Approved: March 7, 1995

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on February 22, 1995 in Room 423-S of the Capitol.

All members were present.

Committee staff present: Norman Furse, Revisor of Statutes
Bill Wolff, Legislative Research Department
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Representative Mike Farmer
Douglas Johnston, Planned Parenthood of Kansas, Wichita
Pat Goodson, Right to Life
Laura L. Malleck, LPN, Topeka
Jeanne Gawdon, Kansans for Life
Peggy Jarman, ProChoice Action League
Barbara Holzmark, National Council for Jewish Women, Leawood
Darlene Greer Stearns, League of Women Voters
Erika Fox, Planned Parenthood of Greater Kansas City

Others attending: See Guest List, Attachment 1.

The minutes of the committee meeting held on February 15, 1995 were approved.

HB 2323 - Ambulatory surgical center defined to include facilities operated for the purpose of performing termination of human pregnancies

The hearing on **HB 2323** was opened. Representative Mike Farmer, one of the sponsors of the bill, testified in support of the bill by providing some history of the issue of licensure of ambulatory surgical centers, and stated that presently K.S.A. 65-425 (which defines "medical facilities") does not require the office of a physician to be licensed under the act. Representative Farmer stated in conversation with the new Secretary of Health and Environment that the interpretation of the statute has not changed so currently abortion clinics are not required to be licensed. Because of that position, he had **HB 2323** drafted. He indicated that if this bill is enacted, the cost of compliance should not be an issue to such a facility, especially to protect the life of a woman. (See Attachment 2 for testimony.)

Some questions were directed to Representative Farmer. Representative Haley asked what is the percentage of abortions being performed, is there a large number? Representative Farmer replied he did not know: one is too many; but this bill insures that the centers would have proper equipment in case of emergency.

Representative Freeborn asked if Pat Turner (her letter is a part of Attachment 2) is a lawyer or in the legal arena. Representative Farmer replied "no." Representative Rutledge asked what problem the bill addresses. Representative Farmer answered that three facilities in Kansas City, Topeka and Wichita, have been performing surgical procedures for abortions. Because of the type of procedure, it is believed the bill will insure safety for the patients.

Pat Goodson, Right to Life of Kansas, testified in support of **HB 2323**, stating that KDHE's interpretation of the existing statute increases the need for the enactment of this bill (see Attachment 3). Ms. Goodson suggested the bill be amended to require that a physician be present during the time a patient is recovering from an abortion while in the clinic.

Laura L. Malleck, L.P.N., from Topeka, testified in support of **HB 2323**, stating that abortions are invasive procedures and the abortion clinics should be licensed and inspected (see Attachment 4).

Jeanne Gawdon, representing Kansans for Life, urged passage of **HB 2323**, stating that all women undergoing a surgical procedure should do so in facilities that are propertly licensed and regulated (see

Attachment 5). She gave an example of an 18-year-old's experience in a Kansas City clinic which ended in her death.

Chairperson Mayans stated that written testimony in support of **HB 2323** had been received and distributed to the members from: Dr. Robert S. McElroy, Topeka (see Attachment 6)
Dr. Lorna L. Cvetkovich, Wichita (see Attachment 7)

Questions were directed at the proponents of the bill. Representative Haley, in questioning Jeanne Gawdon, stated the example of the 18-year-old was over seven years ago and that it was his understanding that death rarely occurs. He asked her if there is any compelling reason to enact the legislation? She replied, "Definitely, yes;" that the example given is why there is a need for the bill. Representative O'Connor questioned Ms. Gawdon why it is necessary to require abortion clinics to register as ambulatory surgical centers. Ms. Gawdon replied that abortion clinics are getting around the current statute by claiming they are maintaining a physician's office, not a surgical center. Representative Freeborn asked if OSHA has anything to do with these clinics. Ms. Gawdon replied not as far as she knew, but would try to determine OSHA's involvement. Representative Freeborn asked if medical histories are studied prior to abortions. Ms. Malleck replied that health histories are obtained.

The hearing was opened for opposing conferees. Peggy Jarman, ProChoice League, Wichita, testified in opposition to **HB 2323**, providing some facts concerning medical procedures; related current trends in the medical community; and reminded committee members of the U.S. Supreme Court Doe v. Bolton decision affirming that states cannot restrict abortions to hospitals and restricting them to licensed facilities could only be done for second trimester procedures with proof they are the only safe place in which they can be done (see Attachment 8).

Douglas E. Johnston, Planned Parenthood of Kansas, Inc., in opposing **HB 2323**, testified that the bill is unnecessary government regulation and will severely restrict access to abortion services for the women of Kansas (see Attachment 9).

Barbara Holzmark, representing the National Council of Jewish Women, testified in opposition to the bill, stating it is one more restriction to a woman's right to choose abortion; that abortions are legal, safe and performed by physicians who are certified. The Council is against any restrictions that limit reproductive freedom and urges the bill not be passed (see Attachment 10).

Darlene Greer Stearns, League of Women Voters, testified against **HB 2323**. She related the League's position to protect the constitutional right of individuals to make reproductive choices, and their belief that this bill clearly restricts the practice of medicine and restricts a woman's right to choose a procedure she deems necessary. Therefore, the League requests the bill not be passed (see Attachment 11).

Erika Fox, Director of Public Affairs, Planned Parenthood of Greater Kansas City, testified in opposition to **HB 2323**, stating the proposal will force most Kansas abortion providers--those who operate within the law--to become ambulatory surgical centers. If the bill is enacted, it will cause increased costs, additional travel to the patients; and a return to unsafe abortion practices (see Attachment 12). Ms. Fox stated enactment of **HB 2323** without data to indicate it will improve the medical outcome for women choosing abortion will cause expensive litigations.

Chairperson Mayans indicated that written testimony from Dr. Steven C. Sebree, of the Mowery Clinic, Salina, in opposition to **HB 2323,** has been distributed to each committee member (see Attachment 13).

Questions were then directed to the opponents of **HB 2323**. Representative Kirk stated that OSHA can lawfully inspect the centers. Representative Landwehr asked Ms. Jarman what an abortion costs today. Ms. Jarman replied she's not certain as it depends on several medical factors of the patient; but probably $300 for someone in the early stages, or as expensive as $3200 for fetal abnormalities.

Representative Landwehr asked he if the bill is enacted what would the cost be to a center to meet the criteria. Ms. Jarman replied that is difficult to answer. Representative Landwehr questioned Ms. Jarman's statement that requiring centers to become ambulatory surgical centers would increase the price and make abortions less available. She then questioned Ms. Fox about her contention that passage of the bill would be a barrier to women seeking abortions by causing additional delays and costs. Ms. Fox answered that around 10 years ago, the cost was $500; now it's $3-400 for the same procedure. She said her testimony was there is no health benefit from imposing this kind of regulation when it is the skilled practitioner that makes the difference; that the bill will raise the cost of abortion; will cause women to delay the procedure; and will increase the risk of harm to women.

Chairperson Mayans questioned Ms. Jarman if she may have a conflict of interest with respect to **HB 2323**, since she also represents Dr. George Tiller of Wichita. Ms. Jarman answered that Dr. Tiller may actually benefit from passage of this bill, but he does not tell her how to lobby; and Dr. Tiller really believes in choice for women. Chairperson Mayans asked if Dr. Tiller is seeking certification as an ambulatory surgical center, and if so he questioned her testimony that "restrictions to ambulatory surgical centers will increase the price and make abortions less available." Ms. Jarman replied that the change to an ambulatory surgical center has nothing to do with abortion services. Dr. Tiller is a family practitioner and envisions the new clinic offering a comprehensive range of services to women.

Representative Freeborn questioned OSHA's inspections of facilities and procedures. Ms. Jarman replied that OSHA looks at what happens to the patient as well as inspecting the facility. Representative Yoh asked if a complication results from an abortion, is it reported to the patient's physician? Ms. Jarman replied that medical reports are forwarded to the patient's physician and patients report to their regular physician for follow up care.

The hearing on **HB 2323** was closed.

HB 2376 - Authority of relatives and custodians to authorize immunization of minors

Chairperson Mayans asked the committee to consider action on **HB 2376**.

Representative Freeborn moved that **HB 2376** be adversely reported. Representative Howell seconded the motion. In discussion, Representative Kirk opposed the motion, stating that we need to do everything possible to assist parents in being good parents. Representative Yoh asked why this bill should be reported adversely. Representative Freeborn replied that it establishes a state policy that family members do not have to be involved any more. Representative Merritt stated he sees some real danger from those wanting to second guess parents, and agreed with Representative Freeborn. A call of the motion was made. By voice vote, the committee voted that **HB 2376** be not passed.

The meeting was adjourned at 3:08 p.m.

The next meeting is scheduled for February 23, 1995.

HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST
FEBRUARY 22, 1995

NAME	REPRESENTING
MIKE FARMER	Rep. 87th District
Barbara Holzmark	NAT'L Council of Jewish Women
Vicky Harth	
Laurie Stearns	LWV of Kansas
Erika Fox	PLANNED PARENTHOOD of GKC
Sally Smith	Pro-Choice Action League
Nick Haines	KS Public Radio
Elaine Mann	LWVK
Barb Fisher	Planned Parenthood GKC
David Hanzlick	KS Dental Assn
Harold Riehm	KAOM
Stacey Empson	Hein, Ebert & Weir, Chtd.
GARY Robbins	Ks optometric Assn
[illegible]	[illegible]
Kay Mettner	NCJW
Rick Guthrie	Health Midwest
Jeanne Gill	self
Jeanne Gawdun	Kansans for Life
Gwendolyn Hooks Talbert	

HOUSE H&HS COMMITTEE
2-22-1995
Attachment 1-1

HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST
FEBRUARY 22, 1995

NAME	REPRESENTING
Eleanor Lowe	—
GREG RESER	KDHE
Joseph Kroll	KDHE
Peggy Jarman	PCAL
Sandy Strand	KINH
[illegible]	Tobacco Free Kansas Inc
[illegible]	[illegible]
Linda [illegible]	—
Aaron [illegible]	K.U. Pro-Choice Coalition
Sara Hupp	K.U. Pro-choice coalition
[illegible]	K.U. Pro-Choice Coalition

STATE OF KANSAS

MIKE FARMER
REPRESENTATIVE, 87TH DISTRICT
SEDGWICK COUNTY
1033 BLACKWILL
WICHITA, KANSAS 67207
(316) 682-0364

ROOM 174-W, CAPITOL BLDG.
TOPEKA, KANSAS 66612-1504
(913) 296-7681

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: APPROPRIATIONS
APPROPRIATIONS SOCIAL SERVICES SUBCOMMITTEE
APPROPRIATIONS K-12
SCHOOL FINANCE SUBCOMMITTEE

February 16, 1995
Health and Human Services Committee
Testimony on House Bill 2323

Mr. Chairman, members of the committee, it is a pleasure to be here this afternoon to testify on behalf of House Bill 2323.

