Approved 2-10-87
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p.m. on February 4, 1987 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Services
Norman Furse, Revisor of Statutes Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
Adele Hughey, Comprehensive Health Associates
Pat Goodson, Kansas Right to Life
Dr. Lauren Welsh, written testimony presented by Pat Goodson
Darlene Greer Stearns, State Co-ordinator for Religious Coalition for Abortion Rights in Kansas
Gail Hamilton, Kansas National Organization for Women
Belva Ott, Planned Parenthood
Theresa Shively, Kansas National Abortion Rights Action League
Ted McFarland, Douglas County, Department of Emergency Medical Services and Emergency Preparedness
Written testimony - Proposed amendment for SB-78 by American Association for Marriage and Family Therapy
James P. Cooney, Jr., Dean of the School of Allied Health at the University of Kansas Medical Center, Written testimony only
Written Testimony only, Lyle Eckhart, Kansas Highway Patrol

Others attending: see attached list

Chairman Ehrlich announced to the committee that he was going to include SB-33 and SB-34 with SB-35 which the subcommittee will be working on.

SB-86 - An Act requiring certain reports concerning the termination of pregnacies;

Adelle Hughey, an opponent to SB-86, requested and received permission to testify first due to scheduling difficulties. Ms. Hughey testified and presented fact sheets to the committee. Ms. Hughey pointed out forms which are already being filled out and sent to the board of healing arts. This form is held two months before turning it in to the state in order that any complications may be reported. It is completed voluntarily at the present time. Another form is sent to the board of healing arts conforming with a new law. It is felt that SB-86 would duplicate what is already being done and be another form to fill out. It was also stated that there was no way to comply so long after the procedure was completed, particularly if the patient desired confidentiality. (attachment 1) Written testimony (attachment 2)

Pat Goodson testified and presented written testimony. Ms. Goodson testified that this bill is not a change in policy but simply updates KSA-65-0445 by extending the reporting requirements to the places where abortions are being performed. Ms. Goodson stated that the only way to obtain accurate statistics is to require them and that with SB-86 the statistics would be accurate and as reliable as we can make them, thus taxpayers money will not be wasted on unreliable statistics. (attachment 3)

Written testimony by Lauren A. Welch, M.D., was also presented by Pat Goodson. This testimony listed some complications which could occur following abortions. (attachment 4)

Darlene Greer Stearns testified and presented written testimony. Ms. Stearns stated that the Religious Coalition for Abortion Rights in Kansas questioned

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

the need for and the purpose of this legislation. Ms. Stearns voiced concern that the real purpose of requiring these reports and questionnaires beyond reporting numbers is to have on record the names of medical facilities and physicians performing abortions only for the purpose of harrassment. (attachment 5)

Gail Hamilton testified and presented written testimony in opposition to SB-86. Ms. Hamilton stated that the Kansas National Organization for Women had a strong interest in accurate reporting but feels that the requirement of follow up reporting does not present a valid public health purpose; also it adds to the paper work burden which adds costs. A major concern is the potential threat and intimidation of doctors, personnel and patients. (attachment 6)

Belva Ott testified and presented written testimony opposing SB-86. Ms. Ott stated that confidentiality is of great concern and with or without this bill if such privacy is desired, probably no additional reporting would be done. (attachment 7)

Theresa Shively testified and presented written testimony opposing SB-86. She stated that this bill was unnecessary as testimony from Barbara Sabol, Secretary of Kansas Department of Health and Environment, February 14, 1985, stated that 90% of medical facilities and physicians voluntarily comply with requirements as set out for hospitals. (attachment 8)

Senator Hayden's pages, Vanessa Goodwin, Da Shell Beeson and Stacey White from Garden City were recognized and welcomed to the committee.

SB-87 - An Act concerning emergency medical services; providing for first responder certification; providing for administration of the act; declaring certain acts to be unlawful and classifying the crime and the penalties for violations; providing exceptions from liability for civil damages.

Ted McFarland testified and presented written testimony on SB-87. Mr. McFarland stated there was a real need for this training level in the communities. This bill would allow better utilization of local resources because it would allow training of the local law enforcement personnel using first responder course instead of the EMT course. (attachment 9)

The American Association for Marriage and Family Therapy presented to the committee members amendments proposed to SB-78. (attachment 10)

James P. Cooney, Jr. presented written testimony to the committee. (attachment 11)

Lyle Eckhart, Kansas Highway Patrol, presented written testimony to the committee. (attachment 12)

Due to the lack of time a number of conferees were not heard and will be heard when the committee convenes tomorrow, Thursday, February 5, 1987, at 10:00 a.m.

Meeting adjourned at 11 a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-4-87

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Nancy Bronaugh	Kansas Medical Society
TED McFARLANE	Ks. EMS Council
Lyle E. Eckhart	BEMS - KHP
James P. Cooney, Jr.	Univ Ks Med Center
Al Dimmitt	Univ. of Ks Medical Center
Maynard Brazeal	Kansas Law Enforcement Trng Ctr.
Ed Redmon	Kans State Fire Marshal
EP Moorman	Ks Highway Patrol
WALT DARLING	DIVISION OF BUDGET
MG WEED	Div of Emer. Prep - Adj. Gen Dept
Thomas P. Kelley	Volunteer FIRE FIGHTER EMT
BARB REINERT	KPOA
Beth Sheffel	LWV
Joan Knoll	ERC
Richard Magnat	SOLDIER TOWNSHIP FIRE DEPT
Karl W. McNalis	Kansas Fire Marshal Dept.
James A. Zockel	Ks State Firefighters Assn
Andrea Lefarw	Ks Hospital Assoc
Pat Goodson	Right To Life
Gary Robbins	KS Optometric assn

Please return white copy to:

Kansas Department of Health and Environment
Topeka, Kansas 66620

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TYPE OR PRINT IN PERMANENT INK

REPORT OF INDUCED TERMINATION OF PREGNANCY

STATE FILE NUMBER

FACILITY-NAME (If not hospital or clinic, give address) 1a.	**CITY, TOWN OR LOCATION OF PREGNANCY TERMINATION** 1b.	**COUNTY OF PREGNANCY TERMINATION** 1c.

PATIENT IDENTIFICATION No. 2a.	**AGE OF PATIENT** 2b.	**MARRIED?** (Circle) 1 YES 2 NO 2c.	**DATE OF PREGNANCY TERMINATION** (Month, Day, Year) 3.

RESIDENCE-STATE 4a.	**COUNTY** 4b.	**CITY, TOWN OR LOCATION** 4c.	**INSIDE CITY LIMITS** (Circle) 4d. 1 YES 2 NO

RACE (Circle)

1 White 2 Black
3 American Indian
4 Other, Specify ______

5.

EDUCATION (Specify highest grade completed)

Elementary or Secondary (0-12) | College (1-4 or 5+)

6.

PREVIOUS PREGNANCIES (Complete each section)

LIVE BIRTHS		**PREVIOUS INDUCED ABORTIONS**	**ALL OTHER TERMINATIONS**
Now living	Now dead		
Number ______	Number ______	Number ______	Number ______
7a. None ☐	7b. None ☐	7c. None ☐	7d. None ☐

8a. **LENGTH OF TIME IN HOSPITAL OR AMBULATORY SURGICAL CENTER:** Hours ______ OR Days ______

8b. **STATUS OF PATIENT:** Inpatient 1 OR Outpatient 2

9. **PRIMARY INDICATION FOR ABORTION:** (Circle only one)

MENTAL HEALTH .... 1 .... (Please specify) ______

SOCIOECONOMIC 2

RAPE 3

INCEST 4

FELONIOUS INTERCOURSE 5
(pregnancy under 16 years of age)

PHYSICAL HEALTH .... 6 .... (Please specify) ______

FETAL DEFECT .... 7 .... (Please specify) ______

EMERGENCY EXISTED .... 8 .... (Immediate abortion to save life of mother) (Please specify) ______

OTHER .... 9 .... (Please specify) ______

10a. **Procedure that Terminated Pregnancy** (Circle only one)	**TYPE OF TERMINATION PROCEDURES**	10b. **Additional Procedures Used for this Termination, if any** (Circle all that apply)
1	SUCTION CURETTAGE	1
2	SHARP CURETTAGE	2
3	INTRA-UTERINE SALINE INSTILLATION	3
4	INTRA-UTERINE PROSTAGLANDIN INSTILLATION	4
5	HYSTEROTOMY	5
6	HYSTERECTOMY	6
7	OTHER (Specify) ______	7

11. **Complications of Pregnancy Termination** (Circle all that apply)

1 NONE
2 HEMORRHAGE
3 INFECTION
4 UTERINE PERFORATION
5 CERVICAL LACERATION
6 RETAINED PRODUCTS
7 OTHER (Specify) ______

12. **Was Sterilization Performed at Time of Abortion:** 1 YES 2 NO

DATE LAST NORMAL MENSES BEGAN (Month, Day, Year) 13.	**PHYSICIAN'S ESTIMATE OF GESTATION** 14. **WEEKS**	**NAME OF ATTENDING PHYSICIAN** (Type or Print) 15.

NAME OF PERSON COMPLETING REPORT (Type or print)

16.

MI-1229

1978 REVISION

S P H&W
2-4-87
attachment 1

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF

RICHARD A. UHLIG, D.O., SECRETARY
CHARLENE K. ABBOTT, EXECUTIVE SECRETARY
LAWRENCE T. BUENING, JR., GENERAL COUNSEL
JOSEPH M. FURJANIC, DISCIPLINARY COUNSEL
503 KANSAS AVENUE, SUITE 500
TOPEKA, KANSAS 66603-3449
PHONE (913) 296-7413

MEMBERS OF BOARD

FORREST POMMERENKE, M.D., PRESIDENT, DE SOTO
CAMERON D. KNACKSTEDT, D.O., VICE-PRESIDENT, PHILLIPSBURG
RICHARD A. UHLIG, D.O., SECRETARY, HERINGTON
HAROLD E. BRYAN, D.C., FORT SCOTT
EDWARD J. FITZGERALD, M.D., WICHITA
FREDERICK J. GOOD, D.C., BENTON
JOHN B. HIEBERT, M.D., TOPEKA
GLENN I. KERBS, DODGE CITY
GORDON E. MAXWELL, M.D., SALINA
BETTY JO MCNETT, WICHITA
THOMAS R. REHORN, JR., KANSAS CITY
HAROLD J. SAUDER, D.P.M., INDEPENDENCE
DAVID WAXMAN, M.D., LENEXA
JOHN P. WHITE, D.O., PITTSBURG
REX A. WRIGHT, D.C., TOPEKA

December 30, 1986

TO: All Medical Care Facilities Myrna Sparrow

FROM: Kansas State Board of Healing Arts

SUBJECT: Quarterly Medical Care Facility Reports

It is again time to file the second of the quarterly reports required under House Bill 2661 (New Section 4(d) of Chapter 229 of 1986 Session Laws of Kansas. This second report should be filed not later than January 31, 1987 and should cover the period October 1, 1986 to December 31, 1986. Enclosed you will find a copy of the form developed for this purpose. Until revisions are made in the form, this will be the last time the board will provide it. Please photocopy this form so that you will have extra copies for use in the future.

