Approved: 2/12/97
Date

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY.

The meeting was called to order by Chairperson Tim Carmody at 3:30 p.m. on February 13, 1997 in Room 313--S of the Capitol.

All members were present except:

Committee staff present: Jerry Ann Donaldson, Legislative Research Department
Mike Heim, Legislative Research Department
Jill Wolters, Revisor of Statutes
Jan Brasher, Committee Secretary

Conferees appearing before the committee: Representative Susan Wagle
Mary Kay Culp
Beatice W. Swoop, Kansas Catholic Conference-written only
Jane Doe #3
Nancy Jo Mann
Dawn McCulland, Advice & Aid Pregnancy Center
Teri Reynolds, President, Pregnancy C.A.R.E.
Donna Voigts
Jeanne Gawdun, Kansans for Life
Reverend Lynn NewHeart, Chaplain/Patient Advocate, Planned Parenthood of Mid-Missouri and Eastern Kansas
Barbara Holzmark, National Council of Jewish Women
Peggy Jarman, ProChoice Action League and Womens' Health Care Services
Monica Neff, Planned Parenthood of Kansas
Ellen Brown, ACLU-written testimony only
Carla Mahany, ACLU-written testimony only
Betty Armstrong, Comprehensive Healthcare for Women-written testimony only
Jana Gryder, National Organization for Women-written testimony only

Others attending: See attached list

The Chair called the meeting to order at 3:40 p.m. The Chair opened the hearing on HB 2269.

HB 2269: Woman's Right-to-Know Act

Representative Susan Wagle testified as a sponsor of HB 2269. The conferee stated that this bill will provide information to women seeking abortions information on alternatives to the procedure, the medical risks of the procedure, the gestational age of the unborn child, and the proposed abortion method. The conferee stated with this bill women will be given written material and that the physician performing the abortion will orally relate the information to the patient at least eight hours prior to the procedure. Representative Wagle distributed booklets used in Louisiana and Pennsylvania. (Attachment 1)

The conferee in response to inquiries stated that Section 4 of the bill is necessary because it is not in current state law. The conferee stated her opinion that the abortion industry has circumvented current law. The conferee related that the practice in many rural areas is that the woman is given a form provided by the doctor in her town before she travels to the area where the abortion is performed and therefore, she has the form eight hours prior to the actual abortion.

Written testimony of Beatice W. Swoop, Kansas Catholic Conference was read by Mary Kay Culp in support of HB 2269. (Attachment 2)

Mary Kay Culp testified in support of HB 2269. The conferee provided written material citing court cases

showing that the advice of a physician before a decision on abortion is an essential part of the abortion liberty guaranteed by the constitution. The conferee provided additional material by David Reardon, Director of the Elliot Institute for Social Sciences Research concerning the aftereffects of abortions. Other written material referred to by the conferee included a statement of deficiencies from a Missouri abortion clinic, documents used by an abortion clinic and other articles. (Attachment 3)

Conferee identified as Jane Doe #3 testified in support of HB 2269. The conferee related her personal experience. The conferee stated that this was a traumatic experience for her. The conferee stated that receiving information like that proposed in HB 2269 would have made a difference in the decision she made. (Attachment 4)

Nancy Jo Mann testified in support of HB 2269. The conferee related her personal experience. The conferee stated that this bill will provide safeguards as required for other types of medical procedures. (Attachment 5)

Dawn McCulland, Advice & Aid Pregnancy Center, testified in support of HB 2269. (Attachment 6)

Teri Reynolds, President of the Board and Interim Director of Pregnancy C.A.R.E., of Olathe, Kansas testified in support of HB 2269. The conferee related her own personal experience, the experience of counseling other women, and the need for women to be informed before the decision to abort is made. The conferee referred to an abortion information survey. (Attachment 7) and (Attachment 8)

Donna Voigts testified in support of HB 2269. The conferee related her personal experience and stated that information about abortions should not be withheld. (Attachment 9)

Jeanne Gawdun, Kansans for Life, testified in support of HB 2269. The conferee stated that the provisions of HB 2269 advocate women's authentic rights by avoiding abortions that are unwanted, uninformed, unscreened as to risks and injuries that are uncompensated. (Attachment 10) The conferee provided information on evaluation of the patient/physician relationship. (Attachment 11) The conferee provided a list of Kansas abortionist. (Attachment 12)

Reverend Lynn NewHeart, Chaplain/Patient Advocate at Planned Parenthood of Mid-Missouri and Eastern Kansas testified in opposition to HB 2269. The conferee stated that passage of HB 2269 would make it very difficult to obtain abortion services for some women. The conferee stated that this bill would increase the cost of abortion services because of the increased time a physician would need for each patient. The conferee related that several factors in the bill are troubling from the standpoint of what is good for the patient. (Attachment 13)

Barbara Holzmark, National Council of Jewish Women testified in opposition to HB 2269. The conferee stated that HB 2269 would put restrictions and obstacles on women seeking abortion services. (Attachment 14)

Peggy Jarman, ProChoice Action League and Womens' Health Care Services testified in opposition to HB 2269. The conferee stated that this bill will prevent many women from accessing abortion services. The conferee stated that HB 2269 was a part of a five year plan to stop all abortions. The conferee provided written material concerning each section of the bill and forms used in an abortion clinic. (Attachment 15)

Monica Neff, Planned Parenthood of Kansas testified in opposition to HB 2269. The conferee stated that Planned Parenthood opposes this legislation because it will severely restrict, if not end, access to physicians and medical services for large numbers of women seeking reproductive health care. (Attachment 16)

Ellen Brown, Planned Parenthood of Eastern Kansas, presented written testimony only in opposition to HB 2269. (Attachment 17)

Carla Mahany, ACLU, presented written testimony only in opposition to HB 2269. (Attachment 18)

Betty Armstrong, Comprehensive Healthcare for Women provided written testimony only in opposition to HB 2269. (Attachment 19)

Jana Gryder, National Organization for Women provided written testimony in opposition to HB 2269. (Attachment 20)

The Committee members discussed the purpose and need for information as well as various sections of the bill with the conferees.

The Chair closed the hearing on HB 2269.

A motion was made by Representative Powell, second by Representative Mayans to amend HB 2269 by striking lines 20 through 43 on page 2 and on page 3 strike lines 1 through 5 and amending Sec 3 of K.S.A.

65-6701 by changing the definition of abortion. The motion carries. (Attachment 21)

A motion was made by Representative Haley, second by Representative Kirk to amend the bill by changing the term, "unborn baby," to "fetus or embryo."

A substitute motion was made by Representative Mayans to pass the bill as previously amended. Representative Mayans withdrew the substitute motion.

The motion by Representative Haley fails.

A motion was made by Representative Mayans, second by Representative Powell to recommend HB 2269 favorably as amended. The motion carries.

The Chair adjourned the meeting at 8:10 p.m.