This bill has a rather long history that I would like to recount to you in a very abbreviated form:

* Letter from Pat Turner requesting assistance (attached)
* Letter from Kansas Department of Health and Environment (attached)
* Events that led me here

Concerns:

* This is NOT a Pro-Life/Pro-Choice Issue . . .This only insures that a woman undergoing abortion is afforded the same care as any other individual.
* Cost of compliance to become licensed should not be an issue. How much is too much when we are talking about protecting the life of a woman undergoing this procedure?
* There has been a lot of rhetoric about safe abortions. If that is really a concern, then no one should oppose this bill.

Thank you, Mr. Chairman, I would be happy to stand for questions.

PAT TURNER
900 COUNTRY ACRES
WICHITA, KS 67212-3136
316/722-4726

January 30, 1994

Rep. Mike Farmer
House District 87
Room 112 S, Capitol Building
Topeka, KS 66612

Dear Mike:

It came to my attention that George Tiller, d/b/a Women's Health Care Services, P.A., 5107 E. Kellogg, Wichita KS, was applying for a change in zoning after acquiring some adjoining residential property. It was published that he is planning an expansion of his facilities. His business is commonly called a medical clinic and often an abortion clinic. It appears that it does fit the definition of a medical facility called an ambulatory surgical center.

Upon investigation it has been determined that the facility has never had, nor does it now have a medical facility license per KDHE requirement. **KSA 65-425** defines medical facilities. It was amended by SB 402 in the 1993 session. It still defines a facility like WHCS as an ambulatory surgical center. **65-426** states: **Purpose of act.** The purpose of this act is to provide for the development, establishment and enforcement of standards: (1) For the care and treatment of individuals in medical care facilities; and (2) for the construction, maintenance and operation of medical care facilities. **65-427. Licensure.** After July 1, 1973, no person or government unit, acting severally or jointly with any other person or governmental unit shall establish, conduct or maintain a medical care facility in this state without a license under this law.

It seems to me that a facility in which delicate surgery is performed on women on a very regular basis should be licensed under these statutes. Particularly at this time when an expansion is planned, it would seem appropriate that it be covered as stated in **KSA 65-426.** If the practitioner really cares for his patients, one would think he would want to abide by the KDHE rules.

I realize that you are a lawmaker, not law enforcement. But since this business is located in your District, I decided to write you about the situation. Perhaps the Governor needs to know that KDHE is not moving on these situations, even when reminded. I am very disappointed that this type of neglect exists. I will no doubt be contacting others regarding this situation. I would appreciate any attention you can give to this matter.

Sincerely,

Patricia A. Turner

Patricia A. Turner

2 - 2

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Robert C. Harder, *Secretary*

February 10, 1994

The Honorable Mike Farmer
State House of Representatives - District 87
State House, Room 112 - South
Inter-Office Mail

Dear Representative Farmer:

Thank you for giving me the opportunity to respond to the concern raised by Patricia Turner concerning Women's Health Care Services, Wichita.

K.S.A. 65-425, which defines medical facilities, states, "Nothing in this section shall be construed to require the office of a physician or physicians to be licensed under this act as an ambulatory surgical center."

Concerns that Women's Health Care Services was operating outside the scope of this statute were evaluated by Robert Eye, General Counsel for KDHE in 1992, and a determination made that Women's Health Care Services was exempt from licensure as an ambulatory surgical center.

Following passage of 1993 SB 402, which made certain amendments to K.S.A. 65-425, my legal office again evaluated the applicability of the statute to Women's Health Care Services and reconfirmed that Women's Health Care Services was not subject to licensure under that statute.

Thank you for bringing to my attention the concerns of Ms. Turner.

Sincerely,

Robert C. Harder
Secretary

RCH/JFK/lh

2 - 3

TESTIMONY OF PAT GOODSON, RIGHT TO LIFE OF KS
HB 2323 - FEBRUARY 22, 1995

We are appearing today in support of HB 2323 with the proviso that this bill does nothing more than the current statute which KDHE has refused to enforce. **Because of that refusal this attempt is being made to force the agency to do what it should already be doing;** require abortion surgery facilities to obtain a license. We would request that if it is the will of the committee to recomend this bill for passage **that the record clearly indicate such a legislative intent in order not to predjudice any future legal or administrative attempts to require the agency to enforce the terms of the existing statute** in regard to abortion clinics, should this bill not make it through the legislative process.

K.S.A. 65-427 requires the licensing of any "medical care facility" in this state. HB 2323 amends K.S.A. 65-425 which defines a medical care facility. These statutes first enacted in 1947 were amended in 1973 in response to a federal health planning act which has since been repealed. The purpose is stated in part in K.S.A. 65-426:

> "...(T)o provide for the development, establishment and **enforcement of standards...For the care and treatment of individuals in medical care facilities...."**

People are incredulous when they learn that the state is not licensing clinics where this serious surgery is performed. In decriminalizing abortion it was the intent of the legislature that abortions be performed in accredited hospitals. The hospital requirement was upheld as reasonable by a 1972 federal court.

If the need for oversight of abortion clinics is not obvious simply from the nature of the procedure then the committee should consider the record of abortionists in this state. George Tiller has had his license suspended while he sought treatment for substance abuse. Malcolm Knarr has been convicted of felony drug charges. His license was suspended after numerous allegations of incompetency and drug abuse, yet he still operates two abortion clinics. Robert Crist who is still licensed in Kansas and has a history of malpractice suits stemming from abortion has been under investigation in Texas in the death of a 17 year old abortion patient. An 18 year old abortion patient of Dennis Miller asphixiated under anesthetic while Miller continued the procedure unaware that she was choking. Miller who has one of the highest records of malpractice settlements in Kansas failed his medical exams 12 times. Yet, today we don't even have an oversight to ensure that there are some minimal standards of safety for unsuspecting women seeking an abortion.

As initially enacted the law defined an Ambulatory Surgical Center which would be required to obtain a license as a facility which has an organized staff of physicians operated primarily for the purpose of performing surgical procedures. **The agency's refusal to enforce the statute in the case of abortion surgical procedures is part of a bias in favor of abortion that dates to the 1950's when they officially worked to decriminalize abortion.**

We have documented KDHE's consistent disregard of this statute in a thick file beginning with the complaint of a citizen's council in Overland Park against Comprehensive Health Clinic in 1980. **We have summarized that history in the attached document which we believe shows clearly the arbitrary nature of the agency's refusal to enforce the law; a refusal which has made it necessary for this legislature to take valuable time from other issues.**

We have one other concern about what we feel is an ambiguity in drafting. The statute was amended, last year, I believe, at the request of surgery clinics to allow them to keep patients in the facility long enough to recover from the effects of an anesthetic. In agreeing to this request the legislature apparently wanted to ensure that a physician would be present in the facility as opposed to on call during that time. We wonder if a facility that is opposing licensing might not simply say that since we don't have a physician in the facility during that time, we do not fall under the definition of a facility that must be licensed. We would propose that that language simply be removed from the definition section and placed in a new section to make it clear that it is a requirement rather than a definition.

FAILURE OF KDHE TO ENFORCE PROVISIONS OF K.S.A. 65-425 & 427

1980 - Allowed Medical Center for Women a license even though they did not have a required agreement with a nearby hospital for emergency services.

1980 - In response to a complaint by a citizen council in Overland Park, KDHE maintained that Comprehensive Health did not require a license because their primary purpose was not surgery since they did more pap smears than abortions. This, despite the fact that the facility advertised in yellow pages all over for their abortion services. Later, they allowed Comprehensive Health to "inherit" the license of MCW, despite the fact that the law did not allow this.

1990 - After ignoring numerous complaints of Right To Life for years, concerning the unlicensed status of George Tiller who not only was performing surgery, advertising that he had a staff of physicians, but was keeping patients overnight with staff supervision for which he should have had a hospital license, KDHE requested a change in the law (1990 HB 2757) which would have permitted Tiller to circumvent the licensing requirement.

1992 - For over a year KDHE stalled on an investigation into the issue promised by the Governor. Our inquiries were met with repeated answers that the "investigation was ongoing". The only evidence of any investigation consists of a letter to Tiller and a response that only one physician "regularly" practiced at his facility. Apparently this time the agency was hanging its hat on the requirement of "one or more physicians" in the definition of an ASC.

1993 - Persistent requests by Right To Life of Kansas finally elicited a response from Secretary Harder that "a determination" had been made that Women's Health Care did not require a license. The agency however could provide no evidence of such a determination. **No paper trail of any kind was produced as the result of an open records request, that would show that the agency had ever made any such official determination, or made any notification of it to anyone**. Such a determination would of course have had to have specified some reason, a reason and a postion that we believe is indefensible.

1994 - Following a change in the multiple physician requirement, and another complaint by RTLK the agency now responded that the legislature did not intend to require licensing of abortion clinics, because they are considered "physicians' offices". Such a contention is ludicrous. The language excluding physicians' offices was a response to concerns of the Kansas Medical Society over possible government intrusion into normal private practice of a physician. That has been an ongoing concern since the statute was initially amended in 1973. I remember discussing with Jerry Slaughter an amendment to HB 2757 to address that concern.

The language of the statute clearly distinguishes an ASC from a physicians' office by the language of the definition of an ASC as a facility operated primarily for the purpose of performing surgery. **Clearly this is simply another circumvention of a biased agency in support of a business that seems to have attained the status of a favored industry which is not subject to restrictions and regulations that apply to everyone else in our state.**

Laura L. Malleck, L. P. N.
Testimony On House Bill No. 2323
February 22, 1995

Today, I stand before you as a licensed nurse. Having worked for seven years in the health care profession, mostly in geriatrics, I am aware of the numerous regulations which are required by the state. To discover that strict guidelines and periodic inspections do not apply to women's health care clinics where invasive procedures are performed daily is appalling. The extent to which the abortion industry in Kansas is unregulated makes it easily described as careless, makeshift, and sloppy.

Medical professionals, medical care facilities and hospitals across this state are required to meet and maintain certain regulations set forth by the Kansas Department of Health and Environment. Abortions are invasive, major surgical procedures. Common sense would tell us that sanitary conditions must be met to safeguard the health of the patient. ***Why*** do other surgical centers have to comply with licensing guidelines? They must do so to protect the patients who have entrusted them with their lives. Women who enter abortion clinics have entrusted their lives to the abortionists and are ***expecting*** to receive adequate medical care and they ***should*** receive adequate medical care.

