defensive medicine, so where are we going to get a non-Ob/Gyn to, in this circumstance, say, yes, I think this procedure should be done? I agree with Representative Reber. I think this is a very dangerous section not only for the women of Pennsylvania but for the practice of medicine. Thank you.

CHAIRMAN CALTAGIRONE: Representative McHale.

REPRESENTATIVE McHALE: Thank you, Mr. Chairman.

BY REPRESENTATIVE McHALE: (Of Dr. Dratman)

Q. Thank you doctor.

Doctor, I've been in the General Assembly for seven years now and I can tell you that throughout that period of time I found no issue more troubling on a personal level of conscience than this one, and I've reached the uncomfortable conclusion, after the best analysis that I can bring to the issue, as thoughtfully as I can approach it, that the issue of abortion inevitably brings into conflict two important rights: The first right being the woman's right to privacy, and that is her freedom to choose to continue or to terminate a pregnancy versus what I think is also an important right, the fetus' right to life. If one recognizes only one of those rights

and disregards the other, it becomes relatively easy. But if you do recognize both rights, as I do, then a balancing between the two becomes quite difficult.

With that kind of an introduction, and I think a helpful introduction to my questioning, this bill specifically draws the line at the 24th week, saying that during the last three months of pregnancy, elective abortions will be prohibited, that abortions will be allowed during the final three months of pregnancy only when there's a threat to the mother's life. Now, if Mr. Freind had drawn the line earlier in the gestational period, let's say perhaps during the first trimester, I almost certainly would oppose the bill, but I find it very difficult to defend, if not impossible to defend, elective abortions after the 24th week. So the questions I have pertain to where do you draw the line? How do you balance those two competing interests that I described to you at the beginning of my questioning?

My first question is, I was struck by the contrast in your testimony between the types of abortions performed by Planned Parenthood and the types of abortions that apparently you have performed in your private practice. I think you indicated that you are in private practice and you are associated with Planned Parenthood of Southeastern Pennsylvania. Is that correct?

A. I was in private practice.

Q. I see.

A. I am now associated with Planned Parenthood.

Q. I see. You indicated in your testimony that Planned Parenthood provides first trimester abortions.

A. That's correct.

Q. Is there a reason for a limitation on abortions contained in that restriction?

A. Yes, there is.

Q. What is that?

A. Okay. First of all, all Planned Parenthoods must operate under the rules of the Planned Parenthood Federation of America. In order for us to carry the imprimatur of Planned Parenthood, we have to say that we will uphold the standard of medical care that they require.

Q. Yes.

A. They require that only abortions of less than 18 weeks gestation be performed within Planned Parenthoods because most of the Planned Parenthood facilities are freestanding clinics. That means that they are not physically associated with a hospital. As we've already discussed, the potential for complications increases with each week of gestation and it's felt that beyond that point, it would be more risky to a woman to

undergo a pregnancy termination in a freestanding place than is medically okay.

Now--

Q. Yes, go ahead.

A. There's only a gap between 14 weeks, where we stop, and 18 weeks.

Q. That's what I was going to ask you.

A. Okay. In order for those procedures to be performed safely, the operator has to have a great deal of expertise and experience. There are a number of ways that abortion can be performed during that period. Do you want me to elaborate on those?

Q. I'm not sure that's necessary to specifically answer the concern that I have.

A. All right. Okay, fine. The reason that our Planned Parenthoood doesn't go beyond 14 weeks right now is that we don't have a physician on staff and we don't have the non-physician staff well enough trained to handle abortions at gestational ages beyond that.

Q. If I understand your testimony correctly then, you're indicating the limitation that Planned Parenthood has itself imposed whereby only first trimester abortions would be performed relates exclusively to the health of the mother and is not based upon an ethical consideration related to the destruction of fetal life

after the first trimester, during the second trimester?

A. May I make a comment on that?

Q. Please. I'm trying to find out what it is that--

A. Okay, this viability issue is a really slippery issue and it's very, very difficult for us as well as for you. You have to understand that I'm not sitting here telling you I know all the answers, it's very easy, every single patient has to have an abortion, and that's it. It's not the case. The problem is that we have two patients here. We have a mother who is viable, and we have a fetus who, in the gestational range of 23 to 26, maybe 27 weeks, might be viable. Now -- hang on.

Q. Doctor, you're not answering my question. I'm not asking about viability. I will later on, but I'm not now.

A. But, you see, until, to my mind, and this is me talking now, not Planned Parenthood, not anybody else. To my mind, until the fetus is capable of extra-uterine life without the support of the maternal circulation, it's not a person. And to keep the mother pregnant because that fetus requires it in effect, to me, makes her a vessel. Okay?

Q. And doctor, that's something I'd like to examine, but my preliminary questions don't reach that

point, at least at this stage.

A. All right.

Q. What I'm asking specifically is when Planned Parenthoood, and I ask you this in your capacity with Planned Parenthood not in your personal capacity as a physician, when Planned Parenthood draws the line at the end of the first trimester, is that based solely upon a concern for maternal health or is there also a reflection of that decision of a medical concern for destruction of fetal life after the first trimester? Are we talking only about the mother's health, or does Planned Parenthood have an institutional concern for the destruction of fetal life once it has developed past the first trimester? Why did they draw that line?

A. For maternal health reasons.

Q. Solely for maternal health reasons?

A. Yes. Now, there are also other Planned Parenthoods across the country who do perform abortions up to 18 weeks. Okay?

Q. And you had indicated that and I appreciate that.

A. All right.

Q. Now, somewhat in contrast to the policy that has been adopted by Planned Parenthood, you indicated that in the past you have performed second trimester abortions?

A. That's correct.

Q. Have you performed elective abortions in the second trimester where the purpose of terminating the pregnancy did not relate to the mother's health? Have you performed them?

A. Yes, I have. For fetal anomalies primarily.

Q. But have you performed them where there have not been fetal anomalies?

A. Yes, I have.

Q. Simply where it was a matter of choice to terminate the pregnancy during the second trimester?

A. That's correct.

Q. That's where I think you and I part company. I am deeply troubled by that procedure at that stage of the pregnancy.

Do you support the legal right to choose to terminate a pregnancy throughout the entire 9-month gestational period? Is there any stage during the nine months of gestation where you believe that the woman's important right to privacy must fall before the paramount right of the fetus' continuing existence? Where do you draw that line?

A. Okay. All right, now, this is me, Cathy Dratman, obstetrician, not medical director of Planned Parenthood.

Q. Yes. I understand that.

A. All right. Yes. At the point at which I feel sure in my clinical judgment that that fetus can survive extra-uterine life.