When completing the form, please type or use ink and be sure to include the address of the facility reporting.

Enclosed you will also find an example of a narrative report asked for when reporting Class II and III patient care incidents and catagories 1-9 of professional conduct.

If you have any questions, please feel free to call Myrna Sparrow or Larry Buening. Have a safe and happy holiday season.

CONFIDENTIAL MEDICAL CARE FACILITY REPORT

MAIL TO: DISCIPLINARY COUNSEL
Kansas State Board of Healing Arts
503 Kansas Avenue, Suite 500
Topeka, Kansas 66603

Instructions for completion on back.

PRINT OR TYPE ALL INFORMATION

1. Name and address of Facility ____________________
____

2. Type of Facility ____________________

3. Reporting period ____________________

4. Number of reportable incidents related to our licensees ____________

5. Name of Internal Committees handling above incidents ____________
____
____

6. Number of investigations conducted as a result of such reports ____________

7. Please list each type of action taken and the number of such actions.____________
____
____

8. Please list the specialties involved relating to actions taken and number of actions relating to each specialty.____________________
____
____

9. During the period covered by the report has there been any findings made that a Licensee of the Board acted below the applicable standard of care? YES ___ NO___

10. If answer to paragraph 9 is yes, please state number of such findings, name of each licensee involved and advise if any such findings have previously been reported to the Board.____________________
____
____

11. For each incident reported involving standard of care, please provide the following information. (See back for Class Categories and Instructions)

CLASS	NUMBER OF REPORTS	NUMBER OF ACTIONS PENDING	NUMBER OF INVESTIGATIONS	NUMBER OF ACTIONS TAKEN
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____

12. For each incident reported involving other areas of conduct please provide the following information. (See back for Class Categories and Instructions)

CLASS	NUMBER OF REPORTS	NUMBER OF ACTIONS PENDING	NUMBER OF INVESTIGATIONS	NUMBER OF ACTIONS TAKEN
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____

PERSON REPORTING (Signature)____________________
(Typed name)____________________
DATE ____________ (Title)____________________
PHONE NUMBER ____________________

KSBHA FORM 2661-1 (8/1/86)

INSTRUCTIONS FOR COMPLETION

NOTICE: This form has been prepared by the Kansas State Board of Healing Arts for use by medical care facilities in submitting reports required once every 3 months in compliance with Sec. 4(d) of 1986 HB 2661. This report and the information contained herein shall be confidential, except as such may be utilized in a disciplinary proceeding. This form should be used only to report incidents involving the following health care providers: Medical and Osteopathic Doctors, Doctors of Chiropractic, Doctors of Podiatry and Physical Therapists.

Instructions for Paragraph 11. -- Standard of Care:
If you have reportable incidents in Classes II & III please fill out a narrative using additional pages including: date of incident, patient identification information, description of incident, action taken on incident with appropriate dates and licensee identification information.

Class Categories:

Class I. Incident which potentially endangers the patient but results in no detrimental effect. (Examples: Fright, rash, minor contusions, minor lacerations, first degree burns, isolated incident of delay in or failure to respond to call, isolated incident of overutilization of drugs or failure to comply in administrative procedures, minimal incomplete charts.)

Class II. A pattern of practice or isolated incident which both endangers the patient(s) and results in temporary or minor detrimental effect. (Examples: Repeated incidents of conduct in Class I, second degree burns, reparable damage to organ or body part.)

Class III. Incident which results in gross and flagrant quality violations and any incident which results in significant morbidity. (Examples: Course of inappropriate treatment, wrong procedure performed and/or unplanned removal of an organ or body part, any incident of abandonment, deafness, loss of eye, brain damage, quadraplegia, MI, CVC, cardiac/respiratory arrest.)

Instructions for Paragraph 12. -- Other Areas of Conduct:
If you have incidents in these classes please attach short statement including date of incident, patient identification information, description of incident, action taken on incident with appropriate dates and licensee identification information. (Attach additional pages if needed)

Class Categories:

Class 1. Unethical/dishonest/dishonorable conduct.
Class 2. Incorrect/inappropriate use of controlled substances.
Class 3. Failure to provide informed consent.
Class 4. Failure to maintain malpractice insurance.
Class 5. Assigning inappropriate duties to others.
Class 6. Impairment (includes mental and physical inability as well as chemical dependency).
Class 7. Conviction of a felony or Class A misdemeanor
Class 8. Misrepresentation to patient and/or professional credentials/ education.
Class 9. Other.

FACT SHEET

Safety of Abortion

COMPREHENSIVE HEALTH ASSOCIATES
4401 W. 109th
OVERLAND PARK, KANSAS 66211
TEL: 913-345-1400

Abortion is now one of the safest medical procedures available. Having an abortion in the first 3 months of pregnancy is considerably safer than bearing a child.

Dangers of Illegal Abortion

Abortion has not always been so safe. Before abortion was made legal, many women died or had serious medical problems after attempting to induce abortions on themselves or going to untrained practitioners who performed abortions in unsanitary conditions. Women streamed into emergency rooms with serious problems— perforated uterus, retained placenta, severe bleeding, cervical wound, rampant infection, shock, gangrene.

Safety of Legal Abortion

Since legalization, women have benefitted from significant advances in medical technology and greater access to high quality services.

Women rarely die from legal abortions. According to the most recent statistics available, only 1 of 200,000 women who have legal abortions die. That is one seventh the number of women who die from childbirth and a tiny fraction of the number of women who used to die from illegal abortions.

Chance of Complications Following Abortion

The chance of complications depends on many factors, the most important of which is how far along the pregnancy is. Generally, abortions are not performed before 7 weeks LMP (weeks since the last menstrual period). From 7 weeks on, the earlier the abortion, the safer it is.

Most women who obtain abortions (90%) are in their first trimester (less than 13 weeks of pregnancy). Of these women, 97% have no complications or any post-abortion complaints; 2½% have minor complications that can be handled at the physician's office or abortion facility; and less than ½ of 1% require some additional surgical procedure and/or hospitalization. In the second trimester (13-24 weeks), complication rates are somewhat higher. The safest time to have an abortion is 7-10 weeks LMP.

Other significant factors that affect the possibility of complications include:

- the skill of the physician,
- the kind of anesthesia used,
- the woman's health, and
- the abortion method used.

(See *Fact Sheet: What is Abortion?*)

Complications from First-Trimester Abortion

In the first trimester, possible complications include:

- blood clots accumulating in the uterus, requiring another suctioning;
- infections, most of which are easily identified and treated if the woman carefully observes follow-up instructions;
- a tear in the cervix, which may be repaired with stitches;
- perforation of the wall of the uterus and/or other organs, which may heal themselves or may require surgical repair or, rarely, hysterectomy;
- abortion that is not complete or that does not end the pregnancy, both of which require the procedure to be repeated;
- excessive bleeding due to failure of the uterus to contract, which may require a blood transfusion.

As mentioned, serious complications arising from first-trimester abortions are quite unusual.

© National Abortion Federation

Complications from Second-Trimester Abortion

COMPREHENSIVE HEALTH ASSOCIATES

Complications from second-trimester abortion (13-24 weeks) include infection, perforation of the uterus and/or other organs, injury to the cervix, bleeding that requires transfusion, and incomplete abortion. General anesthetic is occasionally used and carries its own risks.

In general, from 13-16 weeks the dilatation and evacuation (D&E) procedure is significantly safer and more effective than other second-trimester methods. After 16 weeks, the different methods carry about the same complication rates.

Signs of a Post-Abortion Complication

If a woman has any of the following symptoms after having an abortion, she should immediately contact the facility that provided the abortion:

- severe pain;
- chills or fever with an oral temperature of 100.4° or more;
- bleeding that is heavier than the heaviest day of her normal menstrual period or that saturates more than one sanitary pad per hour;
- foul-smelling discharge or drainage from her vagina; or
- continuing symptoms of pregnancy.

Doctors and clinics that offer abortion services provide a 24-hour number to call in the event of complications.

Preventing Complications

To some extent, complications are a matter of chance, but there are some things women can do to lower their risk. The most important thing is not to delay. After 6 weeks LMP, the earlier the abortion, the safer it is.

Asking questions is also important. Just as with any medical procedure, the more relaxed a person is and the more she understands what to expect, the better and safer her experience will be.

Finally, any woman choosing abortion should:

- find a good clinic or a qualified, licensed physician[1] (for referrals, call NAF's toll-free hotline, (800) 772-9100);
- inform the physician of any health problems, current medications or street drugs being used, allergies to medications or anesthetics, and other health information;
- follow post-operative instructions; and
- return for a follow-up examination.

Antiabortion Claims

Antiabortion activists claim that having an abortion endangers future childbearing. They claim that women who have abortions will have difficulty conceiving or carrying a pregnancy, will develop ectopic (outside of the uterus) pregnancies, will deliver stillborn babies, or will become sterile. However, according to the U.S. Centers for Disease Control, none of these claims is borne out by medical research.

Women's Feelings after Abortion

Women consider abortion for a variety of reasons, but in general, they consider it because being pregnant at that time is in some way wrong for them. Often there is no absolutely "right" solution to a "wrong" situation. Some women feel sad or weepy for a few days or weeks afterwards and may find it helpful to talk about their experience with a family member, friend, or counselor. These feelings of loss, however, should not be confused with regret. Most women also report relief at having ended the pregnancy and are satisfied that they made the right decision for themselves.

[1] *Most abortions in the U.S. are performed by medical doctors. In Vermont, certified physician's assistants may also perform first-trimester procedures.*

For More Information

For information or referrals to qualified abortion providers, call the National Abortion Federation's toll-free Consumer Hotline, (800) 772-9100.

For Further Reading

C. Tietze, *Induced Abortion: A World Review, 1983*, New York: The Population Council.

Centers for Disease Control, *Abortion Surveillance: Annual Summary 1981*, issued 1985.

D.A. Grimes, "Second-Trimester Abortion in the United States," *Family Planning Perspectives,* November/December 1984, pp. 260-265.

Twelve Years of Legal Abortion National Abortion Federation, 1985.

Information in this fact sheet is based on research by the U.S. Centers for Disease Control Abortion Surveillance Branch, The Alan Guttmacher Institute, and other members of the National Abortion Federation.

