Approved: 4-7-95
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY

The meeting was called to order by Chairperson Tim Emert at 10:00 a.m. on March 7, 1995 in Room 514--S of the Capitol.

All members were present except:

Committee staff present: Michael Heim, Legislative Research Department
Jerry Donaldson, Legislative Research Department
Gordon Self, Revisor of Statutes
Janice Brasher, Committee Secretary

Conferees appearing before the committee:
Lorne Phillips, PhD, Director, Center of Health and Vital Statistics
Jeanne Gawdun, Kansas for Life
Bob Runnels, Kansas Catholic Conference
Heidi Armbruster, Right to Life
Sharon Stringfellow, Concerned Women of America
Peggy Jarman, Pro Choice Action League
Douglas Johnston, Public Affairs Coordinator-Planned Parenthood
Darlene Stearns, League of Women Voters
Barbara Holzmark, National Council of Jewish Women-Written testimony only
Senator Harrington--Written testimony only
Annette Hornbach --Written testimony only
Carla Dugger, ACLU, --Written testimony only

Others attending: See attached list

The Chair called the meeting to order at 10:00 a.m. and explained that the hearings will be for both **SB 134** and **HB 2083**, many of the conferees will be testifying on both bills. The Chair announced that sponsors of the bill, Senator Harris and Senator Martin will explain **SB 134**, and that Dr. Phillips who has no position on **HB 2083** will explain that bill.

SB 134--Time period for notification to parent before a minor's abortion and for informed consent

Senator Harris, sponsor of **SB 134,** described the bill as allowing a twenty-four hour reflection period for a woman seeking an abortion and for the parents of the minor to be notified. The bill has two beneficial aims: 1. To further inform the female patient, and; 2. To hopefully save unborn lives. Senator Harris suggested an amendment to require that the informed consent be done in person by the abortionist or their representative not less than 24 hours before the procedure. This requirement would be in line with other non emergency surgical procedures.(Attachment 1)

Senator Martin, sponsor, of **SB 134**, stated that this bill would allow time for consideration, which similarly occurs with other types of surgery, much like getting a second opinion. Senator Martin cited several examples where thoughtful consideration is given before making a major decision. Senator Martin stated that there have been over 30 million abortions in this country since Roe v Wade, and that abortion is just another method of birth control. Senator Martin cited the State's responsibility in protecting all its citizens. Senator Martin stated that the test of a civilized society is the way it treats its most vulnerable, the old, the sick, the young, the poor, the disabled and the homeless. At one time there would have been no question about protecting life in the womb. At the rate of 1.6 million abortions a year, life in the womb could hardly be considered safe for some. There are some circumstances which arguably justify abortions in cases to save the life of the woman, or in cases of rape, however, those are exceptions and account for a very small percentage of the abortions performed. Senator Martin concluded by stating that to say that abortions should be delayed 24 hours on an unemancipated minor is drawing the wrath of that industry. This measure will not stop anything, but perhaps be a small step.

Jeanne Gawdun, KFL, spoke in support of **SB 134** by stating that the idea that important decisions will be

more informed and deliberate if they follow some period of reflection seems reasonable. Ms Gawdun stated that surveys of aborted women consistently show that a significant number of them felt pushed into the abortion decision by others, including counselors with a financial stake in the outcome.(Attachment 2)

Bob Runnels, Executive Director, Kansas Catholic Conference spoke in support of **SB 134**, stating that parental involvement must be paramount in a child's life. It is inconsistent with reality not to have parental support during the trying pregnancy period. This bill corrects a flaw in the current statutes giving a reasonable waiting period before an abortion, so that parents, or guardians can be with their child. Abortion clinics have adopted procedures to circumvent this vital support.(Attachment 3)

Sharon Stringfellow representing Concerned Women for America of Kansas testified in support of **SB 134** stating that it paves the way for better decision making in the crisis pregnancy situation. Ms Stringfellow addressed some concerns regarding the giving of information in person, not by mail to allow women to contemplate such an important decision. A second concern was that women receive good pertinent information such as the baby's gestational age and options and assistance available if the woman decides to carry her baby to term.(Attachment 4)

The Chair noted written testimony in support of **SB 134** from Annette Hornbach.(Attachment 5)

Written testimony was provided by Senator Harrington in support of **SB 134**. Written testimony suggested that written informed consent for minors by the minor's parents or legal guardians for this surgical procedure in not unreasonable, as well, considering written consent is required for any other form of surgery a minor may need.(Attachment 6)

Darlene Stearns, League of Women Voters spoke in opposition to **SB 134** citing the League's position of protecting the constitutional right of women to make this decision. Regardless of attempts to restrict abortion, Ms Stearns, stated that abortion is legal. Women are going to continue to have abortions. Ms Stearns concluded that the intent of both of these bills was to keep women from making a decision themselves. (Attachment 7)

Peggy Jarman, Pro Choice Action League testified in opposition to **SB 134** stating that the 24 hour waiting period for minors is without justification. Ms Jarman stated that women are capable of making health care decisions without mandating restrictions.(Attachment 8)

Doug Johnson, Planned Parenthood, testified in opposition to **SB 134** by stating that the legislation is bad for women's health care. Mr. Johnson cited women in rural areas would face additional detrimental burdens of medical risk, time, expense and travel as a result of mandatory forced delays for abortion services.(Attachment 9)

The Chair noted written testimony from Carla Dugger, ACLU in opposition to **SB 134**.(Attachment 10)

HB 2083--Reporting terminations of pregnancies

Lorne Phillips, PhD, Director of the Center for Health and Environmental Statistics addressed the Committee to provide information relating to **HB 2083**. Dr. Phillips stated that in the past hospitals were the most likely provider of legal terminations. Over time the increasing demands for such procedures has contributed to the evolution of the specialized clinic. These facilities now provide the majority of the terminations. These specialized clinics are not required to report to KDHE. Dr. Phillips stated that his department has assured providers of abortions that the information would be held in strict confidentiality. Dr. Phillips stated that the data from providers is an essential component of any consideration of such problems as teenage pregnancy. A mandatory reporting requirement would help ensure that the KDHE would continue to receive this data regardless of any change in ownership, management, philosophies, etc. that could change the status of cooperation.(Attachment 11)

Questions from the Committee regarding issues of confidentiality were addressed by Dr. Phillips, and Dr. Phillips assured the Committee of strict requirements for confidentiality practiced by his department. Dr. Phillips stated that they are collecting statistical data on a number of sensitive health conditions, and there are security systems within their computer system. Dr. Phillips referred to forms used in reporting termination of pregnancy and still births, and agreed that a code for the facility's name could be used to further ensure confidentially.(Attachment 12) and (Attachment 13)

Jeanne Gawdun, KFL, testified in support of **HB 2083** stating that the number of abortions reported to the Kansas Department of Health and Environment is under reported in comparison to the number reported to the Alan Guttmacher Institute, a research arm of Planned Parenthood. The discrepancies have been as high as

5,021 abortions in one year. Ms Gawdun stated there is a need for this statistical information as it relates to women's health issues. Ms Gawdun cited Missouri's mandatory reporting law in effect since 1979 and related the benefits of such data to health education and prevention program. (Attachment 14) Attached to the written testimony were the 1993 Spring, Summer and Winter newsletters of the Association for Interdisciplinary Research.

Bob Runnels, Executive Director, Kansas Catholic Conference spoke in support of **HB 2083**, stating that it is inconsistent with reality to base decisions on inadequate information. Mr. Runnels stated that other statistical information is available, except in this one area, the area of abortion.(Attachment 15)

Hedi Armbruster, Right to Life in Kansas, testified in support of **HB 2083** stating that this bill simply extends the reporting to those who are performing abortions. It entails no policy change. It is a reasonable and minimal attempt to provide accurate information and statistics regarding the practice of abortion. Ms Armbruster addressed the safeguards concerning confidentially. Ms Armbruster referred to the last page of her written testimony showing discrepancies in abortions reported to KDHE and those reported to the Alan Guttmacher Institute, research arm of Planned Parenthood.(Attachment 16)

Sharon Stringfellow, Concerned Women for America of Kansas spoke in support of **HB 2083** stating that it ensures the intent of the current reporting law, and the integrity of our state's statistical data that is used to direct policy and programs.(Attachment 17)

Peggy Jarman, Pro Choice Action League, spoke in opposition to **HB 2083** stating that it is extremely unreasonable for doctors to put their name on a form.(Attachment 18)

Doug Johnson, Planned Parenthood spoke in opposition to **HB 2083** stating that this bill is unnecessary. Doug Johnson stated that some abortion clinics do not report for a very good reason.(Attachment 19)

Written testimony in opposition to **HB 2083** from Carla Dugger, ACLU was presented to the Committee. (Attachment 20)

Written testimony from Barbara Holzmark, National Council of Jewish Women, in opposition to both **S B 134** and **HB 2083** was given to the Committee.(Attachment 21)

The Chair closed the hearings on **SB 134** and **HB 2083** and adjourned the meeting at 11:05 a.m.

The next meeting is scheduled for March 8, 1995.

SENATE JUDICIARY COMMITTEE GUEST LIST

DATE: 3-7-95

NAME	REPRESENTING
Shannon Peterson	KBA
Bob Wunsch	KUMC
Douglas Johnston	Planned Parenthood
[illegible]	KS Governmental Consulting
Sharon Stringfellow	Concerned Women for America of KS
[illegible]	CA
G. Hanson	Sen Harrington
LINDA TULLER	KU STUDENT - MPA PROGRAM
HEIDI ARMBRUSTER	RIGHT TO LIFE OF KS
Jane L Gawdun	Kansans for Life
Heather Gray	Sen. Karr's office
Darlene Garr Stranz	Law U of Kansas
Kay Mathes	NOW
Bob Rawe [illegible]	KS. Catholic Conf.
Paul Davis	Senator Hensley
Paul Shelby	OJA
Christy Bailey	Senator Karr
Edward Rowe	LWVKS

State of Kansas

Senate

SENATOR MIKE HARRIS
9828 HARVEST CT
WICHITA, KANSAS 67212
316-721-4968

STATE CAPITOL—136-N
TOPEKA, KANSAS 66612-1504
913-296-7385

COMMITTEE ASSIGNMENTS
VICE CHAIRMAN: COMMERCE
JUDICIARY
MEMBER: GOVERNMENT ORGANIZATION
TRANSPORTATION AND UTILITIES

March 7, 1995

Testimony In Support of S.B. 134

To: The Senate Judiciary Committee

MR. CHAIRMAN AND members of the Committee:

Thank you for allowing me to testify in favor of S.B. 134. This bill is designed to establish a 24 hour reflection period for a woman seeking abortion and for the parents of a minor female who is pregnant. A 24 hour period will allow those most affected by this life-changing procedure to briefly contemplate the risks, benefits and impact of an abortion, withouyt pressure from representatives of the abortion industry or the pro-life movement. Thus, the bill has two beneficial aims: 1. To further informed consent for the female patient, and; 2. To hopefully save unborn lives.

To meet these ends, the bill should be amended to require that the informed consent be done <u>in person</u> by the abortionist or their representative not less than 24 hours before the procedure. I expect objections to be made that this is only for harrassment purposes and that poor women will have to come up with motel money to wait overnight. Keep in mind that all but emergency surgical procedures now take place under similar circumstances. Keep also in mind that late term abortionists already require their patients to stay overnight as they await the delivery of their dead babies.