The fact that abortion is major surgery cannot be disputed: Women have **died** from abortions. I do not consider abortion to be the right choice for a woman and her unborn child, but abortion takes place in this country 4,500 times a day and women should be able to enter sterile, safe environments to undergo surgery regardless of the nature of the operation. Abortion clinics **do** perform major surgery, they **must adhere** to certain guidelines, and **must be licensed** and **inspected.**

Thank you.

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Abilene
Atchison
Arkansas City
Augusta
Barber County
Brown County
Chanute
Chase County
Cheyenne County
Clay Center
Coffeyville
Colby
Coldwater
Columbus
Concordia
Copeland
Council Grove
Decatur County
Dodge City
Doniphan County
Edwards County
El Dorado
Elk County
Emporia
Erie
Fort Scott
Franklin County
Garden City
Girard
Great Bend
Hamilton County
Hanover
Harper County
Harvey County
Herington
Hugoton
Hutchinson
Independence
Iola
Jackson County
Johnson County
Kingman
Kiowa County
Larned
Lawrence
Leavenworth
Liberal
Linn County
Manhattan
Marion
McPherson
Miami County
Miltonvale
Norton
Olathe
Osage County
Osborne
Ottawa County
Parsons
Phillips County
Pittsburg
Pratt
Republic County
Rose Hill
St. Paul
Salina
Scott City
West Sedgwick County
Smith County
Sublette
Topeka
Ulysses
West Washington County
Wellington
Wichita
Wilson County
Wyandotte County

Colleges &
Universitites

(12) Chapters

Kansans for Life

3202 W. 13th St., Suite 5
Wichita, Kansas 67203
(316) 945-9291 or 1-800-928-LIFE or FAX (316) 945-4828

February 22, 1995

Mister Chairman and Members of the Committee,

Kansans for Life, the state's largest pro-life organization, supports House Bill 2323. This bill is not about abortion--it is about women's health and the duty of the state to assure that all women undergoing surgical procedures, whether they be hernia operations or abortions, do so in facilities that are properly licensed and reasonably regulated.

A woman entering a respectable suburban abortion clinic would assume that the facility is well-equipped and staffed to handle any medical complications that may arise as a result of the abortion procedure or the use of anesthesia as would be the case were she going into the same-day surgery clinic down the street for a hernia repair. Unfortunately, that is not the case in the state of Kansas. No such assurance exists because abortion facilities are not licensed by the state.

Women are being denied the protection which reasonable regulation provides because of the type of procedure being done. Abortion has been politicized to the extent that women's health is suffering. Let's look at just one example, here in Kansas, as reported May 10, 1988 in the Kansas City Times and June 3, 1990 in the Kansas City Star. It's a tragic story of a mother who confidently brought her 18 year old daughter Erna Mae Fisher to abortionist Dr. Dennis W. MIller in his respectable Kansas City offices. (See attached article.)

During the abortion, Erna Mae aspirated on her own vomit, a consequence of her not having an empty stomach before being anesthetized. Miller proceeded with the abortion, seemingly unaware of the emergency. After some time had elapsed, he called 911 but was unable to assist her, even with CPR. With her mother holding her hand, Erna Mae died on the table in the office of the flustered, incompetent Miller.

HOUSE H&HS COMMITTEE
2 -22 - 1995
Attachment 5-1

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Afi

Abilene
Atchison
Arkansas City
Augusta
Barber County
Brown County
Chanute
Chase County
Cheyenne County
Clay Center
Coffeyville
Colby
Coldwater
Columbus
Concordia
Copeland
Council Grove
Decatur County
Dodge City
Doniphan County
Edwards County
El Dorado
Elk County
Emporia
Erie
Fort Scott
Franklin County
Garden City
Girard
Great Bend
Hamilton County
Hanover
Harper County
Harvey County
Herington
Hugoton
Hutchinson
Independence
Iola
Jackson County
Johnson County
Kingman
Kiowa County
Larned
Lawrence
Leavenworth
Liberal
Linn County
Manhattan
Marion
McPherson
Miami County
Miltonvale
Norton
Olathe
Osage County
Osborne
Ottawa County
Parsons
Phillips County
Pittsburg
Pratt
Republic County
Rose Hill
St. Paul
Salina
Scott City
West Sedgwick County
Smith County
Sublette
Topeka
Ulysses
West Washington County
Wellington
Wichita
Wilson County
Wyandotte County

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Kansans for Life

3202 W. 13th St., Suite 5
Wichita, Kansas 67203
(316) 945-9291 or 1-800-928-LIFE or FAX (316) 945-4828

This was no "back alley" practitioner: Miller was head of Obstetrics at Providence-St. Margaret's Hospital! Like most of his clients, Erna Mae and her mother didn't know that he had flunked his medical exams 11 times before passing. Nor would they have suspected that Miller had settled 6 malpractice lawsuits at an expense of over 1 million dollars to the state of Kansas. And Erna Mae's mother was most certainly horrified to witness Miller's pathetic inability to recognize her daughter's medical emergency, let alone correct it.

Miller still practices today. His only punishment (deemed "severe" by the Kansas State Board of Healing Arts) was that he could not use his office for 1 year. He was not suspended, just not allowed to abort at that location. Has Miller improved the resuscitative setup for his abortions? Who knows?

The PDR (Physicians Desk Reference) absolutely requires resuscitative equipment and specific resuscitative training of attendant staff whenever anesthesia is administered. Because Erna Mae was getting an abortion rather than having a hernia repaired, she was denied the safety of an inspected and regulated surgical center. This is a gross violation of medical safety that has been held hostage too long by politics. What excuse can you offer Erna Mae's mother?

Most people don't know that they may be in danger of resuscitative complications from anesthesia. Most people assume that respectable doctors comply with state supervision. Most people have no idea that the abortion industry continually fights to stay excluded from the most reasonable inspection and regulations.

Like most people, Erna Mae and her mother believed the rhetoric of safe and legal...and they paid a dear price.

I urge the committee to approve House Bill 2323 favorable for passage.

Jeanne L. Gawdun

Safe and Legal Abortion in Kansas

by James A. Miller

Erna Fisher had a serious problem. She was just 18 years old and was about 18 weeks pregnant out-of-wedlock.

Erna went to her mother, and the decision to have an abortion was made. One of those nice, safe, legal ones that we're always hearing about. That would solve the "problem."

The abortionist, Dr. Dennis W. Miller, came highly recommended. After all, he was the chairman of the obstetrics department at Providence-St. Margaret Health Center, a Catholic hospital (!) in Kansas City, Kansas.

And so, on the afternoon of March 30, 1988, Erna entered Dr. Miller's private office — not at the hospital — for her abortion. Within minutes the operation suddenly turned fatal. According to Fisher's mother, who held her daughter's hand during the operation because Erna was frightened, Erna suddenly jerked upright and then went rigid.

Dr. Miller continued removing fetal parts, unaware that his patient had vomited and was, in fact, choking to death. Later, in a sworn deposition for the wrongful death malpractice suit filed in this case, Miller admitted that he had given Erna a painkiller which he knew could cause vomiting, and yet he had never asked the teenager whether she had eaten beforehand. Moreover, during the operation, and afterward while waiting for an ambulance, Miller did not check Erna's airway or give her any oxygen.

The responding ambulance paramedic found Miller cradling Fisher in his arms. "He wasn't doing CPR or anything," said the paramedic, who estimated Fisher had not breathed for up to eight minutes. In a deposition, Miller himself estimated that three to five minutes passed between the time Fisher showed signs of distress and the time the ambulance arrived. Since the ambulance was located "just down the street" from Miller's office, and took "about 90 seconds" to arrive, Miller's own account indicates that he failed to summon aid in a timely fashion in addition to not rendering any meaningful assistance himself.

Erna Fisher was DOA — dead on arrival — at a nearby hospital. Abortionist Miller, denying any liability, settled with Fisher's heirs for $475,000, according to court records.[1]

Twelve Attempts to Pass Medical Exam

Despite his chairmanship of the obstetrics department of a leading Kansas City hospital, and his status as an "approved physician" for 12 area group health plans, Miller's medical career was anything but auspicious. In fact, abortionist Miller was unable to pass the basic state medical licensing exams until at least his *twelfth* try! Miller failed the test in Missouri three times before giving up and going to Kansas, where he finally passed the exam on his *ninth* attempt in that state. Miller later took two exams to become board-certified in obstetrics/gynecology, a designation from his medical peers that he "possesses special knowledge and professional capability" in the field. Miller failed both times.

Malpractice Suits

Miller has had extensive malpractice problems, begining early in his career while he was still in residency. A 1977 sterilization in which Miller assisted resulted in a woman's needing to have 30 inches of her intestine removed; her bowel suffered "multiple burns and perforation." The resulting lawsuit against Miller, two other physicians, and the hospital involved, was settled out of court for an undisclosed sum.

Malpractice suits have continued to dog Miller's career. The *Kansas City Star* found that, in a two and one-half year period from 1987 to mid-1990, Miller settled no less than six malpractice lawsuits.[2] Five of the claims, including Erna Fisher's, totaled $3.4 million and one settlement was undisclosed.

Miller punctured a woman's cervix during a 1985 abortion, but when she returned with complaints of infection and pain, Miller "said there was nothing wrong with [the patient]." New doctors had to hospitalize the woman and remove fetal tissue that Miller had missed. That case was settled for $75,000.

Another 1985 abortion procedure — subsequent tests disclosed the woman wasn't even pregnant — followed by a sterilization, resulted in a bowel perforation. Infection from the perforation led to the removal of some three feet of intestine, a hysterectomy, and a devastated personal life, including a divorce. "No amount of money can make up for that," said the woman, who settled for $200,000.

In a deposition in that case, Miller was asked if he had now changed any of his procedures since the operation. "I wouldn't do anything different," Miller replied.

Miller paid $450,000 to settle his role in the death of a 21-year-old pregnant woman suffering from a severe kidney infection, which Miller misdiagnosed and treated perfunctorily. Prior to her

[1] This article is based on stories appearing in the *Kansas City Star* and the *Topeka Capital-Journal* (June 4, 1990) and on conversations with two attorneys who successfully sued Miller.

[2] June 3, 1990, p. A1.

"Safe and Legal"
from page 5

"slowly suffocat[ing] to death," the woman developed septic shock, a bloodstream infection, respiratory distress, and had eleven separate surgical procedures, including removal of a dead fetus and part of her lung.

A mistreated pregnancy and botched birth case was settled for $2.2 million by Miller and two partners with whom he was practicing. That money will be needed to provide lifetime care for a severely retarded and physically disabled youngster who was deprived of oxygen during a preventable premature birth.