HOUSE JUDICIARY COMMITTEE COMMITTEE GUEST LIST

DATE: 2-13-97

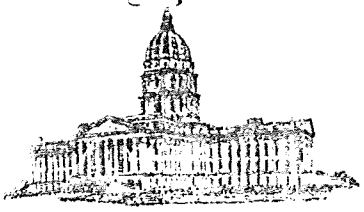
NAME	REPRESENTING
Jeanne Gawdun	ICFL
Cleta Reneyer	Right to Life of Ks.
Judy Smith	Concerned Women for America
Marsha Strahm	" "
Barbara Duke	AAUW - Baldwin Branch
Marilyn Hanny	- Baldwin
Peggy Jarman	PCAL + WHCS
Sally Gryder	KS NOW
Monica [illegible]	Planned Parenthood of Ks.
Beverly Mumert Hart	Planned Parenthood - M. M. & E. Kansas
Marty Jones	Planned Parenthood MM & E. Kansas
Ellen W. Brown	"
Barbara Hobzmark	National Council of Jewish Women
Erica C. Lee	Planned Parenthood MM + E. Kansas
Cory Brashears	" "
Clyde Graber	Governors Staff
Matt Tarrell	AP
Susan Baker	Hein + Weir
Amy Jones	INTERN

HOUSE JUDICIARY COMMITTEE COMMITTEE GUEST LIST

DATE: 2-13-97

NAME	REPRESENTING
David Tallman	KBA
Robyn Johnson	Kansans For Life
Tom Cox	CPO
Nancyjo mann	
Donna Wright	
Laura McClelland	
Deri Reynolds	
Nicole Johnson	Legislative Intern
Bruce Dimmitt	Independent Lobbyist
Kevin Hoffock MD	Pfizer
Michelle Leigh Ecklund	KSU
Erika Eckert	KSU
Jeff Kraft/s	

State of Kansas
House of Representatives



Susan Wagle

Speaker Pro Tem

Testimony--Woman's Right to Know Act
House Judiciary Committee
February 13, 1997
H.B. 2269

Thank you Chairman Carmody and members of the Judiciary Committee, for the opportunity of addressing you about the need in Kansas for expanding our present informed consent law. In 1992, I was instrumental in getting passed our present informed consent statute relating to abortion. It was my intent at the time to empower Kansas women involved in a crisis pregnancy by giving them all the material facts and possible alternatives to abortion in order that they might make an informed "choice." Without full disclosure of this information, I believe the word "choice" is a propaganda tool; a tool used to deceive women and place them under the control of fathers who want to avoid responsibility, parents who want to protect reputations, well-meaning friends who might not know all the possible physical and psychological side effects, and abortion providers whose main goal, most often, is turning a profit.

Attached to my testimony is a copy of the current Kansas statute and a copy of the consent form now being used by Dr. Tiller in Wichita. I believe that Dr. Tiller and other abortion providers in Kansas have made a mockery of legislative intent. It was very clear to me when we debated K.S.A. 65-6706 in 1992 that the legislature wanted each woman to be informed of alternatives to abortion. We assumed that an honest discussion about adoption possibilities would take place. We also envisioned that each woman would be informed of her legal right to obtain financial support from the father, or to receive state financial assistance, such as Aid to Dependent Children, if she should choose to keep her baby. We thought an effort would be made to connect a woman in crisis with nonprofit agencies such as HopeNet an organization in Wichita, which not only provides needed medical attention for the mother and child, but also provides for the mother an education so that she might eventually become self-sufficient and support herself and her child.

Instead, as you can see, the form I have attached to this document states in item #2 that "[t]he alternative to abortion is vaginal delivery or caesarean section at the end of the pregnancy." What real choice does such a disclosure offer a woman in crisis? **I assure you that in Kansas today, positive discussions about viable alternatives often do not take place.** The word adoption is not mentioned. The

REPRESENTATIVE, 99TH DISTRICT
BUTLER/SEDGWICK COUNTIES
14 SANDALWOOD
WICHITA, KANSAS 67230

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ROOM 330-N
STATE CAPITOL
TOPEKA, KS 66612-1504
(913) 291-3500

physical characteristics of the fetus about to be aborted or the possibility of post abortion stress syndrome are not disclosed. Simply put, women in Kansas are not empowered with noninflammatory, scientifically accurate information critical to making the best decision for her well being and the well being of her preborn infant.

The legislation being considered today is patterned after current Pennsylvania law. The United States Supreme Court has determined that this legislation is constitutional under the restraints of Roe v. Wade. Similar legislation has also been passed in Louisiana. I have available for committee members a sample of the information booklet printed by Pennsylvania and the booklet and directory of helping agencies printed by Louisiana. I believe you will agree upon examination of these materials that they are not biased, either towards promoting an abortion or towards carrying the preborn to term.

Last year a number of women came forward to testify about their abortion experiences and how the "Woman's Right to Know" Act, if in place, could have helped them. Today, there are more women who will be coming forward to tell of their abortion experiences. For some of them it will be the first time they have ever spoken publicly about their private decision. For most of them, their decision to abort was made because they felt they had no alternatives. Many of them were young at the time and they had nowhere to go and no one to talk to. For some of them, the decision they made has become a vivid nightmare -- one they revisit often, and one they are still working through. Some of them will call themselves "Jane Doe" in order to protect their identities. I ask Chairman Carmody to please request the press to withhold their identity in news releases and not to photograph or film them. They, and I, would appreciate respect for their privacy.

(l) Except as necessary for the conduct of a proceeding pursuant to this section, it is a class B misdemeanor for any individual or entity to willfully or knowingly: (1) Disclose the identity of a minor petitioning the court pursuant to this section or to disclose any court record relating to such proceeding; or (2) permit or encourage disclosure of such minor's identity or such record.

History: L. 1992, ch. 183, § 5; July 1.

65-6706. Abortion; informed consent required. (a) No abortion shall be performed or induced unless:

(1) The woman upon whom the abortion is to be performed or induced gives her informed consent; or

(2) a medical emergency compels the performance or inducement of the abortion.

(b) Consent to an abortion is informed only if the physician who is to perform or induce the abortion or another health care provider informs the woman, in writing not less than eight hours before the abortion, of:

(1) The nature of the proposed procedure or treatment and of those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the abortion;

(2) the gestational age of the fetus at the time the abortion is to be performed;

(3) the medical risks, if any, associated with terminating the pregnancy or carrying the pregnancy to term; and

(4) community resources, if any, available to support the woman's decision to carry the pregnancy to term.

(c) If a medical emergency compels the performance or inducement of an abortion, the attending physician shall inform the woman, prior to the abortion, if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert the woman's death or to avert substantial and irreversible impairment of the woman's major bodily functions.

History: L. 1992, ch. 183, § 7; July 1.

65-6707. Same; severability clause. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

History: L. 1992, ch. 183, § 8; July 1.

Women's Health Care Services, P.A.
George R. Tiller, M.D., DABFP, Medical Director
5107 E. Kellogg, Wichita, Kansas 67218
(316) 684-5108
1-800-882-0488

Dear Prospective Patient:

I am Dr. George Tiller, a 1967 graduate of the University of Kansas School of Medicine, a diplomat of the American Board of Family Practice. My medical practice has included legal and safe abortion services for thousands of women since 1973 here in Wichita, Kansas.

The 1992 Kansas abortion law requires that I provide certain written information to patients seeking abortion services at least eight hours before an abortion is performed. This document will satisfy the basic notification requirement. We will provide you with additional detailed information before your procedure, as we have always done.

1) The nature of an abortion procedure is to medically induce the termination of a pregnancy.

2) The alternative to abortion is vaginal delivery or caesarean section at the end of the pregnancy.

3) The risks of an abortion are related to the duration of the pregnancy. Generally speaking, an abortion performed early in a pregnancy is safer than one performed later in the pregnancy. The generally recognized minor (non-hospitalization) complications such as infections, laceration, and incomplete or retained material in the uterus vary in occurrence from one to five per one hundred abortions (1/100 to 5/100) at five to six weeks up to as much as five to ten per one hundred abortions (5/100 to 10/100) at later stages.

   The major (hospital type) complications of transfusion, hemorrhage, amniotic fluid embolism, laceration, infection, and uterine perforation vary in occurrence from one per eight hundred abortions (1/800) at five to six weeks up to two major complications per one hundred abortions (2/100) at the latest gestation. We believe that, in the vast majority of patients, abortion is safer than full term delivery at all legal stages.

4) Based on the first date of your last menstrual period or an ultrasound evaluation, the gestation of your pregnancy is estimated to be _____, plus or minus 11 to 14 days.

5) The generally recognized medical risks associated with carrying the pregnancy to full term delivery or caesarean section at term include but are not limited to the following: unplanned major surgery, hemorrhage, transfusion, blood clots in legs, blood clots in the lungs, hysterectomy, major infection, cervical laceration, vaginal laceration, rectal laceration, perforation of the uterus, injury to bowel/bladder, major and minor emotional problems, amniotic fluid embolism, cervical incompetence, major and minor depression, and even death.