National Abortion Federation
900 Pennsylvania Avenue, S.E.
Washington, DC 20003
(202) 546-9060

May 1986

© Copyright 1986 National Abortion Federation

10000586

A PATIENT'S BILL OF RIGHTS

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1 The patient has the right to considerate and respectful care.

2 The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name, the physician responsible for coordinating his care.

3 The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent, should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4 The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

5 The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6 The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7 The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8 The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.

9 The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

10 The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

11 The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

12 The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

APPROVED BY THE HOUSE OF DELEGATES OF THE AMERICAN HOSPITAL ASSOCIATION FEBRUARY 6, 1973

© 1972 by the
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611
All rights reserved
Printed in the U.S.A.
15M-3/73-3004

comprehensive
health
associates

a member of the national abortion federation

POST-ABORTION CARE

Office phone: 913/345-1400
After hours phone: 913/345-1403

All patients must obtain a post-abortion checkup, either at this facility or your doctor's office.

Consider the next two weeks your "special care" time. Throughout this period you may be bleeding or spotting. It is not unusual to have minimal bleeding or none at all right after your procedure and then to start a period-like flow a few days later; nor is it unusual to have a heavy flow beginning right after the procedure. Spotting or a light flow may persist as long as three weeks following your procedure.

Avoid remaining in one position for long periods of time. Be up at least 15 minutes each hour. If you must sit a lot, try to get some exercise during the day. If you must stand a lot, try to sit down during breaks or lunch with your feet up. You may resume normal, non-strenuous activity as soon as you feel comfortable doing so. Most women are able to go back to work immediately.

Infection and hemorrhage are possible complications after an abortion. You can help control these complications by using good judgment. Avoid any extreme physical exercise such as swimming, dancing, jogging, motorcycling, bowling or heavy lifting. Eat well. Avoid over-tiring yourself. Take your temperature twice a day for the next week. Take showers rather than tub baths--that is, do not sit in a tub of water.

The doctor will give you a prescription for Tetracycline, an antibiotic which helps prevent infection. It is important that you take all the capsules. Take one capsule four times daily one hour before or two hours after each meal and at bedtime until they are gone. Do not take with milk products or antacids because those milk products interfere with your absorption of the medicine. Tetracycline increases your skin's sensitivity to the sun and you can become sunburned very easily, so avoid prolonged exposure and use a good sunscreen. Should you develop any signs of an allergic reaction (hives, swelling, difficulty breathing), call us. These reactions could be due to the Tetracycline.

The doctor also may prescribe Ergotrate Maleate for you. Take one tablet every four hours until bedtime. This medication helps contract your uterus to its normal size and helps control bleeding. You may feel some mild cramping when you take it, but this should be relieved by aspirin or Tylenol.

The following symptoms indicate that you need further medical attention from us. Please call our regular office number (913/345-1400) if you experience these symptoms during one of our work days (Monday-Saturday). After hours and on Sunday, please call 913/345-1403. A doctor and a nurse are on call 24 hours a day to handle medical emergencies. If your after-hours call is not answered with 45 minutes, please call again and be sure the answering service has your correct area code and phone number. Your call will be answered as quickly as possible.

1) excessive bleeding (more than is normal for you during a period or more than one pad an hour), or excessive cramping not relieved by aspirin or Tylenol;

2) a fever of more than 100.4 degrees, or sudden exhaustion;

3) continued passing of large size blood clots (larger than a lemon). It is not uncommon

4401 west 109th street / I-435 and roe / overland park, kansas 66211 (913) 345-1400

3) continued passing of large size blood clots (larger than a lemon). It is not uncommon to pass small clots (quarter size), especially after sitting or lying for a long time.

4) a foul-smelling, yellow discharge. This most likely is a vaginal infection, meaning you should wait to call during regular office hours. However, if you have a temperature of 100.4° or more, or if there is severe cramping with the discharge, call us immediately.

5) severe abdominal pain which is not relieved by normal pain remedies, walking, a heating pad, or massaging your uterus.

IF YOU CALL WITH A MEDICAL CONCERN, PLEASE TAKE YOUR TEMPERATURE FIRST AND HAVE A PHARMACY PHONE NUMBER AVAILABLE. THESE STEPS WILL SAVE TIME FOR YOU AND FOR US IN DEALING WITH YOUR CONCERNS. You can also help us and yourself by waiting until regular office hours to ask questions about appointments, medical problems that are not emergencies, and birth control.

The first menstrual period following an abortion usually occurs 4-6 weeks after the procedure, but may not occur for as long as 8 weeks. It is not unusual for the first period to be heavier than your normal period. If you do not have a menstrual period after 8 weeks, you need to call our office during regular office hours.

Two last points: 1) You can get pregnant immediately after an abortion. It is important to begin a reliable method of birth control now. If you are using birth control pills, be sure to start taking them on the Sunday following your procedure even if you are bleeding. Diaphragms can be fitted at your post-abortion checkup.

2) It is not unusual to feel irritable, depressed or let down for the next week or two because of the changes in the hormone levels in your body. If you feel concerned about emotional problems you are experiencing, please call us about those too, at our office number during office hours. We want you to call us if you need us.

POST-ABORTION CHECKUP: It is essential that you return to Comprehensive Health Associates or to your regular doctor for a checkup within ten days to three weeks from today to make sure that you are healing properly, that you are no longer pregnant and that you do not have an infection. YOUR ABORTION CARE IS NOT COMPLETE UNTIL YOU HAVE HAD THIS CHECKUP. If you go to your own doctor or practitioner for your checkup, you need another pregnancy test (a two-minute slide test) and a pelvic exam. You or your doctor should contact CHA if an abortion-related problem is discovered during your post-abortion checkup. Problems occurring after one month are more likely to not be related to your abortion procedure and should be managed by your own doctor or practitioner. If you wish, you may contact us and you will be followed as a gyn patient.

If you plan to return to your regular doctor, please tell the recovery room nurse so that she can give you a follow-up form to take with you when you leave. If you plan to return here, call for an appointment during the next two to three days. Our GYN schedule is fairly full so you need to call well in advance to be sure you can be seen. Our GYN hours are: Monday, 11:00-7:00; Wednesday, 9:00-1:00; Thursday, 10:00-6:00; Friday, 9:00-1:00. The cost for the post-abortion checkup (PAC) for a first trimester patient is $20. The PAC fee is included for laminaria patients. A PAC appointment plus a Pap smear costs $30. A PAC appointment plus a diaphragm fitting costs $30-42. If other lab tests are required, there may be additional charges.

To make an appointment: call 913/345-1400 Monday-Friday 9:00-5:00; on Saturday call 9:00-2:00.

Take care. Please ask if you have questions about this information.

Testimony Presented Before the Committee on Public Health and Welfare
Senate Bill No. 86
February 4, 1987

My name is Adele Hughey, Executive Director of Comprehensive Health Associates in Overland Park, KS. Briefly, Comprehensive Health Associates started in 1974 and we have been at our present location since 1981. We are a state licensed outpatient surgery facility, besides providing abortion services, we offer complete gynecological examinations; lab work; prescription contraception; diagnosis and treatment of vaginal infections, urinary tract infections, and sexually transmitted diseases; colposcopy; cryosurgery; tubal ligations; and diagnostic D&C and laparoscopy.

We are opposed to Senate Bill 86 on several counts.

1- We voluntarily complete the "Report of Induced Termination of Pregnancy". We hold the report for two months so that we can accurately reflect any complications from the abortion procedure before we mail the form to the State.

2- Also, we are required by the State of Kansas Board of Healing Arts to complete a "Quarterly Medical Care Facility Report" to report incidents involving Health Care providers. For Medical Care facilities Senate Bill 86 duplicates efforts and requires the State to review another form.

3- Next, I would like to explain some of our policies and precedures to clear up some misunderstandings. 1)We provide 24-hour on-call , the number is givento all patients, 2)The counseling group covers decision, information, and consent, (A portion of consent form was read.), 3)A post-abortion check up can be scheduled at our facility or the patients own doctor within 10 days to 3 weeks following the procedure. We estimate that approximately half of our patients schedule their check-ups. Even with strong encouragement women do not schedule because they are feeling fine. This is why I question whether patients will even remember to return a form in 60 days.

4- The naure of Senate Bill 86 is another form of harrassment and intimindation toward abortion providers and especially to women who seek abortion services. Every woman has the right to every consideration of her privacy concerning her own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in her care must have the permission of the patient to be present. And---The patient has the right to expect all communications and records pertaining to her care be treated as confidential. The State can not insure patient confidentiality and does not require such form completion with other types of surgery or health care providers.

Thank You

SPH&W
2-4-87
attachment 2

February 4, 1987

Senate Public Health and Welfare Committee

Senate Bill 86 - Testimony

Right To Life of Kansas, Inc.

Mr. Chairman, members of the committee, K.S.A. 65-445 was enacted at the time the legislature legalized abortion. It required reporting of all abortions which were at the time restricted to hospitals only. Today most abortions are performed outside of hospitals in clinics and doctor's offices. Senate bill 86 simply updates the law by extending the reporting requirements to the places where abortions are being performed. It is not a change of policy. You are not being asked to determine whether or not we should keep abortion statistics but only whether or not we should make sure we have complete and accurate statistics.

Compilation of data relating to maternal and infant health is an important responsibility of the KDHE. Significant resources are expended for this purpose. Abortion statistics are an important part of this responsibility. Further, K.S.A. 65-153 charges the KDHE with the duty of infant mortality studies. Abortion is an infant mortality and the KDHE properly recognizes this by classifying abortion statistics as mortality statistics.

K.S.A. 65-445 leaves to the department the determination of what information is to be compiled regarding abortion. Attachment A is a sample of the information the department chose to compile and what they apparently believe is important. I don't believe the department would be wasting the taxpayers money otherwise. For example on the monthly printout you will see the category of "previous induced abortions". The numbers of women having repeat abortions is a serious public health concern because multiple abortions significantly increase the risk of complications in future wanted pregnancies particularly the risk of premature birth which is the leading cause of infant morbidity and mortality.

I believe the first time this category of previous abortions was noted in Kansas it was something like 1 or 2 %. It has steadily risen with each annual report. Today, according the figures we do keep in Kansas, 31 % of the women undergoing abortions have had one or more previous abortion! These are trends that we should be aware of, trends that present significant public health concerns.

SPH&W
2-4-87
attachment 3

Information relating to abortion is important in determining population trends.

I could not state the purpose of SB 86 any better than it is stated in the Missouri statute requiring abortion reports: "A purpose and function of (these reports) shall be the preservation of maternal health and life by adding to the sum of medical knowlege through the compilation of maternal health and life data...."