A 24 hour reflection period <u>is</u> constitutional and is certainly beneficial both to the patient <u>and</u> the unborn.

Mike Harris
Senator, District 27

MTH:dr

Senate Judiciary
3-7-95
Attachment 1

#3

Chapters and Affiliates

Abilene
Atchison
Arkansas City
Augusta
Barber County
Brown County
Chanute
Chase County
Clay Center
Coffey County
Coffeyville
Colby
Columbus
Concordia
Decatur County
Dodge City
Doniphan County
Edwards County
El Dorado
Elk County
Emporia
Erie
Fort Scott
Franklin County
Garden City
Garnett
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
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 and Universities

(12) Chapters

Kansans for Life

PO BOX 4492 • TOPEKA, KS 66604 • (913) 234-3111

KANSANS FOR LIFE SUPPORTS SB 134

The Supreme Court in Casey has already defended waiting periods. "The idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly where the statute directs that important information become part of the background of the decision." The notion that some women will be inconvenienced does not invalidate the state's obligation to set up a protective time frame for those who, for a variety of reasons, may need more time to reflect.

The argument for gun control places the need to prevent tragedies above the minor inconvenience to law-abiding hunters. A waiting period may be an irritation to a woman who is determined to abort, but to a woman who is unsure or is being rushed, a waiting period will protect her from making the wrong decision. "In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."

Not all women who enter abortion facilities have an equal understanding of the medical facts of abortion. Neither is the abortion information delivered consistently. Too often over the years the first time the woman sees the doctor who is going to do the abortion is when she is on her back and her feet are in the stirrups and often after she's been given relaxants or other drugs. Many women report that they were aborted without having all of their questions answered.

Surveys of aborted women consistently show that a significant number of them felt pushed into the abortion decision by others, including counselors with a financial stake in the outcome. Waiting periods are a shield to protect women from being manipulated by those with ulterior motives. For these reasons we ask you to recommend SB134 favorable for passage.

Jeanne L. Gawdun, KFL Lobbyist

Kansas affiliate to the National Right to Life Committee

Senate Judiciary
3-7-95
Attachment 2

Table I

Study of 252 Women Members of Women Exploited by Abortion as Related to Informed Consent

Questions answered on a scale of 0 to 5 indicated unsure as well as not applicable to their circumstances. 1 indicated not at all while 5 indicated very much. Women were interviewed several years following their abortion. (Avg. 10 years)

	Not at all			Very Much
Do you feel you had all of the necessary information to make the decision (to have an abortion).				
1. 74%	2. 8%	3. 9%	4. 2%	5. 6%
When you went to the clinic or counselor, was your decision already firm?				
1. 30%	2. 9%	3. 16%	4. 10%	5. 31%
Did the clinic, doctor, or counselor help you to explore your decision?				
1. 84%	2. 7%	3. 3%	4. 1%	5. 3%
Were you adequately informed about the procedure?				
1. 49%	2. 17%	3. 15%	4. 10%	5. 6%
Were you given information about the biological nature of the fetus?				
1. 90%	2. 3%	3. 2%	4. 0%	5. 2%
Were you encouraged to ask questions?				
1. 64%	2. 16%	3. 8%	4. 3%	5. 2%
Were your questions thoroughly answered to your satisfaction?				
1. 52%	2. 12%	3. 8%	4. 4%	5. 4%
Do you believe there was information you were not given, or were misinformed about?				
1. 10%	2. 1%	3. 4%	4. 4%	5. 73%
Were risks and dangers discussed?				
1. 65%	2. 16%	3. 5%	4. 4%	5. 4%
Did you feel in control of your life when making your decision?				
1. 65%	2. 8%	3. 9%	4. 6%	5. 10%

What are your feelings about abortion today?				
	Negative			**Positive**
1. 98%	2. 1%	3. 0%	4. 0%	5. 0%

Source: Aborted Women: Silent No More, David Reardon (1987)

Note: A sub-group of 53 women involved with Planned Parenthood had virtually the same responses.

Hospitals mislead women about abortion complications

by Jim Rudd

Hundreds of women every day check into hospitals, emergency rooms, health clinics and doctors' offices suffering from abortion-related complications, and yet the medical community remains silent. Why? I have a hypothesis.

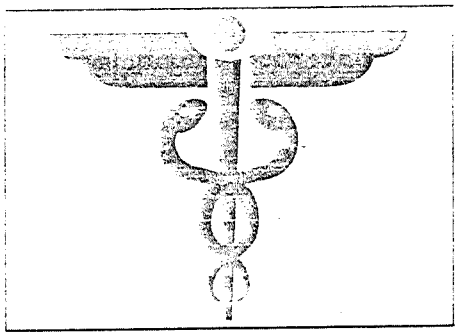
The principles from which I derive the hypothesis stem from working as system director at a national abortion information clearinghouse that provided a 1-800 referral service to post-aborted women. My job was to help post-aborted women get appropriate medical care, emotional counseling and medical malpractice attorneys, when necessary. During that time I worked on hundreds of post-abortion cases and had lengthy discussions and interviews with ex-abortion clinic employees, obstetricians, gynecologists, nurses, hospital administrators, accountants, attorneys, and emergency room doctors.

Within the medical industry, those involved in the follow-up care of abortion injury make more money than those performing the abortion service. The cash-over-the-counter that abortion providers make is about 500 million dollars a year. Although staggering, this amount is just a fraction of the abortion cash cow.

The big money is generated by the supply and demand placed on the medical industry from women injured during the abortion procedure. Abortion creates the need for more medical care. This after-care is paid for by government subsidized health care and private health insurance; these pass the expense to the citizens through tax hikes and rate increases.

For hospitals, doctors' offices, medical supply companies, health clinics, pharmaceutical companies and drug stores, both Direct Abortion Complications (DAC) and Chronic Abortion Complications (CAC) mean billions of dollars a year in extra revenue. With this much to be made, the bottom line is this: it is bad business to oppose abortion. The medical community considers the bottom line more important than life.

The following three situations typify how physical complications begin for millions of women. There is not enough room to list all abortion-related complications, and some of the complications



mentioned here are not limited to being abortion-related. However, abortion is the great stimulator; it radically changes the natural function of a woman's body, causing a whole spectrum of chain reactions to occur sporadically, which the medical industry is more than willing to accommodate.

The doctor's fee mentioned in this first situation reflects an average fee charged for the surgery performed by the attending doctor. That fee is just a small fraction of the total cost. It does not reflect the charges for office visits, prescribed medicine (with one exception), or the still greater charge for hospital services.

- First: A woman in her late twenties believes she may be pregnant and visits her obstetrician/gynecologist who confirms the pregnancy. After some gentle encouragement she decides to have an abortion. The doctor's office gives her the name and address of an abortionist and tells her the abortionist will only take cash.
- She goes to the abortion clinic; they give her a pregnancy test. She signs the papers, pays the cash; the doctor performs the suction abortion, and she goes home.
- During the three years following the abortion, she suffers a spontaneous miscarriage and has problems with pelvic infection and pain, which her gynecologist has been treating with antibiotics. Now her doctor tells her that due to the infection, her fallopian tubes have become scarred, causing the possibility of tubal pregnancy. The doctor removes the fallopian tubes. Doctor's fee is $1,500.
- Five years after the abortion, she suffers from endometriosis (pieces of the uterus lining found in other parts of the pelvic cavity), which her gynecologist has been treating with drugs and then laser beam surgery. Doctor's fee is $2,400. Now her doctor tells her she needs to have her uterus removed. Doctor's fee is another $2,400.
- Nine years after the abortion, because of recurring inflammation and extreme pain, the gynecologist removes her ovaries. Doctor's fee is $2,000. Then the doctor starts her on an estrogen-progesterone hormone replacement program, which will last the rest of her life to prevent a bone disease called osteoporosis. Prescription costs are $1,200 a year.
- Ten years after her abortion, this misinformed, misguided, maimed and mangled woman is emotionally and physically crippled. Responsible for starting the chain of physical problems, the doctor who made the abortion referral never told her the high rate of CAC.
- Every time she visits the doctor's office or hospital they send information to her health insurance company to be reimbursed for all the services rendered. If she's named on her husband's business group health care

continued on page 3

Medical cover-up
from page 4

plan, the abortion aftercare causes the insurance rates to go up for the whole business.

■ Second: A large corporation employs 3,000 women, of whom one out of every three have abortions. Half the women who have had abortions, now have abortion related gynecological problems. The abortion aftercare for these women causes the health insurance rates to skyrocket for the whole corporation. This kind of thing has been going on all over the United States. Of course the insurance companies don't say much about abortion. As you can see, they also have a billion dollar piece of the abortion-cash-cow.

■ Third: A young low-income woman using a home pregnancy test finds that she is pregnant. She pulls together $300, then goes to the big nice abortion clinic in the city. The clinic gives her a pregnancy test, she signs the papers, pays the cash, the doctor performs the suction abortion, and she goes home.

■ Three days later she experiences a lot of pain and bleeding. Using her Medicaid card she goes to the local hospital emergency room. Upon examination they find out she is suffering from an incomplete abortion — something they see regularly.

■ They move her to the operating area for a dilatation and curettage. In the operating room they give her general anesthesia, then the doctor performs the D&C, removing the rest of the baby, which was causing the pain and hemorrhaging that threatened to take her life. She recovers, they prescribe antibiotics and pain medicine, schedule a return appointment. And then she goes home.

■ To be reimbursed, the hospital sends the appropriate information to Medicaid describing services rendered, but there is no mention of medical malpractice. This one time visit for an incomplete abortion, resulting in what they call a routine D&C, costs the taxpayers around $2,800. A $300 botched abortion costs the taxpayer $2,800! This does not take into account future appointments, prescribed medicines and future related surgery.

In one day, how many times do you think this happens in America? Right now there is no way to know, because the medical community will not call abortion-injury medical malpractice. Instead they call it by another name: "good business." Abortion means higher gross profit and increased cash flow. After all, hospitals administrators have budgets to meet. Staff must be paid, medical supply and pharmaceutical companies must be paid, up-keep and building expansions must be paid. As the saying goes, "while abortion is legal, walk-in emergency room business is good!" Why kill the goose that lays the golden eggs?

A crafty ob/gyn with a small office and access to one hospital, will carry several hundred women suffering from DAC & CAC. The larger offices with two or more gynecologists that have access to major metropolitan hospitals will carry several thousand women suffering from DAC & CAC. Living off these victims, doctors who make abortion referrals resemble the lowest parasite at the end of the food chain.

Pharaoh said to the obstetricians of the day, "When you practice the office of midwife, if it be a boy, kill him." The obstetricians feared God and did not do what the king commanded. So God was kind to the obstetricians - then.

Today we can see how the medical community has changed its work ethic by trading its honor and integrity for the love of money. When they found they could take normal healthy women and by the unnatural act of abortion create chronic patients that feed their industry, they not only perverted themselves but all of society as well.

Here are some questions that, for the love of money, go unanswered. Since abortion is one of the most frequent operations performed in the United States:

■ Why don't we mandate the federal, state and local health departments along with the Centers for Disease Control, instructing them to track the number of abortion related injuries receiving medical care at taxpayers expense?