In open court testimony regarding this case, Miller, to the amazement of those in the courtroom, admitted that he probably hadn't done part of an essential examination of the pregnant mother and that "he and his two partners failed to provide the appropriate standard of care." "You won't find many malpractice cases where a physician admits on the stand that he departed from the appropriate standard of care," said the opposing attorney.

Disciplinary Action

The Kansas State Board of Healing Arts reviewed the Erna Fisher case and reached an agreement with Miller that he was not to perform abortions in his office. This was the sole disciplinary action taken against Miller! The agreement, which did not find that Miller had departed from accepted standards of medical care, allowed Miller to continue doing abortions elsewhere and to resume doing abortions in his own office after the lapse of one year.

The executive director of the Kansas board termed the "limits" on Miller "relatively harsh" and "a significant blow to a doctor's practice." Did the reader hear someone's wrist being slapped?

Catholic Hospital Affiliation

Despite Miller's appalling record, for more than two years after Erna Fisher's death he remained "a member of the staff in good standing" at the Catholic hospital Providence - St. Margaret Health Center. That status ended only after the newspaper stories about Miller began to appear. He was quickly eased out of the hospital and allowed to "resign."

But how could anyone with a record like Miller's have been granted privileges at a Catholic hospital in the first place, much less made chairman of the ob/gyn department? Even a cursory examination of Miller's background should have disclosed his medical ineptitude and his malpractice misadventures. And what about his abortion and sterilization business? According to court depositions, Miller had performed "more than 8,000 abortions" in his career through mid 1989. Even if those activities were conducted entirely apart from the hospital, how could a Catholic institution tolerate an active abortionist on its staff?

Indeed, Miller was retained as ob/gyn chairman even after he landed the hospital in a malpractice case involving the death at Providence - St. Margaret of the pregnant woman with the misdiagnosed kidney infection (mentioned above). The Emergency Room Physicians' Corporation at the hospital settled their part of the case for $375,000.

Providence — St. Margaret Health Center, whose roots date back more than 100 years through the old Providence Hospital, is run by the Sisters of Charity of Leavenworth, Kansas. The order, founded in 1858, operates nine hospitals in five states.

Still in Business

Medical directories and Kansas City telephone listings indicate that abortionist Dennis W. Miller is still in business in Kansas City at this writing. The Director of the local abortuary, C[illegible]ehensive Health for Women, [illegible]n has employed Miller since the early 1980s, describes him as "provid-[ing] excellent abortion services and . . . very good [at his work.]" A recent telephone call to Miller's office verified that the abortionist is still doing "procedures" at that ironically named clinic.

KANSAS CITY STAR

A Kansas doctor's medical mishaps

SUNDAY, June 3, 1990

Physician's history includes several lawsuits.

By BILL DALTON
Special Projects

Erna Fisher was 18 years old, 18 weeks pregnant and already a mother when she anxiously stepped into Dr. Dennis W. Miller's office for an abortion the afternoon of March 30, 1988.

Within minutes, the operation turned fatal. Fisher's mother — who held her daughter's hand because Erna was frightened — said Erna jerked upright, then went rigid, apparently from a seizure. A medical assistant ran for smelling salts.

Miller continued removing tissue, unaware that his patient had vomited and was choking to death. Later, Miller acknowledged he had prescribed a painkiller he knew could cause vomiting. He admitted not asking the young woman whether she had eaten. During the operation and afterward, while waiting for an ambulance, he did not check her airway or offer her oxygen.

"Since I didn't realize what was going on, I don't think it would have made any difference," Miller

See **DOCTOR, A-16,** Col. 1

Continued from A-1

stated later in a sworn deposition.

Miller settled with Fisher's heirs last December for $475,000, according to court records. He denied any liability, which malpractice lawyers said is routine.

Other patients in Miller's care have suffered serious complications. *The Kansas City Star* found that since 1987, Miller has settled six malpractice lawsuits, with five claims totaling nearly $2 million. The other settlement was not disclosed.

Miller

Public records and Miller's own depositions reveal a series of medical mishaps by the doctor, who flunked state licensing exams at least eight times.

To be sure, a few other Kansas doctors have had more malpractice claims filed against them and some have had bigger individual judgments. But some medical malpractice experts said Miller's recent track record is beyond the norm, and Kansas insurance records support those assertions.

Thomas E. Sullivan, an Overland Park lawyer who represented patients who have sued Miller, said, "He's not typical in terms of the number of claims or in terms of real serious cases."

"Six or seven lawsuits and settlements for $2 million would be greater than average," said Homer Cowan, administrator of a state insurance plan for Miller and other doctors who often are considered such high risks they cannot buy malpractice coverage from private companies.

Kansas insurance records show a state-run fund will pay more than $1 million of the claims for Miller. He is one of only three practicing Kansas doctors who have had claims against the fund exceeding $1 million. Two others with claims exceeding $1 million faced disciplinary action and no longer practice medicine, officials said.

Miller, 41, continues to practice medicine at his office in Kansas City, Kan., and at Comprehensive Health for Women in Overland Park.

He declined to comment for this story or respond to written questions.

Certainly Miller is in a risky profession. The American Medical Association says obstetrician-gynecologists are among the most likely physicians to be sued, with 15.1 claims for every 100 doctors, according to 1988 statistics, the last year numbers were available. The AMA does not know the outcome of those claims.

But monetary settlements do not ease the pain suffered by some of Miller's patients, such as a 33-year-old Kansas City woman who asked not to be identified.

Her attorney said she settled for $200,000 in 1988 after an infection from a sterilization operation led to a hysterectomy, removal of 36 inches of intestine and a devastated personal life.

"No money can make up for that," she said.

Failed exams

Despite graduating in 1975 from Meharry Medical College in Nashville, Tenn., Miller had to stop practicing medicine between June 1981 and February 1982 because he couldn't pass licensing exams in Kansas and Missouri.

In a deposition, Miller explained his test trouble "was in basic science."

He failed the test in Missouri three times before giving up, he said. Miller passed the test in Kansas in December 1981, on his ninth attempt.

"Good grief," said Dr. William Cameron, vice chairman of the department of gynecology and obstetrics at the University of Kansas Medical Center.

"The overwhelming majority of physicians pass the first time. I would think that would be most unusual. It may even be a record," Cameron said.

No limit is set on the number of times a doctor can take the test in Kansas. Richard Gannon, executive director of the Kansas State Board of Healing Arts, which regulates health care professionals, said a few doctors had taken the exam as many as six times. But they were what he termed "foreign" and may have had language difficulties.

In depositions, Miller said he also took tests two times in the early 1980s to become board-certified in obstetrics-gynecology, signifying an expertise in that field.

He failed both times.

Yet Miller apparently has been held in high regard at area hospitals. In 1988 he served as chairman of the obstetrics department at Providence-St. Margaret Health Center, hospital officials said.

"He's a member of the staff in good standing at this moment," said Executive Director James O'Connell. O'Connell said Miller's duties as chairman of the department were primarily administrative and had "little to do with direct medical practice."

Miller has stated he also was on the medical education committee at Bethany Medical Center and an approved physician for 12 area group health plans.

Apparently Miller does not lack patients. In a 1987 deposition, he said he delivered 100 to 150 babies a year and had done about 400 to 500 hysterectomies.

Miller said about 40 percent of his practice was abortions, estimating he has performed more than 8,000 in his career.

"We have a lot of confidence in him. He knows how to provide excellent abortion services and is very good," said Adele Hughey, director of Comprehensive Health for Women. She said Miller has practiced at the clinic since the early 1980s.

Miller's legal troubles started early in his career. He was sued while in residency at Truman Medical Center between 1975 and 1979. Jackson County Circuit Court records show Miller assisted in a 1977 sterilization in which a woman's bowel suffered "multiple burns and perforation" during the procedure. She required removal of 30 inches of intestine.

The suit against the hospital, two other physicians and Miller was settled in 1981 for an undisclosed amount.

Inadequate care

Leon Taylor, 10, will struggle the rest of his life. Lack of oxygen at birth left the Kansas City, Kan.,

Doctor has settled six malpractice lawsuits since 1987

Dr. Miller is "not typical in terms of the number of claims or in terms of real serious cases."

— Thomas E. Sullivan, an Overland Park lawyer

Continued from A-1

boy severely retarded and with physical disabilities.

"It was absolutely preventable," said Sullivan, the attorney who represented Leon and his mother, Carmona Ellis.

Leon was born prematurely because his mother has an incompetent, or weak, cervix, a part of the uterus. Medical experts say a common procedure — tying a "ribbon" around the cervix to strengthen it — probably would have prevented the premature birth.

In his deposition and in court testimony, Miller agreed. He also acknowledged failing to examine the cervix regularly, to treat Carmona's anemia, to treat a possible urinary tract infection or to stop her from taking a drug suspected of causing birth defects prescribed by another doctor.

Miller didn't deliver Leon, but he signed charts showing he had examined Carmona before the delivery. In court testimony last October, however, Miller acknowledged he probably hadn't done part of the examination.

In fact, Miller testified that he and his two partners failed to provide the appropriate standard of medical care.

"You won't find many malpractice cases where a physician admits on the stand that he departed from the appropriate standard of care," said Sullivan, who is a governor of the American Trial Lawyers Association.

Miller, as well as the two partners with whom he was practicing when Leon was born, settled for $2.2 million, records show. The state fund paid $533,333 on Miller's behalf.

The money will be needed to care for Leon, who already has had several operations. Sullivan said experts believe Leon will have a mental capacity no greater than a 7-year-old.

Carmona's first child also was born prematurely and died. Leon, who weighed only 2 pounds, 7 ounces, "was so little, I thought he was going to die, too," she said.

He will be her last child. "I had my tubes tied because I didn't want to go through this again," she said

More settlements

A lawyer for Lisa Allen's heirs described Allen's last days as ones in which she "slowly suffocated to death."

Allen came to Miller in September 1986 complaining of back pain. When a test found protein in her urine, Miller said in a deposition, he assumed that it was because of a possible pregnancy, but he didn't investigate other causes.

About a week later, pain forced Allen into the emergency room at Providence-St. Margaret Health Center. Later, a hospital doctor diagnosed a severe kidney infection; Allen ended up in intensive care.

Allen developed septic shock, a bacterial bloodstream infection, and then adult respiratory distress syndrome. She underwent 11 surgical procedures, court records show, including removal of parts of her lung and a dead fetus.

Allen, 21, died Oct. 16, 1986. Her heirs sued Miller and an emergency room physician corporation for not promptly diagnosing and treating her illness.