Section 1 a) of the bill changes the word hospital in the present statute to medical care facility. A medical care facility by definition includes hospitals and licensed ambulatory surgical centers. There is presently to my knowlege only one licensed medical care facility ambulatory surgical center performing abortions. It is located in Overland Park. A sentence is added to require persons licensed to practice medicine and surgery to report. This sentence is needed to cover all unlicensed abortion clinics and doctors offices. The bulk of abortions are done in these facilitys. By way of comparison, note the small graph in the lower right hand corner of attachment B. This gives the numbers of abortions performed in Missouri hospitals and non hospitals. As you can see almost all of abortions done in Missouri are done in clinics and doctors offices.

Section 1 b) would require the health department report to include also the type of facility in which the abortion was performed. You will note also that the statute provides that the report is confidential as to the names of patients and is only a summary report. When this bill was in the House committee two years ago the committee added language concerning confidentiality of the providers, and that was fine. We have no objection to doing that. It isn't in the bill now because the statute already provides the same thing in another section. We don't feel there is any need to repeat it here but we certainly have no objections to doing so.

Testimony in opposition to this bill two years ago, I would say bordered on paranoia. Some of the witnesses seemed to believe that the only reason we wanted this bill was so we could get spys in the health department and find out who was reporting abortions. In the first place if we were going to have "spys" in the health department we would already have them there. Believe me if our intent was to find out who is doing abortions there are plenty of easier ways to do that than trying to pass a bill in the Kansas ~~lig~~

legislature!

Section c) is an attempt to obtain more accurate reporting of complications. Abortion is not just another simple medical procedure.
Of course almost every abortion kills an unborn child and it is fraught with danger for the mother.

Dr. Lauren Welch of Wamego prepared a report on abortion complications but was not able to be here to present it to you today and I would ask the committee's permission to enter Dr. Welch's testimony in the record. He concludes that complication rate being reported now is extremely unrealistic even for immediate comlications. One of the reasons for this is that women ordinarily do not go back to the abortion facility for follow up care. If there is a complication they will see their own physician or another one perhaps closer to their home if they have gone out of town for the abortion. We know this from the countless women who have had abortions and have come to us later. Many of them have joined an organization called WEBA, Women Exploited By Abortion.

Thus the facility has no way of reporting many of these complications. We would hope that if women were given a form to return more complications might be reported. Missouri requires any physician who treats a post abortion complication to report it. That is also Dr. Welch's reccomendation.

If you will look again at attachment B I will discuss some of our concerns with the extent of current reporting or what we believe is significant underreporting. As you can see the Kansas DHE figures indicate a sharp rise until 1973 when abortion was legalized elsewhere by the supreme court decision and many who were coming to Kansas went elsewhere for their abortions. There is then a leveling off until 1979. The Missouri statistics and the national continue to rise sharply for this period. The reason for this is that the Kansas figures reflect only hospital abortions and abortions during this period were increasingly being performed in non-hospital facilities.

In 1979 the KDHE began including in their total figures some voluntary clinic reporting. If I understand them correctly they make phone calls or otherwise determine the numbers of abortions done in clinics of which they are aware and add these to the total. They have no other information

for these clinic abortions. In addition we believe there are significant numbers of abortions that are not included at all. Many of the abortion clinics have large ads in the yellow pages but there are others of which we are aware that do a large practice by word of mouth and referrals mainly.

In 1982 for instance, the KDHE records 11,107 of which 1,764 were non-hospital abortions for which no summary information is available. In the same ya year AGI received reports on 14,440 Kansas abortions.

From 1979 on despite the inclusion of some non-hospital abortion totals the KDHE figure drops sharply. While at the same time the Missouri and U.S. numbers reported continue rising or leveling off slightly.

So while the health department may be recording some of the non-hospital abortions there is none of the important information they have elected to keep for hospital abortions and there is still significant under-reporting of the totals. The only way to obtain accurate statistics is to require them and that is the purpose of SB 86. Remember we are not asking you to make the decision as to whether we should keep abortion statistics. We are already doing that. Only by passing SB 86 can we be certain that those statistics are as accurate and reliable as we can make them and we will not be wasting the taxpayers money on unreliable statistics.

Thank You

Pat Goodson
Right To Life of Kansas

From Wichita, Kansas Telephone Book

Abortion Services

For businesses that provide abortion services and/or information and/or counseling on the attainment of abortion services.

ABORTION AID 3013 E Central ---------- 688-0107

Don't fuel around. When you want to make every drop of gas count, you'll get more mileage by shopping *The One and Only* Southwestern Bell Yellow Pages. Why waste gas and time driving around town when you can know before you go. The Yellow Pages is your resource.

ABORTION AID-WICHITA FAMILY PLANNING

ABORTION SERVICES
FREE PREGNANCY TESTS
CONFIDENTIAL COUNSELING
PROMPT APPOINTMENTS
"WOMEN HELPING WOMEN"

WICHITA FAMILY PLANNING INC
3013 E Central ---------- 688-0107

COMPREHENSIVE HEALTH ASSOCIATES
Abortion Services & Referrals
4401 W 109
Overland Park ---------- 913 345-1400

Business people: Have you thought about your ad in *The One and Only* Southwestern Bell Yellow Pages recently? Do you take bid work? Be sure and say so in your Yellow Pages ad.

FAMILY LIFE SERVICES

Considering Abortion?
YOU HAVE THE FREEDOM OF CHOICE
Confidential Information
& Counseling 24 Hours
FREE PREGNANCY TESTING
2645 W Douglas ---------- 945-9400

Wichita Women's Center Inc
700 N Market ---------- 265-4349

WOMEN'S HEALTH CARE SERVICES PA
5107 E Kellogg ---------- 684-5108
★FOR MORE INFORMATION
See Advertisement This Page

Ask a Friend...

"I would like to express my thanks to the entire staff at WHC for their caring attitudes. Special thanks to my physician"

Women's Health
Care Services P.A.

Personalized Physician Care
Abortions Through All Legal Stages
Free Pregnancy Tests
Modern Medical Facilities
5107 E. Kellogg (316) 684-5108
Wichita, Kansas

11/17/86

SELECTED INDUCED ABORTION STATISTICS FOR OCTOBER AND CUMULATIVE TOTALS FOR THE YEAR

KANSAS, 1986

	OCTOBER	JANUARY - OCTOBER
TOTAL ABORTIONS...	855	4,301
RESIDENCE		
IN STATE........	441	2,700
OUT OF STATE....	414	1,601
UNKNOWN.........	-	-
AGE GROUP OF PATIENT		
UNDER 11........	-	-
11 YEARS........	-	-
12 YEARS........	-	-
13 YEARS........	2	7
14 YEARS........	5	24
15 YEARS........	22	114
16 YEARS........	50	246
17 YEARS........	79	327
18 YEARS........	58	332
19 YEARS........	72	337
20-24 YEARS.....	278	1,447
25-29 YEARS.....	159	804
30-34 YEARS.....	77	403
35-39 YEARS.....	43	209
40-44 YEARS.....	8	46
45 AND OVER.....	1	2
UNKNOWN-NS......	1	3
RACE OF PATIENT		
WHITE...........	751	3,781
BLACK...........	90	435
OTHER...........	13	74
UNKNOWN-NS......	1	11
MARITAL STATUS OF PATIENT		
YES.............	155	815
NO..............	695	3,460
UNKNOWN-NS......	5	26

	OCTOBER	JANUARY - OCTOBER
PRIMARY INDICATION FOR ABORTION		
MENTAL HEALTH.......	773	3,139
SOCIO-ECONOMIC......	78	1,094
RAPE................	-	2
INCEST..............	-	-
FELONIOUS INTERCOURSE.......	2	11
PHYSICAL HEALTH.....	2	7
FETAL DEFECT........	-	4
EMERGENCY EXISTED...	-	-
OTHER OR NS.........	-	44
METHOD OF ABORTION		
SUCTION CURETTAGE...	854	4,289
SHARP CURETTAGE.....	-	3
INTRA-UTERINE SALINE INSTILLATION......	-	-
INTRA-UTERINE PROSTA-GLANDIN INSTILLATION......	-	2
HYSTEROTOMY.........	-	-
HYSTERECTOMY........	-	-
OTHER...............	1	7
UNKNOWN OR NS.......	-	-
NUMBER OF DAYS IN HOSPITAL		
LESS THAN 1 DAY.....	855	4,286
1 DAY...............	-	2
2 DAYS..............	-	7
3 DAYS AND OVER.....	-	2
NOT STATED..........	-	4

	OCTOBER	JANUARY - OCTOBER
NUMBER OF OTHER TERMINATIONS		
NONE.................	786	3,943
ONE..................	60	285
TWO..................	6	49
THREE................	3	9
FOUR.................	-	6
FIVE OR MORE.........	-	2
UNKNOWN-NS...........	-	7
PREVIOUS INDUCED ABORTIONS		
NONE.................	580	2,952
ONE..................	204	987
TWO..................	53	245
THREE OR MORE........	18	110
UNKNOWN-NS...........	-	7
NUMBER OF LIVING CHILDREN		
NONE.................	562	2,686
ONE..................	144	805
TWO..................	108	563
THREE................	29	165
FOUR.................	11	54
FIVE OR MORE.........	1	19
UNKNOWN-NS...........	-	9
NUMBER OF PREVIOUS PREGNANCIES		
NONE.................	406	1,932
ONE..................	182	970
TWO..................	117	641
THREE................	97	430
FOUR.................	26	189
FIVE.................	21	70
SIX..................	4	31
SEVEN OR MORE........	2	31
UNKNOWN-NS...........	-	7

3-6

11/17/86

SELECTED INDUCED ABORTION STATISTICS
FOR OCTOBER AND CUMULATIVE TOTALS FOR THE YEAR

KANSAS, 1986

WEEKS GESTATION	OCTOBER	JANUARY - OCTOBER
LESS THAN 8 WKS.	110	787
8 WEEKS.........	144	699
9 WEEKS.........	139	614
10 WEEKS........	124	534
11 WEEKS........	98	423
12 WEEKS........	90	424
13 WEEKS........	24	158
14 WEEKS........	20	142
15 WEEKS........	1	30
16 WEEKS........	15	73
17 WEEKS........	10	68
18 WEEKS........	13	73
19 WEEKS........	3	21
20 WEEKS........	9	61
21 WEEKS........	14	39
22 WEEKS........	17	53
23 WEEKS........	10	31
24 WEEKS........	12	63
25 AND OVER.....	-	-
UNKNOWN-NS......	2	8