■ How much money is the taxpayer paying for the care of abortion related injuries?

■ Why don't we mandate the federal and state insurance commissions, instructing them to report the number of abortion related injuries receiving medical care through private and group health insurance?

■ How does abortion related injury impact both private and group health insurance rates for all citizens?

To ask the questions is one thing, but to implement the policies is another. The medical industry and the health insurance companies, along with their supportive special interest groups, own the second most powerful lobbying force in the nation. To protect their abortion cash cow, they would spend millions to stop the implementation and enforcement of such policies. Using their medical authority they suppress the truth, perpetrating a great fraud against the American people at the expense of human life.

Just as flies prosper from the cow-patty, so the medical industry fattens on the blood and treasure found in abortion.

2-4

2-4

Test7-95

TESTMONY

S.B. 134

Senate Judiciary Committee - Room 514-S
Tuesday, March 7, 1995 - 10:00 a.m.

KANSAS CATHOLIC CONFERENCE
Bob Runnels, Executive Director

Mr. Chairman, members of the Senate Judiciary Committee, my name is Bob Runnels, I am Executive Director of the Kansas Catholic Conference and speak under the authority of the Roman Catholic Bishops of Kansas.

It is a pleasure for me to be with you today and give testimony regarding **S.B. 134.**

The principle of parental involvement must be paramount in a child's life. A child with a pregnancy problem needs the strong support of parents during perhaps the most frightening challenge the child would have to face in her young life.

It is inconsistent with reality **NOT** to have parental support during this trying pregnancy period.

This bill corrects a flaw in the current statutes giving a reasonable waiting period before an abortion, so that parents or guardians can be with their child. Abortion clinics have adopted procedures to circumvent this vital support.

We support this improvement and ask that you report **S.B. 134** favorably for passage.

Senate Judiciary
3-7-95
Attachment 3

Dr. Beverly LaHaye
President

CONCERNED WOMEN for AMERICA

Cathy Holthaus
Area Representative

March 7, 1995

SENATE JUDICIARY COMMITTEE
Tim Emert, Chairman
SB 134

Chairman, members of the Committee:

My name is Sharon Stringfellow. I am a volunteer legislative liason for Concerned Women for America of Kansas. We are a pro-family women's organization with over 600,000 members nationwide and approximately 10,000 members statewide. We support SB 134, with the changes it makes in the current abortion law, because it paves the way for better decision making in the crisis pregnancy situation. I will discuss the changes that SB 134 makes and why we support them.

The first change adds to the parental or guardian notification law, a requirement that a parent be notified "not less than 24 hours" before the abortion. We suppport this as the bare minimum. Parents deserve at least a day to consider their daughter's situation and help her in her very critical decision; most likely, the most significant decision she will ever make.

The second change adjusts the time from 8 to 24 hours between the time of providing the woman with the required information to the actual abortion. After receiving the information, the waiting period is supposed to provide time for the woman to reflect upon the information and her situation. We support the 24 hour change, but we do have the following concerns:

1) It is important for the information to be given in person at the clinic site. This cements the reality of the situation and decision in the woman's mind and gives her an added dimension to consider. The common practice of mailing the information form to the woman subverts this contemplative process.

2) It is important for the woman to receive good pertinent information. Although the current law requires that the woman be given information concerning the procedure, her baby's gestational age and options and assistance available to her if she decided to carry her baby to term, it gives the abortionist great liberty, too much liberty, in how he meets the requirements. We would encourage you to get copies of actual informed consent forms and peruse them yourelves. We have found that although the letter of the law has been met, the intent of the law has not.

For the intent of the law to be fulfilled, further changes in the letter of the law are needed. Seeing it as a beginning, we support SB 134.

Concerned Women for America of Kansas
P.O. Box 4 • Seneca, KS 66538 • Phone (913) 336-2091

Senate Judiciary
3-7-95
Attachment 4

#7

ANNETTE S. HORNBACH
12420 BENNINGTON
GRANDVIEW, MO 64030
816-765-8667

DEAR CHAIRMAN & THE REST OF THIS COMMITTEE,

THANK YOU FOR THE OPPORTUNITY TO ADDRESS YOU TODAY. THE REASON I CAME HERE TODAY IS TO APPEAL TO YOU ON BEHALF OF ALL WOMEN FACING AN UNEXPECTED PREGNANCY. IN THE CLINIC THE COUNSELING I RECEIVED WAS VERY BRIEF AND THERE WAS LITTLE TIME TO LET IT SINK IN BEFORE THE ABORTION WAS DONE. I DID ASK TO BE GIVEN ANESTHETIC , KNOWING I COULDN'T GO THROUGH THIS AWAKE. BEFORE I KNEW IT I WAS IN A GOWN AND ON A TABLE. IN MY HEART I WANTED TO STOP IT AND WAS TRYING TO TELL THEM THAT I COULDN'T GO THROUGH WITH THIS. THE NEXT THING I KNEW I WAS WAKING UP , THE FIRST THING I SAID WAS " I WANT TO GO HOME, I DON'T WANT TO DO THIS". THE NURSE TOLD ME IT WAS ALREADY DONE, I WENT IN TO SHOCK FOR DAYS AFTER WITH MY HEART BROKEN AND MY BABY DEAD.

AT THE SAME TIME MY HUSBAND WAS OUT SIDE TALKING TO A MAN ABOUT WHAT ABORTION REALLY DOES. HIS THOUGHTS ALSO TURNED TO REALIZE THAT THIS WASN'T WHAT HE WANTED EITHER, BUT IT WAS TOO LATE FOR HIM TO LET ME KNOW. I TRULY BELIEVE THAT GIVEN A SIMPLE DAY TO THINK IT THROUGH WE WOULD HAVE 3 CHILDREN ALIVE TODAY.

WE BOTH PLEAD WITH YOU TO GIVE OTHER MEN & WOMEN THE TIME TO CONSIDER ALL THE OPTIONS WE NOW KNOW THAT ARE AVAILABLE. SUCH AS ST. LUKE'S MATERNITY PROGRAM AND SCORES OF OTHER AGENCIES THAT PROVIDE SHELTER, FOOD, CLOTHING ETC..

OUR CHILD WOULD HAVE BEEN 9 YEARS OLD THIS MONTH, THE PAIN AND GRIEF ARE AS REAL TODAY AS IT WAS THEN. THERE WILL ALWAYS BE A GREAT VOID IN OUR LIVES FOR THE BABY THAT DIED THAT DAY. SINCE THAT TIME WE HAVE TRIED TO HAVE MORE CHILDREN. SEVERAL MISCARRIAGES LATER AND MY AGE INCREASING OUR HOPES HAVE BEEN DIMINISHED OF EVER HAVING MORE CHILDREN. ONE DAYS TIME OUT OF OUR ENTIRE LIFE WOULD HAVE GIVEN US THE OPPORTUNITY TO LOVE OUR CHILD FOR EVER, INSTEAD WERE LEFT WITH ONLY GRIEF AND PAIN.

A DIFFICULT DECISION, ONE WITH CONSEQUENCES THAT LAST A LIFE' TIME SHOULD NOT BE CARRIED OUT IN A MATTER OF MINUTES.

PLEASE CONSIDER WHAT I HAVE TOLD YOU TODAY. THANK YOU AND MAY GOD BLESS YOU.

ANNETTE HORNBACH

Annette S Hornbach

Senate Judiciary
3-7-95
Attachment 5

NANCEY HARRINGTON
SENATOR TWENTY-SIXTH DISTRICT
9811 SOUTH 183RD WEST
CLEARWATER, KANSAS 67026
(316) 584-3267

STATE CAPITOL
ROOM 143-N
TOPEKA, KANSAS 66612-1504
(913) 296-7367

STATE OF KANSAS

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
EDUCATION
PUBLIC HEALTH AND WELFARE
TRANSPORTATION

Testimony presented to Senate Judiciary Committee on Senate Bill 134
March 7, 1995
By Senator Nancey Harrington

Thank you Chairman Emert and members of the Senate Judiciary Committee for allowing me the opportunity to present written testimony on Senate Bill 134.

The purpose of SB 134 is to allow for an appropriate amount of time after informing the patient the nature of the procedure and of any medical risks involved, a 24 hour waiting period to provide time for reflection. Allowing for a 24 hour time of reflection on a procedure that is irrevocable and of this nature is not unreasonable. Expecting written informed consent for minors by the minor's parents or legal guardians for this surgical procedure is not unreasonable, as well, considering written consent is required for any other form of surgery a minor may need.

In the case of a minor, where written consent is needed, and a judicial bypass necessary, the bypass would take at least one day, therefore providing the 24 hour waiting period.

Senate Bill 134 is worthy of consideration and passage. I ask the committee's support for SB 134. Thank you.

Senate Judiciary
3-7-95
Attachment 6

#

TESTIMONY IN OPPOSITION TO SB 134
SENATE JUDICIARY COMMITTEE
TUESDAY 7 MARCH 1995 10;00 ROOM 514 SOUTH

Senator Emert and Members of the Committee:

I am Darlene Stearns, League of Women Voters of Kansas, appearing in opposition to SB 134. The League of Women Voters position on reproductive choice is as follows: " to protect the constitutional right of individuals to make individual choices."

The requirements in SB 134 to increase the notification period for minors and the notification for informed consent for all women from eight to twenty-four hours is simply another attempt to make abortion more difficult to obtain for all women.

Since Roe V. Wade was decided yearly attempts have been made to overturn the decision, and failing that, to place one barrier after another in the way of women seeking legal abortions. Couched in language that aims to protect women, these bills only make the decision more difficult in terms of time spent, available finances, and in the case of minors, support from persons willing and able to help the minor through the legal procedures. There seems to be a conviction by those promoting this restrictive legislation that women are incapable of making as serious decision as abortion without the government guiding them step by step.

The mind-set against choice seems to permeate the legislative agendas these days. We son't want teen-age women to get pregnant but we don't want to teach sex education in the schools. We don't want to pay teen mothers (or any mothers) more ADC if they have more children but we want to give more money to states that reduce their abortion rates. We don't want teen-age women to become mothers at all but we put obstacles in their way to obtain abortions. The reality is, members of the Committee, that women will continue to become pregnant and will continue to seek abortions regardless of laws that attempt to prevent either pregnancy or abortion. Birth control is legal. Abortion is legal. We believe these restrictions interfere with a woman's choice and we ask you to vote against this bill.

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

Senate Judiciary
3-7
Attachment 7

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

Dedicated • Determined • Decisive

To: Members of the Senate Judiciary Committee
From: Peggy Jarman
Regarding: S.B. 134

In 1992 after many hours and much debate, a compromise abortion bill was signed into law. I have heard many times that it must be a pretty good law because no one likes it. That statement is inaccurate. A recent poll of ProChoice Action League members indicated that 70% found the law acceptable. Of those who understood the full scope of the law only 3% indicated they thought the law was terrible. The Kansas abortion law guarantees access, protects minors, restricts abortions after viability, protects clinics from blockades, and protects our cities from being emotionally shredded by abortion extremists at every council meeting and in every election. It is a good law, not because no one is happy with it, but because the overwhelming majority are happy with it. It remains true that this is an arena where government should not be involved, but to the extend that it is, its role—in the interest of women's health— should be to assure access not impede access and that is exactly what this law does as it is currently written.