The case was to go to trial in April, but lawyers said Miller settled for $450,000 and the emergency room physicians' corporation settled for $375,000.

Two Kansas City women sued Miller for problems after surgical procedures. Both women, who had abortions, asked not to be identified.

In the first case, Miller performed an abortion in his office in 1985.

"He was fast and it hurt," his patient recalled.

She developed an infection and went to other doctors. They found a punctured cervix, she said, and advised her to see Miller again.

"He said there was nothing wrong with me."

Her new doctors put her in the hospital, her attorney said, and then had to remove fetal material Miller had missed. Miller settled for $75,000, her attorney said.

The other woman alleged in a lawsuit that Miller perforated her bowel during a sterilization, also in 1985.

Before the sterilization, Miller performed an abortion procedure on the woman, based in part on a positive pregnancy test. Because so little tissue was removed, Miller cautioned she still might be pregnant.

Miller, however, acknowledged in a deposition that he didn't perform other procedures, including a sonogram, to confirm the pregnancy. Tests later showed she wasn't pregnant.

An infection from the perforation led to removal of about 36 inches of the woman's intestine and a hysterectomy. Phil Cartmell Jr., the woman's attorney, said the perforation occurred because the bowel was attached or too near one of the woman's fallopian tubes for it to be safely sealed off.

"When he saw the tube was not clear he should have canceled the procedure," Cartmell said.

The woman settled in 1988 for $200,000, according to Cartmell. Miller, who denied responsibility, paid most of the claim, Cartmell said, and other doctors who treated the infection also paid part for allegedly not acting quickly enough.

"I had a whole different life before this," the woman said. Her husband divorced her because "he couldn't put up with me being ill so frequently," she said.

"I'm amazed that the man is still in practice," she said. "I don't think people's lives should be in his hands."

In a deposition, Cartmell asked Miller whether he had changed any of his procedures since operating on the woman.

"I wouldn't do anything different," Miller responded.

Disciplinary action

Asked to respond to some of the newspaper's findings, Gannon said the state Board of Healing Arts "may need to have another look at Dr. Miller."

"Right now I can't respond because it's all new information to me," Gannon said.

The only board action against Miller came in December 1988, after a review of the Erna Fisher case "revealed matters that, in the opinion of Disciplinary Counsel, could result in the revocation, suspension, or limitation" of Miller's license.

The disciplinary counsel's review was not public. But court records in the Fisher case painted a chilling picture. Dr. Ralston R. Hannas Jr., a doctor serving as an expert witness for the plaintiff said no second trimester abortion should ever be performed in a doctor's office. And Hannas agreed that Miller was grossly negligent for not discovering Fisher's obstructed airway.

"We're all taught the ABCs, Airway, breathing, circulation and shock," Hannas said.

Michael Weckwerth, an ambulance paramedic, said he found Miller cradling Fisher in his arms. "He (Miller) wasn't doing CPR or anything," Weckwerth said in an interview.

The paramedic said it took the ambulance about 90 seconds to reach Miller's office, just down the street. He estimated Fisher hadn't breathed for up to eight minutes. In a deposition, Miller estimated three to five minutes passed between the time Fisher showed signs of distress and the ambulance arrived.

But if lifesaving efforts had been under way "it definitely would have helped," Weckwerth said. "If he had called us when she seized we might have been able to save her."

State Board of Healing Arts records show Miller avoided a formal hearing on the case by agreeing not to perform abortions in his office. The agreement stopped short of finding that Miller departed from any standards of medical care, something Miller denied.

It also allowed Miller to continue doing abortions in licensed health care facilities and to resume abortions in his office in one year.

Gannon said the state board's limits on Miller were "relatively harsh" and "a significant blow to a doctor's practice."

But in a sworn affadavit, Miller said he had already stopped doing abortions at his office the day after Fisher died — eight months before the board's prohibition. Miller continued, however, doing thousands of abortions at Comprehensive Health.

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February 21, 1995

Kansas House of Representatives
Capitol Building
Topeka, Kansas 66612

RE: House Bill #2323

Dear Sir/Madame:

This is a letter in support for House Bill #2323 which would require medical offices that are involved in the induced termination of human pregnancy come under the same regulation as ambulatory centers. Ambulatory surgical centers, such as the one in Topeka, are highly regulated by the State. I know that they are personally intensively reviewed regarding the training and accreditation of their medical staff, both physicians and nurses. The quality of care given and the record keeping are also closely monitored. Credentialing done prior to appointment is reviewed to see that they meet the approved standards. The physical plant is examined including such things as recovery space, OR rooms, and air turnover. Attention is given to how the OSHA standards for blood borne pathogens is scrutinized and drug usage.

It is my understanding that general anesthesia is used during the induced termination of pregnancy. Termination of second and third trimester pregnancies is a very invasive procedure and has potential for significant complications, especially related to blood loss. It would seem reasonable to me for the State to require these offices or clinics to meet the same standards as ambulatory surgery centers. I do not think it is unreasonable to ask that a woman who seeks an abortion be treated in a safe and humane manner.

Thank you for your attention to this matter.

Sincerely yours,

Robert T. McElroy, M.D.

RTM/das

HOUSE H&HS COMMITTEE
2-22-1995
Attachment 6-1

Appendix L

Interpretive Guidelines and
Survey Procedures - Ambulatory Surgical Services

Standard	Interpretive Guideline	Survey Procedures
416.2 Definitions As used in this part;		
"Ambulatory surgical center" or "ASC" means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with HCFA under Medicare to participate as an ASC, and meets the the conditions set forth in Subpart B of this part.	The space constituting the ASC must be exclusively used for ambulatory surgery or directly related activities. o The ASC is not required to be in a building separate from other health care activities (e.g., hospital, clinic, physician's office, etc.) It must, however, be separated physically by (at least) semi-permanent walls and doors. o The regulatory definition of an ASC precludes the ASC and another entity from mixing functions and operations in a common space during concurrent or overlapping hours of operation. Another entity may share common space only if the space is never used during the scheduled hours of ASC operation. The operating and recovery rooms, however, must be used exclusively for surgical procedures. ASC staffing and recordkeeping must be separate and exclusive. For example, a nurse could not provide coverage in the ASC and in an adjacent clinic (or hospital) at the same time.	Verify, through onsite inspection and review of records, staffing patterns, etc., that the facility is a distinct entity, providing only surgical and directly related (e.g., routine lab) services to patients not requiring an inpatient stay in a hospital. Physicians may not see non-surgical patients in the ASC. Confirm that in ASCs sharing space, the equipment and supplies necessary for ASC operation are maintained by the ASC.
416.40 Condition for Coverage- Compliance with State licensure law.		
The ASC must comply with State licensure requirements.	If the facility is subject to State licensure, it must be licensed in order to be able to be eligible to participate in Medicare. In this instance, if the State license is is revoked, the ASC would be out of compliance with this condition and this may result in termination.	In States where licensure is required for facilities providing ambulatory surgical services, verify that the facility has a current license.

REGULATIONS	INTERPRETIVE GUIDELINES	SURVEY PROCEDURES
		If the facility provides directly for all radiological services, they must be Medicare approved. To be Medicare approved apply the Condition of Participation for hospitals (482.26) radiology department or Condition for Coverage of portable x-ray services 405.1141-405.1416. If the services are operated for other than patients of the ASC, the Center could not be certified as an ASC. (See section 416.2 Definition.) When the ASC fails to meet either the radiology requirements for hospitals or portable x-ray, then all services must be obtained from a Medicare approved facility.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987—181-270/60171

Standard	Interpretive Guideline	Survey Procedures
The ASC must have a written transfer agreement with such a hospital, or all physicians performing surgery in the ASC must have admitting privileges at such a hospital.		
416.42 Condition for coverage - Surgical Service Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC.	"In a safe manner" encompasses: o building and equipment safety (e.g., equipment calibration), o functional safety (e.g., following aseptic techniques), and o appropriate training of OR support personnel.	Observe the operating suite(s) to determine: - The adequacy of equipment and the facility, based on the type and volume of surgery performed. The equipment and supplies should be sufficient so that the type of surgery conducted can be performed in a manner that will not endanger the health and safety of patients. - That access to the operative and recovery area is limited. - The conformance to aseptic technique by all individuals in the surgical area. - Evidence of appropriate cleaning between surgical cases. - That operating room attire is suitable for the kind of surgical cases performed. Persons working in the operating suite must wear clean surgical costumes, in lieu of their ordinary clothing. Surgical costumes should be designed for maximum skin and hair coverage. - That suitable equipment is available for rapid and routine sterilization of operating room materials. - That sterilized materials are packaged, labeled, and stored in a manner to ensure sterility and that each item is marked with the expiration date.

Standard	Interpretive Guideline	Survey Procedures
	Where a State has no applicable licensure requirements, or where ambulatory surgical services may be provided without licensure, a facility will be eligible if it meets the definition in Section 416.2 and all other applicable Medicare requirements.	
416.41 Condition for coverage - Governing body and management. The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation and for ensuring that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.	The ASC must have a designated governing body that demonstrates its oversight of ASC activities by issuing, monitoring, and enforcing policies intended to protect the health and safety of patients. o An individual may act as the governing body in the case of sole-ownership, absentee ownership, or in other special cases. o Responsibilities may be formally delegated to administrative, medical, or other personnel for carrying out various activities. However, the governing body must retain ultimate responsibility. The ASC must establish and carry out activities that will ensure that contracted services are provided in a safe manner. This may include periodic personal inspections, reporting mechanisms, or other well-defined activities appropriate to the situation.	Review charter or titles of incorporation, bylaws, partnership agreements to determine that full legal responsibility has been established. Examine records and policies and interview personnel to determine whether the governing body (or individual) is exercising its authority and satisfying its responsibilities. Look specifically for evidence of policy implementation and monitoring of performance. Request records demonstrating the oversight of contracted services (e.g., contracts, minutes indicating approval of all contracts, periodic evaluation reports).
Standard: Hospitalization. The ASC must have an effective procedure for the immediate transfer to a hospital, of patients requiring emergency medical care beyond the capabilities of the ASC. This hospital must be a local, Medicare participating hospital or a local, nonparticipating hospital that meets the requirements for payment for emergency services under 405.1011 of this chapter.	An "effective procedure" encompasses: o written guidelines (e.g., policies and/or procedures), o arrangement for ambulance services, and o transfer of medical information.	Request documentation of a transfer agreement or evidence of admitting privileges. - Review policies and procedures for the transfer of patients requiring emergency care. - Interview appropriate personnel to determine if they are aware of transfer procedures.