   The types of medical risks (listed above) associated with abortion, are, in general, the same as those associated with carrying the pregnancy to term. The medical risks of an early abortion (5-12 weeks) and a second trimester abortion (13-26 weeks) occur at a lower rate than at full term delivery or caesarean section. The medical risks of an abortion in the third trimester may occur at about the same rate as full term delivery or caesarean section. The death rate for abortion is less than the death rate for full term delivery.

6) Community resources available to support a woman's decision to carry a pregnancy to term include Lutheran Social Services, Planned Parenthood of Kansas, YWCA, Self-Help Network of Kansas, Family Consultation Service, United Way First Call for Help, United Way Center, Childcare Association of Wichita, Kansas, Children's Service League, Episcopal Social Services, and United Methodist Urban Ministry.

By signing below, you acknowledge that you have read and understood the information above, and that you have received this information eight hours prior to your abortion.

SIGNATURE: _____

Note to Patient: Please see the back of this form for important information about your visit.

Women's Health Care Services
Visit Checklist

All patients

___No one will be allowed in the clinic without photo identification.
___Bring your signed Informed Consent (the other side of this sheet).
___Arrive with a full bladder.
___Drink no alcohol 24 hours prior to your visit.
___No children are allowed in the clinic.
___The fee will be collected prior to the procedure.
___No personal checks will be accepted.
___Remember to park in our fenced parking lot.
___Our security staff will be on duty and will scan you electronically and check in all handbags prior to allowing you into the clinic.
___Minors: You will need a parent to accompany you **OR** have a notarized Waiver of Notification and be accompanied by person 21 years of age or older.

One-day patients

___If your appointment time is at 12:00 noon or after, eat nothing after 8:00 a.m. the morning of your appointment. After 8:00 a.m., you may drink only coffee, tea, or water.
___If your appointment is on Saturday morning, eat nothing after 12:00 midnight the night before your appointment. After midnight, you may drink only coffee, tea, or water.
___We request that you bring only one person with you.
___The person accompanying you will be asked to wait outside while we do your sonogram and collect your fee, unless you are a minor. We will then invite him/her inside.
___You will need to have a person accompanying you to receive the preoperative medication which relaxes you for your surgery.
___Plan to be in the clinic for 3-4 hours.

Two-day patients

___You may eat a light breakfast the first day.
___Bring along $10.00 for your prescription.
___Plan to be in the clinic for 3-4 hours the first day.

Out-of-town patients

___You must stay in Wichita until you are released from our care. Call us for hotel information, if you wish.
___If you use a cab, use American Cab Company. They are pro-choice. Their number is (316) 262-7511.
___Bring a supply of sanitary pads.
___No luggage is allowed in the clinic.

Four-to-five-day patients

___Bring along $75.00 for your prescriptions.

#2

TESTIMONY

H.B. 2269

HOUSE JUDICIARY COMMITTEE
Thursday, February 13, 1997 - 3:30 p.m.

KANSAS CATHOLIC CONFERENCE
Beatrice E. Swoopes, Program Coordinator

Chairman Carmody, members of the Judiciary Committee -- my name is Beatrice Swoopes, Program Coordinator for the Kansas Catholic Conference, which represents the Roman Catholic Bishops of Kansas. Thank you for the opportunity to speak to the provisions of **H.B. 2269**.

The Kansas Catholic Conference supports and encourages the passage of legislation which will enable women anticipating abortion to be educated and informed about the medical and psychological consequences of their actions, as well as feasible alternatives.

A woman deciding whether to carry her baby to term needs the support of family and needs good information. Oftentimes she has neither. She needs time to reflect on the medical information available from competent scientific research. Also she needs to know that the people caring for her at such a traumatic time are qualified to counsel her and meet her physical needs.

Today many church organizations (including our own) give counseling and support to concerned pregnant women, but

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this information may not be readily accessible at the time of the planned abortion.

H.B. 2269 which addresses a "woman's right to know" is a good approach. It would guarantee a woman's thorough understanding of the physical and mental aspects of the abortion procedure she is contemplating. It would also help alleviate the confusion and the tragic aftermath of a decision made many times out of fear and panic.

The proposed legislation offers a woman a comprehensive package of services as she faces one of the greatest challenges of her life.

We support passage of H.B. 2269.

Cc Cecil #3

ABORTION SHOULD INCLUDE DOCTOR'S CONSULTATION: LEGAL

As the following quotations demonstrate, the Supreme Court has constantly said that the advice of a physician before a decision on abortion is part and parcel of the abortion liberty guaranteed by the constitution. SB 238 carries out what the Supreme Court has stated in these decisions.

"This holding . . . vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects in inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician."

Roe v. Wade, 410 U.S. 113, 166 (1973) (emphasis added).

"In Doe v. Bolton, post, p. 179, procedural requirements contained in one of the modern abortion statutes are considered. That opinion and this one, of course, are to be read together."

Roe v. Wade, supra, at 165 (1973).

"We agree with the District Court . . . that the medical judgment may be exercised in the light of all factors--physical, emotional, psychological, familial, and the woman's age--relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment."

Doe v. Bolton, 410 U.S. 179, 192 (1973).

"A woman cannot safely secure an abortion without the aid of a physician . . . . [T]he constitutionally protected abortion decision is one in which the physician is intimately involved."

Singleton v. Wulff, 428 U.S. 106, 117 (1976).

"Roe stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out."

Colautti v. Franklin, 439 U.S. 379, 389 (1979).

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"Our prior decisions establish that as with any medical procedure, the State may require a woman to give her written informed consent to an abortion. . . . Petitioners challenge the statute's definition of informed consent because it includes the provision of specific information by the doctor . . . . To the extent [two ruling from the 1980s] find a constitutional violation when the government requires, as it does here, the giving of truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth, and the 'probable gestational age' of the fetus, those cases go too far . . . and are overruled."

Planned Parenthood v. Casey, 112 S.Ct. 2791, 2823 (1992).

"It cannot be questioned that psychological well-being is a facet of health. . . . 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. If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible."

Planned Parenthood v. Casey, supra.

ABORTION SHOULD INCLUDE DOCTOR'S CONSULTATION: MEDICAL

"The term menstrual extraction is used to designate the performance of an early abortion before the diagnosis of pregnancy has been established through pregnancy test or examination. . . .

"Part of the impetus for the popularity of menstrual extraction arises from the desire in some groups to deny that abortion is a medical procedure. The dangers of this view are that the real risks of pregnancy and abortion will be ignored or discounted by both women whose lives are at stake and public officials who make decisions about health-care policies. The additional risks of complications and death imposed by the denial of the medical aspects of abortion only enhance the arguments of those who are opposed to choice . . . ."

> William M. Hern, M.D., M.P.H., Abortion Practice 120, 122 (1984) (emphasis added. Dr. Hern operates one of the oldest legal abortion clinics in the U.S., the Boulder Abortion Clinic in Boulder, Colorado. He was a founder of the National Abortion Federation and served on its Standards Committee for four years.)

"The physician should review the medical history form and brief counseling notes to determine whether there are any unusual questions that should be discussed with the patient at the patient-physician encounter. The counselor then brings the patient to the physician's office for the physician to have an opportunity to meet with the patient.

Some patients wish to have prolonged conversations with the physician and may have many questions. . . . The principal purposes of this encounter are for the physician to meet the patient and vice versa, to determine whether the patient understands the risks of the abortion, and to obtain the patient's signature on the consent form."

William M. Hern, M.D., M.P.H., id. at 90-91.

"It the physician's responsibility to inform the patient of the nature of the surgical or medical procedure being recommended. In most cases, the explanation should encompass the nature of the condition or illness that requires medical or surgical intervention, the recommended course of treatment and its alternatives, the risks and potential complications of treatment, and its relative chance of success. The patient should have an adequate opportunity to ask questions in order to ensure that she understands the information. The physician should note in the patient's record that the proposed treatment

and its risks have been explained and discussed with the patient and should document the patient's decision."