A waiting period of any amount is an unnecessary intrusion by government into women's lives. It is paternalistic. It is condescending. Can you imagine a waiting period to purchase a gun that applied to women only? Can you imagine a waiting period for men to have a vasectomy? If this committee were to consider anything about waiting periods, it should be to remove the eight hour waiting period that is current law. The governor, however, has stated clearly that he will veto any attempts to change the law. My conclusion, therefore, is to let it be. As philosophically demeaning as eight hours may sound, it does not delay abortion services nor interfere with access. No law should.

The addition of a 24 hour waiting period for minors is totally without justification. Notification is about parents who are <u>not</u> involved with the abortion decision. Parents who are not involved in the decision are not called and told their daughter is having an abortion. This does not happen. If a parent is not involved, the judicial by-pass is used. The judicial by-pass always necessitates a delay of at least 24 hours.

Senate Judiciary
3-7-95
Attachment 8

4-2

Planned Parenthood®
Of Kansas, Inc.

Testimony in opposition to SB 134
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 Senate Bill 134.

> 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."

• After the 12th week of pregnancy, abortions require more skill, and there is greater risk of uterine perforation, hemorrhage and other complications. By compelling women to delay their abortion into the second trimester, a forced waiting period adds a significant risk factor to the abortion procedure.

Mandatory waiting periods are exacerbated by distance. Women in rural areas would face additional detrimental burdens of medical risk, time, expense and travel as a result of mandatory forced delays for abortion services.

• Young women delay getting an abortion longer than do adult women. A built-in delay already exists between the moment a woman finds out she is pregnant and actually enters a clinic, during which period a woman has more than enough time to think over her decision.

• Dr. Willard Cates, former head of the Abortion Surveillance Branch of the U.S. Center for Disease Control, concludes that "delay has the largest single effect on the risk to teenagers for complications and death from abortion."

• Forced delays demean women's decision-making ability. The mandatory waiting period ostensibly exists so that a woman has time to "think over" her options. A forced delay law implies that women who seek abortions do so without adequate reflection, and are incapable of making reasoned decisions regarding their health and future.

Senate Judiciary
3-7-95
Attachment 9

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

• Women having abortions carefully consider their decisions in light of their individual circumstances and whether they are ready to have children. Most women have more than one reason for wanting to terminate a pregnancy; the average abortion patient cites four different reasons for her decision.

• Whereas first-trimester abortions usually cost between $200 to $400, a second-trimester abortion can cost $1,000 or more.

• Women having abortions carefully consider their decisions in light of their individual circumstances and whether they are ready to have children. Most women have more than one reason for wanting to terminate a pregnancy; the average abortion patient cites four different reasons for her decision.

• In one study, nearly two-thirds of the women who had complied with a state-mandated waiting period could name one or more problems caused by the requirement. Problems most frequently cited were additional mental anguish, transportation and logistical problems, and extra physical discomfort.

• The logistics of arranging a second appointment may be cumbersome or even prohibitive for many of the 68 percent of patients who are working (and would have to arrange additional time off from work), the 42 percent who already have children (and would have to make child care arrangements), and the 31 percent who are in school.

• In one study, 62 percent of patients who had complied with a state-mandated waiting period said the requirement had resulted in additional costs in terms of lost wages, transportation, lodging, or additional child care.

Please oppose SB 134. It is not good for women's health.

9-2

#9

Testimony
in Opposition to Senate Bill No. 134
March 7, 1995
Senate Judiciary Committee
Hon. Tim Emert, Chair

Thank you, Mr. Chairman and members of the Committee for this opportunity to address SB 134 in writing this morning.

My name is Carla Dugger, and I am the Associate Director of the American Civil Liberties Union of Kansas and Western Missouri. We are a private, not-for-profit membership organization which supports and defends civil liberties.

SB 134 requires that "not less than 24 hours" of "notice of the intent to perform [an] abortion" be given to the parent or legal guardian of a minor seeking an abortion.

Please hold the proponents of SB 134 strictly accountable to show how this mandated waiting period aids minors in any way which supersedes the potential damage done to them. SB 134 would, in fact, further delay their access to this needed and constitutional service, and delay means risk.

The need to reinforce family relationships is the reason most often cited to justify state laws calling for various parental notification requirements before a minor may obtain an abortion. However, such laws are unnecessary for stable and supportive families, and they are ineffective and cruel for unstable, troubled families. They create delays that increase the medical risks of abortion and effectively eliminate the option of abortion for many minors. Senate Bill 134 would only serve to increase these already serious risks.

The American Civil Liberties Union opposes parental notification laws on the grounds that they infringe upon minors' constitutional rights and serve no useful purpose. We oppose those restrictions already in Kansas law, and we even more strongly oppose any legislation which would worsen them.

In order to prevent unwanted pregnancy from being a dangerous condition for teenagers, we must ensure that young women have access to confidential counseling, contraception and abortion services, as well as prenatal care. At stake are young women's lives, safety, health and dignity.

SB 134 in no way benefits "young women's lives, safety, health and dignity." Please reject SB 134.

Senate Judiciary
3-7-95
Attachment 10

#2

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

Testimony presented to

Senate Judiciary Committee

by

The Kansas Department of Health and Environment

House Bill 2083

K.S.A. 65-445 currently requires that hospitals keep records of induced terminations of pregnancy that are performed and report them to the Secretary of Health and Environment. At the time that this statute was passed, hospitals were most likely the provider of choice for legal terminations. Over time the increasing demands for such procedures has contributed to the evolution of the specialized clinic. These facilities now provide the majority of the terminations and hospitals currently provide a small proportion of the procedures.

Even though these specialized clinics are not required to report to KDHE, we have been fortunate in being able to secure the cooperation of these providers to voluntarily report. We have worked very hard to contact any provider that is made known to us and request their cooperation and assure them that the confidentiality they desire will be maintained. We feel the amended version of this bill should significantly decrease any concerns about the confidentiality of the data collected and thereby encourage even greater participation in the reporting process. This in turn will increase the reliability, validity and usefulness of the data.

We believe that the information that is provided by these clinics is an essential component of any consideration of such problems as teenage pregnancy. A mandatory reporting requirement would help ensure that KDHE would continue to receive these data regardless of any change in ownership, management philosophies, etc. that could occur and change the current status of cooperation. On the other hand, a mandatory reporting requirement proposed at a time when cooperation is extremely high could be viewed as unnecessary government intervention.

It is the goal of KDHE and the Center for Health and Environmental Statistics to provide high quality information for program staff, the legislature and the public in general. We will therefore continue our efforts to ensure that we have a comprehensive reporting system as a mandatory or a voluntary effort.

Testimony presented by:

Lorne A. Phillips, PhD., Director
Center for Health and Environmental Statistics
March 7, 1995

Senate Judiciary
3-7-95
Attachment 11

Center for Health and Environmental Statistics, 900 SW Jackson, Room 152, Topeka, KS 66612-1290
Telephone: (913) 296-1415——Fax: (913) 296-8075

TYPE OR PRINT IN PERMANENT INK

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Office of Research and Analysis
Topeka, Kansas 66620-0001
913-296-5645

REPORT OF INDUCED TERMINATION OF PREGNANCY

STATE FILE NUMBER

INSTRUCTIONS SEE HANDBOOK

1. FACILITY NAME (If not clinic or hospital give address)	2. CITY, TOWN, or LOCATION OF PREGNANCY TERMINATION	3. COUNTY OF PREGNANCY TERMINATION

4. PATIENT'S IDENTIFICATION NUMBER	5. AGE LAST BIRTHDAY	6. MARRIED? ☐ Yes ☐ No	7. DATE OF PREGNANCY TERMINATION (Month, Day, Year)

8a. RESIDENCE - STATE	8b. COUNTY	8c. CITY, TOWN, OR LOCATION	8d. INSIDE CITY LIMITS? ☐ Yes ☐ No

9. ANCESTRY--CUBAN, MEXICAN, PUERTO-RICAN, VIETNAMESE, HMONG, ENGLISH, GERMAN, ETC. Specify_____	10. RACE 1. ☐ White 2. ☐ Black 3. ☐ American Indian 4. ☐ Other (Specify)_____	11. EDUCATION (Specify only highest grade completed)	
		Elementary/Secondary (0-12)	College (1-4 or 5 +)

12. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	13. CLINICAL ESTIMATE OF GESTATION (Weeks)	14. PREVIOUS PREGNANCIES (Complete Each Section)			
		LIVE BIRTHS		14c. PREVIOUS INDUCED ABORTIONS	14d. ALL OTHER TERMINATIONS (DO NOT INCLUDE THIS TERMINATION)
		14a. Now Living	14b. Now Dead		
		Number ___ None ☐	Number ___ None ☐	Number ___ None ☐	Number ___ None ☐

15. TERMINATION PROCEDURES

15a. PROCEDURE THAT TERMINATED PREGNANCY

TYPE OF TERMINATION PROCEDURES

15b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY

(Check only one)

(Check all that apply)

1. ___ Suction Curettage ___ 1.
2. ___ Sharp Curettage ___ 2.
3. ___ Dilation & Evacuation (D&E) ___ 3.
4. ___ Intra-Uterine Saline Instillation ___ 4.
5. ___ Intra-Uterine Prostaglandin Instillation ___ 5.
6. ___ Hysterotomy ___ 6.
7. ___ Hysterectomy ___ 7.
8. ___ Other Specify_____ ___ 8.

_____

17. NAME OF PERSON COMPLETING REPORT (Type or Print)_____

VS-213
Rev. 6/92

Senate Judiciary
3-7-95
Attachment 12

TYPE IN
P IT

Kansas Department of Health and Environment
Office of Vital Statistics

CERTIFICATE OF STILLBIRTH (FETAL DEATH)

SEE HAN FOR INSTRUCTIONS

STATE FILE NUMBER

FETUS

1. NAME — FIRST — MIDDLE — LAST | 2. DATE OF DELIVERY *(Month, Day, Year)* | 3. TIME OF DELIVERY M.

4. SEX | 5. CITY, TOWN, OR LOCATION OF DELIVERY | 6. COUNTY OF DELIVERY

7. PLACE OF DELIVERY:
☐ Hospital ☐ Freestanding Birthing Center ☐ Residence
☐ Clinic/Doctor's Office ☐ Other *(Specify)* _____

8. FACILITY NAME (If not institution, give street and number)

MOTHER

9. MOTHER'S PRESENT NAME *(First, Middle, Last)* | 10. MAIDEN SURNAME | 11. DATE OF BIRTH *(Month, Day, Year)*

12. STATE OF BIRTH *(If not in U.S.A., name country)* | 13. PRESENT RESIDENCE—STATE | 14. COUNTY | 15. CITY, TOWN, OR LOCATION

16. STREET AND NUMBER OF PRESENT RESIDENCE | 17. INSIDE CITY LIMITS? ☐ YES ☐ NO | 18. MOTHER'S MAILING ADDRESS *(If same as residence, enter Zip Code only)*

FATHER

19. FATHER'S NAME *(First, Middle, Last)* | 20. DATE OF BIRTH *(Month, Day, Year)* | 21. STATE OF BIRTH *(If not in U.S.A., name country)*