Q. So you draw the line at viability?

A. I didn't say viability because of all of those considerations that I outlined in my testimony. I don't want to talk about viability because once you start talking about codifying viability, you miss all of the subtleties where the meat of the issue really is. And, yes, there have been reports in the literature of a few fetuses that have survived in high-risk centers at 24 weeks, maybe one at 23 weeks gestation, but for me to say to a woman who's severely diabetic, who's infected, who has lupus, who is suicidal because of the pregnancy, and that I didn't address in my testimony here but it's in the paper, that I can't do an abortion on you because that fetus might be viable, I can't do that.

Q. Doctor, if I may, I'm trying to get to a different issue that doesn't involve any of the problems hypothetically that you just raised.

A. All right.

Q. Let's say we have a healthy woman and let's say that we have a fetus which appears to be totally free of any disabilities.

A. Okay.

Q. And I understand what you're saying where you draw the line, and I think with clarity based on biology at the time of the ability of the fetus to survive outside the womb.

A. Um-hum.

Q. My question really is an ethical question, and that is, why is a non-viable fetus, perhaps in the 20th week of the pregnancy, not deserving of legal protection? If we take as a premise that indeed that fetus in the 20th week of pregnancy could not survive outside the womb, why does that fact lead to the conclusion that the fetus is therefore undeserving of legal protection? The reason for my question is when I look at the biological facts of a non-viable fetus, 20th week of pregnancy, and I see what is really existing in the woman's womb at that point, in my view, that being, though non-viable, is deserving of protection. Why do you conclude that it is not?

A. With all due respect to you, sir, that is your opinion.

Q. Yes.

A. There are opinions of other thoughtful people who disagree with you.

Q. I'm speaking to one now, I think.

A. And because there are those disagreements, I don't see how any of us can codify a restriction for what everybody else has to think. That's my problem.

Q. All right. The question I posed to you, and that's a legitimate commentary, but the question I posed to you is really your opinion. Why is it in your opinion that that non-viable fetus, though a healthy fetus, in the 20th week of pregnancy is not deserving of legal -- is not deserving of protection? I mean, why do you feel that way?

A. Because once it comes out, I can't help it.

Q. All right. I think we probably have reached a philosophical impasse.

A. Look. This whole debate on this point is a philosophical debate.

Q. No question about it.

A. It's been debated since the beginning of time in one form or another. What you're getting at here is where does life begin?

Q. No, no. No, Ma'am.

A. And really, it's the same question, sir.

Q. No, I'm not.

A. And if philosophers cannot make this judgment, how can we sitting here?

Q. Ma'am, I'm not asking that question. I'm

saying that you and I might agree on the biological facts of that which exists in the 20th week of pregnancy, and I'm not getting into the debate of how many angels can dance on the head of a pin. We will have differing points of view throughout this room as to when life begins. I'm not asking that. I'm saying when we look at what biologically exists at the 18th, the 19th, the 20th week of pregnancy, why do you philosophically conclude that that life is not deserving of legal protection? And I was looking for perhaps a--

A. I've explained it to you in the best way that I can.

Q. And I think you have. And I think that's where perhaps you and I part company.

Final question.

A. Sure.

Q. You implied that many, if not most, late term abortions, for instance after the 18th week of pregnancy--

A. Excuse me. I didn't say that. Late term abortions, to me, is after the 24th, 25th week of pregnancy. 18 weeks is still mid-second trimester. There are 40 weeks of gestation. Okay?

Q. All right. And because I agree with much of what you said earlier, I really don't mean to be

confrontational here, so let's just refer to the weeks rather than a term such as "late term abortions."

A. Fine. Sure.

Q. Is it your opinion that most abortions after the 18th week of pregnancy involve fetal disabilities or a threat to the mother's health or indeed her life?

A. Most, but not all.

Q. Do you have a basis for that conclusion? I asked the same question of a previous witness and she quite candidly said that she didn't know the answer to the question. You have an answer, and I guess I'd like to know the basis for it.

A. It's based clearly on my clinical experience, sir. I can't back it up with figures for you. If you would like, I will research it for you and send the information to you. I don't know if it's available.

Q. If you could research it. That, to me, is a very important question. When we talk about over 1,100 abortions after the 18th week of pregnancy, it is, for me, extremely important to find out why those abortions occur, how many of them are elective in nature, how many of them involve the threat to the mother's life, and I sense from your testimony, Doctor, you believe a very large percentage of those abortions are in fact related to fetal disabilities or a threat to the mother's life?

A. Yes, I do. And I would also like to make the point, sir, as I did in my testimony, that many of the provisions in this bill are going to mandate delays in a procedure and may actually increase the number of procedures that are done later.

Q. I understand. Doctor, I think that's a legitimate commentary and I think that in some cases that is in fact a correct prediction of what might happen in some cases, but finally, you did indicate a few moments ago that here in the Commonwealth of Pennsylvania under existing law there do occur, though I think you would say rarely, there do occur elective abortions not involving a threat to the mother's life or health after the 18th week of pregnancy.

A. Oh, yes. Up to about the 20th week of pregnancy. There are a few up to 24 weeks. None that I am aware of over 24 weeks.

Q. And I guess I close with this comment: It is the fact of those abortions at that stage electively performed after the 18th week that troubles me deeply, regardless of the number. If there is one electively performed in the State at that stage of pregnancy, that, to me, is ethically indefensible and it is that fact more than anything else related to this legislation which will probably prompt me to vote for it. I am, without a doubt,

and I realize it's a philosophical difference, all I can tell you is that ethically, I am appalled at the legality of electively taking fetal life at that late stage of pregnancy after the 18th week.

A. That's certainly your philosophical right, sir. I hope as well then that you will add to this bill money for contraception, for prenatal care, and for the services that the women and the babies born because of this legislation are going to need. They are mostly women in need and they are going to need a lot of help.

Q. That is an absolutely excellent point. I think it ought to be recognized that there are some of us who will probably vote for this bill who hardly ever vote with Mr. Freind. My voting record is a mirror image of his, and I think both he and I are grateful for that fact. In the areas that you have just described, I have always supported family planning, contraception, prenatal care, increased financial assistance for women who choose to carry their pregnancy to full term. You make an absolutely valid point, and those of us who vote for this bill, in my view, have a moral obligation to financially address and ethically address the consequences of its passage, and that's where I part company with some of the other people who, in fact, will be voting the same way I do on the underlying legislation. You make a very good

point.