> Committee on Professional Standards, The American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services 88-89 (1989) (emphasis supplied).

"If Planned Parenthood's denial of this reality [psychological or psychiatric disturbances in women who have had abortions] is not . . . dishonest . . . I can only regard it as delusion or ignorance." William West, M.D., "Honesty at Issue," Dallas Morning News, Feb. 12, 1995, p.3J.

ELLIOT INSTITUTE

FOR SOCIAL SCIENCES RESEARCH

I am David Reardon, Director of the Elliot Institute for Social Sciences Research. I have been engaged in research into the aftereffects of abortion on women for fourteen years. The results of my research are reported in three books and numerous peer review journal articles.

I enthusiastically support this bill because it will greatly improve the standard of care for screening of patients who are at highest risk of suffering physical or psychological complications post-abortion. It is clear in my extensive research, including over 2000 case studies, that many abortion practitioners are simply providing abortions on request. In doing so, they are failing to provide the type of good medical care which protects the interests of their patients. In order to reduce the risk of post-abortion injuries, it is clearly necessary to: 1) properly screen patients for the existence of predisposing risk factors; 2) take appropriate steps to alleviate risk factors which have been identified; and 3) fully inform patients that they may be at higher risk of one or more known post-abortion sequelae so that the patient can knowledgeably make an informed decision based on her unique needs and circumstances.

I would also like to emphasize the following points which focus specifically on the psychological problems post-abortion:

1) All studies of the psychological aftereffects of abortion, including that published by pro-choice researchers, demonstrate that at least some women, though perhaps a minority, experience severe psychological problems post-abortion.

2) Statistical research demonstrates that severe psychological reactions are most likely if a decision to abort is made too quickly or with insufficient information. (Franz, 1992)

3) Fully 77 percent of women who seek post-abortion therapy claim they were misinformed or denied relevant information about the abortion. Sixty-six percent report their abortion counseling was strongly biassed toward choosing abortion. (Reardon, 1987)

4) Numerous studies show that between 40 to 80 percent of women seeking abortions would prefer to keep the baby if their situation could be improved. For many, if not most women, abortion is a marginal decision which they can easily be dissuaded against. This is why some abortion providers (those who pursue profit over their patients' welfare) will conceal information which may "chill" a woman's ambivalent and

tentative decision to abort. (Reardon, 1987)

5) Information about risks, alternatives, and fetal development will help to empower women to resist pressure from third parties to undergo unwanted abortions. For example, if a woman is being pressured into an unwanted abortion by her boyfriend information about risks (even if exaggerated in her own mind) can be exactly the excuse she needs to refuse to do what he wants on the grounds that it is "too dangerous."

6) The counseling provided by at least some abortion providers are biased by financial self-interests and/or racist or social engineering ideologies. (Chicago Sun-Times, 1978)

7) Anyone who supports the right of women to make their own informed choices, free of paternalistic or even deceptive counseling, should support this bill. The only reason to oppose this pro-woman/pro-choice legislation is if one is willing to protect abortion industry profits at the expense of individual women.

8) This bill is about protecting the women most at risk of suffering post-abortion problems, even if these women represent a minority of all patients. The lowest reported figure for women suffering post-abortion trauma is 10 percent, with lesser negative reactions reported in up to 80 percent. These high risk women need this protection, even if it causes some delays or added costs for low risk abortion patients.

EVEN ABORTION SUPPORTERS CONCEDE THE NEED FOR BETTER COUNSELING AND SCREENING TO PROTECT THE MENTAL HEALTH OF WOMEN

Dr. William West, who performs abortions in Texas, told the Dallas Morning News, "If Planned Parenthood's denial of this reality [post-abortion trauma] is not ... dishonest...I can only regard it as delusion or ignorance."

In an interview with the *Wall Street Journal* Sylvia Stengle, director of the National Abortion Federation, admits that at least one in five women seeking abortion are doing so in violation of their own moral beliefs and that this is a "very worrisome subset of our patients" and admits: "Sometimes, ethically, a provider has to say, 'If you think you are doing something wrong, I don't want to help you do that.'"

Dr. Julius Fogel, a psychiatrist and obstetrician who has performed over 20,000 abortions, told a *Washington Post* columnist that: "Every woman--whatever her age, background or sexuality--has a trauma at destroying a pregnancy... She destroys a pregnancy, she is destroying herself... A psychological price is paid. It may be alienation; it may be a pushing away from human warmth, perhaps a hardening of maternal instinct. Something happens on the deeper

levels of a woman's consciousness when she destroys a pregnancy. I know that as a psychiatrist."

Anne Baker, Director of Counseling at The Hope Clinic for Women, an abortion clinic in Granite City, Illinois, reports in the clinic's newsletter that she is conducting research into the potential connection between a history of emotional, physical, or psychological abuse and more severe post-abortion emotional sequelae. If this link is confirmed, it would be an important factor for screening and counseling of women considering abortion.

In a major study, undertaken and frequently cited by pro-choice researchers, Bryan Lask found that 32 percent of women receiving abortion experienced an "unfavorable outcome" which was defined as having experienced moderate to severe feelings of guilt, loss, or self-reproach, evidence of mental illness equal or greater to that which existed prior to the abortion, or the patient strongly regretted having chosen the abortion. Most importantly, Lask determined that by using pre-abortion screening for as few as seven risk factors, all of the "at risk" patients could have been pre-identified.

In another major study by pro-choice advocates, Belsey found that 49% of the women experienced maladjustments within three months post-abortion. Belsey found, however, that by using five high-risk screening criteria, 72% of the women who experienced post-abortion sequelae could have been pre-identified as being at high risk and referred to receive additional counseling.

CONCLUSION

Clearly the health and freedom of women is served by this bill. It does not infringe on women's rights in any way. It does, however, prevent the shoddy medical practice of allowing a patient to proscribe her own treatment without any determination of that treatment's risks to that unique individual. Women cannot be expected to know in advance all of the high risk factors associated with abortion, or the complications which can result. Only with this knowledge can they make an informed decision. It is the physician's task to protect the woman's health and to provide her with *all* the information which is relevant to making an informed and free choice to terminate her pregnancy.

I urge everyone to support for this very important pro-woman legislation. Women deserve better care than they are presently receiving.

Respectfully submitted,

David Reardon

David C. Reardon

IDENTIFYING HIGH RISK ABORTION PATIENTS

While there is intense controversy regarding how many women experience post-abortion psychological problems, even pro-abortion researchers admit that at least some women are negatively effected. According to the disposition of the individual researcher, these negative reactions may be loosely labeled as "serious," "significant" or "minor" and the number of women experiencing these reactions may be vaguely described as "many," "some" or "only a few." But statistics are less subjective than adjectives. In one review of the literature, the lowest reported rate for adverse post-abortion outcomes was 6 percent, with most reports ranging from 12 to 25 percent, and the highest estimates rising above 50 percent. With such findings, only the most biased of researchers are so rash to claim that "no one" experiences post-abortion psychological sequelae.

Because the existence of post-abortion trauma is now almost universally accepted, many researchers are now focusing on the factors which may identify which women are at higher risk. From a political viewpoint, researchers who favor abortion on demand are hoping to show that the "few" women who do report negative post-abortion reactions were actually emotionally "unbalanced" prior to the abortion. If this is true, they argue, then it is possible that the abortion itself is not the cause of psychological injury, but instead women who were previously "unbalanced" are unfairly blaming their problems on abortion.

BLAMING THE VICTIM

This "politically correct" view of post-abortion trauma includes a kernel of truth surrounded by a lot of "blaming the victim." It is certainly true that women who are suffering from mental disorders or have previously suffered psychological trauma are more likely to subsequently report more severe negative post-abortion reactions. Indeed, if one thing is clear from post-abortion research over the last forty years, it is that abortion is contraindicated when a woman has mental health problems.

This is true because abortion is always stressful. How well a person copes with this stress depends on the individual's resiliency and the conditions under which the stress occurs. When a woman's psychological state is already fragile, the stress of an abortion can more easily overwhelm her. But the fact that she was more vulnerable to stress than others does not mean that the abortion is not the cause of her psychological injuries.