PARENT

22. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.
Signature of Parent (or Other Informant) ▶ | 23. DATE SIGNED

CAUSE

24. PART I. FETAL DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) | SPECIFY FETAL OR MATERNAL

FETAL OR MATERNAL CONDITION DIRECTLY CAUSING FETAL DEATH
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF:

FETAL AND/OR MATERNAL CONDITIONS, IF ANY, GIVING RISE TO THE IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST
(b) _____
DUE TO, OR AS A CONSEQUENCE OF:
(c)

PART II. OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER: Conditions contributing to fetal death but not related to cause given in Part I(a) | 25. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN (Specify) | 26a. AUTOPSY ☐ YES ☐ NO | 26b. Were findings considered in determining cause of death. ☐ YES ☐ NO

CERTIFIER

27a. I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED ABOVE AND THE FETUS WAS BORN DEAD
SIGNATURE X | 27b. DATE SIGNED *(Month, Day, Year)* | 27c. ATTENDANT—M.D., D.O., MIDWIFE, OTHER (Specify)

27d. CERTIFIER—*MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip)* | 28. ATTENDANT (If delivery not attended by physician)
SIGNATURE X

DISPOSITION

29a. BURIAL, CREMATION, OR REMOVAL (Specify) | 29b. CEMETERY OR CREMATORY—NAME | 29c. LOCATION (City or Town, State)

30. FUNERAL DIRECTOR OR HOSPITAL ADMINISTRATOR
SIGNATURE | 31. FOR VITAL STATISTICS USE ONLY

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

	32. ANCESTRY—*Cuban, Mexican, Puerto Rican, Vietnamese, Hmong, etc. (Specify)*	33. RACE—*Nat. Amer., Black, White, etc. (Specify)*	34. EDUCATION *(Specify only highest grade completed)* Elementary/Secondary (0-12)	34. EDUCATION College (1-4 or 5 +)	35. OCCUPATION AND BUSINESS/INDUSTRY Occupation	35. OCCUPATION AND BUSINESS/INDUSTRY Business/Industry (Do not give name of company)
MOTHER	32a.	33a.	34a.		35a. (Most recent)	35c.
FATHER	32b.	33b.	34b.		35b. (Usual)	35d.

36. PREGNANCY HISTORY (Complete each section)				37. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*	38. CLINICAL ESTIMATE OF GESTATION *(Weeks)*
LIVE BIRTHS *(Do not include this child)*		OTHER TERMINATIONS *(Spontaneous and Induced)*		39. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. *(Specify)*	40. PRENATAL VISITS—Total Number *(If none, so state)*
36a. Now living Number ____ ☐ None	36b. Now dead Number ____ ☐ None	36d. Before 20 weeks Number ____ ☐ None	36e. 20 weeks & over Number ____ ☐ None	41. PLURALITY—Single, Twin, Triplet, etc. *(Specify)*	42. IF NOT SINGLE DELIVERY—Born First, Second, Third, etc. *(Specify)*
36c. DATE OF LAST LIVE BIRTH *(Month, Year)*		36f. DATE OF LAST OTHER TERMINATION *(as indicated in d or e above) (Month, Year)*		43. WEIGHT OF FETUS (Grams)	44. MOTHER MARRIED? (At delivery, conception or any time between) ☐ Yes ☐ No

(Please use X to mark boxes. Mark all that apply.)

PRENATAL

45. Nutrition of Mother
1. Height _____
2. Prepregnancy weight _____
3. Total pregnancy weight gain _____

46. Medical Risk Factors
1. ☐ None
2. ☐ Uterine bleeding
3. ☐ Incompetent cervix
4. ☐ Isoimmunization *
5. ☐ Hydramnios/ Oligohydramnios *
6. ☐ Eclampsia
7. ☐ Pre-eclampsia (PIH) *
8. ☐ Previous preterm or SGA infant *
9. ☐ Previous infant, > 4000 grams
10. ☐ Hepatitis B/HBsAg
11. ☐ Genital herpes
12. ☐ AIDS or HIV antibody
13. ☐ Other STD *
14. ☐ Anemia (Hct. < 30/Hbg. < 10)
15. ☐ Hemoglobinopathy
16. ☐ Cardiac disease
17. ☐ Diabetes
18. ☐ Hypertension, chronic
19. ☐ Acute/chronic lung dis.
20. ☐ Renal disease
21. ☐ Underweight (< 10%)
22. ☐ Obesity (> 20%)
23. ☐ Tobacco use— No. of cig. per day_____
24. ☐ Alcohol use—No. of drinks per wk. _____
25. ☐ Other *
* Specify

47. Prenatal Procedures
1. ☐ None
2. ☐ Diabetes screening
3. ☐ Alpha-fetoprotein (serum)
4. ☐ Ultrasound
5. ☐ Chorionic villus sampling
6. ☐ Amniocentesis
7. ☐ Tocolysis
8. ☐ Other *
* Specify

LABOR-DELIVERY/STILLBORN FETUS

48. Conditions of Labor and Delivery
1. ☐ Normal
2. ☐ Placenta previa
3. ☐ Placenta abruptio
4. ☐ Other intrapartum hemorrhage
5. ☐ PROM (> 12 hrs.)
6. ☐ Induction of labor
7. ☐ Stimulation of labor
8. ☐ Dysfunctional labor
9. ☐ Precipitous labor (< 3 hrs)
10. ☐ Prolonged labor (> 20 hrs)
11. ☐ Cephalopelvic disproportion
12. ☐ Electronic fetal monitoring
13. ☐ Fetal distress
14. ☐ Febrile (100 F./38 ° C.)
15. ☐ Meconium, moderate/ heavy
16. ☐ Breech presentation
17. ☐ Seizures during labor
18. ☐ Cord prolapse
19. ☐ Anesthetic complications
20. ☐ Placenta/Cord normal
21. ☐ Placenta/Cord Abnormal
22. ☐ Other *
* Specify

49. Method of Delivery
1. ☐ Spontaneous vertex
2. ☐ VBAC
3. ☐ C-Sec.—Prim.
4. ☐ C-Sec.—Repeat
5. ☐ C-Sec.—Elect.
6. ☐ C-Sec.—Unsched.
7. ☐ C-Sec.—Emerg.
8. ☐ Vaginal breech
9. ☐ Forceps
10. ☐ Vacuum
11. ☐ Hysterotomy/Hysterectomy
12. ☐ Other *
* Specify

50. Condition of Fetus
1. ☐ Normal appearance
2. ☐ Some maceration
3. ☐ Severe maceration
4. ☐ Edema
5. ☐ Birth injury *
6. ☐ Other *
* Specify

51. Congenital Anomalies of Fetus
1. ☐ None
2. ☐ Spina bifida/Meningocele
3. ☐ Anencephalus
4. ☐ Hydrocephalus
5. ☐ Microcephalus
6. ☐ Other CNS anomalies *
7. ☐ PDA
8. ☐ Heart malformations, except PDA
9. ☐ Other circulatory/respiratory anomalies *
10. ☐ Rectal atresia/stenosis
11. ☐ Tracheo-esophageal fistula/Esophageal atresia
12. ☐ Omphalocele/Gastroschisis
13. ☐ Other gastrointestinal anomalies *
14. ☐ Malformed genitalia
15. ☐ Renal agenesis
16. ☐ Other urogenital anomalies *
17. ☐ Cleft lip/palate
18. ☐ Polydactyly/Syndactyly/Adactyly
19. ☐ Club foot
20. ☐ Diaphragmatic hernia
21. ☐ Other musculoskeletal/integumental anomalies *
22. ☐ Down's syndrome
23. ☐ Other chromosomal anomalies *
24. ☐ Fetal alcohol syndrome
25. ☐ Other *
* Specify

Senate Judiciary
3-7-95
Attachment 13

THIS IS NOT A PART OF THE CERTIFICATE OF STILLBIRTH
Required by K.S.A. 65-153F, 153G

Serological Test Made: ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester ☐ At Delivery ☐ Not Performed
If no Test made state reason: _____

Chapters and Affiliates

Abilene
Atchison
Arkansas City
Augusta
Barber County
Brown County
Chanute
Chase County
Clay Center
Coffey County
Coffeyville
Colby
Columbus
Concordia
Decatur County
Dodge City
Doniphan County
Edwards County
El Dorado
Elk County
Emporia
Erie
Fort Scott
Franklin County
Garden City
Garnett
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
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 and Universities

(12) Chapters

Kansans for Life

PO BOX 4492 • TOPEKA, KS 66604 • (913) 234-3111

March 7, 1995

Mister Chairman and Members of the Committee:

Kansans for Life, the state's largest pro-life organization, supports House Bill 2083. With an issue as controversial as abortion, the state is entitled to know the facts. Currently, the majority of facilities performing abortions in the state of Kansas are not required by law to report the number of abortions performed to the Department of Health and Environment.

According to the Alan Guttmacher Institute, a research arm of Planned Parenthood, in 1973, 81% of abortion providers were hospitals and they performed over 50% of all abortions. However, in 1992, only 36% of providers were hospitals and they performed only 7% of all abortions in the U.S.

In the state of Kansas, we allow the majority of abortion providers to "voluntarily" report the number of abortions they perform. In no other industry does the state settle for this type of voluntary reporting. Even waiters and waitresses are required by law to accurately report their income from tips! It is not unreasonable to require accurate reporting from the abortion industry, which deals primarily in cash. Surely the temptation exists to "under-report" in this type of cash business and settling for "voluntary" reporting does not encourage truthfulness.

In the past ten years, we have consistently seen discrepancies between the number of abortions reported to the Alan Guttmacher Institute by providers as compared to the numbers given to the Kansas Department of Health and Environment by those same abortionists. The discrepancies have been as high as 5,021 abortions in one year being under-reported to the KDHE! Whose numbers are we to believe?

Senate Judiciary
3-7-95
Attachment 14

The state of Kansas, in its Healthy Kansans 2000 initiative, places a priority on the need to define the impact of health problems through baseline incidence rate and the identification of data needed to monitor progress toward goal achievement. The KDHE indicates that state-specific data resources are needed, not national estimates. Five of the seven top health issues targeted by HK 2000 are directly impacted by abortion! Therefore, HK 2000 absolutely requires mandatory abortion statistics. (The five areas affected by abortion are: Alcohol and drug use, Cancer, Heart disease, STDs and Maternal and Infant health. See attached colored research newsletters.)

The neighboring state of Missouri has had mandatory reporting since 1979 and their statute (188-055), states as its purpose and function:

(1) the preservation of maternal health and life by adding to the sum of knowledge through the compilation of relevant meternal health and life data and

(2) to monitor all abortions performed to assure that they are done only under, and in accordance with, the provisions of the law.

Why do the women of the state of Kansas not enjoy this same dignity and protection? Certainly this body should not want to jeopardize the future safety of Kansas women by denying them health education and prevention programs grounded in accurate data. I ask you to find HB 2083 favorable for passage.