A. Thank you. Please lobby for that.

CHAIRMAN CALTAGIRONE: Thank you, Doctor. Are there any other questions?

(No response.)

CHAIRMAN CALTAGIRONE: Thank you, Doctor.

We will next hear from Suzi Dewing.

MS. DEWING: Mr. Chairman, members of the committee, thank you very much for allowing me to be here to testify. I would like to ask your permission just to expand a little bit on my written testimony. I was planning on just submitting written testimony and ask to testify orally at a late date, so I'm just going to expand a little bit from what I have written there.

My name is Suzi Dewing, and I am the Pennsylvania State representative of American Victims of Abortion. AVA is a national organization comprised of mothers and fathers, grandparents, and siblings of aborted children. We meet in support groups, we do public speaking and education from the voice of experience, those who have been touched by abortion in their lives.

Today you have heard many testimonies from different areas of expertise. My expertise is only in that of my own experience and in hearing experiences from others who have been through an abortion. We have a

sincere interest in the 1979-1989 Abortion Control Act being accepted by this committee, specifically concerning the informed consent portion of this bill. As women of this State, we have had a personal experience with abortion and we feel that women in this country and in this State have a right for all the information available to be provided to us by this Abortion Control Act.

And I would also like to address the spousal notification at this point because we do have fathers of aborted children involved in our organization and they have been left out of the decisionmaking process, and because of that they have had great emotional regrets and they would like to be given the privilege of being recognized as those who participated in the original act that brought the decision for abortion to be. They feel they have the right to know of a baby and an impending abortion.

In order for a woman to make a choice, she must be given the best information available to make an honest and clear decision. If important facts are withheld, many times that decision is made in error.

I would like to take this opportunity to share with you my personal experience and let you aware that I do have affidavits from other women within the State who have experienced similar things concerning

informed consent. Prior to the actual abortion procedure, I did not receive any explanation of the surgical procedure itself that was to be performed on my body or any physical or emotional complications that I was at risk for. No one suggested that there were alternative services available to me and I want to make it clear at this point that when I found out I was pregnant, at the exact time the doctor told me I was pregnant he recommended abortion simply by asking my marital status. I had never seen this doctor before, he did not know anything about me. He simply asked me if I was married. When I told him the answer was no, he suggested abortion. He did not suggest any other alternative services that were available.

I would have liked to carry my child, and I believe if somebody had approached me at any time within the next two days and told me that there were services, that there was help available for me, that I would have chosen life for my baby. I was under the impression that if I chose life for my baby I would be the only one responsible for that child and I would have to take care of all of the financial and medical expenses required. I had absolutely no idea of fetal development. I did not even know what state of pregnancy I was in. I had been on birth control, I had been sick for several weeks. When

the doctor told me I was pregnant, he did not explain to me at what stage in pregnancy I was, and I really had no idea what was happening to my own body other than the fact that I was pregnant.

As he referred me to abortion and I felt that I had no other alternative, I went ahead with the procedure. At the clinic that I was sent to, the only counseling that I received was in a room with 10 other girls. Questions pertaining to what kind of birth control was I using and what kind of birth control was I interested in upon leaving the clinic. Again, there was no explanation about the procedure that was to be performed, any risks that would be involved, or any alternative services available.

The doctor began the actual procedure. As he dilated my cervix, he began explaining to me what he was doing. I never heard a complete explanation. I passed out from pain. I was never given any anesthetic, and it was extremely painful. When I came to, I was in another room curled up in a bed -- actually, I think it was an army cot -- very confused, feeling very alone. A counselor came in, told me to sit up and get dressed and get out. I stood up -- I sat up to get dressed and passed out. She left me and came back 10 minutes later and asked me to get up and dressed again. She handed me a package

with a pill to take, a glass of orange juice, and escorted me out the door.

As I left that clinic, my emotional state immediately began to change. I began suffering depression, anger, confusion. I withdrew from my family and friends. I began abusing drugs and alcohol to try to suppress the pain that I was suffering. I became so unable to make decisions. I could not even decide what to have for dinner. I didn't trust my ability to make a decision because I knew that the decision I had made to abort my baby was the wrong decision. I eventually, within just a few short months, became obsessed with getting pregnant. So obsessed that I insisted on my boyfriend marrying me and within three months was pregnant. I was ecstatic with the pregnancy, looking forward to it, and at 16 weeks I miscarried. I went through labor and I delivered a dead baby at six weeks in a hospital room. I was kept overnight, I was sent home with flowers, condolences from family members, and given a week to recover physically.

Three months later, I was pregnant again, only to miscarry. All of the pain that I had felt from my abortion experience and the loss of that baby became compounded with guilt. I felt my decision to abort my baby the first time was the reason that I was miscarrying,

and when I confronted my physician about this, he told me that there was no way to connect them but there was no way to disprove it.

When I was pregnant again, I was able to carry the baby full term, although I was treated as a high-risk patient, and I delivered a healthy baby boy on Christmas day. But I never forgot my abortion. I never forgot that baby and I never forgot the children that I lost since then. I have learned since then through talking with other women similar experiences that there is almost always some guilt, and it's not uncommon to become depressed, to use alcohol or drugs to suppress those feelings. Even women I have talked to who have attempted suicide because they could not live with their decision, and yet they were never counseled before their abortion that they might have an emotional response to their decision.

As I look at each one of my precious children that I have delivered since, I see individuals unique and special. They can never replace the ones that were lost. And I do grieve today and mourn for the ones that I have lost, all of them.

My testimony, along with several other women from across the State, has revealed the need to be adequately informed and prepared. Each woman needs to

have the information to make her decision. We have been kept in the dark, we have been led astray, and we have been told that because abortion is legal it is also safe. That has not been the case. For many of us we have suffered greatly, and we really sincerely ask you to consider legislation that would at least protect us from the lies and deceit that go on in abortion clinics today.

I would also like to ask you to consider, on behalf of the fathers, that if a woman chooses to maintain the pregnancy and deliver that baby they are held legally responsible for that child's maintenance for the next 18 years. I believe that that shows that they have the right to know that that child is in existence from the moment of conception, or determining the termination of the pregnancy. Now, the bill has made it clear in certain cases of abuse that they can be protected.