If a glass plate and a plastic plate are both dropped, the glass plate is likely to shatter, while the same stress may cause the plastic plate to only crack or chip. In either case, the damage cannot be blamed on the material; it must be blamed on the fall. While the *extent* of the damage is related to the nature of the material, the fall itself is the direct *cause* of the damage.

In the same way, while the nature of an individual psyche determines the *extent* of post-abortion injuries, it is the abortion itself which is the *direct cause* of these injuries.

This "blame the victim" strategy which is being employed by some pro-abortion researchers is not new. It is identical to the type of reasoning used during World War I when veterans suffering from "shell shock" were diagnosed by military psychiatrists as "malingerers" or even cowards. In an age when fighting for one's country was romantically idealized as adventurous passage into manhood, this "politically correct" diagnosis was necessary to deflect attention away from the fact that modern warfare was often more traumatic than ennobling. Military officials therefore attempted to suppress reports of psychiatric casualties because accurate reports would have had a demoralizing effect on the public.

In the same way, when pro-abortion researchers are confronted with women who suffer from post-abortion trauma, there is a tendency to blame the woman for being "whiners" or "dysfunctional," since it is common knowledge in pro-abortion circles that abortion normally "empowers" women. Some pro-abortion researchers even argue that women should not be told of the psychological risks associated with abortion because such "demoralizing" information may make them even more prone to an adverse outcome. It is better, they would claim, to be ignorantly optimistic about the future than informed and worried.

WOMEN AT RISK

The comments above are useful for understanding the impetus behind much of the recent efforts of pro-abortion researchers. With this in mind, we can now look at some of the very useful findings which these same researchers have made in the area of cataloging pre-identifying factors which can be used to predict post-abortion psychological sequelae.

The risk factors for post-abortion psychological maladjustments can be divided into two general categories. The first category includes women for whom there exists significant emotional, social, or moral conflicts regarding the contemplated abortion. The second category includes women for whom there are developmental problems,

including immaturity, or pre-existing and unresolved psychological problems. Women with characteristics in either or both of these categories would properly be classified as high risk patients.

Conversely, a low risk patient can be described as a woman who has maturely, thoughtfully, and freely arrived at her abortion decision and has no emotional, social, or moral conflicts which challenge that decision.

The following outline summarizes the major risk factors and includes pre-identifying characteristics upon which women can be screened for these risk factors.

RISK FACTORS PREDICTING POST-ABORTION PSYCHOLOGICAL SEQUELAE

I. CONFLICTED DECISION

A. Difficulty making the decision, ambivalence, unresolved doubts[1,2,11,14,16,17,19,23,27,30,36,39,40]

1. Moral beliefs against abortion
   a. Religious or conservative values[1,17,27,31,35,36]
   b. Negative attitudes toward abortion[7]
   c. Feelings of shame or social stigma attached to abortion[1]
   d. Strong concerns about secrecy[37]

2. Conflicting maternal desires[27,23]
   a. Originally wanted or planned pregnancy[11,17,21,23,39]
   b. Abortion of wanted child due to fetal abnormalities[2,5,11,14,15,20,22]
   c. Therapeutic abortion of wanted pregnancy due to maternal health risk[2,11,14,20,32,36]
   d. Strong maternal orientation[35,27]
   e. Being married[6]
   f. Prior children[19,35]
   g. Failure to take contraceptive precautions, which may indicate an ambivalent desire to become pregnant[4]
   h. Preoccupation with fantasies of fetus, including sex and awareness of due date.[16]

3. Second or third trimester abortion,[20,31,32,36] which generally indicates strong ambivalence or a coerced abortion of a "hidden" pregnancy.

B. Feels pressured or coerced[11,12,14,27,33,35,39,40]

1. Feels pressured to have abortion
   a. By husband or boyfriend
   b. By parents
   c. By doctor, counselor, employer, or others

2. Feels decision is not her own, or is "her only choice"[14]

3. Feels pressured to choose too quickly[13,18]

C. Decision is made with biased, inaccurate, or inadequate information[13,35,36]

II. PSYCHOLOGICAL OR DEVELOPMENTAL LIMITATIONS

A. Adolescence, minors having an increased risk[3,9,12,13,23,26,32,35]

B. Prior emotional or psychiatric problems[2,4,11,14,17,19,20,27,32]
1. Poor use of psychological coping mechanisms[1,23,27]
2. Prior low self-image[27,33,35,40]
3. Poor work pattern [4,40]
4. Prior unresolved trauma[35]
5. A history of sexual abuse or sexual assault.[17,25,38]
6. Blames pregnancy on her own character flaws, rather than on chance, others, or on correctable mistakes in behavior[23,24,29]
7. Avoidance and denial prior to abortion[10]

C. Inadequate network of social support
1. Few friends [4,40]
2. Made decision alone, without assistance from partner[28]
3. A poor or unstable relationship with the male partner[4,19,27,33,39]
4. Lack of support from parents and family, either to have baby or to have abortion[1,7,8,14,23,28,40]
5. Lack of support from male partner, either to have baby or to have abortion[1,4,7,8,14,19,23,27,28,32,34,39,40]
6. Accompanied to abortion by male partner[24]

D. Prior abortion(s)[11,33,35,40]

THE ROLE OF THE MALE

The attitude of the male partner toward the pregnancy is an important factor in a woman's abortion decision and is also significantly related to how she will adjust after the abortion. Because numerous studies have found support from the partner to be an important predictor of good post-abortion adjustment, researchers were recently startled by the finding that accompaniment to the abortion by the male partner was actually a predictor of *greater* post-abortion depression.

This finding suggests that an outward show of support, accompaniment to the abortion clinic, is not an accurate measure of the emotional support a woman *feels*. Instead, accompaniment by the male partner may actually indicate one or more of the following: 1) greater pre-abortion anxiety

10-29-92 News Leader

Abortion clinic to address state citations

■ Inspection: The state says complaints center on the new clinic physician.

By Kathleen O'Dell
The News-Leader

A Springfield abortion clinic will fix 12 deficiencies cited by a Missouri Department of Health inspector last week, clinic interim administrator Lynn Wilson told the state in a letter.

Most of the issues involve lack of verification of staff credentials; a few noted non-sterile conditions. Wilson said she has resolved some issues already. Once she's finished, a state inspector will re-inspect the clinic.

"It is our intent to be within all areas of the law," Wilson said Tuesday. "We are a licensed facility and we will continue to be. Our main purpose is to provide a quality health care for the women of this area."

An inspector with the state Bureau of Hospital Licensing and Certification surveyed the clinic last week on the basis of complaints, according to a state record.

A state spokesman said the complaints centered on the new clinic physician, Dr. Malcom Knarr, who has done abortions there since Dr. Robert Crist resigned in August. Knarr travels from Kansas City on Wednesdays to perform abortions at the clinic.

Around the time of the complaints, former clinic Administrator Leah Guymon resigned and told the state she closed the clinic until it resolved some needed staff changes as a result of the physician changeover.

Deficiencies cited by the state:

- Patient care services aren't under the direction of a registered professional nurse.
- Little or no documentation was found to verify qualifications, credentials, health status or continuing education of various employees with direct contact with patients.
- There was no documentation that the licensed practical nurse on duty had current CPR training.
- There was no indication the medical consultant available to the facility was involved in the peer review process to assure the quality and appropriateness of treatment.
- There was evidence of the presence of insects in the recovery area.
- Rust was found on an operating room table drawer and the table used for the suction device.
- A mop and bucket and washing machine are stored in a closet adjacent to a utility room used for sterilizing instruments, setting up the chance of cross traffic of dirty

Pendergraft

Attachment I

WOMEN'S COMMUNITY HEALTH CENTER
OF SPRINGFIELD, MO., INC.
1837 E. CHERRY STREET
SPRINGFIELD, MISSOURI 65802

MINUTES OF THE BOARD OF DIRECTORS MEETING
EN'S COMMUNITY HEALTH CENTER OF SPRINGFIELD, MO., INC.
FEBRUARY 15, 1994

Members Present: Paul J. Leight; Irving Greenman; J. ...t; Jeanne Burger; Vicki Bordo; Etta Thayer.
-Wilson? maybe/maybe not Pam says no.