Jeanne L. Gawdun
Lobbyist
Kansans for Life

Ch and
Aff

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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

1. ***Why is routine, confidential, abortion reporting important?***
Women are the losers when medical facts and statistics are withheld from researchers, doctors, educators, insurers, etc. It is women who will suffer the effects of inadequate compilation and comparison of scientific data. It is they who will endure the side effects, avoidable medical consequences, including death, and the absence of timely research. It is women who will pay the price for abortion decisions made without accurate scientific information. Who has the gall to tell Kansas women that they just don't need to know the health affects of abortion?

2. ***Does reporting violate a woman's Constitutional right to privacy?***
NO! Since 1976, the Supreme Court held: Reporting and record-keeping of abortion facilities and physicians have medical value and are useful to the state for protecting female health. With reasonable confidentiality and retention provisions, and without burdensome administration, reporting does not interfere with either the abortion decision or the doctor-patient relationship. (Planned Parenthood of Cent. Missouri v. Danforth 96S.Ct.2831,428 U.S.52,49 L.Ed.2d788)

3. ***If abortionists are volunteering information, why does the state have to get involved?*** Over the past years, discrepancies in annual state totals have been as high as 5000! Kansas is still reporting inaccurate figures to the Center for Disease Control (CDC). Jack Smith, head of CDC's Reproductive Health Statistics, says this is the ONLY kind of health data that is held hostage to politics. AIDS, Sexually Transmitted Diseases, Cancer, etc. are all mandatorily reported without privacy leaks. The question should be, why is the abortion industry treated so specially? Certainly, women assume that the state would not cooperate with abortionists to repress routine medical data at the expense of women's safety!

4. ***How is abortion related to women's health and other state health initiatives?***
Abortion raises breast cancer risk 150% -900% according to 42 studies from scientists (including pro-choicers). Smoking increases for women who abort, approximately 10% increase each abortion. Smoking during pregnancy for aborted women was twice the rate of non-aborted. 96% of teens drinking alcohol thru all 9 months of a subsequent pregnancy, had been aborted. Thus, abortion directly impacts the state's targeted health problems of low weight babies, heart disease and cancer. Budget decisions for the Healthy Kansas 2000 initiatives, possible welfare reform which monitors abortion, and impending developments in health insurance will be directly impacted by accurate, mandatory abortion reporting.

*HB2083 promotes women's health by mandating routine, confidential abortion reports such as Missouri has had for 21 years: sane, Constitutionally sound & unburdensome.

Health issues in Adolescent Pregnancy Decision-Making

Early Child Bearing Provides Protection From Breast Cancer

A womans age at her first full term pregnancy is a critical risk factor for breast cancer. This is an issue of particular interest to adolescents. The longer the length of time from the onset of the first menstrual period to the first full term pregnancy the greater the risk of breast cancer. If one arbitrarily assigns a relative risk of 1.0 to nulliparous women, then a nearly three-fold variation in breast cancer risk can be observed ranging from 0.5 for women who have their first child before age 20 to 1.4 for women who give birth to their first child after age 37. *Etiology of Human Breast cancer*, MacMahon B. et al, J. National Cancer Institute 50:21 (1973). *Diagnosis and Management of Breast Cancer*, Lippman, Marc E. et al, W.B. Saunders Co. (1988) p. 3

Induced abortion, which is usually in the first trimester, does not appear to provide the protective effect of a full-term pregnancy. Thirteen studies have reported that an induced abortion is a risk factor for breast cancer (Relative Risk 1.1-2.7); 4 studies report that an induced abortion provides a slight protective effect against breast cancer and 6 studies report that an induced abortion has no effect on breast cancer risk. *Early Abortion and Breast Cancer Risk Among Women Under Age 40*, H. L. Howe et al, Int'l J. Epidemiology 18(2): 300-304, (1989) citing various studies.

Abortion Increases Risk of Adolescent Infection

Induced abortion by aspiration curettage (the most common method) is directly implicated in post-abortion infections such as endometritis (inflamation of the uterine wall) or (PID) Pelvic Inflammatory Disease (inflammation of the female genital tract). Adolescents are at a particularly high risk especially when unrecognized sexually transmitted diseases (STD) such as chlamydia or gonorrhea are present at the time of the abortion. The abortion procedure stimulates the spread of the unrecognized STD into the uterine cavity causing the infection. Also, instruments used during the abortion procedure may introduce micro-organisms into the uterine cavity or fetal remains following the abortion may also cause infection. *Culture and Treatment Results in Endometritis Following Elective Abortion,* Burkman, et al Am. J. Obstet. Gynecol 128: 156 (1977. *Genital Infections Women Undergoing Therapeutic Abortion,* Avonts and Piot, Europ. J. Obstet., Gynecol. Reprod. Biol, 20: 53 (1985).

Over one million U.S. women annually experience an episode of pelvic inflammatory disease (PID) with 16-20% of cases in teenagers. Acute PID is a major direct cause for infertility, chronic pelvic pain, ectopic pregnancy or even death. *PID and its Sequelae in Adolescents*, Washington et al, J. Adolescent Health Care 6: 298 (1985). The reported incidence of untreated PID following abortion is 0-13% in Scandinavian studies. If chlamydia trachomatis is present at the time of abortion the incidence of untreated PID is 10-37%. *Sexually Transmitted Diseases*, Holmes, Mardh et al, McGraw-Hill (1989) p. 598-599. Women age 15-19 are 2 1/2 times more likely than women 25-29 and five times more likely than women 30-34 to aquire PID when chlamydia or gonorrhea is present in the cervix. *Id.*

A John Hopkins Hospital study found that teenagers 17 years or less were 2.5 times more likely than women 20-29 to aquire endometritis following abortion. The incidence of untreated endometritis following abortion ranges from 3.5% to 14.7% according to John Hopkins Hospital Studies. *Morbidity Risk Among Young Adolescents Undergoing Elective Abortion*, Burkman et al, Contraception , Vol. 30: 99-105 (1984); *Post-abortal Endometrtis and Isolation of Chlamydia, Trachomatis,* Barbacci, M. et al Obstet. Gynecol. 68: 686 (1986).

Adolescent Abortion Risks Increased Maternal Smoking

Women tend to smoke for emotional reasons and as a coping reaction to stress. There is a particular intensification of fear and anxiety in pregnant women who have had previous abortions. Women who have had elective abortions are more likely to smoke during subsequent pregnancies intended to be carried to term compared with women with other reproductive outcomes. A Swedish study of maternal smoking among 4719 women during 1970-78 found that 37.4% of women having prior abortions smoked 10 or more cigarettes per day compared with 21.1% of parity matched controls and 18.9% of all Swedish women. The women with prior abortions were more often teenagers and unmarried at delivery than the control groups. *Outcome of First Delivery After 2nd Trimester Two-Stage Induced Abortion: A Controlled Historical Cohort Study*, Meirik, Nygren, Acta Obstetricia et, Gynecol Scand. 63(1): 45-50 (1984);

TESTIMONY

H.B. 2083

Senate Judiciary Committee - Room 514-S
Tuesday, March 7, 1995 - 10:00 a.m.

KANSAS CATHOLIC CONFERENCE
Bob Runnels, Executive Director

Thank you Mr. Chairman and members of the Senate Judiciary Committee for allowing me to testify in support of obtaining better information regarding the total number of abortions that are being performed in Kansas.

It would seem that it is about time that we are to look at and be able to respond to accurate information.

We ask that you report **H.B. 2083** favorably for passage.

****

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TESTIMONY - HOUSE BILL 2083
KANSAS SENATE COMMITTEE ON THE JUDICIARY
FEBRUARY 7, 1995

BACKGROUND AND PURPOSE OF THE BILL:

House Bill 2083 is simply an update, fulfilling the original intent of an existing statute. **It entails no policy changes.** In 1970 the Kansas Legislature deemed **abortion reporting of such importance that they made reporting of all abortions mandatory.** I do not believe that the legisature then, had a hidden agenda or that their intent was to harrass or intimidate abortion providers, any more so than that is the intent of the sponsors of this bill. In 1970 abortions were restricted to hospitals so that was the language of the statute. **This bill simply extends the reporting to those who are performing abortions today**.

It is a reasonable and minimal attempt to provide accurate information and statistics regarding the practice of abortion, and does not go near as far as some other states. For instance, **in Missouri, any physician who sees a patient with complications from an abortion is required to file a report.**

CONFIDENTIALITY

Reports gathered under this statute are confidential and may be used for statistical purposes only. Another section of the act which was amended in 1993 required confidentiality of reports made to KDHE. The House added an

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amendment to this bill, an amendment supported by Right To Life of Kansas, which specifically ensures the confidentiality of pregnancy termination reports.

An item of misunderstanding in the House concerned a table in the Annual Summary which lists abortions by county of residence of the patient. This is important demographic information but some House members were led to believe that this information related to the location of providers. No such information is published and the House amendment specifically prohibits it.

In the Hospital Handbook KDHE states;

> "The State Registrar protects the information on vital records from unwarranted or indiscriminate disclosure by adhering to the laws and regulations that stipulate who may obtain copies of individual records and for what purposes the files may be accessed."

The KDHE handles volumes of confidential records of a sensitive nature. They have been collecting abortion records since 1970. Opponents of this bill in the House, who said they were concerned over confidentiality, nevertheless did not even attempt to allege that there had been any breaches of confidentiality during that time.

NEED FOR THE BILL

Abortion statistics compiled by the KDHE are included in the Annual Summary of Vital Statistics about which KDHE writes; "**The facts contained in this report are essential for effictive health policy decisions and program planning.**" and in the Hospital Handbook; (these statistics) "are essential to the fields of social welfare, public health, and demography. They are also used for business and government program planning and evaluation."

16-2

Other uses of pregnancy termination data according to KDHE, include analysis of health risks related to factors such as age of the patient, length of gestation, etc., impact of abortion on fertility rates and so on. Abortion statistics are an integral component of fertility rates. Without accurate abortion stats you can not have accurate fertility rates on which to base population projections essential to planning decisions.

As the KDHE also states; **"The quality of the analyses in the Annual Summary of Vital Statistics depends on the accuracy of the Kansas vital statistics data."** Underreporting of abortion by the KDHE **not only affects Kansas, but the entire nation because the Centers for Disease Control (CDC) and the National Center for Health Statistics (NCHS) which compiles national health data use KDHE information for their analyses.** The pregnancy termination form currently in use by KDHE is modeled after forms in use across the country.

As we are learning more and more, for instance with breast cancer, abortion and particularly multiple abortions, do have an effect on the future health of women and babies. Another issue of vital concern, escalating teenage pregnancy rates, cannot be accurately assessed unless we have accurate abortion rates.

ACCURACY OF THE KANSAS DATA

Opponents will tell us that most abortions are reported voluntarily. Ten years ago when this bill was introduced for the first time the health department claimed that 90 % of abortions were being reported then. Yet for the past few years increases in reported abortions have been attributed to increased voluntary reporting.

I have charted two sets of stats for abortions in Kansas. The first set is from surveys made by AGI (Planned Parenthood). The second (in red) is from KDHE reports. **The significant annual discrepancys show from over 65 hundred to over 14 hundred more abortions identified by the Planned Parenthood survey than reported to KDHE.** I believe these charts demonstrate conclusively that voluntary reporting has failed. In addition voluntary reports in the past have included a total number only without the statistical data that KDHE, CDC and NCHS consider important.