I think it's important for women to make choices, that they need to make informed choices, and I think it's time to stop hiding behind names like "products of conception" and saying that we're getting counseling when we're not. I think we need to be presented with facts, shown development of babies. It's a baby that's being killed in an abortion and we know it because we feel the pain and the loss. Every woman I've talked to who has had an abortion has felt a loss. It wasn't a loss of a

piece of tissue, it was the loss of a baby. And she has the right to know what she's getting into prior to it, not afterwards. And I ask that you listen to the voice of experience here today and understand that we have a right to be protected within the confines of the law from an organization such as Planned Parenthood and other organizations that are out for money and not caring about women.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you.

Questions from the members?

Representative Heckler.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

BY REPRESENTATIVE HECKLER: (Of Ms. Dewing)

Q. Could you tell me when was the abortion which you had performed? What year?

A. It was in the year 1976.

Q. And where was it performed?

A. It was performed in Boston, Massachusetts. I also have with me several letters of women even recently who had similar experiences here in Harrisburg, Philadelphia, Lancaster County.

Q. Um-hum. And have you been to a -- you mentioned Planned Parenthood specifically. Have you been

to a Planned Parenthood facility of any sort since that time?

A. Have I?

Q. Yes.

A. No, I would not go back, but I have talked to several girls who have been since.

Q. All right. How old were you when that occurred?

A. I was 19 years olds.

Q. Were you living at home at that time?

A. No, I was living with my boyfriend.

Q. Okay.

A. Engaged to the married.

Q. So your parents weren't involved in that decision?

A. Yes, my mother was present in the physician's office when the physician told me I was pregnant and recommended abortion. He handed her the phone number of the local clinic and told her to make that appointment the very same afternoon.

Q. So that you had an opportunity to consult with her? She was involved?

A. My mother and I did not consult, we did not talk about it outside of the doctor's office, and she was just as misinformed as I was.

Q. Did you sign a medical consent of some sort?

A. The only thing that I can remember signing, which must have been a consent form, was a very vague mimeographed sheet that just had simple questions, how many weeks pregnant do you think you are? I guessed. I did not know. Had other questions, what kind of birth control were you using at that time, and then you signed at the bottom. I did not understand what I was signing, and I want you to understand that it was one counselor in a group of 10 women handing out these papers. There was not even a desk to sit at and sign the paper.

Q. You mentioned in your testimony that you became pregnant as part of a reaction to all of this fairly rapidly, twice thereafter. Were you married at that time?

A. Yes.

Q. So that you did ultimately marry the gentleman who was the--

A. Yes, we got married three months after the abortion.

Q. Are you familiar with the provisions of existing Pennsylvania law concerning informed consent?

A. Yes, I am, but they seem to be inadequate because the women that I'm speaking with today in Pennsylvania are not getting that kind of informed consent

and it is not clear enough stated.

Q. Well, let me ask, you've made sort of general references to other women who are part of your organization and have had these unfortunate experiences. Do you have -- can you tell us when those experiences occurred?

A. I have -- the most recently dated one I have here is in 1985. And I believe that was in Chester, Pennsylvania.

Q. So the most recent one is 1985, and then they range back in time?

A. I'd also like to add that several other women are writing right now. We only had a week to get letters signed and they haven't arrived yet, but several women are writing letters and they will be submitting them to you.

Q. Could you tell us, are you an official with your organization?

A. Am I an official? I'm a State representative.

Q. State representative?

A. Right.

Q. Okay. And can you give us any idea of how many people there are in the Pennsylvania Chapter, or whatever it is, of the American Victims of Abortion?

A. I would list that -- American Victims of Abortion is more of an education and kind of an overall for the State. There are several organizations that we work directly with. Mostly post-abortive counseling organizations like Hope, Heal, PACE, WEBA, Open Arms, those kinds of groups that hold support group meetings within their only communities, and there are several of them throughout the State.

Q. I have no other questions.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you.

Are there any other questions?

(No response.)

CHAIRMAN CALTAGIRONE: Thank you.

By the way, Mrs. Dewing, if you would like to submit those letters now to the court reporter, we can make sure that you get the originals back and we will just use copies for the record.

The last witness to be called to testify today is Thomas Zemaitis. If you would so state your name for the record?

MR. ZEMAITIS: It's Thomas E. Zemaitis, Z-E-M-A-I-T-I-S.

Mr. Chairman, members of the committee,

thank you for hearing me today. I am a practicing attorney. I've been a member of the Bar in Pennsylvania since 1976. I'm currently a partner with the law firm of Pepper, Hamilton & Scheetz, headquartered in Philadelphia. Since 1982, I have represented clinics and physicians in challenges of the Pennsylvania Abortion Control Act. I was co-counsel in the case of Thornburgh v. American College of Obstetricians and Gynecologists, which was decided by the Supreme Court in 1986. I am currently co-counsel in a case pending in the eastern district of Pennsylvania, Planned Parenthood of Southeastern Pennsylvania v. Casey.

In Roe v. Wade, the Supreme Court concluded that the right of privacy, "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." The proposed amendments to Pennsylvania's Abortion Control Act in House Bill 1979 constitute a frontal assault on this right of privacy. Most of the provisions of this bill are in direct conflict with controlling decisions of the United States Supreme Court. In fact, some of the provisions are, with minor modifications, the same provisions as in earlier versions of the Pennsylvania Abortion Control Act that have already been held unconstitutional.

If the proposed amendments are enacted,

Pennsylvania will have the distinction of being a State whose government willingly flaunts the United States Constitution by depriving its citizens of the liberties that Constitution protects. In a week when the United States Congress has reinforced the right of privacy by restoring Medicaid funding for abortions for victims of rape and incest, in a week when the Florida legislature has resoundingly rejected efforts to restrict women's exercise of their fundamental right to choose an abortion, and in a week when the United States Supreme Court let stand the decision of the Third Circuit Court of Appeals in which it held that those who conspire to interfere with women's rights face liability under the Federal RICO statute, it would be ironic and ultimately tragic for the Pennsylvania General Assembly to push this plainly unconstitutional legislation toward final enactment.

I'd like to spend the remainder of my statement dealing with specific sections of the act, pointing out to this committee precisely how they are in conflict with the existing precedent, and I'd like to start with the two provisions that would restrict abortion after 24 weeks of gestations, Section 3210 and 3211 of the bill.

In Roe v. Wade, again, the Supreme Court concluded, "For the stage subsequent to viability, the

State, in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe abortion, except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."

Section 3210(a) of the existing Abortion Control Act, the statute that is on the books, comports with this holding. It prohibits abortions after viability except where necessary to protect the life or health of the mother. I listened to the testimony of Ms. Everett this morning and was struck by the fact that if any of that had occurred in Pennsylvania, she and her colleagues would probably be behind bars, and the clinics at which she worked would certainly be closed down. There is simply no need to enact new legislation on this subject except legislation that is intended to cross the line drawn by Roe, and this is precisely what House Bill 1979 does.