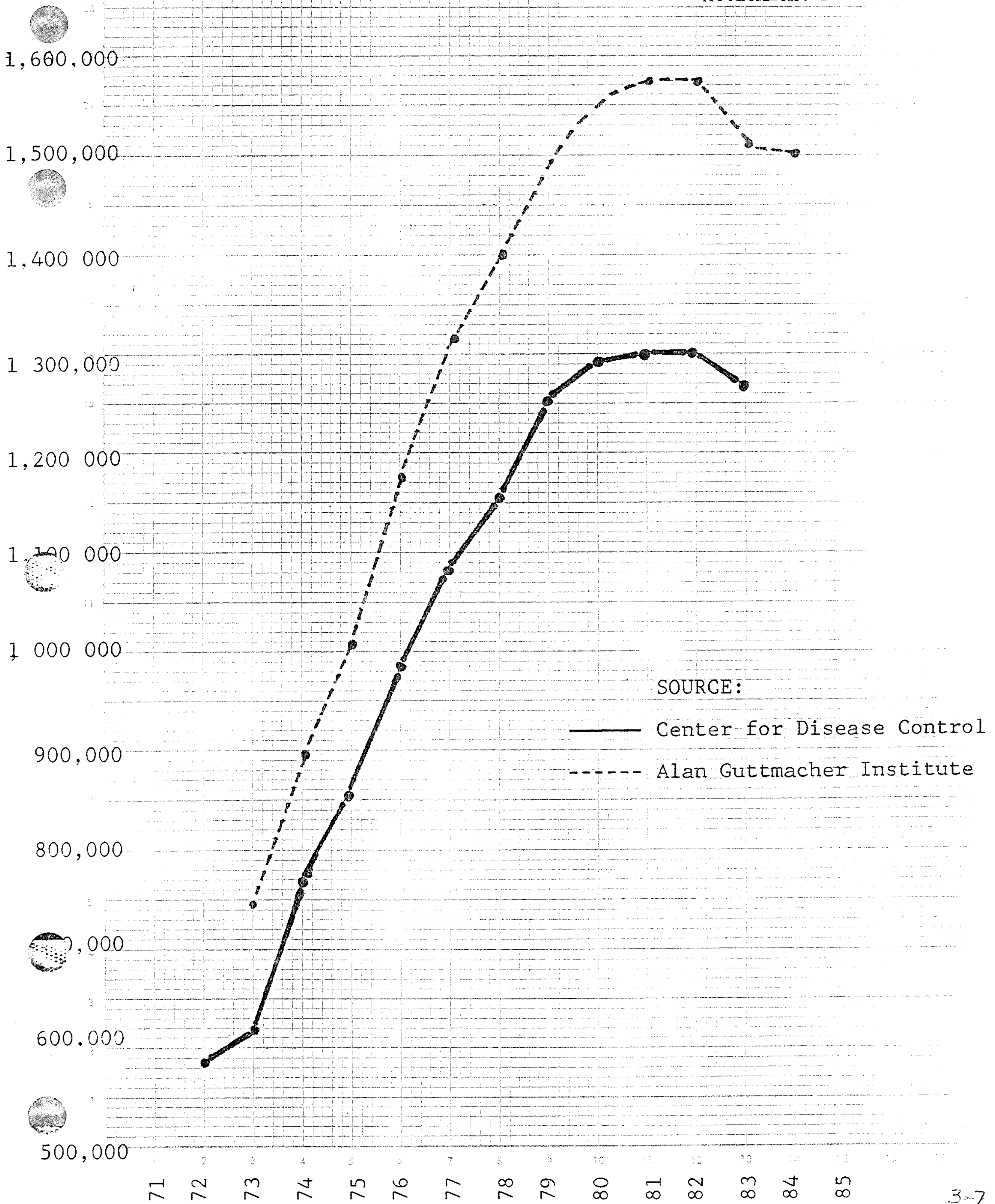
CHILDREN BORN ALIVE NOW DEAD	OCTOBER	JANUARY - OCTOBER
NONE.................	853	4,275
ONE..................	2	15
TWO..................	-	1
THREE................	-	-
FOUR.................	-	-
FIVE OR MORE.........	-	-
UNKNOWN-NS...........	-	10

STERILIZATION PERFORMED	OCTOBER	JANUARY - OCTOBER
YES..................	2	36
NO...................	853	4,246
UNKNOWN-NS...........	-	19

COMPLICATIONS OF ABORTION	OCTOBER	JANUARY - OCTOBER
NONE.................	839	4,237
HEMORRHAGE...........	-	-
INFECTION............	3	10
UTERINE PERFORATION....	1	3
CERVICAL LACERATION....	-	1
RETAINED PRODUCTS......	7	13
OTHER................	5	29
UNKNOWN-NS...........	-	8

NUMBER OF HOSPITALS PERFORMING ONE OR MORE ABORTIONS.................. 2

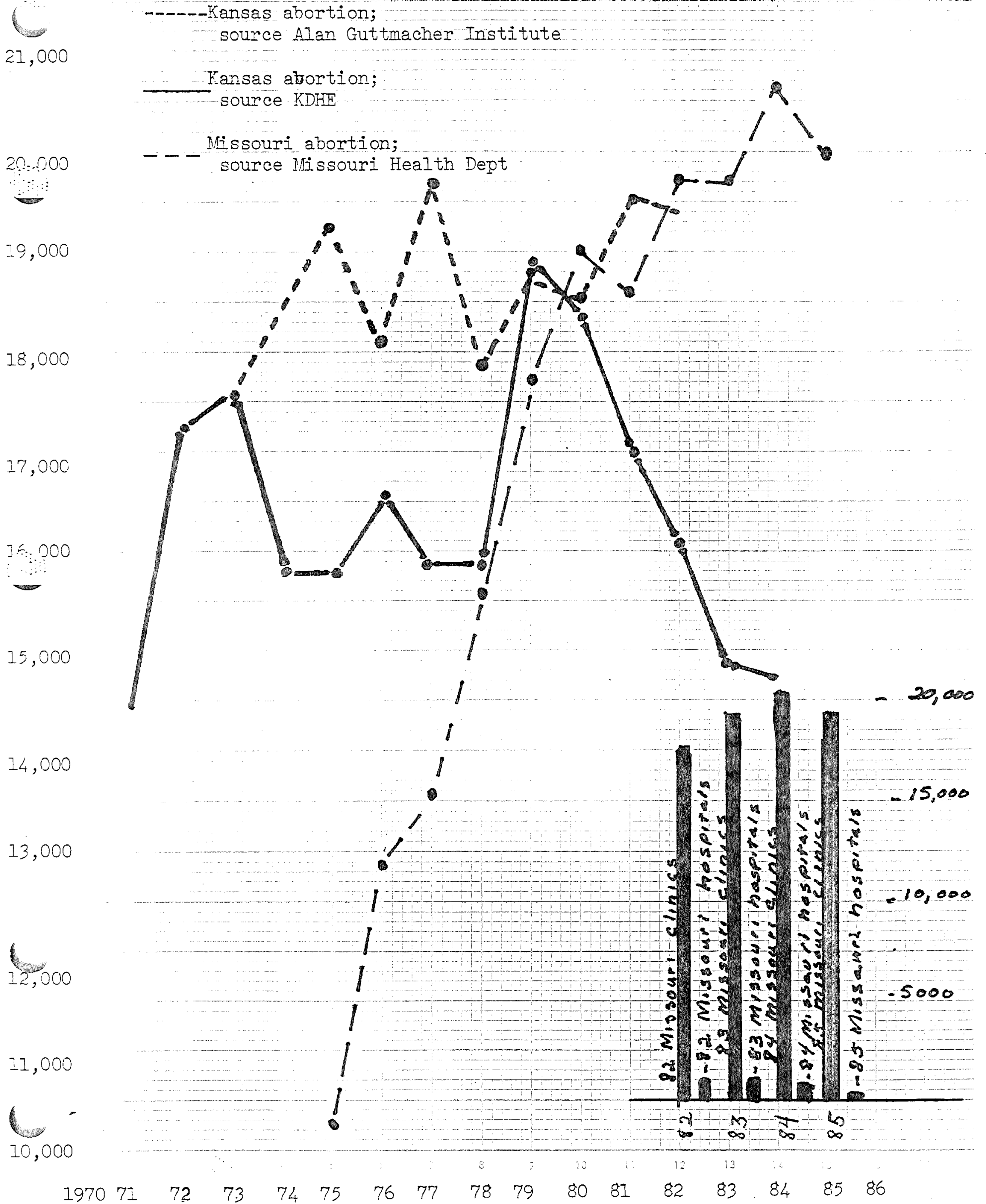
3-12



ABORTION OCCURENCE UNITED STATES
Attachment B
1,600,000
1,500,000
1,400 000
1 300,000
1,200 000
1 000 000
900,000
800,000
,000
600,000
500,000
SOURCE:
Center for Disease Control
Alan Guttmacher Institute
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85

KANSAS / [illegible]SSOURI ABORTION OCCURENCE

Attachment B



With induced abortion legal and prevalent today, I am amazed at how few people in general know about the complications which are known to occur as a result of the operation. I am also amazed at how many physicians, including myself, have been unaware of the frequency and the severity of these complications.

After searching through the medical literature to prepare for today's presentation, I have divided the complications of induced abortion into two groups: immediate complications (those which occur at the time of, or soon after the operation), and late, or delayed complications (those which occur anytime from several weeks to several years after the abortion). Please understand, I make no attempt to list all of the possible complications, only those most frequently recognized.

Some of the immediate complications are:

1. Perforation of the uterus (2, 3, 7, 8, 9): Perforation of the uterus by an abortionist's instruments may of course also injure adjacent bladder and intestine. (Incidence .34%)

2. Laceration or perforation of the cervix (2, 3, 8, 9): (Incidence .93%; combined incidence of #1 and #2 .14% to 1.27%)

3. Hemorrhage (1, 7, 9, 14): Bleeding from within the uterus itself, with production of a large blood clot, which the newly assaulted uterus is unable to expel (the so-called "Post Abortion Syndrome"(1)). (Incidence .03% to .34%)

4. Retained parts (3, 7, 8, 9, 14): These parts can be of either placenta, or baby, especially the head, since calcification

SPH&W
2-4-87
attachment 4

occurs early and makes the head difficult to crush with the abortion instruments. (Incidence .56%)

5. <u>Significant infection</u> (2, 3, 7, 8, 9, 14): This may be salpyngitis (infection in the fallopian tubes), endometritis (infection inside the uterus), sepsis (infection in the blood), peritonitis (infection outside the uterus and inside the abdomen), bladder infections. (Incidence .5% to 1.5%) 89% of all abortion patients develop a fever post-op (7).