CONCLUSION

This legislature has recognized the importance of the collection of health data and has passed more and more legislation to ensure the collection of such information. **The taxpayers of this state are investing a considerable sum of money in the collection of abortion data**. The only way to ensure that the data is complete and accurate on such a controversial procedure is to make it mandatory. At least one full time employee has been engaged since 1992 to monitor abortion reporting. This bill will ensure the authority to properly collect that data and give the taxpayers a legitimate value for the dollars they are already spending on abortion reporting.

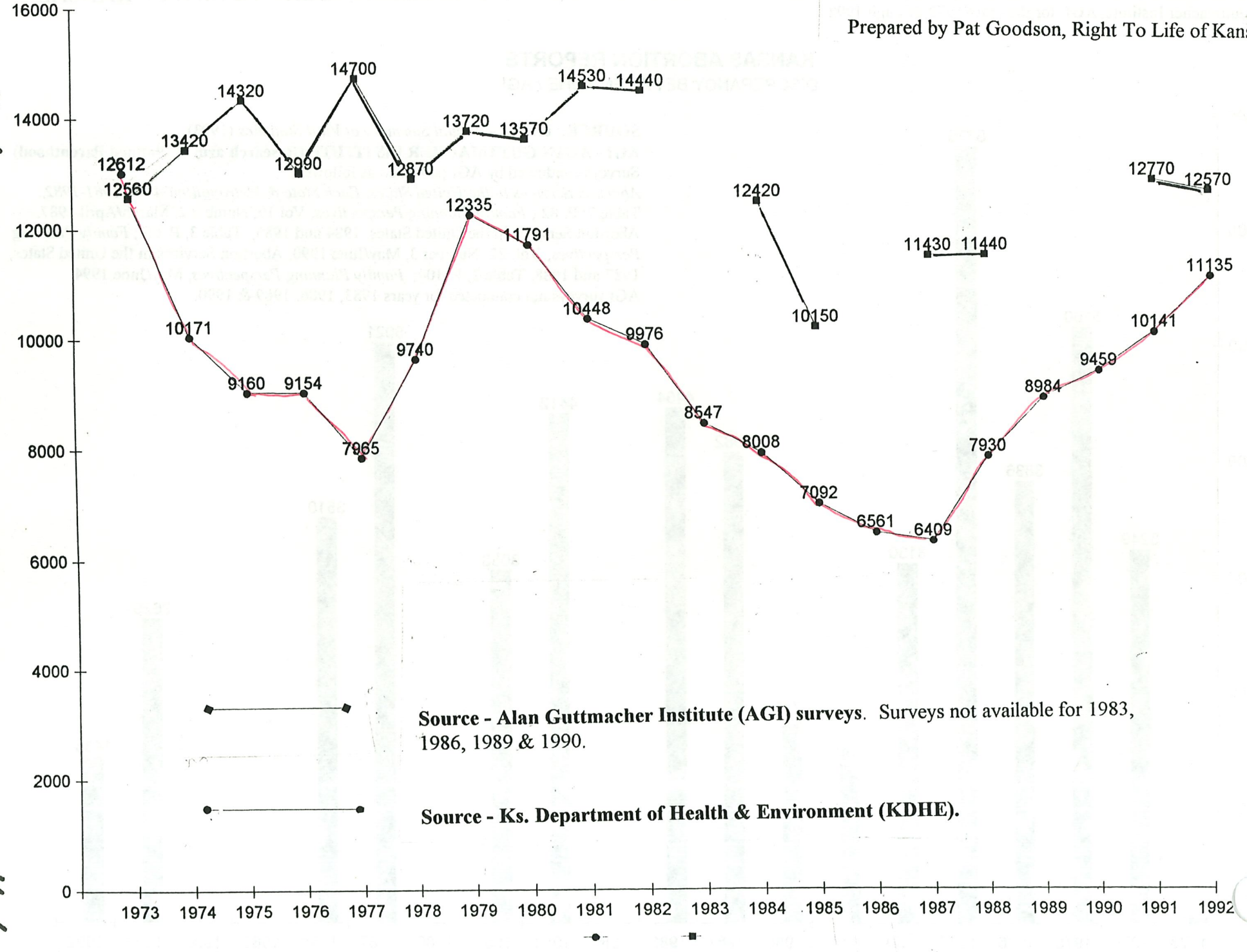
Respectfully submitted
Pat Goodson

16-4

16-4

KANSAS ABORTION STATISTICS

Prepared by Pat Goodson, Right To Life of Kans



Source - Alan Guttmacher Institute (AGI) surveys. Surveys not available for 1983, 1986, 1989 & 1990.

Source - Ks. Department of Health & Environment (KDHE).

EXPLANATION: Chart shows the difference between the number of abortions reported to **KDHE** and the number of abortions reported in surveys conducted by Guttmacher Institute, **AGI**, for the years 1973 through 1992.

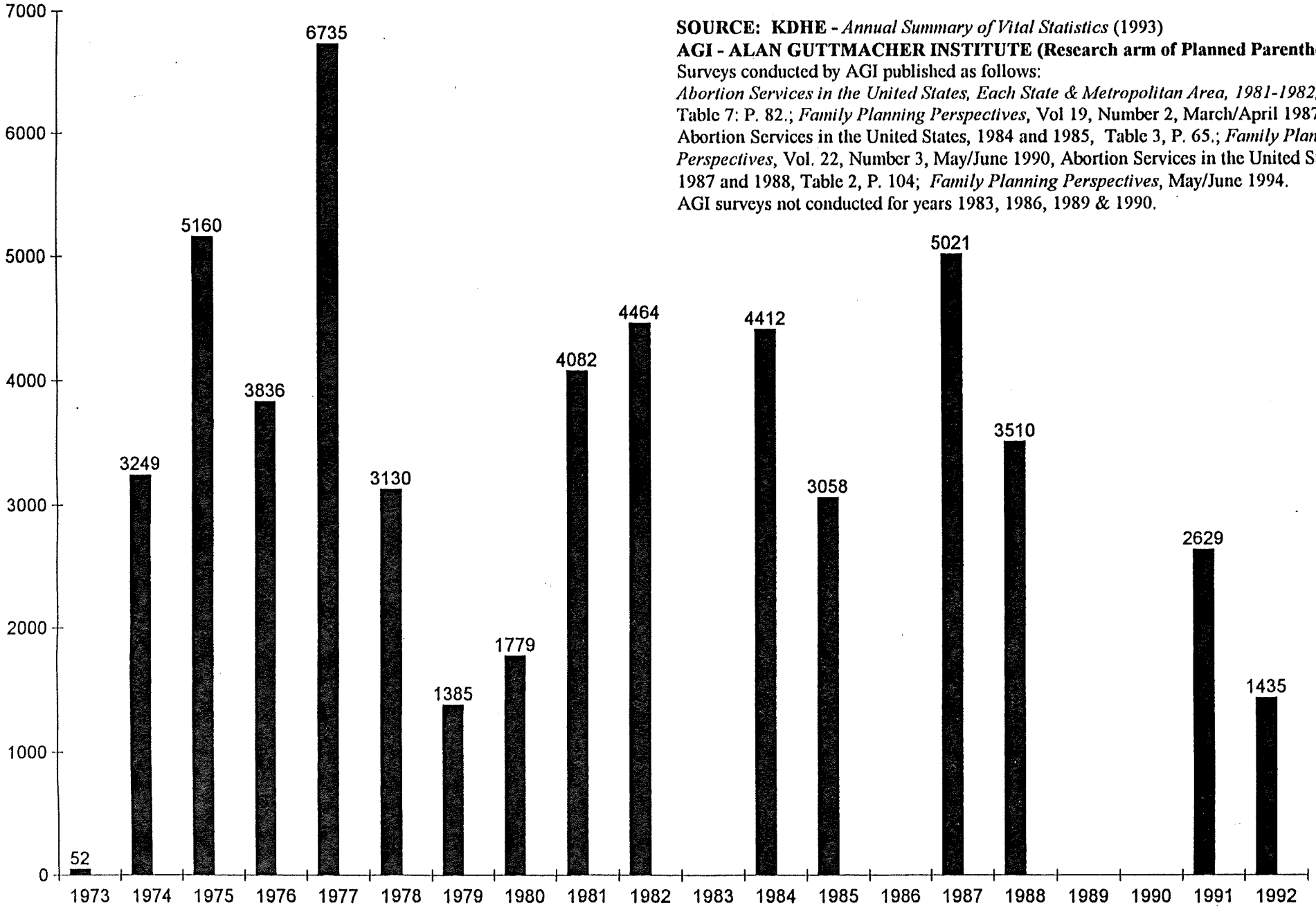
PREPARED BY PAT GOODSON, RIGHT TO LIFE OF KANSAS

16-5

KANSAS ABORTION REPORTS

DISCREPANCY BETWEEN KDHE / AGI

SOURCE: KDHE - *Annual Summary of Vital Statistics* (1993)
AGI - ALAN GUTTMACHER INSTITUTE (Research arm of Planned Parenthood)
Surveys conducted by AGI published as follows:
Abortion Services in the United States, Each State & Metropolitan Area, 1981-1982,. Table 7: P. 82.; *Family Planning Perspectives*, Vol 19, Number 2, March/April 1987, Abortion Services in the United States, 1984 and 1985, Table 3, P. 65.; *Family Planning Perspectives*, Vol. 22, Number 3, May/June 1990, Abortion Services in the United States, 1987 and 1988, Table 2, P. 104; *Family Planning Perspectives*, May/June 1994.
AGI surveys not conducted for years 1983, 1986, 1989 & 1990.



Dr. Beverly LaHaye
President

CONCERNED WOMEN for AMERICA

Cathy Holthaus
Area Representative

March 7, 1995

SENATE JUDICIARY COMMITTEE
Tim Emert, Chairman
HB 2083

Chairman, members of the Committee:

I am Sharon Stringfellow representing Concerned Women for America of Kansas. We support HB 2083 because it ensures the intent of the current reporting law and the integrity of our state's statistical data that is used to direct policy and programs.

The intent of the law, when it was written, was to know how many abortions were performed each year. Since the site of abortions has changed, the wording of the law needs to change, so as to include all abortions performed. With this change the intent of the law will be upheld.

As statistics often drive policy and programs, it is critical that we have accurate statistics. One reason we need good abortion statistics is for women's health. Abortion has been related to infertility, breastcancer, and depression among other things. Having good abortion statistics would help us to better understand some of these health risks. Likewise, abortion numbers are used in the compilation of teenage pregnancy numbers which are used to drive program and funding decisions. In any case, if we have incorrect data we are bound to make incorrect assumptions and conclusions resulting in bad decisions, harmful to women and to our children.

A couple of things need to be briefly addressed. We acknowledge that voluntary reporting already occurs, but we are not convinced that it is either complete or accurate. But, if thorough reporting really was the practice, passing this bill would not be burdensome, rather, it would merely be a formality.

This bill does not affect the confidentiality of the abortionist or the anonymity of the mother seeking the abortion. The state and the Department of Vital Statistics are required to keep the name of the abortionist and the abortion facilities completely and entirely confidential. There is no place for the woman's name on the report. The wording of the current law is maintained in this bill where it states, beginning on line 29, "the report shall not include the names of the persons whose pregnancies were so terminated." The purpose of this bill is to get numbers not names, to get information about abortion not the people involved.