In fact, it's kind of ironic because this provision, these two sections are so obviously unconstitutional that if this bill is enacted, those sections will likely be stricken. At the same time, this bill repeals existing Section 3210(a) of the Abortion Control Act. We are likely to end up with a situation where despite the efforts of those who are the proponents

of this bill, we have less regulation of abortions after viability than we have today.

Let's look at some of the specifics of these provisions. First of all, Section 3211 says that the health needs of the woman no longer provide a basis on which late term abortions can be performed. Beyond being unconstitutional, as the case law I just cited, Roe v. Wade itself tell us, this provision is utterly cruel. Only when a physician determines that sure and certain death will come to his patient can he give her the medical care that he has been trained to give. The cruelty of this provision I think is obvious in the portion of Section 3211 stating that, and I quote, "no abortion shall be deemed necessary to prevent the death of a pregnant woman if such death would result from suicide."

In addition, both Section 3210 and 3211 proceed from the premise that the State can dictate through legislative fiat when viability concurs. This is directly contrary to the Supreme Court's opinion in Colautti v. Franklin. Again, this is another case that declared a portion of Pennsylvania's 1974 Abortion Control Act to be unconstitutional. The court concluded in that case, "Because this point," that is the point of viability, "may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the

elements entering into the ascertainment of viability -- be it weeks of gestation or fetal weight or any other single factor -- as the determinant of when the state has a compelling interest in the life or health of the fetus. Viability is the critical point," and that's got to be left to the medical determination of the physician, as does existing Pennsylvania law.

The proposed Section 3211, subsection (c)(4) requires that the physician terminate the pregnancy, and I quote, "in a manner which provides the best opportunity for the unborn child to survive." Again, this plainly runs afoul of the Supreme Court decisions, both the Thornburgh case and the Colautti case, cases which held Pennsylvania statutes to be unconstitutional. And the Third Circuit's decision in Thornburgh goes specifically to this issue. It says, "The new Pennsylvania statute," that was the new statute in 1982, "like the old," that is the statute in 1974, "fails to require that maternal health be the paramount consideration." I would submit that the statute that's before this committee right now, House Bill 1979, does precisely the same thing, and it is, therefore, plainly unconstitutional.

Finally, Section 3210, which requires this determination of gestational age, is simply unnecessary. A determination of probable gestational age is part of the

routine care of the pregnant woman, whether or not she's having an abortion, but this section requires that the doctor perform a battery of tests to make an accurate diagnosis, whatever that means, that he must report the basis for his diagnosis to the authorities and that he must subject himself to disciplinary proceedings and criminal liability if he fails to do so. There simply is no compelling State interest under the standard laid down by the Supreme Court sufficient to justify that kind of intrusive regulation.

The informed consent provision, Section 3205 and 3208 of the proposed legislation. Again, these two sections would reenact -- the amendment to Section 3205 would reenact that section almost the same as it existed in the 1982 Abortion Control Act. That version was found to be unconstitutional on its face by the Supreme Court in Thornburgh. The court's holding was based on a series of statutory features, each of which is repeated in the proposed amendment. First, Section 3205 requires a 24-hour waiting period. Even before Thornburgh, the Supreme Court had declared what it characterized as "arbitrary and inflexible waiting period" to be unconstitutional. That was in the Akron case.

Second, the amendment, like the earlier version of Section 3205, requires that some of the

mandated information can be provided only by a physician and not by a counselor or other health professional. Again, this requirement of physician only counseling was declared unconstitutional in the Akron case and the section in Pennsylvania's 1982 act that had that requirement was found to be unconstitutional.

Finally, the proposal, like its earlier counterpart, is unconstitutional because it requires the physician to recite specific pieces of information in all cases in order to obtain informed consent, whether or not that information would otherwise be appropriate. The Thornburgh court, again, found this kind of required providing of information to be unconstitutional. First because, as the court found, it's not designed to inform the woman's consent but rather to persuade her to withhold it all together. And secondly, the rigid requirement that a specific body of information be given in all cases, irrespective of the needs of the patient, intrudes upon the medical discretion of the physician.

I would point out that the Thornburgh court found it particularly offensive that the required printed information in Section 3208 contain a description of fetal characteristics at 2-week intervals. House Bill 1979 goes even further and requires that pictures representing the development of unborn children at 2-week gestation

increments be made available. I would remind this committee of what Governor Thornburgh said in 1981 when he vetoed a prior Abortion Control Act that had that provision. He said, and I quote, "I doubt that requiring the preparation and availability of detailed color photographs of a fetus at various gestational increments is necessary to an informed abortion decision. Moreover, the presentation would likely cause many women considerable anguish and distress." I couldn't have said it better myself.

The reporting requirements in Section 3214 (a). Today in Pennsylvania there are reporting requirements in the existing statute. The amendment continues the requirement in the existing statute that the physician report the basis for his medical determinations, such as the determination of gestational age required in Section 3210. This requirement, the requirement that the physician report his basis for various medical determinations, was found to be unconstitutional by Judge Huyett in Planned Parenthood v. Casey. He said, and I quote, "I now hold that a requirement that a physician justify his medical judgment by reporting the basis therefor in a written report impermissibly interferes with the woman's ability to effectuate her abortion decision. I will, therefore, enjoin the enforcement of these

provisions." Well, they're back and they're going to be enjoined again. I would point out, again, the irony of a situation. After Judge Huyett made that ruling, the Department of Health developed a form for reporting individually abortions that removed the need to report that information, and that was held to be constitutional, at least on a preliminary basis. That report form is now in use, but if House Bill 1979 passes, a new form consistent with the new statute will have to be in place and it will be, I predict, enjoined. So again, House Bill 1979 may be directly contrary to the intent of its sponsors because it will result in the replacement of existing constitutionally acceptable regulations with unconstitutional regulations subject to injunction.