The meeting was called to order at 1:15 p.m. by ident, Paul J. Leight. Previous minutes were read accepted by unanimous vote.

Jeanne Burger stated that it is taking an ually long amount of time to receive reimbursement the health insurance company. After some ussion, a motion was made by Lynn Leight to have the etary review the options of changing to another th ...surance company. The motion was seconded and ed.

Mr. Leight inquired as to how referrals ared this year with last year. Ms. Burger made a on, seconded by Ms. Bordo to have the administrator are a plan to increase patient numbers which will be ented at the next Board meeting. The motion passed imously.

After review of his application, a motion was by Paul Leight to appoint Thomas Tvedten, M.D. to medical staff. The motion was seconded by Etta ... and passed unanimously.

3-11

The administrator, Lynn Wilson, has been employed in the health care field since May 1989.. She has a bachelors degree in education. College coursework included chemistry, biology, chemistry, phychology, abnormal psychology, and sociology. She also attended the University of Texas Graduate School of Social Work for a six month course in Advanced Human Services Planning while employed by the Governor's Office of Arkansas.

She received training in abortion counseling from Jean Burger, senior consultant for the parent company of WCHC. Dr. Tom Tvedten also worked with her for a period of six months before she began providing information to patients.

Ms. Wilson has attended numerous meetings for abortion providers including NAF, company training sessions in Florida, and symposiums such as that conducted by Parke-Davis pharmaceuticals in 1993.

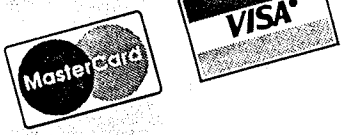
Significant reading include such topics as contraception, female anatomy and health; adoption, natural childbirth and articles written by and for physicians on abortion procedures.

Jackie Martie is a licensed practical nurse who has been employed by WCHC for over a year. Ms. Martie has spent time with Drs. Knarr and Pendergraff to observe and understand the abortion procedure. She has worked with Mary Beth Rainwater, MA in Counseling, to understand the patient's fears and reservations. She has observed more than fifty sessions conducted by others.

She has also read the following literature for a more comprehensive understanding of factors involved in decision making: A Clinical Guide for Contraception by Speroff and Darney. Abortion Practice by Warren Hern, and Open Adoption in Your Community by the National Federation for Adoption.

SPRINGFIELD, MO. Women's Comm. Health Center

For Your Convenience, Life Dynamics Now Accepts MasterCard & Visa



Child Killing

Continued from Page 1

and his skull crushed in a "surgical procedure" that is perfectly legal. That's not called a tragedy, that's called a choice.

In fact, let's suppose that in the murder trial the defense argues that Peterson crushed the baby's head while it was still in the birth canal. Wouldn't the legal conclusion have to be that the young parents were not guilty of murder, but of practicing medicine without a license? Perhaps Peterson and Grossberg had previous abortion experiences and saw no reason this time around to fork over perfectly good money to accomplish the same thing that they could do themselves for free.

We're not the only ones to recognize this possibility. *Detroit News* columnist, Tony Snow, observed that, "the only thing more haunting than the idea of murdering a newborn is the realization that these two teens [illegible]ution—not because [illegible]but because

Material Girl Sees the Truth

Rock singer Madonna wrote in her diary after she first saw an ultrasound of her unborn child, "I was stunned when I saw on the ultrasound a tiny, living creature spinning around in my womb. Tap-dancing, I think. Waving its tiny arms around and trying to suck its thumb. I could have sworn I heard its laughing."

Change of Heart

Dr. John Nwannunu of Merrillville, Indiana, performed hundreds of abortions in the last few years. But on November 15, 1996, he telephoned Bishop Dale Malczek of Gary, Indiana, and told him that he would "never again do this procedure." Nwannunu says he was moved by the way Cardinal Joseph Bernardin "handled death" and by the cardinal's letter to the Supreme Court in opposition to assisted suicide, and that these events instigated his change of heart.

The More Things Change ...

Judith Campbell Exner, mistress of President Kennedy, recently admitted that in 1962 she aborted his child.

Let's see now. A Democratic president is a known womanizer whose mistress lets him off the hook by aborting his child. Hmmmm ... Rocketing forward to 1996, we find a Democratic president who is a known womanizer and whose secret squeez (Gennifer Flowers) says she aborted his child.

It has often been observed that Republican scandals inevitab involve money, while sex seems to be what gets Democrats trouble. Perhaps that explains why Democrat politicians are devoted to legalized abortion. Call me cynical, but I suspec of political careers have been rescued by a timely abortion all, dead babies tell no tales.

Talk About Your Verbal Gymnastics

At a recent National Abortion Federation conference, I abortionist George Tiller told his colleagues that he n his customers about abortion or terminating a pregna who specializes in killing late term babies, said that just tell these women that "they are making a decis this pregnancy by the premature delivery of a stillb

[illegible]n't it amazing that these people continue to def[illegible]are not even utter to their own patient

3-13

MISSOURI DEPARTMENT OF HEALTH
BUREAU OF HOSPITAL LICENSING AND CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

TYPE OF LICENSE	DATE INSPECTION COMPLETED	INSPECTOR'S NAME	TYPE OF VISIT
☐ HOSPITAL ☐ ASC ☒ ABORTION CLINIC	1/19/94	Yolanda Richardson RN	☐ SURVEY ☒ REVISIT ☐ COMPLAINT
FACILITY NAME	PLAN OF CORRECTION	BY
Women's Community Health Center	☒ APPROVED ☐ DISAPPROVED	YRichardson
STREET ADDRESS	CITY	STATE	ZIP CODE	EACH PLAN OF CORRECTION MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.
835-7 E. Cherry	Springfield	MO	65802	

REGULATORY REFERENCE 19CSR 30-20	STATEMENT OF DEFICIENCY	REGULATORY REFERENCE 19CSR 30-20	PLAN OF CORRECTION	DATE OF CORRECTION
9 CSR30-30.60 (1)(A)1.	The governing body has not taken full responsibility for determining, implementing, and monitoring policies governing the facilities total operation. This is evident by:			
	1. The policies/procedures are not approved by the governing body or designee.		1. Lynn Wilson is the designee of the Board. She will approve policies and procedures. See Attachment I	2-28-94
	2. Some policies are non-existant such as those pertaining to: reporting of suspected incidences of child abuse; smoking; reporting of infections to DOH; consents for procedures regarding minors; employee required health status; retention of records for cases performed on minors; quality assurance program; preventive maintanance of equipment.		2. Child abuse - See Attachment II Smoking - See Attachment III Infections - See Attachment IV Minors - See Attachment V Health status - See Attachment VI Minor records - See Attachment VII QA - See Attachment VIII Equipment - See Attachment IX	2-28-94 2-07-94 2-07-94 2-07-94 3-25-94 2-07-94 3-25-94 2-10-94
	3. Upon review of clinical records, it was evident that patients are premedicated before a decision to proceed with the abortion had been made by the facility and according to established criteria. Thirteen (13) patients were premedicated prior to the identification of the gestation age which turned out to be over 16 weeks. Internal criteria exclude patients over 16 week gestation. Also, one (1) patient was premedicated prior to the pregnancy test, which turned out to be negative.		3. See Attachment X The administrator is responsible for monitoring this activity.	2-28-94

met 4/23 YR

RETURN TO THE BUREAU OF HOSPITAL LICENSING AND CERTIFICATION WITHIN 10 DAYS

FACILITY REPRESENTATIVE'S SIGNATURE: Wilson

TITLE: Admin.