Standard	Interpretive Guideline	Survey Procedures
(b) Standard: Administration of Anesthesia. Anesthetics must be administered by only: 1. A qualified anesthesiologist; or 2. A physician qualified to administer anesthesia, a certified registered nurse anesthestist, a supervised trainee in an approved educational program, or an anesthesia assistant. In those cases where a non-physician administers the anesthesia, the anesthestist must be under the supervision of the operating physician. Anesthesia assistants must have successfully completed a four year educational program for physicians' assistants that includes two years of specialized academic and clinical training in anesthesia.	For non-physician anesthetist, an approved educational program is a formal training program leading to licensure or certification in anesthesia recognized by the State. Supervision, in this instance, does not refer to administration or management of all anesthesia services, but to medical oversight of anesthesia care during surgery.	(b) The ASC delineates those persons qualified to administer anesthesia. Review the credentials of persons approved by the ASC to administer anesthesia to determine if anesthesia is administered by only: . a qualified anesthesiologist . a physician qualified to administer anesthesia . a CRNA . an anesthesia assistant . a supervised trainee in an approved educational program
(c) Standard: Discharge. All patients are discharged in the company of a responsible adult, except those exempted by the attending physician.		(c) The surveyor should review discharge procedures and interview staff to confirm that patients are accompanied by an adult at discharge. Any exceptions to this requirement must be made by the attending physician.
416.43 Condition for coverage - Evaluation of quality. The ASC, with the active participation of the medical staff, must conduct an ongoing, comprehensive self-assessment of the quality of care provided, including medical necessity of procedures performed and appropriateness of care, and use findings, when appropriate, in the revision of center policies and consideration of clinical privileges.	There is evidence of a well-defined, organized program designed to enhance patient care through the ongoing objective assessment of important aspects of patient care and the resolution of identified problems. Participation of the Medical Staff There should be some evidence of assessment of professional services by practitioners. The necessary review can be accomplished by a specified member(s) of the medical staff or by the staff as a group.	The requirement that there be a functioning program that assesses the quality of patient care is one of the most important conditions to be surveyed, yet it is one of the most difficult for the surveyor. The requirement is important, because a facility that controls the quality of care on an ongoing basis can be expected to provide high quality of care. The difficulty in surveying this particular condition is that the surveyor must at all

Standard	Interpretive Guideline	Survey Procedures
(a) Standard: Anesthetic risk and evaluation. A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Before discharge from the ASC, each patient must be evaluated by a physician for proper anesthesia recovery.		Review policies and procedures to ascertain whether they contain, at a minimum: - Resuscitative techniques. - Aseptic technique and scrub procedures. - Care of surgical specimens. - Appropriate protocols for all surgical procedures performed. These may be procedure specific or general in nature and will include a list of equipment, materials, and supplies necessary to properly carry out job assignments. - Procedures addressing the cleaning of operating room after each use. - Sterilization and disinfection procedures. - Acceptable operating room attire. - Care of anesthesia equipment. - Special provision for infected or contaminated patients. (a) Review the medical record to confirm: - The existence of an evaluation by a physician prior to surgical intervention. If laboratory studies were ordered as part of the patient evaluation, the report should be a part of the medical record or notation of the findings recorded on the chart. For general anesthesia the evaluation should contain, at a minimum, a brief note regarding the heart and lung findings the day of surgery. - That a physician evaluated patient's condition at time of discharge. Depending on the type of anesthesia and length of surgery, the post operative check should include some or all of the following: . level of activity . respirations . blood pressure . level of consciousness . patient color

Standard	Interpretive Guideline	Survey Procedures
	Comprehensive To be considered comprehensive, the self-assessment should take into consideration medical necessity as it relates to the condition of patients. At least on a random sampling basis, the ASC should review all information in patients' records (e.g., history and physical, lab reports, x-ray findings, EKG reports, etc.) and review final decisions to operate. Evaluation of appropriateness of care should include analysis of: o anesthesia recovery, o infection rates, o pathology reports, o nursing services, o completeness of medical records, and o any complications that have occurred.	Ascertain that the program is comprehensive by review of the plan, by discussion of activity with staff personnel, and by review of minutes and documentation of the studies performed to ensure that they encompass all types of personnel performance and all types of procedures performed in the ASC. Use a wide variety of sources to determine that the QA program is identifying potential problems and making an assessment of the problems. In addition to the above sources, interview staff personnel and patients, review medical records or other documentation such as incident reports, and infection control records that reflect direct patient care. There should be sufficient data in the medical records to support the diagnosis and determine that the procedures are appropriate to the diagnosis. The methods used for the facility self assessment may be very flexible and there may be a wide variety of assessment techniques used. The assessment may look at the structure, process, or outcome of care, and care may be assessed prospectively, concurrently, or retrospectively.
	Revision of Center Policies & Consideration of Privileges Where problems (or potential problems) are identified following the above analysis, ASCs should act as soon as possible to avoid any risk to patients. Examples of appropriate action include: o changes in policies and procedures o staffing and assignment changes o appropriate education and training o adjustments in clinical privileges o changes in equipment or physical plant.	Determine, through discussion with administrator or staff person responsible for the QA program, that actions have been taken to resolve problems and that there is continuing monitoring to assure that actions taken have resolved the problem. Ascertain that the facility has a mechanism for evaluation of the QA program and that there is periodic reappraisal of the program.

Standard	Interpretive Guideline	Survey Procedures
		times be aware that it is compliance with the condition that is being surveyed. In assessing the QA program, the surveyor becomes privy to information about the problems the facility is encountering in patient care; to make use of this information in citing deficiencies in other requirements would be detrimental to the survey process. If the facility has a strong QA program and identifies problems which it takes action to correct, the facility should be commended. If the QA program is assessed early in the survey and is found to be a strong program, the surveyor may find less need to be critical of many other requirements during the survey because the facility has a demonstrated capability to effectively identify and correct problems. Usually, the survey of this condition will start with the ASC Administrator and/or the staff person(s) responsible for the QA program. Items for discussion include: - How and when self-assessment is conducted. - How the medical staff participates in QA. - How medical necessity is reviewed. - How appropriateness of care is reviewed. - How policies and clinical privileges are revised based on QA.
	Ongoing means that there is a continuing or periodic collection and assessment of data concerning all areas of patient care. The program continually identifies areas of potential problems and indicates the data which should be collected and assessed in order to identify whether a problem exists. The program must be organized sufficiently to provide the ASC with routine findings regarding quality of care.	Ascertain that the QA program is ongoing by review of the plan, by discussion with the staff person responsible for the program, by minutes, by review of the data collected, and other documentation.

Standard	Interpretive Guideline	Survey Procedures
(b) Standard: Safety from fire. The ASC must meet the provisions of Life Safety Code of the National Fire Protection Association (NFPA-1981 edition) that are applicable to ambulatory surgical centers, with the following exception. In consideration of a recommendation by the State survey agency, HCFA may waive, for periods deemed appropriate, specific provisions of that code which, if rigidly applied would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients	The provisions of the NFPA (1981 edition) Life Safety Code that apply are: Section 12-6 re: New Ambulatory Care Centers, and Section 13-6 re: Existing Ambulatory Health Care Centers (for buildings existing on September 7, 1981 or prior). The assumption may be made that the ASC meets the NFPA definitions of an ambulatory health care center contained in Sections 12-1.3(e) and 13-1.3(e) (i.e., referring to the facility's provision of treatment to four or more patients at the same time should be disregarded.)	Use the State fire marshall's office to assess compliance with LSC. If you do not have a contract with the State fire marshall's office, use a a surveyor trained in the assessment of LSC. Whenever a waiver is requested, submit documentation to substantiate or deny the waiver.
(c) Standard: Emergency equipment. Emergency equipment available to the operating rooms must include a least the following: (1) Emergency call system. (2) Oxygen. (3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. (4) Cardiac defibrillator. (5) Cardiac monitoring equipment. (6) Thoracotomy set. (7) Tracheostomy set. (8) Laryngoscopes and endotracheal tubes. (9) Suction equipment (10) Emergency drugs and supplies specified by the Medical staff.		(c) Verify that: - The facility has a written policy on inspection and maintenance of the emergency equipment, and - The specified emergency equipment is available to the operating rooms. o The thoracotomy set consists of a chest tube and a water seal bottle.
(d) Standard: Emergency personnel. Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC.		(d) Check the duty records and staffing pattern to ascertain that sufficient numbers of physicians and support personnel trained to handle a variety of emergency situations are available.

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Standard	Interpretive Guideline	Survey Procedures
416.44 Conditions for coverage - Environment 1. The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. (a) Standard: Physical environment. The ASC must provide a functional and sanitary environment for the provision of surgical services. 1. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. 2. The ASC must have a separate recovery room and waiting area. 3. The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.		Tour the facility to determine whether it is adequately designed and equipped, clean and orderly, and free of hazards. (a) Verify that each operating room is designed and equipped for the types of surgery performed, and free of hazards to patients and staff, e.g., sufficient space, adequate lighting, necessary furniture. Observe the functional layout to verify that the ASC has a waiting room separate from the recovery room and that the recovery room is used exclusively for post-surgical care. Review the written policies and procedures to ascertain whether they contain, at a minimum: - Methods to minimize sources and transmission of infection, including adequate surveillance techniques - Sterilizing techniques for supplies and equipment - Procedures for isolation - Procedures for orientation of all new employees in infection control and personal hygiene - Aseptic technique procedures Interview staff to determine their knowledge of infection control techniques and verify implementation of the ASC's infection control program. - Procedures for reporting infections, including post-op infections: o An ongoing log is maintained of reported incidents of infection.

Standard	Interpretive Guideline	Survey Procedures
(c) Standard: Other practitioners. If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities.	Patient care responsibilities (which may or may not include formal privileges) may be assigned to practitioners not meeting the definition of physician in Section 1861(r) of the Act. However, policies and procedures must be established (e.g., either as part of overall medical staff bylaws or as separate documents) to oversee their clinical activities. "Physician" is defined in Section 1861(r) of the Social Security Act and in regulation under Section 405.232a as: o doctor of medicine or osteopathy, o doctor of dental surgery or of dental medicine, o doctor of podiatric medicine, o doctor of optometry with respect to services related to aphakia, and o chiropractor with respect to treatment by manual manipulation of the spine (to correct subluxation diagnosed by x-ray). All of the above must practice in accordance with State licensure.	(c) Review appropriateness of nonphysician responsibilities and adequacy of supervision and evaluation. Check performance appraisals, policies and procedures.
A16.46 Condition for coverage - Nursing Services The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met. (a) Standard: Organization and staffing. Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC.	"Recognized standards of practice" are standards promoted by national, State, and local nursing associations, relating to safe and effective nursing services. The requirement does not refer to standards of practice removed from patient care (e.g., organizational, administrative, etc.). "Available" means on the premises and sufficiently free from other duties to	The following measure will assist the surveyor in determining if the nursing services are directed and staffed to meet patient needs: - Interview the individual responsible for directing the service: . Read the job description of the responsible individual to verify that the responsibility and authority for nursing service is clearly delineated. . Verify that there is supervision of both personnel performance and patient care.