6. <u>Stress Incontinence</u> (14): Damage is done to the muscles and/or nerves which control the flow of urine from the bladder, so that when a woman coughs or sneezes, she wets her pants. (Incidence 23.7% to 40.9% acutely)

Other immediate complications I discovered in doing a literature search of the complications of induced abortion, but for which I could not find frequency are:

7. <u>Kidney failure</u> (14)

8. <u>Heart failure</u> (14)

9. <u>Lung failure</u> (14)

10. DIC (disseminated intravascular coagulopathy) (11, 14): This results from the using up of clotting materials in the blood, such that the woman who has had an abortion can no longer form clots, and she bleeds into her various body tissues and out of her various body orifices.

If we now consider the total incidence of all of the above complications for which I was able to find statistics, the total incidence of immediate significant, serious surgical complications following induced abortion approaches 4%. Bear in

mind that this figure excludes numbers 6 through 10. If #6 were included the complication rate would be between 28% and 45%.

Consider that the complications 1 through 5 can require hysterectomy for cure, and all but number 6 can be fatal! What is the mortality rate of abortions? The U.S. statistics most often quoted are those published by the Abortion Surveillance Branch of the CDC (Center for Disease Control). These suggest a mortality rate of about 5/100,000 abortions. The range is from 1.1/100,000 for suction abortions, to 208/100,000 for hysterotomy abortions. If there are about 1.5 million induced abortions a year in the U.S., then about 75 women die each year in our country as a result of induced abortion. I will address the probable inaccuracy of these figures in a moment.

Now for the more serious, and more common, delayed complications of induced abortion.

1. Chronic pelvic inflammatory disease (PID) (8, 9): If an infection of the fallopian tubes or uterine cavity is not treated appropriately post abortion (and sometimes even if it is) it can lead to a smoldering, chronic infection in the pelvic organs. This frequently requires hysterectomy for cure.

2. Infertility (2, 4, 7, 8): Women who have had abortions may develop infertility secondary to infection and scarring in the fallopian tubes, PID, obliteration of the uterine cavity from infection or aggressive scraping at the time of the abortion, or secondary to hysterectomy (Incidence 8%-10% after one abortion, perhaps as high as 20% after three or more abortions)

3. Ectopic or tubal pregnancy (4, 8, 9): The risk of this

possibly fatal complication may be increased ten times in the post abortion woman. The etiology is probably impaired parastalsis and/or fallopian tube narrowing/scarring from infection.

4. Spontaneous abortion (miscarriage) (3, 4, 5, 8, 9): This occurs twice as often in women who have had an induced abortion, in both the first and second trimester. Spontaneous abortion may occur because of scarring of the uterine cavity, making it unable to support a placenta. (Incidence 30-40%)

5. Incompetent cervix (3, 5, 8, 9): This is probably the cause of some of the spontaneous abortions, especially those occuring in the second trimester. Incompetent cervix occurs after a tear or laceration of the cervix at the time of an induced abortion. (Incidence 10% (8))

6. Toxemia of pregnancy (3): This sometimes fatal complication of subsequent pregnancies may be 5 times more likely in the post abortion woman.

7. Premature birth (4, 5, 7, 8, 9), and

8. Decreased birth weight (4, 7, 8, 9, 10): These two late complications of induced abortion are probably due to cervical incompetence and/or chronic infections in an abraided uterus with infection traversing the amnionic sac surrounding the baby.

9. Prolonged labor (4, 9): This may occur because the cervix is scarred and tough, so it requires more force to dilate it (cervical dystocia), or it may occur because the uterine muscle has been damaged and can no longer contract with the force it possessed prior to the induced abortion (uterine atony).

10. Perinatal mortality (death of the baby shortly before or shortly after birth) (5, 8)

11. Breech presentation (bottom first, instead of head first) and other abnormal fetal presentations at the time of labor and delivery (10)

Numbers 7 through 11 may also be secondary to placental abnormalities resulting from previous induced abortions:

12. Placental insufficiency (3): The placenta is unable to adequately support the nutritional requirements of the baby.

13. Placenta previa (5, 9): The placenta attaches at or near the opening of the cervix, so with dilatation of the cervix, the placenta tears and hemorrhage occurs. This is fatal to the mother and the baby unless immediate cesarian section is done.

14. Premature separation of the placenta (5, 9, 10): The placenta separates from the inside of the uterus before the baby is born. Bleeding from the mother and baby occurs with risk of loss of life of both without cesarian section.

15. Need for manual extraction of the placenta (3, 8, 9): The placenta will not separate from the inside of the uterus after the baby is born, and must be forcefully dug out by hand.

16. Post-partum hemorrhage (3, 9): This may result either from placental abnormalities, or from uterine atony.

17. Stress incontinence (14): As already mentioned this is a very common immediate complication of induced abortion. However, most women's stress continence resolves, and only 6.3% of those initially affected develop chronic stress incontinence.

The psychological affects of induced abortion have received even less publicity. However, they certainly do exist (2, 8, 12). Serious psychological sequelae of induced abortion are reported to occur in anywhere from .2% to 20% of post abortion women.

18. Guilt: There is no doubt that this is a significant complication following induced abortion. Of women who have had abortions, 20%-25% admit guilt feelings, another 10% actively suppress their guilt feelings, and 10% develop "impaired mental health" as a result of their abortions (8). It is interesting that according to one report, 63% of women who have had an induced abortion will deny it to another doctor in another hospital, and 1.6% will deny it later to the doctor who performed the abortion, at the hospital where it was done (3).

19. Suicide: There may be an increased risk of suicide among women who have had an abortion. This risk is especially serious in teenagers (13), among whom the overall incidence of suicide is on the rise already. Appropriately, the suicides commonly occur on the due date of the baby who was aborted.

The Abortion Surveillance Brance of the CDC compiles statistics on abortion from those abortion centers which report to it. In general their reported incidence of immediate serious complications of induced abortion is lower (less than 1%) than the ones I have presented here (about 4%). Likewise, their figures for delayed complications are much lower. In considering the validity of their statistics, we must take into account two things: first, not all states require that all abortion providers report their complications, and second, of those abortion providers who do report

complications, no more than 20-30% of their patients are ever seen in follow up (2). This would mean that any statistics published by the CDC should be viewed with guarded skepticism. A more accurate reflection of the incidence of abortion complications might be obtained by multiplying their figures by a factor of 3 or 4, to compensate for the 70-80% of patients who are not followed (and therefore their complications go unreported). The fact is that most immediate complications following induced abortion are seen in emergency rooms by physicians who did not do the abortion, and therefore/do not get reported. Most late complications are seen several weeks to several years later by another physician in the office. These likewise therefore also do not get reported.

On the basis of what I have learned by preparing this information for you today, I have concluded certain things. First of all, the frequently quoted "less than 1%" complication rate following induced abortion in the U.S. is quite obviously incorrect. In an extremely well equipped, well staffed university medical center, maybe such an outcome is achievable. However, I fearfully suspect that my 4% estimate may even be too low, if all of the office and clinic abortions were to be included.

Regarding the true incidence of late complications from induced abortions in the U.S., nobody really knows, and only a fool would pretend to know. Because of the duration of the problems, it will take at least 20 years of close follow up of post abortion women to get a realistic idea of the scope of their problems. So far, we don't even have adequate follow up of the

immediate complications.

The only way we can begin an accurate, honest evaluation of the complications of induced abortion in the U.S. is to require all abortion providers (clinics, doctors' offices, hospitals) to follow all their post abortion women, and report all complications for ideally the next 20 years. Realizing that this would not be possible, we should also require all health care providers who later identify a complication of induced abortion, to report it.

Most importantly every woman who is considering an abortion must be informed of these complications before giving her consent for the operation. Anything less would be blatant exploitation.

BIBLIOGRAPHY

1. Borten, Max; and Friedman, Emanuel. Drainage of Post Abortion Hematometria by Foley Catheter. AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY. 149:8, pp. 908-909.

2. Bulfin, Matthew. Complications of Legal Abortion: A perspective From Private Practice. NEW PERSPECTIVES ON HUMAN ABORTION. 1981, pp. 145-150.

3. Bracken, Michael. Induced Abortion as a Risk Factor for Perinatal Complications: a Review. YALE JOURNAL OF BIOLOGY AND MEDICINE. Vol. 51, 1978, pp. 539-548.

4. Faser, Ian; and Weisbert, Edith. Fertility Following Discontinuation of Different Methods of Fertility Control. CONTRACEPTION. 26:4, pp. 389-415.

5. Iffy, Leslie; Frisoli, Garry; and Jakobovits, Antal. Perinatal Statistics: The Effect Internationally of Liberalized Abortion. NEW PERSPECTIVES ON HUMAN ABORTION. 1981, pp. 92-127.

6. Kapotski, Bela. The American Relevance of the Hungarian Legal Abortion Experience. INTERNATIONAL REVIEW OF NFP, 8:4, 1984, pp. 283-296.

7. LaFerla, John. Midtrimester Abortion: Techniques and Complications. CLINIC IN PERINATOLOGY. 10:2, pp. 305-320.

8. Larsen, J. V. Induced Abortion. SOUTH AFRICAN MEDICAL JOURNAL. 24 May, 1978, pp. 853-857.

9. Lembrych, Stănislaw. Fertility Problems Following an Aborted First Pregnancy. NEW PERSPECTIVES ON HUMAN ABORTION, 1981, pp. 128-134.

10. Linn, Shai; Schoenbaum, Stephen; Monson, Richard;; Rosner, Bernard; Stubblefield, Phillip; and Ryan, Kenneth. The Relationship Between Induced Abortion and Outcome of Subsequent Pregnancies. AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY. 146:5, 1983, pp. 136-141.

11. Silber, Thomas. Abortion in Adolescence: The Ethical Dimension ADOLESCENCE, 15:58, pp. 461-474.

12. Sim, Myre. Abortion and Psychiatry. NEW PERSPECTIVE ON HUMAN ABORTION, 1981. pp.151-163.

13. Tishler, Carl. Adolescent Suicide Attempts Following Elective Abortion. PEDIATRICS. 68:5, pp. 670-671.

14. Watson, Richard. Urologic Complications of Legal Abortion. NEW PERSPECTIVES ON HUMAN ABORTION, 1981, pp. 135-144.

15. Yonas, Susan. Teenage Pregnancy and Motherhood: a Review of the Literature. AMERICAN JOURNAL OF ORTHOPSYCHIATRY. 50:3, 1980. pp. 403-431.

16. Zimmer, Fritz. Die Problematik des Schwangerschaftsabbruchs. HAUTARZT. 31:4, 1980. pp. 31-35.

RCAR in KANSAS

Religious Coalition for Abortion Rights in Kansas

4February, 1987

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

Mr. Chairman and Members of the Committee:

I am Darlene Stearns, State Co-ordinator for Religious Coalition For Abortion Rights in Kansas. We appear in opposition to SB 86.