Section 3209, the spousal notice provision. Of course, there's no existing provision in Pennsylvania law that requires any kind of notice to the spouse before a woman can receive an abortion. In Planned Parenthood, the Supreme Court held that spousal consent provisions were unconstitutional because the spouse cannot have a veto over his wife's decision whether or not to have an abortion. Following Danforth, lower Federal courts have consistently held that spousal notice statutes are also unconstitutional. Again, I would remind this committee of what Governor Casey said in 1987 when he vetoed the first

round of amendments to the '82 act. He concluded, "The Supreme Court's decisions make it clear that the paternal notice requirement" in that statute "will be struck down as unconstitutional if enacted. Moreover, every state statute requiring merely spousal notice that has been taken before a federal court has been struck down. I am forced to conclude that this provision poses the almost certain and unacceptable process of invalidation, and costly, unsuccessful, and avoidable litigation." Again, I couldn't have said it better myself.

Beyond the fact that Section 3209 as proposed would require spousal notice, this section raises serious implications for State law generally. The section specifically states that the purpose of the notice requirement is to quote, "protect a father's right to procreate within marriage," closed quote. I'm not aware of any constitutional basis for such a right, so this provision, if enacted, would create a new right of undefined proportion. For example, in defense to a charge of spousal rape, will a husband be able to invoke his right to procreate within marriage? Since Pennsylvania has an Equal Rights Amendment in its Constitution, this right to procreate must also extend to the wife. Can a woman whose husband undergoes a vasectomy without her knowledge recover from the physician performing that

procedure because he has violated her right to procreate within marriage? Plainly, declaration of a new right should not occur in an offhand manner that fails to consider fully the impact it will have on Pennsylvania law generally.

Obviously, in a marriage that is stable and caring, a pregnant woman would likely consult with her husband before having an abortion. Therefore, this section would only have effect when the woman feels she cannot inform her husband of her choice. The section obviously recognizes that. There are some exceptions that are ungrafted to try to relieve the burden on the woman so that she doesn't have to report in all cases, but those exceptions have their own set of problems. For example, what constitutes, quote, "diligent effort," closed quote to find the husband? When is the furnishing of notice, quote, "likely to result in the infliction of bodily injury," closed quote, upon the woman? .What about other reasons that might be equally valid but which are statutorily unavailable, such as that the woman has instituted divorce proceedings or that she and her husband have entered a legal separation agreement?

This is not an area with which the legislature should be interfering. The marital relationship is itself an intensely private one and

frankly, the State should not involve itself there.

The last section I'd like to address is the section prohibiting sex selection abortions. That's the amendment to Section 3204. The notion that sex selection abortions are occurring with a frequency to warrant any kind of regulation against them is, I think, wholly unfounded. I have heard no evidence to suggest it's happening. But I'm here today to tell you why it should not be part of this statute on a constitutional basis. And for that, since this provision applies throughout pregnancy, we have to go back to Roe v. Wade itself and see what the Supreme Court says. When the State's interest in maternal health becomes compelling, then the State is permitted to regulate to protect maternal health. As the court said, however, "This means, on the other hand, that, for the period of pregnancy prior to this 'compelling' point, the attending physician, in consultation with his patient, is free to determine, without regulation by the state, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State." That's the constitutional pronouncement of the Supreme Court in Roe, and since Roe, the court has consistently drawn a bright line around abortion in the

early stages of pregnancy and consistently resisted countless efforts, many of them by the State of Pennsylvania, to resist to invade that very private decisionmaking process.

Dr. Dratman's already testified to some of the, I would hope, unintended consequences of this kind of a provision, and it certainly will chill doctors. Physicians will be reluctant to provide genetic testing, even where otherwise indicated, because the product of that testing is knowledge of the sex of the fetus. While the provision purports to limit its application to instances where the abortion is, quote, "solely because of the sex of the unborn child," closed quote, a health care provider and perhaps the woman herself or her spouse or her parents or any other person involved in the decision are subject to criminal prosecution any time a zealous district attorney, or the Attorney General of the Commonwealth under the new bill, believes that sex selection may have entered into an abortion decision. This provision invites the intrusion of public officials into the confidentiality files of physicians and health care facilities throughout the Commonwealth. It's bad policy and it's bad constitutional law.

In conclusion, as I discussed above the major provision of the proposed amendments to the Abortion

Control Act are plainly unconstitutional and it is likely that they will be successfully challenged. Moreover, certain other provisions, such as the prohibition of abortions after 24 weeks of gestation and the prohibition against sex selection abortions, strike at the heart of the privacy right defined in Roe. Passage of this legislation will inevitably result in protracted litigation over whether the right of privacy in the abortion decision will continue as it has since 1973.

Let me just part with the words that Justice Blackmun penned at the end of his majority decision in the Thornburgh case because while he was directing them to judges, they apply equally to legislators:

"As judges, "and I would say as legislators, "we are sworn to uphold the law even when its content gives rise to bitter dispute. Our cases long have recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government. That promise extends to women as well as to men. Few decisions are more personal and intimate, more properly private or more basic to individual dignity and autonomy than a woman's decision -- with the guidance of her physician and within the limits specified in Roe -- whether to end her pregnancy. A woman's right to make that choice freely is

fundamental. Any other result, in our view, would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all."

Thank you.

CHAIRMAN CALTAGIRONE: Representative Ritter.

REPRESENTATIVE RITTER: Thank you, Mr. Chairman.

I just want to point out also that with Tom -- you may have mentioned it and I didn't hear it--

MR. ZEMAITIS: No, I did not.

REPRESENTATIVE RITTER: --is Diane Van Reed from the Pennsylvania Chapter of the American Association of University Women. You have a copy of their written testimony that was submitted by AAUW, and Diane is here just to answer any questions that anyone might have on her testimony which you have.

CHAIRMAN CALTAGIRONE: Representative McHale.

REPRESENTATIVE McHALE: Thank you, Mr. Chairman.

BY REPRESENTATIVE McHALE: (Of Mr. Zemaitis)

Q. Mr. Zemaitis, as I look at this bill, and I think there's even a consensus on this point, there appear to be at least three major provisions of the bill, you

touched on all three. The first has to do with the prohibition on elective abortions after the 4th week. The second provision, which I believe is an important provision, whether or not one agrees with it, is spousal notification, and the third has to do with the 24-hour waiting period, and I'd like to go through each one of those to clarify your position.

You indicated on page 2 of your testimony that in your opinion, Section 3210(a) of the existing Abortion Control Act comports with the holding that Roe v. Wade elective abortions after the point of viability may in fact be prohibited. And you indicate on the next page of your testimony that the provision of the bill that would now be substituted banning abortions not after viability but after the 24th week is unnecessary. Do you think that that provision is also unconstitutional or is it simply redundant?