HB 2083 is good law because it fulfills the intent of the current law, and provides for good statistics upon which policy and spending decisions are made. We ask that you pass HB 2083.

Concerned Women for America of Kansas
P.O. Box 4 • Seneca, KS 66538 • Phone (913) 336-2091

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#10

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

Dedicated • Determined • Decisive

To: Members of the Senate Judiciary Committee
From: Peggy Jarman
Regarding H.B. 2083

Following the confidentiality statement being added to the reporting bill, ProChoice Action League withdrew its opposition to the bill. Events of last week, however, have caused me to reconsider that position. It is obvious from house debate on ambulatory surgical centers that the anti-choice people are disingenuous at best. Their refusal to separate medical abortions from surgical abortions in the ambulatory surgical center bill proved conclusively that they are determined to stop medical abortions. H.B. 2083 provides them with another vehicle for accomplishing just that.

Doctors throughout this state, not associated with an abortion clinic, simply cannot be asked to put their names on a form indicating they have performed an abortion. The confidentiality statement is not sufficient. Right or wrong, doctors will not trust that information will remain confidential and everyone knows that in a climate where people are willing to risk the electric chair for killing a physician, the Class A misdemeanor will be viewed as immaterial.

Our desire to be reasonable and to give people the benefit of the doubt was naive. Unless medical abortions can be excluded from this bill it is simply bad public policy to require doctors to place themselves at risk. It is equally bad public policy to pass a law that would interfere with access to medical abortions—a procedure available to women in France, England and elsewhere for over a decade that has been denied women in this country for only political reasons. That is exactly what would happen: women will be denied access because doctors will not take the risk.

We are not talking about huge numbers of abortions. Medical abortions will never take the place of surgical abortions. We are talking about a small number of physicians serving family practice patients who might be willing to save patients long trips to clinics or the trauma of picketers by providing medical abortions in their offices. These few unreported abortions will not make or break any case for fertility or teen pregnancy studies. Clinics will continue to provide the overwhelming majority of abortions in this state—probably 95 - 99%. The majority of clinics will continue to voluntarily report.

This bill is not needed.

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Planned Parenthood®
Of Kansas, Inc.

Testimony in opposition to HB 2083
By Douglas E. Johnston
Planned Parenthood of Kansas

Thank you for this opportunity to address this Senate Committee in regard to House Bill 2083. House Bill 2083 would require all clinics that perform abortions to report such procedures annually to the Kansas Department of Health and Environment for the purpose of vital statistics accumulation.

At present, very few physicians are providing abortions in their private offices. Abortions are primarily being done in abortion clinics. Nevertheless, as senators you know well the law of unintended consequences. You bear the burden of creating or defeating legislation with your focus on the future: In this case, the future of women's health care. In the not too distant future medical abortion services--as opposed to surgical abortions which are the norm today--will become more widely available. What will happen when methotraxate and RU-486 become the norm? And while Legal abortion services have a long and safe history under current regulations, safety and efficiency may improve via the use of non-invasive surgical abortions. Abortions along with physical exams, cancer screenings and treatment, removal of warts, treatment of strep throat, blood pressure regulation, and the wide variety of medical procedures taking place daily in the offices of physicians around this state will be available all in one place. If there are 20 providers as opposed to six, should they all be forced to report?

As with any piece of legislation, the sponsoring legislator bears the burden of proof. I submit to you today that the sponsors of HB 2083 have failed to prove a legitimate need for HB 2083. Further, they have failed to show any significant benefits of HB 2083 that outweigh the costs of such additional regulation.

- House Bill 2083 is unnecessary government regulation. Legal abortion services have a long and safe history under current regulations. Legitimate need for such government regulation remains unproved.

  Almost all providers of abortion services already report. The Kansas Department of Health and Environment did not request this legislation. Nor did KDHE testify in favor of HB 2083.

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

Reporting of similar surgical procedures--such as vasectomies--should be required by the state. Other such invasive surgical procedures may include, but not be limited to, circumcisions, D & C's, biopsies, hernia operations, rectal surgery, ocular surgeries of all types, plastic and reconstruction surgeries, and major dental extractions.

Very similar surgical procedures, gynecological, dental and others should be treated equally. The question becomes, "Does Big Brother really need to know all this?" Clearly the answer is no. Women should not be made to bear the burden of additional regulatory expenses. There is no need proven to justify inequitable legislation.

• This increase in government regulation will increase the cost of women's health care as the number of providers increases. House Bill 2083 is a fine example of unnecessary government regulation.

House Bill 2083, being unnecessary, is an unwarranted gamble with the lives of patients. Please consider the following:

The Westark Christian Action Council, a militant anti-abortion group in Arkansas, attempted to force the Arkansas Health Department to release the individual abortion reports for three Arkansas counties. On August 18, 1994 an Arkansas trial court judge ordered the records released under the Arkansas Freedom of Information Act.

The Arkansas abortion reports do not contain the patients' names, but they do contain enough other information to identify a patient, especially if she is from a small town. Each report gives the woman's county of residence, town of residence, zip code, age, level of education, number of prior pregnancies, and her race. Releasing this information would therefore expose women to harassment from anti-abortion zealots who already use license plate numbers to track down and harass patients.

The case is now pending on appeal before the Arkansas Supreme Court. An *amicus* brief has been filed by the American Medical Association, the American College of Obstetricians and Gynecologists, the American Public Health Associations and others, arguing that release of the information is contrary to accepted practices for gathering health data and protecting patient confidentiality.

19-2

• Requiring reporting of abortion services will further restrict reproductive freedom.

> "Ultimately, abortion must be integrated into the full spectrum of women's reproductive, family-planning, primary, and preventive health care. This will require initiatives in several domains, including medical education, health planning, health services research, and medical ethics.
>
> "In the long run, policies guiding the locations of abortion services (at clinics or in hospitals) and the configuration of services ("specialized" or "mainstreamed" into general ambulatory gynecology) should be driven by the careful examination of health outcomes, the quality of care, and patients' experiences and satisfaction. The introduction of non surgical approaches to abortion will provide an unprecedented opportunity to improve access to abortion services and ensure privacy, the integration of women's health services, and the assessment of outcomes."
>
> -- Barbara R. Gottlieb, M.D., M.P.H. *The New England Journal of Medicine*, February 23, 1995

Confidentiality and the health of women should be everyone's concern. House Bill 2083 is a threat both. Treating abortion services and providers inequitably is inappropriate and damaging to women's health.

I submit to you today that the sponsors of HB 2083 have failed to prove a legitimate need for HB 2083. Further, they have failed to show any significant benefits of HB 2083 that outweigh the costs and inequities of such additional regulation.

19-3

House Bill 2083 & House Bill 2323
Unnecessary Government Regulation
Politically Motivated
Danger to Women's Health

Stricter facility regulation is medically unnecessary.--The evidence is irrefutable that first-trimester abortions may be performed at least as safely in physicians' offices and clinics as in ambulatory surgical centers or hospitals. The factors chiefly responsible for determining the safety of induced abortion--the length of gestation, the procedure used, and the skill of the physician--all operate independently of the setting in which the abortion is performed. In this respect, first-trimester and early second-trimester abortions are no different than other minor surgical procedures such as aspiration of a cyst or removal of skin lesions.

Abortion is a regulated medical procedure--Abortion is subject to regulation like any other medical procedure. Only health professionals licensed by the state may perform abortions, and facilities must meet, at a minimum, the same standards as physician offices or clinics. Abortion is a safer procedure than many that physicians are allowed to perform routinely in their offices or clinics. The American College of Obstetricians and Gynecologists standards recognize that abortion services may be performed in a physician's office.

There is no public health benefit.--Eliminating physicians' offices and clinics as facilities that provide abortions will reduce substantially the availability of abortion services and add greatly to the cost of an abortion without providing any compensating benefit to women's health. Women, particularly those who live outside major metropolitan areas, will be delayed in their attempt to obtain an abortion, thereby adding significantly to the risks of the procedure. Moreover, the psychological trauma may be greater for the patient when the procedure is taken out of the familiar and more psychologically comforting setting of an office of the patient's personal physician or clinic.

19-4

#9a

Testimony
in Opposition to House Bill No. 2083
March 7, 1995
Senate Judiciary Committee
Hon. Tim Emert, Chair

Thank you, Mr. Chairman and members of the Committee for this opportunity to address HB 2083 in writing this morning.

My name is Carla Dugger, and I am the Associate Director of the American Civil Liberties Union of Kansas and Western Missouri. We are a private, not-for-profit membership organization which supports and defends civil liberties.

House Bill 2083 broadly expands abortion reporting requirements. It requires all medical care facilities and physicians to keep records of various statistics regarding pregnancy terminations, and requires them to submit an annual written report detailing these statistics to the Secretary of Health and Environment. The names of women whose pregnancies were terminated are not required, but the bill would help anti-choice forces target physicians for harassment and violence, particularly those who perform abortion abortions by surgical procedures (and soon via RU-486) in their private offices away from abortion provider clinics.

The question must be asked of the sponsors of HB 2083 -- "Why single out abortion procedures from all other medical procedures, since the same requirements are not demanded of physicians who perform vasectomies, tonsillectomies or even brain surgery?"

Even with the addition of confidentiality language by the House, the question remains, "Why is HB 2083 needed?"

This bill is a poorly disguised attempt to restrict abortions under guise of regulation. It is, in fact, an example of the worst kind of government regulation -- unnecessary and intended to <u>increase</u> bureaucracy in order to erect as many barriers as possible to block access to a needed and constitutional service.

The sponsors of HB 2083 have shown no rational relationship between these requirements and protecting the health of women, and no useful state purpose has been shown.

Please reject HB 2083.

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NCJW

National Council of Jewish Women

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

March 7, 1995

Members of the Senate Judiciary Committee:

I am writing to you today in opposition to both HB 2083 and SB 134. I am the Kansas State Public Affairs Chairperson for the National Council of Jewish Women, representing 200 sections in the United States, nearly 100,000 members of which nearly 1200 reside in the Greater Kansas City area.

Founded in 1893, we are the oldest Jewish Women's organization in the country. The National Council of Jewish Women (NCJW) believes that individual liberties and rights guaranteed by the Constitution are keystones of a free and pluralistic society. Inherent in these rights is our responsibility to protect them. We therefore endorse and resolve to work for the protection of every female's right to choose abortion and the elimination of obstacles that limit reproductive freedom. Furthermore, the NCJW believes that individual well-being, acceptance of the diversity of families and respect for human dignity are fundamental to a healthy society. Therefore, confidential, comprehensive family planning and reproductive health services for all, regardless of age or ability to pay would be considered our responsibility to all human beings.

HB 2083, while amended to protect the confidentiality of all Doctors performing even a medical abortion (in his/her office), is an obstacle to a woman's reproductive freedom. On the other hand, SB 134 restricts further the waiting period, another obstacle to a woman's reproductive freedom.

These bills are no more than harassment to women. We have a law in Kansas that restricts all women seeking abortions. The numbers are down and more and more women are having their babies. This is their choice, not ours!! I urge you to reconsider both HB 2083 and SB 134 and vote unfavorably upon both bills. Thank you.

Please feel free to contact me if you have any questions. I do feel, however, that the National Council of Jewish Women must go on record having opposed both bills.

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