Standard	Interpretive Guideline	Survey Procedures
		Confirm that the staff are knowledgeable about their role in the event of an emergency and that physicians, nurses, and specified professional personnel are trained as often as necessary in: - Cardiopulmonary resuscitation - Effective and safe use of electrical and electronic life-support and other equipment used in emergency treatment.
416.45 Condition for coverage - Medical Staff The medical staff of the ASC must be accountable to the governing body.	The organization of the medical staff is left to the discretion of the ASC governing body. (Membership may include physician and non-physician practitioners.) Privileges granted, however, must be consistent with the license to practice in the State and experience of each clinical practitioner.	Review documentation (minutes, memos) of governing body oversight of medical staff activities.
(a) Standard: Membership and clinical privileges. Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.	The ASC is not required to follow each recommendation (re: acceptance or denial of privileges), but granting of privileges must be supported by recommendations.	(a) Review personnel qualifications, privileges granted, appropriate records, documents, policies and procedures. Review roster of surgical privileges and compare with surgical procedures performed.
(b) Standard: Reappraisals. Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.		(b) Request ASC policies regarding reappraisals, review, and evidence that these are occurring regularly. Medical staff appointment is ordinarily granted for a period of not more than two years.

Standard	Interpretive Guideline	Survey Procedures
		Review policy manual to determine that retention, preservation, and confidentiality are addressed.
(b) Standard: Form and content of record. The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: 1. Patient identification 2. Significant medical history and results of physical examination. 3. Pre-operative diagnostic studies (entered before surgery), if performed.		(b) Review a random sample of records to evaluate the completeness of information, recording of treatment/services provided, and content as specified in this standard. The random sample should include a sample of records from all practitioners. If specific problems or trends of incomplete records are identified, additional records may need to be evaluated.
4. Findings and techniques of the operation, including a pathologist report on all tissues removed during surgery, except those exempted by the governing body.	Exemptions to a pathology report should be made only when the quality of care is not compromised by the exemption and when another suitable means of verification of removal is employed. In these cases the authenticated operative report must document the removal. Exceptions to sending specimens to the pathologist for evaluation could be made for such limited categories as foreign bodies, teeth or other specimens that by their nature or condition do not permit fruitful examination.	Request the list of approved exemptions o Determine that the list of exemptions is appropriate o Review medical records to determine that only those exemptions of the type identified on the list have been exempt.
5. Any allergies and abnormal drug reactions. 6. Entries related to anesthesia administration. 7. Documentation of properly executed informed patient consent. 8. Discharge diagnosis.		

Standard	Interpretive Guideline	Survey Procedures
	enable the individual to respond rapidly to emergency situations.	. Check job description for each category of nursing personnel to verify that there is delineation of function, qualifications, and patient care responsibilities. Check staffing schedule to verify that sufficient registered nurses are available onsite for emergencies during hours of ASC operation. They must be sufficiently free from other duties to respond to emergencies when needed. Check number of surgical cases, schedules, and numbers and types of nursing staff available for a two week period. Review policies and procedures to determine if they are consistent with current acceptable standards of practice.
416.47 Condition for coverage - Medical records. The ASC must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care. (a) Standard: Organization. The ASC must develop and maintain a system for the proper collection, storage, and use of patient records.		(a) Determine that facilities, equipment, etc., are adequate to allow an effective, functioning medical record system and to safeguard the retention of the records. Verify that medical records are properly indexed and readily retrievable by asking for records of different procedures/diagnoses. Examine filing and storage of records to determine whether they are protected from fire, unauthorized access, etc.

Standard	Interpretive Guideline	Survey Procedures
3. Orders given orally for drugs and biologicals must be followed by a written order, signed by the prescribing physician.		3. - Review medication orders to determine that they are signed by the physician. - Review medication cards to determine whether they conform with the physician's order (that drug, dosage, and administration are as directed).
416.49 Condition for coverage - Laboratory and Radiologic Services The ASC must have procedures for obtaining routine and emergency laboratory and radiologic services, from Medicare approved facilities, to meet the needs of patients.	The procedures should encompass: o a well-defined arrangement (need not be contractual) with outside services, o routinized procedures for requesting lab tests and radiological exams, and o incorporation of lab/radiologic reports into patients records. "Medicare approved" means facilities that have been certified and found eligible for Medicare reimbursement.	Many laboratory tests may be done in the physician's office or by a laboratory prior to the patient's admission to the ASC. When tests are performed prior to admission, the results should be readily available to the attending physician in the ASC. Examine the facility's arrangement or contract(s) for laboratory and radiologic services to verify that the specifications meet the applicable requirements of the condition on governing body and management (416.41) and that the services are provided by Medicare approved facilities. o An ASC would have an arrangement or contract with a Medicare-approved laboratory (hospital or independent laboratory) for the provision of all laboratory services, this includes pathology and clinical laboratory services. The ASC, however, is permitted to perform routine tests (such as urinalysis, hemoglobin, and hematocrit) the day of, or a few days prior to surgery. o An ASC would have an arrangement or contract with a Medicare-approved hospital or portable x-ray service for the provision of radiological services.

Standard	Interpretive Guideline	Survey Procedures
416.48 Condition for coverage - Pharmaceutical services. The ASC must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services.	"Accepted professional practice" and "acceptable standards of practice" mean patient care standards promoted by national, State, and local professional associations regarding clinical use of drugs and biologicals. This encompasses: o control procedures o proper labelling o disposal procedures	- Review procedures for control and accountability of drugs and biologicals. - Review records of receipt and disposition of controlled drugs. - Check labels of drug containers to assure they are labelled with name, stength, and expiration date, when applicable. Review procedures for disposal of discontinued, outdated, and deteriorated drugs. Check that drugs and biologicals are current, not outdated, and properly refrigerated, if necessary. Inspect drug storage area to verify it is properly controlled. Review organizational chart to determine responsibility for pharmaceutical services.
Standard: Administration of drugs. Drugs must be administered according to established policies and acceptable standards of practice. 1. Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record. 2. Blood and blood products must be administered only by a physician or registered nurse.		1. Check to see that there are policies and procedures covering the administration and preparation of drugs, reporting of adverse reactions, etc., and that they are being followed. 2. Review reports of medication errors, their nature and frequency, and corrective action taken.

818 N. Emporia, #415
Wichita, KS 67214
February 22, 1995

To Whom It May Concern:

I have been recently advised that abortion clinics in this country are neither required to report the numbers of the abortions they do, nor the complications that accrue from these procedures. Also, and more importantly, these clinics are not required to fulfill criteria that are required in the case of any other free standing minor surgery center. As a practicing obstetrician gynecologist, this seems to be a very inconsistent situation with regard to the health of women who have obtained the services of these clinics.

Although first trimester abortion is a minor surgical procedure, there are risks associated with it, namely, a 5.2 percent incidence of infection with the first trimester abortion, and 18.5 percent with a mid trimester abortion. These infections, if not properly tracked and treated could lead to major complications including pelvic abscess and subsequent infertility. Hemorrhage is another such complication which could result in the necessity for blood transfusion and the risks associated with that including hepatitis and AIDS. Perforation of the uterus during the course of the procedure is also a serious complication which may even result in significant bowel or bladder damage and significant future health problems for the mother. I can testify personally to the incidence of these sorts of complications having been the physician to take care of many of these patients who were suffering complications of their first trimester abortions while I was in Omaha, Nebraska.

Given these complications and the fact that this is a surgical procedure, it seems only reasonable that these facilities would be accredited, licensed and made to undergo the same standards that other free standing minor surgery centers are required to go through, simply to insure that any woman undergoing abortion is afforded the same care as any other individual. Thank you for consideration of these opinions.

Sincerely,

L.L. Cvetkovich, M.D., FACOG

dg

ProChoice Action League • P.O. Box 3622, Wichita, KS 67201 • 316-681-2121

Dedicated • Determined • Decisive

To: Members of the Health and Human Services Committee
From: Peggy Jarman, ProChoice Action League
Regarding: H.B. 2323

First, I would ask that you look at some facts:

1. A woman giving birth is 11 times more likely to die than a woman having an abortion.
2. A non-allergic patient receiving a shot of penicillin in a doctor's office is more likely to die than a patient receiving an abortion.
3. Complication rate at Women's Health Care Services for first trimester abortions is 1 in 10,000 and 1% for induction patients.
4. Women giving birth are 100 times more likely than women having abortions to need major surgery to manage complications.
5. Epesiotomy and significant types of cervical trauma occur in less than one-half of 1% in first and second trimester procedures. Compare that to 90% with full term deliveries.
6. Dozens and dozens of surgical procedures are performed in non licensed surgical centers including vasectomies, circumcisions, D and C's, breast biopsies, hernia operations, rectal surgery, ocular surgeries of all types, plastic and reconstruction surgeries, and major dental extractions.

Second, please examine some philosophy:

1. The medical and surgical professions are now following the exodus of abortion services out of the hospital into out-patient facilities. It is forecast that as much as 60 to 70% of all surgical procedures will be performed in out-patient settings by the year 2000.

2. At a time when health care costs are of great concern, at a time when government is suppose to be dedicated to less interference, at a time when legislators are theoretically concerned about reducing government mandates, consideration of such a measure should be unthinkable. Indeed, can you imagine the outrage that would be expressed from the medical community if you added any or all those surgeries listed above for ambulatory surgicenter status?

Third, look at the law:

The U.S. Supreme Court spoke to this issue in *Doe vs. Bolton* when they affirmed that states could not restrict abortions to hospitals and further stated that restricting them to licensed facilities could only be done for second trimester procedures with proof that they were the only safe place for them to be done. No data exists to indicate that restricting abortion to licensed facilities or to hospitals would be in the best interest of maternal health.

Fourth, examine the costs:

Actual costs runs between $50,000 and $75,000 per operating room or $125 to $150 per square foot. Restrictions to ambulatory surgical centers will increase the price and make abortions less available. Abortions made less available or so expensive that the surgery cannot be afforded is the same thing as abortion made illegal. Or indeed, is that the purpose of this legislation?

In conclusion, this bill is unnecessary, unreasonable, unwarrented, and probably unconstitutional. It is just another poorly disguised attempt by anti-choice legislators to close clinics, force their particular beliefs on others, and control the lives of women? There are no reasons other than those to support this bill.