A. Absolutely. No, it is unconstitutional for several reasons, but let me touch on the major ones. First of all, the fact that it references 24 weeks throws it right out of the Supreme Court's very specific direction in Colautti v. Franklin. Viability is the point that must determine when the State's interest permits it to prohibit abortions except under limited circumstances in late term abortions, as we talked about them earlier.

Secondly, the statute advertently, explicitly, and I think tragically, says that the only thing that can justify a procedure after this 24-week fiat of the State is that the woman will die. It's not might die, it's not if we do it she's got a 70 percent chance of death, it's will die. Now that, to me, is in direct conflict of Roe v. Wade because we must be permitted to consider the health of the woman. That's why these abortions are occurring, as Dr. Dratman explained. And frankly, I'm not even sure calling them abortions is right. They're termination procedures, and I think most doctors, I would hope every doctor in this Commonwealth, would recognize his obligation, as Dr. Dratman does, to the second patient, the fetus, but the problem is when these procedures occur, the fetus is fragile, sometimes not in fact viable, and if viable, only at the margin, shall we say. And what's happening is that a physician is going to be chilled from giving--

CHAIRMAN CALTAGIRONE: Attorney Zemaitis, I'm sorry to interrupt you, but there's others that would love to hear you. If you will speak closer to the mike.

MR. ZEMAITIS: I will get myself closer to the microphone.

In those procedures, a doctor is going to say, why should I do this? Because let's say that fetus

is alive when it emerges from the womb after the procedure and it dies because it simply didn't have the wherewithal to sustain life. That doctor is going to be hauled into court, I would venture to guess, very quickly by a zealous prosecutor who is going to say this is a chance to make his mark in the public forum, and I think that chilling effect is serious and severe. The doctor has got to be able to look at the viable life before him, the woman. This statute prevents that, and I think therefore directly contradicts Roe.

BY REPRESENTATIVE McHALE: (Of Mr. Zemaitis)

Q. Mr. Zemaitis, I agree with at least a portion of your legal analysis concerning the present state of the law, and I think you're correct when you indicated that Roe v. Wade drew the line in terms of permissible State intervention at the point of viability. As I have expressed during some earlier questioning, I would afford that right of protection at a stage before viability, and I guess the question I present to you is, in light of the closeness in recent decisions presented to the Supreme Court, in light of the fact that there clearly is a very divided court on this question, can a reasonable argument be made, whether or not you agree with the argument, that the Supreme Court at some point in the not too distant future may in fact afford protection to

fetuses prior to viability? Does that remain a real possibility in terms of future court holdings?

A. The Supreme Court has the power to declare its precedent over rule--

Q. Or to modify its precedent, sure.

A. This would require a direct overruling of Roe v. Wade because the test, as it's set out in Roe, is very much framed to the point of viability as the point where we have concluded that the State's interest in the fetus is sufficiently compelling to prevent it. I don't see how a decision sustaining this provision could live beside the continued existence of Roe v. Wade.

Q. In part. And that's the key. I think you're correct logically in that in order to protect the life of a fetus before viability would require at least a revision, if not an outright rejection, of a part of the original Roe holding. Most of that holding could be left intact while the court rolled back the timeframe for protection to a point prior to viability.

A. Certainly you can change the text, but it is changing the test. The principle that underlies the Roe decision would have to be jettison before you could find this constitutional because it's not consistent with that principle.

Q. I agree with that. I think you're correct

in your analysis and what I would simply suggest is that in light of the very divided court that we have seen in recent years, there is a legitimate argument with which one can agree or disagree the court may choose to become more protective of fetal life prior to viability but perhaps in the 17th, 18th, or 19th week of gestation, and I raise that simply to point out that although you are correct in taking a very traditional, static analysis of Roe v. Wade, I'm not sure that the court a year from now will have adopted that same approach.

A. I understand.

Q. In the real world, I think that's something that we, as legislators, have a right to consider.

A. You may have a right to consider it and it may give you a right to push the law as far as you can go, but I don't believe it gives you a right to enact a statute that is, under existing standards, patently unconstitutional not in a single respect, not because it crosses the line by 2 inches, but because it pushes aside 16 years of precedence and says it's no good; it doesn't matter, it's not the way the law is, even though the Supreme Court, presented with an opportunity to do that this summer, consciously elected not to do so. That's my opinion.

Q. "The life of a law is not logic, it is

experience," to quote someone we both know , at least by reputation, and I think it is likely that the court will continue to re-examine this issue in a much more fluid way than perhaps a static reading of Roe v. Wade might imply. The specific question that I have is one with which I really don't know the answer, so I don't present this in a confrontational way. You indicated that Section 3210(a) of existing law, which is the prohibition of abortion after viability, was used in the successful prosecution of Dr. Melnick.

A. That's my understanding. I understand--

Q. If I may finish.

A. I'm sorry.

Q. And for that reason you see the proposed statute as being redundant. Unnecessary, I think, is the word I think you used. There is simply no need to enact new legislation. We heard testimony earlier today that is in direct conflict, factual conflict, with your presentation in which another witness, who may or may not be right, indicated that the section to which you made reference was not in fact the basis of the doctor's conviction and that some other section in Pennsylvania law was in fact used by Judge Abraham to sustain the conviction. Who's right and who's wrong?

A. The judge was convicted of infanticide,

which is another provision under the Pennsylvania Abortion--

Q. The judge wasn't.

A. I mean -- I'm sorry. Pardon me. Dr. Melnick was convicted of infanticide.

Q. Judge Abraham would be very disappointed to hear that.

A. She certainly would be. No, Dr. Melnick was convicted of infanticide.

Q. And that's 3212?

A. That's right. It's in the same statute. The provision in Section 3210(a) was not found to be unconstitutional. In fact, it was declared to be constitutional in the Thornburgh series of decisions. As I understand it--

Q. You make reference to the Melnick case and you have cited the wrong section, and I think we ought to be clear on that, if you made an invertent error.

A. I may have, and I don't have the decision of Judge Abraham before me so I don't--

Q. And I'm not trying to embarrass you. I've made far worse mistakes, I guarantee, often in public, but the person who testified earlier also indicated, and I don't know the voracity of the statement, that Judge Abraham did question the vagueness of Section 3210(a).

Did she or did she not?

A. Not to my knowledge, but I can't say -- I don't have the opinion of hers before me so I don't want to state one way or another. Let me posit the situation that you're facing now.

Q. Yes.

A. If this section was held not to be vague by the Federal courts, it is held to be one which could be applied and that the defenses were specifically stated in a sufficient fashion, I can assure you that Section 3211, the new section which purports to replace Section 3210(a), isn't vague, it's unconstitutional. It's plainly unconstitutional. So you will be enacting legislation that repeals a section that has been found to be constitutional and that does control abortion after viability. And you're going to replace it with nothing.