We question the need for and the purpose of this legislation. Generally, legislation is requested to control a specific activity by those persons most directly affected by that particular activity, or, by government itself seeing a clear need to protect the populace as a whole.

SB 86 would impose more controls than presently required over medical clinics, private physicians and patients seeking health care from those clinics and physicians. The Department of Health and Environment is required to develop a questionaire and expand record keeping to handle the required reports and returned questionaires.

We have been unable to find groups of physicians or patients seeking this legislation. Past testimony from the Department of Health and Environment stated that these records are indeed kept, and reported, by clinics and physicians . The Department has not requested this legislation.We have seen no public outcry to require this legislation.

Section 1,(c) raises even more questions as to need. Here again, we can find no groups of physicians or patients requesting mandated questionaires to determine possible complications arising from a pregnancy termination. The Department of Health and Environment has not requested this procedure.

As to the purpose of this legislation, we fail to find a purpose properly served in this section. If the purpose is to truly determine incidence of complications, a questionaire sent to a patient is useless. A patient recovering from any other surgical procedure is not required or expected to be capable of, determining a possible complication of their surgery. We see no purpose in asking these particular patients to do so.

Finally, we suspect that the real purpose of requiring these reports and questionaires, beyond simply reporting numbers, is to have on record names of medical facilities and physicians performing abortions, with as much information as is possible to collect, only for the purpose of harassment. We all know clinics hospitals and physicians are not picketed, bombed and otherwise harassed for performing tonsillectomies or heart surgery. We do know they are the recipients of organized harassment and violence for performing abortions.

The questions are: Where is the need and what is the purpose for this legislation? We submit there is not a need and the purpose borders on invasion of the privacy of the doctor/patient relationship.

Darlene Greer Stearns

Darlene Greer Stearns

SPH&W
2-4-87
attachment 5

1248 Buchanan • Topeka, KS. 66604

KANSAS

Wednesday, February 4, 1987

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE ON PUBLIC HEALTH AND WELFARE, THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY. I AM GAIL HAMILTON, KANSAS NATIONAL ORGANIZATION FOR WOMEN. ON BEHALF OF THE MEMBERS OF KANSAS NOW, WE ASK THAT YOU OPPOSE SB86.

OUR ORGANIZATION HAS A STRONG INTEREST IN ACCURATE REPORTING, HOWEVER, THE REQUIREMENT OF FOLLOW-UP REPORTS WITH NAMES OF PHYSICIANS, HOSPITALS, AND CLINICS DOES NOT PROMOTE A VALID PUBLIC HEALTH PURPOSE. IN FACT, THE PURPOSE FOR THE FOLLOWUP IS UNCLEAR. ADDITIONALLY, THESE REPORTS BECOME A PAPERWORK BURDEN FOR BOTH THE DEPARTMENT OF HEALTH AND ENVIRONMENT AND FOR SOME OF THE DOCTORS OF THIS STATE. INHERENT IN ANY PAPERWORK BURDEN IS A COST.

BECAUSE THERE IS NO VALID PUBLIC HEALTH PURPOSE THESE DOLLARS--BOTH THE PUBLIC AND THE PRIVATE--COULD BE USED FOR PROGRAMS THAT WOULD BENEFIT OUR STATE'S CITIZENS.

A FINAL CONCERN IS THE POTENTIAL THREAT AND INTIMIDATION OF DOCTORS, CLINIC AND HOSPITAL PERSONNEL AND PATIENTS. EVEN WITH A STATUATORY ASSURANCE THAT THE NAMES APPEARING ON THESE REPORTS WILL BE KEPT CONFIDENTIAL, THOSE WHO ARE DETERMINED TO OBTAIN THE INFORMATION ALREADY HAVE AND WILL CONTINUE TO OBTAIN IT. I AM SURE YOU ARE ALL AS AWARE AS I AM A CLINIC IN WICHITA, KS AND ONE IN ST. LOUIS, MO. WERE BOMBED IN 1986. THIS BILL HAS THE POTENTIAL TO INCREASE ATTEMPTS TO THREATEN AND INTIMIDATE HEALTH CARE PROVIDERS. Please consider these reasons and oppose SB86.

THANK YOU.

SPH&W
2-4-87
attachment 6

Planned Parenthood of Kansas, Inc.

2226 East Central • Wichita, Kansas 67214 • (316) 263-7575
122 East Twelfth • Hays, Kansas 67601 • (913) 628-2434
810 Loomis • Winfield, Kansas 67156 • (316) 221-1326

TO: MEMBERS OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

FROM: BELVA OTT, PUBLIC AFFAIRS DIRECTOR

RE: SENATE BILL 86 HEARING: FEBRUARY 4, 1987

SENATE BILL 86 ADDS AN UNNECESSARY BURDEN TO THE KANSAS BUDGET. Testimony during the 1986 Legislative Session showed 95% compliance in reporting according to the Secretary of Health and Environment. By law, hospitals report all pregnancy terminations; medical care facilities report voluntarily. I recognize that any figures can be suspect. But will we ever "know" exact figures? the other 5%? I don't know.

In the emotionally charged climate of today patients and physicians wish to maintain confidentiality. It is a private matter of choice and is between patient and physician. With or without this bill, if confidentiality is preferred, there will probably be no additional reporting over what we get now. The risk in losing confidentiality, even when only the physicians name is required may prevent that last 5% of pregnancy terminations reported.

Do physicians in individual offices report and lose their annonymity? Do they risk becoming the object of picketers not only at their offices but in their homes? Last year, Joe Schiedler, who heads the Pro-Life Action Network and is affiliated with Right-to-Life, scheduled a list of activities he would accomplish for the year (see attached schedule). He targeted physicians homes, if they terminated pregnancies! It is bad enough women

SPH+W
2-4-87
attachment 7

and health-care providers must be subjected to violence and harrassment when going to their physicians office...who knows what reason brings them to the office...they all are verbally abused and harrassed. Do you want to enlarge upon the problem so physicians, their families and neighbors become the object of picketing, verbal abuse and harrassment?

Put yourself in the women's place. Your physicians gives you the medical complications form and tells you to return it in 60 days to the office. Do you, as a lay-person patient, have the medical expertise to complete this evaluation? If you desire confidentiality will you return the form? Or, is it more likely you'll discard it so there is no possibility you'll ever be identified? Do you have the medical expertise to evaluate cramping, blood flow, etc? What exactly do they want you to look for? The average lay person will have difficulty giving a medical evaluation. Remember, complications are the exception not the rule. Carrying a pregnancy to term is many times more dangerous to some than terminating a first trimester pregnancy.

If the desire for confidentiality is strong and the forms are discarded, the State of Kansas has spent time and money for design, printing and the distribution of the forms to all Kansas Physicians. Wasted.

WHAT IS THE COMPELLING STATE INTEREST? I submit to you there is no compelling state interest to be achieved with this bill. There will be money spent which could better go to those poor and needy who have suffered budget cuts already. SPENDING STATE DOLLARS TO ACHIEVE A 5% REPORTING, WHICH IS PROBABLY NOT GOING TO BE ANY BETTER THAN WHAT WE HAVE NOW, IS UNWISE AND UNNECESSARY. SUBJECTING PATIENTS AND PHYSICIANS TO ADDITIONAL VERBAL ABUSE AND HARRASSMENT IS UNWISE AND UNNECESSARY.

<u>I URGE YOU-----PLEASE, VOTE NO, TO THE PASSAGE OF SENATE BILL 86.</u>

Joe Scheidler's Activities

December 28 - Feast of the Holy Innocents
"will seek a Christmas truce in the killing of the innocent pre-born."

January 22 - Roe v. Wade anniversary
a national sit-in probably in Washington D.C.

February 14 - St. Valentine's Day
"a national day of mourning"

Sometime in March - "homes of abortionists will be picketed. This reporter knows which day is planned, but the abortionists should not. Plans change anyhow."
(The underlining is mine.)

March 28 - Good Friday
"a different kind of event will take place in the same month."

April 13 - "Planned Parenthood will be called to account by the activist pro-lifers."

PRO-LIFE ACTION NETWORK (PLAN) HOTLINE 1-800-851-CALL

Kansas NARAL

February 3, 1987

Testimony before the Senate Public Health and Welfare Committee on Senate Bill 86.

Mr. Chairman and Members of the Committee, my name is Theresa Shively and I am the Executive Director of the Kansas National Abortion Rights Action League, a statewide membership organization dedicated to keeping abortion safe, legal and accessible.

Kansas NARAL opposes Senate Bill 86. Mandating reporting requirements is unnecessary, a regulatory burden on the state and physicians and invades the privacy of a woman who exercises her constitutional right to an abortion.

Senate Bill 86 is unnecessary since it has been estimated that 90% of medical care facilities and physicians voluntarily comply with the reporting requirements as set out for hospitals in KSA 65-445. (Testimony from Barbara Sabol, Secretary of Health and Environment on House Bill 2052, House Public Health and Welfare, February 14, 1985.) Expanding the reporting requirement will not quarantee that the estimated ten percent who do not report will do so. The termination of a pregnancy poses no health risk to the public at large and is voluntarily reported without the extra burden of state dollars and state time to monitor and regulate compliance.

The follow-up reporting requirement in Section 1(c) is an unfair regulatory burden on hospitals, medical care facilities and physicians who perform abortions. No other surgical procedure requires this type of follow-up, which Kansas NARAL regards as harassment and the invasion of a woman's right to privacy. There is no justification from a health standpoint in handing a woman a form which is doubtful that she will fill out and return to her health care provider. Failure to return the form will cause staff at the health care facility to waste time in tracking down a patient to request the form which she may not want to complete.

Since the state has no compelling reason to expand the reporting requirement of abortions and for the above stated reasons, Kansas NARAL opposes Senate Bill 86.

Thank you for allowing me to appear here today. I will be happy to stand for questions.

SPH&W
2-4-87
attachment 8

Affiliate
National
Abortion Rights
Action League

Kansas NARAL

1195 SW Buchanan
Room 201
Topeka, KS 66604
913-235-3405

FACT SHEET

Safety of Abortion

Abortion is now one of the safest medical procedures available. Having an abortion in the first 3 months of pregnancy is considerably safer than bearing a child.

Dangers of Illegal Abortion

Abortion has not always been so safe. Before abortion was made legal, many women died or had serious medical problems after attempting to induce abortions on themselves or going to untrained practitioners who performed abortions in unsanitary conditions. Women streamed into emergency rooms with serious problems— perforated uterus, retained placenta, severe bleeding, cervical wound, rampant infection, shock, gangrene.