Planned Parenthood®
Of Kansas, Inc.

Testimony in opposition to HB 2323
By Douglas E. Johnston
Planned Parenthood of Kansas

Thank you for this opportunity to address the House Health and Human Services Committee in regard to House Bill 2323. The bill under consideration would require all clinics and physicians offices that perform abortions to become ambulatory surgical centers. Planned Parenthood of Kansas opposes this bill for the following reasons:

- House Bill 2323 is unnecessary government regulation. Legal abortion services have a long and safe history under current regulations. Legitimate need for such government regulation remains unproved.

- House Bill 2323 will severely restrict access to abortion services for the women of Kansas. If HB 2323 became law it would immediately restrict access to only two providers in the state. There are currently eight providers. Access would be restricted to Women's Health Care Services in Wichita and Comprehensive Health for Women in Overland Park.

  Women in rural areas would face additional detrimental burdens of time, expense and travel as a result.

The American Medical Association stated "[m]andatory waiting periods [and other barriers] have the potential to threaten the safety of induced abortion. Each of these factors increases the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure."

Clearly, HB 2323 represents the greatest threat to freedom of choice currently facing the Kansas Legislature.

HOUSE H&HS COMMITTEE
2 -22- 1995
Attachment 9

Wichita - 2226 East Central, Wichita, Kansas 67214-4494 (316)263-7575
Hays - 122 East 12th, Hays, Kansas 67601 (913)628-2434

NCJW

National Council of Jewish Women

Testimony of Barbara Holzmark
8504 Reinhardt Lane
Leawood, Kansas 66206
913/381-8222

February 22, 1995

Mr. Chairman and Members of the House Health and Human Services Committee:

My name is Barbara Holzmark and I am the State Public Affairs Chairperson for the National Council of Jewish Women, representing 1200 members in the Greater Kansas City area and nearly 100,000 members nationwide. NCJW is the oldest Jewish Women's organization in the country, founded in 1893 with Jewish Values and Democratic Principles. I am here today in opposition to HB 2323.

The NCJW believe that individual liberties and rights guaranteed by the Constitution are keystones of a free and pluralistic society and must be protected. A Democratic society, must recognize its obligation to provide for the needs of those persons unable to provide for themselves. Individual well-being, acceptance of the diversity of families and respect for human dignity are fimdamental to a healthy society. We therefore endorse and resolve to work for a continuum of services which are accessible and responsive to the needs of all individuals and families. We will also work for confidential family planning and reproductive health services for all, regardless of age and ability to pay. The protection of every female's right to choose abortion and the elimination of obstacles that limit reproductive freedom is of utmost concern. HB 2323 is yet one more restriction toward a woman 's reproductive freedom. Abortions are legal, safe and performed by Doctors with certification. The same risk factor is present in having root canals, teeth extractions, vasectomies, and other surgeries under local anesthetics. The mothers of today are using birthing centers and midwives with no restrictions such as in HB 2323. These doctors and midwives are permitted to operate within the confines of their facilities which may or may not be ambulatory. Why then must only procedures for termination of pregnancy be included in this bill? Costs are down today due to procedures performed out of hospitals, or limited stays in the hospital due to rising costs of insurance. Enact this legislation and watch costs rise once again. This may seem ridiculous to you, however, to me HB 2323 is an insult. Abortions are sought through Doctors in their offices or licensed medical care facilities in the state of Kansas. To my knowledge, there are no physicians who would consider performing an abortion in any surrounding less surgical than their own medically, sterile facility.

The National Council of Jewish Women is against any restrictions that limit reproductive freedom, therefore I urge you to act unfavorably on HB 2323.

ESTIMONY IN OPPOSITION TO HB 2323
HEALTH AND HUMAN SERVICES COMMITTEE
WEDNESDAY 22 FEBRUARY 1995 1:30 ROOM 423 SOUTH

Chairman Mayans and Members of the Committee:

I am Darlene Stearns, League of Women Voters of Kansas appearing in opposition to HB 2323.

The League of Women Voters of Kansas position on reproductive choice is as follows: " to protect the constitutional right of individuals to make reproductive choices". We believe this applies to both physicians and their patients, the physicians to practice medicine, lawfully as they choose, and patients to choose medical treatment they need.

The League believes that HB 2323, by requiring any physicians office where abortions are performed to become ambulatory surgical centers clearly restricts the practice of medicine and clearly restricts a patients right to choose a procedure she deems necessary.

As a mother of five children I spent lots of time in physicians offices where my children received surgical treatment, wounds surtered, ingrown toenails removed, and in dentists offices where teeth were removed requiring surgery.

If this bill is designed to protect patients by requiring ambulatory licensing for just one specific procedure why not for all surgical procedures? Consider the small clinics in rural Kansas, and indeed small communities where the only available medical care is in a physicians office.Obviously this bill is concerned only with restricting performance of abortions. More importantly, this bill is aimed at preventing a physician from performing medical abortions, routinely done in a physicians office, when they become legal in this country.

Driving women from licensed physicians care will only result in their seeking abortions from those persons willing to operate beyond the law. There are those of us who remember the days of illegal abortions and their tragic consequences and I cannot believe this committee is willing to return to those times.

I respectfully request you vote against a bill aimed only at denying, only women, a medical procedure they need.

Darlene Greer Stearns
League of Women Voters of Kansas
112 Woodlawn
Topeka, Kansas 66606
913 235 3757

Planned Parenthood®
of Greater Kansas City

Testimony
of
Erika Fox
Director of Public Affairs
Planned Parenthood of Greater Kansas City
before the
House Health & Human Services Committee
on
February 22, 1995
in Opposition to
House Bill No. 2323

My name is Erika Fox. I've served as the Director of Public Affairs for Planned Parenthood of Greater Kansas City for ten years. In that position, I have as one of my responsibilities to monitor legislation in Kansas and Missouri and to help educate the Planned Parenthood community, our legislators and the public about the effects of these proposals on the ability of our agency and other reproductive health care providers to serve our clients.

I appear here today, on behalf of Planned Parenthood, in opposition to House Bill No. 2323. This proposal would force most Kansas abortion providers--those who operate within the law--to become ambulatory surgical centers or to stop providing this life-saving medical procedure It would certainly discourage the entry of additional physicians into the practice of early, safer, medically-induced abortions when drugs such as RU-486 become available. You will undoubtedly hear today from others about the hardships and dangers this would cause in terms of delay, later abortions, cost, travel, lack of access, resort to unsafe practices and the birth of sick, abused and neglected babies.

I would like to focus on the lack of a rational connection between this

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proposed state regulation and any claimed health or safety benefits. This proposal simply cannot be supported by an interest in protecting women's health. Where this is so, the state is not legally justified in interfering with constitutional rights--whether it is operating in the area of transportion, agriculture or the right to obtain an abortion.

This global, rigid mandate ignores all of the factors which significantly affect the safety of abortion. It makes no allowances for the stage of gestation, the health of the woman, what type of surgical or pharmaceutical methods are used, whether or not the patient will be under general anesthesia or an incision will be required. The fact is that the setting of the abortion has very little to do with the safety of the abortion. Studies show that mortality and complication rates for regular abortion clinics and hospitals are comparable after adjusting for factors involving hospital patients with pre-existing. conditions and the skill of the physician. This would help account for the fact that only three percent of women obtaining abortion actually require a hospital setting for health reasons.

Furthermore, all clinics have a gestational age limit beyond which abortions will not be performed. If the clinic determines that the gestational age is beyond the clinic's limit, or if there are medical problems that prevent the clinic from providing abortion services, the woman can be referred to an appropriate medical facility based on the factors relevant to her own situation.

It is also important to note that those few complications that do occur as a result of abortions performed in any setting, most notably infection and retained tissue, usually do not manifest themselves until after the patient leaves the site of the procedure and can be dealt with then by her physician in the most appropriate location. The very unusual need for immediate acute care back-up for surgical abortion patients can be provided by assuring

appropriate procedures are in place for transfer to an appropriate facility.

All of the evidence shows that the most important factor in the safety of abortions is the skill and experience of the practitioner--a factor that can be and is addressed by licensing of individuals, but is not addressed by bricks-and-mortar hospital-equivalency requirements. (For example, rules governing construction of facilities would do nothing to correct unsterile conditions, the failure to perform pregnancy tests or improper use of anesthesia.) Increased skill on the part of physicians and improved technology have resulted in the almost exclusive use of the safest methods of surgical abortion-- curettage and D&E procedures--even in the second trimester in regular abortion clinic settings. In fact, over the last 20 years as the number and percentage of abortions performed in clinics by skilled specialists have increased, rates of abortion mortality and serious complications have declined. Current work on testing medically-induced techniques of abortion will also increase the safety of abortion for the women who choose a non-surgical method.

The safety of abortion today may be placed in perspective by comparing it with other common medical practices and procedures. The risk of mortality from abortion is no greater than the risk from an intramuscular injection of penicillin and is significantly lower than the mortality risk from childbearing, specifically: the risk from childbirth is 20 times greater at 8 weeks gestation, 10 times greater than abortion at 11-12 weeks, and 61/2 times greater than from abortion at 13-15 weeks.

The State should save itself the cost of unsuccessful and expensive litigation which would certainly result from the adoption of HB 2323 without any data indicating that it would improve the medical outcomes for women choosing abortions. Instead, we should concentrate on factors that would have that effect, such as removing the barriers that delay abortions until later in pregnancy and making unplanned pregnancies more infrequent.

MOWERY CLINIC, L.L.C.

737 E. Crawford
Post Office Box 260
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2/20/95

Repr. Deena Horst

Re: House Bill No. 2323

I read Through this bill earlier today. It does not make sense from the standpoint of medical risk to select out induced termination of pregnancy for special legislation when other procedures of much greater risk to the patient are regularly performed as office procedures.

Examples would be diagnostic D&C, hernia repair, breast biopsy. All of these entail risk comparable to or greater than therapeutic abortion.

Also, Blue Cross / Blue Shield, on a yearly basis reviews a list of surgical procedures for appropriateness of site of performance. This list is

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reviewed by a number of consultants before a final decision is reached. Pregnancy termination was determined many years ago to be appropriate in an office, surgery center or hospital with no difference in risk.

To assert this revision is needed to protect the citizens of Kansas, one would have to be totally out of touch with the realities of surgical risk, or trying to reduce the availability of abortion services by the "backdoor." The former demonstrates ignorance and the latter dishonesty, at least intellectual dishonesty.

If the legislature feels it is desirable to regulate the site of performance of surgical procedures, then the bill should be written to provide assignment of all procedures to a specific level of facility. This at least would be more honest.

Thanks.

If you have any questions, please let us know.

Glenn Lebree