DATE: 3-7-94

MO 580-1579 (5-91)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

FACILITY NAME	DATE INSPECTION COMPLETED	SURVEYOR'S NAME
Women's Community Health Center	1/19/94	

REGULATORY REFERENCE 19CSR 30-20	STATEMENT OF DEFICIENCY	REGULATORY REFERENCE 19CSR 30-20	PLAN OF CORRECTION	DATE OF CORRECTION
	credentialing mechanism is available.			
CSR30-30.060 (2)(c)	The medical record does not contain evidence of physical examinations and discharge summaries. This is evident by: 1. Fifteen (15) records reviewed failed to have a physical examination and a discharge summary. 2. Refer to 19 CSR30-30.060(3)(C) for evidence of lack of physical exam. 3. The discharge summary available only states "uncomplicated procedure."		1. Physician will note physical examination and write discharge summaries. Charts will be reprinted to reflect the necessary changes. The administrator is responsible for monitoring this activity.	4-01-94
CSR30-30.060 (2)(D)	There is no policy that addresses the retention of records of patients considered to be minors. This is evident by: 1. Policy is unavailable. 2. Personnel was unaware of need for policy.		See Attachment VII.	2-07-94
CSR30-30.060 (3)(C)	A health assessment is not being conducted on patients scheduled for an abortion. This is evident by: 1. Fifteen (15) of fifteen (15) records reviewed contained only a medical history which is written by the patient the day of surgery. 2. The physical exam consists only of a pelvic exam and vital signs. 3. According to personnel interviewed, an ultrasound exam is taken by a nurse technician who determines the gestation age and decides whether an abortion should take place. This technician has no special training.		See Attachment XX. The physician makes the final determination of gestational age by ultrasound. A staff member will attend a sonography course offered by a medical institution.	3-18-94 6-01-94

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

FACILITY NAME	DATE INSPECTION COMPLETED	SURVEYOR'S NAME
Women's Community Health Center	1/19/94	

REGULATORY REFERENCE 19CSR 30-20	STATEMENT OF DEFICIENCY	REGULATORY REFERENCE 19CSR 30-20	PLAN OF CORRECTION	DATE OF CORRECTION
CSR30-30.060 (3)(H)	~~There~~ is no evidence that trained personnel ~~provides information on alternatives to~~ abortion. This is evident by:			
	1. The people conducting the counseling are the Administrator and a surgical technician. No evidence of special training provided.		See Attachment XXI.	3-04-94
	2. Although the Administrator stated two (2) BSW people are available to provide counseling, they are not utilized in that capacity.		One counselor has an MA in Counseling. One counselor is completing work on her masters in	
	3. The only evidence that information on abortion alternatives is provided is contained in the "information session" of the patient's history which states "the options have been explained."		A review of 1,267 charts in 1993 shows that 753 information sessions were conducted by these individuals, or 68% of sessions held.	
		Dave is mailing the attachments 2/27/95 - MKC	Each patient reads and signs a "Disclosure of Risks, Benefits and Alternatives statement. See Attachment XXII.	2-07-94
CSR30-30.060 (3)(I)	No preventive maintanance on emergency equipment is available. This is evident by:			
	1. There is no evidence that the suction machines have been checked or that they are on a routine maintanance program to ascertain its proper functioning.		See Attachment IX.	2-10-94
CSR30-30.060 (3)(J)(K)	The abortion clinic has not developed a quality assurance program that includes all health and safety aspects of patient care. This is evident by:			
	1. There is no organized, written, and approved protocol for a quality assurance program.		See Attachment VIII. The administrator and medical director will have responsibility for this activity.	3-25-94
	2. The only study conducted at this time has to do with record review, however, documentation of the study was unavailable for review. A copy of a check form was provided which, according			

3-16

MI URI DEPARTMENT OF HEALTH
BUREAU OF HOSPITAL LICENSING AND CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

TYPE OF LICENSE	DATE INSPECTION COMPLETED	INSPECTOR'S NAME	TYPE OF VISIT
☐ HOSPITAL ☐ ASC ☒ ABORTION CLINIC	10-21-92	Dorothy V. Wheeler, R.N.	☐ SURVEY ☐ REVISIT ☒ COMPLAINT
FACILITY NAME: Women's Community Health Center		PLAN OF CORRECTION: ☐ APPROVED ☐ DISAPPROVED	BY
STREET ADDRESS: 1837 East Cherry Street	CITY: Springfield	STATE: MO	ZIP CODE: 65802

EACH PLAN OF CORRECTION MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.

REGULATORY REFERENCE 19CSR	STATEMENT OF DEFICIENCY	REGULATORY REFERENCE 19CSR	PLAN OF CORRECTION	DATE OF CORRECTION
30-30.060 (3)	1. Patient care services are not under the direction of a registered professional nurse. The only R.N. on duty was a prn Agency Nurse who had no responsibility for the supervision of the non-professional personnel.	NO R.N.		
30-30.060 (3)(H)	2. No documentation was found to support or verify the qualifications of the individual providing information on abortion procedures, alternatives, informed consent and family planning services. *	No verification of qualif of counselors		
30-30.060(1)(B)11A	3. No documentation was available to support that employees were oriented to the policies and objectives of the facility nor any evidence of appropriate continuing employee training.	No doc. of orientation or approp. emply training		

RETURN TO THE BUREAU OF HOSPITAL LICENSING AND CERTIFICATION WITHIN 10 DAYS

FACILITY REPRESENTATIVE'S SIGNATURE | TITLE | DATE

MO 580-1579 (5-91)

THE BUSINESS OF LAW

Abortion Doctors' Patients Broaden Suits

By Junda Woo
Staff Reporter of The Wall Street Journal

Abortion doctors are facing a new kind of malpractice lawsuit.

Women have started making unusual claims in such suits, alleging that their abortions amounted to assault and battery or caused posttraumatic stress disorder.

An anti-abortion group called Life Dynamics Inc., which encourages such claims, even suggests accusing abortion clinics of deceptive trade practices for pressuring women and misrepresenting their options. Racist or sexist doctors, it also says, can sometimes be accused of violating a plaintiff's civil rights. (The group won't say whether any deceptive-trade practices or civil-rights claims have been filed.)

LEGAL BEAT

The additional claims, the group says in material distributed to lawyers, can help women avoid caps on malpractice awards. In some cases, the group says, the additional claims can be used as grounds for punitive damages.

The group, which also gives free legal help to attorneys who file ordinary claims alleging botched procedures or inadequate information about risks, is up front about its political agenda. "We would like to see all of them [abortion doctors] out of business," says Mark Crutcher, president. But he says his group encourages lawsuits to protect women from bad doctors. He argues that the vast majority of abortion doctors do such an inadequate job in screening and informing patients of the risks that they can be sued in cases of physical injury.

To the National Abortion Federation, however, the group appears to be trying to drive all abortion providers out of business with harassing litigation. "We believe [Life Dynamics' activities] to be unethical and to be very damaging to what should be a legal process for redress of genuine malpractice," says Sylvia Stengle, the group's executive director.

It's unclear how much of a threat Life Dynamics poses. Mr. Crutcher says the group is assisting attorneys in 43 suits, which he declines to discuss. Abortion-rights groups say they are aware of no more than a handful. But in response, some abortion clinics are tightening their policies, so that women would have a hard time claiming they didn't know the risks. Some clinics are asking women to write out in longhand a copy of the standard consent form spelling out what can happen. Other clinics now videotape patients giving their consent.

In a recent case, a lawyer affiliated with Life Dynamics alleged that a Louisville, Ky., abortion clinic assaulted a 14-year-old who gave consent for an abortion after she was raped. An aunt had forced the girl to undergo the procedure against her will, her attorney argued, so the girl's consent wasn't valid. The patient, now 18, was traumatized by the abortion, said her lawyer, Theodore H. Amshoff Jr., who sought both compensatory and punitive damages.

The case was dismissed last month because the statute of limitations was shorter after the plaintiff got married, and the court never addressed the allegations. But the clinic, EMW Women's Surgical Center, spent about $8,000 and a year's effort on the litigation. "I believe it was a frivolous suit and a suit of harassment," said Donn Wells, executive director.