Safety of Legal Abortion

Since legalization, women have benefitted from significant advances in medical technology and greater access to high quality services.

Women rarely die from legal abortions. According to the most recent statistics available, only 1 of 200,000 women who have legal abortions die. That is one seventh the number of women who die from childbirth and a tiny fraction of the number of women who used to die from illegal abortions.

Chance of Complications Following Abortion

The chance of complications depends on many factors, the most important of which is how far along the pregnancy is. Generally, abortions are not performed before 7 weeks LMP (weeks since the last menstrual period). From 7 weeks on, the earlier the abortion, the safer it is.

Most women who obtain abortions (90%) are in their first trimester (less than 13 weeks of pregnancy). Of these women, 97% have no complications or any post-abortion complaints; 2½% have minor complications that can be handled at the physician's office or abortion facility; and less than ½ of 1% require some additional surgical procedure and/or hospitalization. In the second trimester (13-24 weeks), complication rates are somewhat higher. The safest time to have an abortion is 7-10 weeks LMP.

Other significant factors that affect the possibility of complications include:
- the skill of the physician,
- the kind of anesthesia used,
- the woman's health, and
- the abortion method used.

(See *Fact Sheet: What is Abortion?*)

Complications from First-Trimester Abortion

In the first trimester, possible complications include:
- blood clots accumulating in the uterus, requiring another suctioning;
- infections, most of which are easily identified and treated if the woman carefully observes follow-up instructions;
- a tear in the cervix, which may be repaired with stitches;
- perforation of the wall of the uterus and/or other organs, which may heal themselves or may require surgical repair or, rarely, hysterectomy;
- abortion that is not complete or that does not end the pregnancy, both of which require the procedure to be repeated;
- excessive bleeding due to failure of the uterus to contract, which may require a blood transfusion.

As mentioned, serious complications arising from first-trimester abortions are quite unusual.

© National Abortion Federation

Complications from Second-Trimester Abortion

Complications from second-trimester abortion (13-24 weeks) include infection, perforation of the uterus and/or other organs, injury to the cervix, bleeding that requires transfusion, and incomplete abortion. General anesthetic is occasionally used and carries its own risks.

In general, from 13-16 weeks the dilatation and evacuation (D&E) procedure is significantly safer and more effective than other second-trimester methods. After 16 weeks, the different methods carry about the same complication rates.

Signs of a Post-Abortion Complication

If a woman has any of the following symptoms after having an abortion, she should immediately contact the facility that provided the abortion:

- severe pain;
- chills or fever with an oral temperature of 100.4° or more;
- bleeding that is heavier than the heaviest day of her normal menstrual period or that saturates more than one sanitary pad per hour;
- foul-smelling discharge or drainage from her vagina; or
- continuing symptoms of pregnancy.

Doctors and clinics that offer abortion services provide a 24-hour number to call in the event of complications.

Preventing Complications

To some extent, complications are a matter of chance, but there are some things women can do to lower their risk. The most important thing is not to delay. After 6 weeks LMP, the earlier the abortion, the safer it is.

Asking questions is also important. Just as with any medical procedure, the more relaxed a person is and the more she understands what to expect, the better and safer her experience will be.

Finally, any woman choosing abortion should:

- find a good clinic or a qualified, licensed physician[1] (for referrals, call NAF's toll-free hotline, (800) 772-9100);
- inform the physician of any health problems, current medications or street drugs being used, allergies to medications or anesthetics, and other health information;
- follow post-operative instructions; and
- return for a follow-up examination.

Antiabortion Claims

Antiabortion activists claim that having an abortion endangers future childbearing. They claim that women who have abortions will have difficulty conceiving or carrying a pregnancy, will develop ectopic (outside of the uterus) pregnancies, will deliver stillborn babies, or will become sterile. However, according to the U.S. Centers for Disease Control, none of these claims is borne out by medical research.

Women's Feelings after Abortion

Women consider abortion for a variety of reasons, but in general, they consider it because being pregnant at that time is in some way wrong for them. Often there is no absolutely "right" solution to a "wrong" situation. Some women feel sad or weepy for a few days or weeks afterwards and may find it helpful to talk about their experience with a family member, friend, or counselor. These feelings of loss, however, should not be confused with regret. Most women also report relief at having ended the pregnancy and are satisfied that they made the right decision for themselves.

[1]*Most abortions in the U.S. are performed by medical doctors. In Vermont, certified physician's assistants may also perform first-trimester procedures.*

For More Information

For information or referrals to qualified abortion providers, call the National Abortion Federation's toll-free Consumer Hotline, (800) 772-9100.

For Further Reading

C. Tietze, *Induced Abortion: A World Review, 1983*, New York: The Population Council.

Centers for Disease Control, *Abortion Surveillance: Annual Summary 1981*, issued 1985.

D.A. Grimes, "Second-Trimester Abortion in the United States," *Family Planning Perspectives,* November/December 1984, pp. 260-265.

Twelve Years of Legal Abortion National Abortion Federation, 1985.

Information in this fact sheet is based on research by the U.S. Centers for Disease Control Abortion Surveillance Branch, The Alan Guttmacher Institute, and other members of the National Abortion Federation.

National Abortion Federation
900 Pennsylvania Avenue, S.E.
Washington, DC 20003
(202) 546-9060

May 1986

© Copyright 1986 National Abortion Federation

Douglas County

Department of Emergency Medical Services and Emergency Preparedness

Ted McFarlane, Director

TO: Senate Health & Welfare Committee
FROM: Ted McFarlane
DATE: February 4, 1987
SUBJECT: Testimony on S.B. 87 (First Responder Bill)

Thank you for the opportunity to give testimony on Senate Bill 87. I am the Director of the Douglas County Department of Emergency Medical Services and Emergency Preparedness. I am also a member of the Governor's Emergency Medical Services Council and Secretary of the Kansas Association of EMS Administrators. I am here before you wearing all three hats and in that capacity I would urge your passage of this bill to the floor of the Senate.

As a member of the Kansas EMS Council I helped draft the bill. The Council supports this bill as a necessary step in improving the EMS system in the state. As a director of a local paramedic ambulance service I have been asking for this legislation for two years. We have a real need for this training level in our community. This bill will allow us to better utilize our local resources because it will allow us to train our local law enforcement personnel using the First Responder Course instead of the EMT course. The EMT course is a 120 hour program and the First Responder course is a 48 hour program. However, this reduction in hours will not materially affect the quality of care provided because it allows more emphasis on the critical activities of first responders and eliminates the portion of the training designed to prepare the student to be an ambulance attendant.

There are three important points to keep in mind.

1) this is a local option program , and
2) this does not change the minimum qualifications for ambulance attendants,
3) this is a federally approved training cirrculum.

In conclusion, I urge your support for this bill.

TED McFARLANE

Ambulance Service Division
225 Maine Street
Lawrence, Kansas 66044
(913) 843-7777

Emergency Preparedness Division
Judical and Law Enforcement Center
111 East Eleventh
Lawrence, Kansas 66044
(913) 841-7700 Extension 259

S PH & W
2-3-87
attachment 9

February 2, 1987

TO: Senate Public Health & Welfare Committee

FROM: American Association for Marriage and Family Therapy

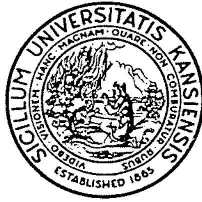
SUBJECT: Amendment to Senate Bill No. 78

We propose the following amendment be added to Section 13,

"Nothing in the professional counselors licensing act shall be construed to apply to the services of full members of the American Association for Marriage and Family Therepy."

With the inclusion of this amendment, the American Association for Marriage and Family Therapy support Senate Bill No. 78.

SPH&W
2-4-87
attachment 10



THE UNIVERSITY OF KANSAS
MEDICAL CENTER
School of Allied Health
Office of the Dean
39th and Rainbow Blvd., Kansas City, Kansas 66103

February 4, 1987

Mr. Chairman, Members of the Committee on Public Health and Welfare:

I am James P. Cooney, Jr., Dean of the School of Allied Health at the University of Kansas Medical Center. I am here today to testify on behalf of the Senate Bill No. 87.

Bill No. 87 basically provides for the development and maintenance of an important new level of the emergency medical services system of Kansas. The level proposed in the Bill of first responder is extremely important and necessary within the State for several reasons. Among the most important are: 1. the standardization and corresponding quality enhancement of first responder training; 2. given the rural nature of many parts of our State, first responders are increasingly a necessary keystone to an effective emergency medical services system -- the Bill will encourage the development of increasing numbers and appropriate placements of the responders.

Both the level of first responder and the provisions of the Bill appropriately relate to those of the other EMS statutes related to providers of service: CIMT, EMT, EMT-Intermediate, amd MICT.

In the Bill, the description of the University of Kansas Medical Center role in training is similar to that of the other EMS training-related statutes.

We will be happy to respond to any questions concerning our position in support of this Bill.

One final point, before questions, is that we would note there is a cost to the Bill for our role. We estimate those costs to total approximately $16,000 in the first year of implementation. We can provide financial details and functional information related to that estimated cost.

JPC:mcm

S PH&W
2-4-87
attachment 11

SUMMARY OF TESTIMONY
BEFORE THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

SENATE BILL 87

PRESENTED BY THE KANSAS HIGHWAY PATROL

February 4, 1987

APPEARED IN SUPPORT

The Kansas Highway Patrol supports Senate Bill 87.

This bill creates a new level of training for individuals who are typically first to arrive at the scene of a medical emergency or accident. Survival of a patient may well depend on their ability to provide essential life saving care.

Historically, Kansas has depended upon these individuals receiving basic emergency medical technician training to fill their first responder role. There has been a resistance to this practice due to the length of the EMT course. A curriculum has now been established nationally and approved for implementation in Kansas if this bill is passed into law. There is substantial interest in this training program among firefighters and law enforcement personnel.

Passage of this bill will strengthen the EMS system in Kansas and fulfill a need not adequately met at the present time. The training program is coordinated with other levels of training programs so the trained first responder can continue to assist the ambulance personnel upon their arrival in a meaningful way.

It should be understood that first responders are not trained ambulance attendants and are not transporters of patients. Their role is clearly to provide life saving care until the ambulance arrives. The State EMS Council has been reviewing the need for this training for over a year and they have concluded that it will improve our system in Kansas. This bill enables firefighters and others to be trained but does not require participation.

The instructor network is already in place since EMT instructor/coordinators are qualified to instruct the entire course. The implementation of the training program should be immediate. Additionally, the Director of Emergency Medical Services intends to utilize trained examiners that are already located around the state to conduct the examination described in the bill.

The Kansas Highway Patrol supports your favorable action on this bill.

SPH&W
2-4-87
attachment 12