Q. And that is an argument obviously that deserves to be weighed on its merits. You may or may not be right in that argument, but that's not the argument you presented in your testimony. In your testimony you argued that a conviction had already occurred under a certain section and that therefore it was necessary to adopt a new law, when in fact it appears the individual convicted was convicted under another section of the statute.

A. The record in the Melnick case speaks for

itself. The fact is that the statute's available for prosecution if prosecutors want to use it, and I don't believe they have but I think they can.

Q. Without belaboring the issue, one section pertains to the decision to abort late in the term. The other decision, the other sanction pertains to a failure to act once an aborted fetus in fact becomes a live-born child. Those are two very different criminal actions that are obviously related, but they are not in the same act and I think that's significant in reviewing your presentation.

A. Fine.

Q. The second very brief question I have is you're speaking to someone who opposed paternal notice in the last Abortion Control Act and voted against the bill for that reason. I support spousal notification within the context of marriage. Without belaboring it, I think there are different public policy considerations that come into play when you talk about notice within a marital relationship that do not impact upon notice outside the marital relationship. Has the United States Supreme Court, and I truly don't know the answer to this question, ever held that spousal notification is unconstitutional?

A. No, nor have they been confronted by the issue.

Q. All right, so it's a matter that has to be addressed by the court at some point in the future.

With regard to the 24-hour waiting period, has the United States Supreme Court ever ruled that a 24-hour waiting period is unconstitutional?

A. Twice. The Akron case and the Thornburgh case, which dealt with this specific section of the Abortion Control Act.

Q. Was the court divided on that issue at the time?

A. Yes. There was a majority of the court that found it to be unconstitutional, but there were dissenters who concluded that in their reading of the Constitution it was not.

Q. All right. I thank you, Mr. Zemaitis. I found your testimony to be very helpful. As one who weighs very seriously questions of constitutionality, often to my own discomfort, your testimony has been very helpful.

I remain reasonably convinced that a prohibition after the 24th week would withstand the test of constitutionality on that basic point. There may be some other peripheral issues that are unquestionable of constitutionality, but I am doubtful that the current Supreme Court would strike down a ban on elective

abortions after the 24th week holding that such a prohibition violated the Constitution.

As far as spousal notice, we'll have to wait and see. And I do have concerns about the waiting period, in light of your testimony, and that's something that I'm going to look into much more carefully.

REPRESENTATIVE McHALE: Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you.

Representative Hagarty.

REPRESENTATIVE HAGARTY: Thank you. I think just one question.

BY REPRESENTATIVE HAGARTY: (Of Mr. Zemaitis)

Q. We have heard much about the fact that this is post-Webster legislation and that it's the result of Webster that has caused this renewed effort to restrict abortion in Pennsylvania. Is there anything in the Webster decision which you believe changes the constitutionality of any of the provisions that are proposed in this bill?

A. No. Quite advertently, eight of the Justices concluded that they would not question Roe's basic tenets. Specific provisions involved in the Webster decision involved public funding for the most part. There was one section that involved requirements of certain

tests to determine viability which the Supreme Court found to be constitutional, and one could argue whether or not they would have so found some time ago, but the key to that provision was that it maintained the distinction the Supreme Court has recognized since Roe v. Wade between a non-viable fetus and a viable fetus.

Q. That brings to mind, sorry, one other question. Would you say that the major provisions that the Webster court allowed were already passed by this Pennsylvania legislature and so that even if you support the Webster decision those laws have already been passed in Pennsylvania? Is that fair to say in any way?

A. I'm not sure I understand your question.

Q. I guess what my thought is, is those provisions with which Webster dealt, such as funding, viability testing, it just seems to me that we have already passed, and so that even if you agreed with the court in Webster, this legislature has already responded affirmatively on those issues. Is that true?

A. I think that's essentially true, yes. Certainly in the public funding area.

Q. Because what concerns me is that I believe we're revisiting all of the issues which have been either vetoed by this Governor or former Governor or struck down by the court in each and every instance and there is no

reason just because Webster was handed down to think that there was one shred, one potentiality that any of this is constitutional.

A. Agreed.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Representative Reber.

REPRESENTATIVE REBER: Just as a quick follow-up on that.

BY REPRESENTATIVE REBER: (Of Mr. Zemaitis)

Q. Then it's fair to say, and from my reading of Webster, and I'm sure my reading wasn't done with the detail that Pepper, Hamilton at their hourly rates get their reading of Webster.

A. Uncompensated hourly rates, but that's okay.

Q. In Webster, there was no attempt to overrule any of those definitive statements of earlier Supreme Court decisions that we've been talking about ala Akron and Thornburgh, and most specifically Colautti. That would have been the opportune time if they said that those decisions ran afoul of permissible intrusion areas by the legislature in the abortion issue to have overruled those particular decisions as being nondefinitive for future consideration of whether those issues should be addressed. I would think that those would have been overruled, opening it up and making it for post-Webster fair game by

the legislature to now revisit. Would that be a fair statement?

A. I think that's absolutely right.

Q. Isn't that the real jugular issue on this thing in post-Webster legislative deliberations?

A. That's right. I think the legislature has the obligation to look afresh at each piece of legislation and determine whether it's constitutional under existing standards. This legislation doesn't pass.

Q. Thank you, sir.

CHAIRMAN CALTAGIRONE: Thank you.

Are there any other questions?

(No response.)

CHAIRMAN CALTAGIRONE: If not, thank you very much, and this hearing is adjourned.

(Whereupon, the proceedings were concluded at 1:50 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me during the hearing of the within cause, and that this is a true and correct transcript of the same.

Ann-Marie P. Sweeney

ANN-MARIE P. SWEENEY

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APPENDIX

Order in which Testimony and Exhibits may be found:

Carol N. Everett

Sue Roselle

Photos submitted by Ms. Roselle

Maggie D'Alesio

Copy of photo from Taber's submitted by Ms. D'Alesio

Dr. Cathy K. Dratman, M.D.

Suzi Dewing

Submitted affidavits from Ms. Dewing

Thomas E. Zemaitis, Esquire

American Association of University Women

Juvenile Diabetes Foundation of Greater Pittsburgh

Dr. Denise Mindo DeHaas

Susan Karlovich

Pennsylvania Pro-Life Federation

Juvenile Diabetes Foundation International

Letters submitted by Representative Josephs