Mr. Amshoff disagrees. "It doesn't behoove us, from an attorney's perspective, to bring cases without substantial merit, because these are contingency cases," he says, meaning that lawyers collect a share

In addition, the group provides lawyers with material they can use to solicit clients, including a professionally produced television commercial, radio scripts, marketing brochures and tips for getting media attention.

The TV commercial, for instance, shows a distressed woman on a stormy night. "If you've been physically or emotionally injured by an abortion, don't suffer in silence," a voice-over says. "You have a right to seek compensation in a court of law."

The ads appear to be aimed, at least partly, at the weak links of the abortion movement — women who have had abortions despite being philosophically opposed to the procedure. Ms. Stengle of the National Abortion Federation says one in five abortion patients falls into this group. "It's a very worrisome subset of our patients," she says. "Sometimes, ethically, a provider has to say, 'If you think you are doing something wrong, I don't want to help you do that.'"

While courts haven't yet decided whether the new claims are frivolous, judges in other types of malpractice suits have allowed them.

Assault and battery, for instance, can be used in malpractice cases if a patient didn't give "informed consent" to an operation, several courts have said. But malpractice lawyers say they seldom file the more-serious assault-and-battery claim because patients don't collect much money if they win. The reason is that insurers refuse to write coverage for assault and battery and other intentional misconduct.

Some courts have allowed claims for posttraumatic stress disorder in abortion-malpractice suits. In a notable 1992 case, New York state's highest court allowed such a claim against a doctor who performed an incomplete abortion that led to a grotesque miscarriage. The patient was awarded $125,000. Life Dynamics suggests to lawyers that posttraumatic stress disorder occurs in one out of five abortions.

One law firm that often draws on Life Dynamics' resources is Mr. Amshoff's firm, Swendsen, Amshoff, Maroney, Strahan, Smith & McInerny. One of the firm's partners has even done legal research that the group has published. The Washington, D.C., firm, founded in February to specialize in abortion malpractice, says it has 22 pending cases.

In a continuing Rhode Island case, Mr. Amshoff argues that, in addition to committing malpractice, a clinic inflicted emotional distress by performing an incomplete abortion that led to an infection. The case against the Women's Medical Center of Rhode Island also includes an assault-and-battery claim, based on arguments that the woman wasn't fully aware of the risks.

Patricia A. Sullivan Zesk, an attorney for the Women's Medical Center, denies the allegations.

Swendsen Amshoff has come under fire because several partners have done work for the anti-abortion movement. But partner Amy McInerny says, "We are not movement activists or philosophers. We are a law firm."

Swendsen Amshoff partners say they have negotiated settlements worth hundreds of thousands of dollars and worked on two cases in which the physicians subsequently had their licenses suspended.

Legal ethics experts, meanwhile, say they see nothing wrong with Life Dynamics' tactics — even if they are politically motivated. "Everything that this group is doing," says New York University professor Stephen Gillers, "is within their First Amendment authority to advance their view of the world through the courts."

LAWYERS & CLIENTS

Coudert Brothers Risks Losing Global Franchise to Competitors

Continued From Page B1

wouldn't turn around," says departing Paris partner Nicolas Sokolow, who added that financial considerations were not the reason for his own departure. Both the firm and Mr. Sokolow attributed their separation to "irreconcilable differences."

When he was elected the firm's chairman last year, one of Mr. Williams's goals was "to push down to local offices as many administrative decisions as possible," he says. "I think we have succeeded," he adds.

After Mr. Williams took over, the executive committee swiftly eliminated the position of managing partner. Instead of having a New York attorney responsible for making administrative decisions world-wide, partners with those duties were appointed in every office. Mr. Williams acknowledges that the firm's previous leaders wanted to centralize decision making. "We have gone the other way," he says.

But the changes came too late for some. Four Coudert partners in Paris and one in New York leapt at an offer from Washington's Arent, Fox, Kintner, Plotkin & Kahn. Under the arrangement, the Coudert group formed its own partnership but agreed to exchange client referrals and related fees with Arent Fox. The two firms will also jointly pitch for business and say they will consider closer ties in the future.

Such affiliation agreements are growing common as U.S. law firms attempt to test foreign waters without making the firm and of Arent Fox.)

Coudert says the departures aren't significant. Mr. Williams won't say how much the Paris defectors billed last year but says other people had "materially overstated" the figures. He adds that the defectors' billings declined 40% last year from the prior year and had continued to be "on the decline" this year. "It's not some kind of death blow," says Coudert partner Thomas Brislin in New York. He says the firm's revenues last year were a "a bit over" $125 million. The firm now has 127 partners working out of 20 offices.

Coudert's Mr. Williams contends that, after all the defections, the firm is "a much stronger and more efficient partnership."

But Mr. Sokolow, who won't discuss his billings, says Coudert seems to be "taking an aggressive view in terms of damage control . . . The fact that you have a split in the second-biggest office is a nonevent? Fine, let it be a nonevent."

Stephen Heard of Arent Fox's New York office adds: "Let's face it, Coudert is the franchise we're all nibbling away at." Mr. Heard, who led the talks with the Coudert group, says Arent Fox was eager to expand its overseas presence, which previously consisted of two small offices in Hungary and Saudi Arabia.

Although it couldn't offer the Coudert lawyers the kind of vast international network they were accustomed to, the Washington firm promised something else: "I told [Mr. Sokolow] we were an unstructured unbureaucracy," Mr. Heard says.

Morris Get[illegible]ts At Warner Unit, Averting a Crisis

By Jeffrey A. Trachtenberg
Staff Reporter of The Wall Street Journ[al]

NEW YORK—Heading off a crisis at t[he] world's largest record company, Warn[er] Music Group Chairman Robert Morga[do] has agreed to give a new title and great[er] operating responsibilities to Doug Morri[s,] president and chief operating officer [of] Warner-U.S.

As of this morning, Mr. Morris w[ill] be chairman and chief executive of Wa[r]ner-U.S., which oversees all domestic re[c]ord operations of the Time Warner In[c.] unit. In addition, Mr. Morris will direct[ly] oversee one of the labels, Warner Bro[s.] Records, until a new chief executive is a[p]pointed. It is expected that Mr. Morris w[ill] move from Warner Music's New Yo[rk] headquarters to Burbank, Calif., whe[re] that label is based.

During the last 48 hours, Mr. Mo[r]gado and Mr. Morris met in inten[se] discussions at Warner Music's headqua[r]ters at 75 Rockefeller Plaza in New Yo[rk] over whether Mr. Morris would be e[m]powered to make critical manageme[nt] decisions. Although Mr. Morgado name[d] Mr. Morris to his current post in July, M[r.] Morgado continued to play a highly acti[ve] role in the management of the group['s] domestic labels, creating tension a[nd] sparking Mr. Morris's rebellion.

Under Mr. Morgado, the Warner Mus[ic] Group, though highly successful, has be[en] beset by uncertainty and manageme[nt] turnover, which record label executive[s] blame on Mr. Morgado. Had Mr. Morga[do] not made concessions to Mr. Morris, man[y] in the industry feared a wholesale d[e]fection of executives and recording artis[ts] from the company.

Mounting discontent was brought to head earlier this week when Lenn[y] Waronker, president of Warner Bros. Re[c]ords, declined to take the chief executive post, a role he earlier agreed to assume[.] Mo Ostin, current chairman and chi[ef] executive of Warner Bros. Records, a[n]nounced his departure earlier this sum[mer], after losing a power struggle f[or] independence with Mr. Morgado.

"All of the issues have been resolved[,"] said Mr. Morris. "We've resolved o[ur] differences, and we are moving onwa[rd] and upward. There was a problem [of] overlapping responsibilities, which to[ok] several days of difficult talks to unde[r]stand and work our way through, but [we] have done so."

One of Mr. Morris's most critical de[ci]sions will involve finding a new ch[ief] executive to head Warner Bros. Record[s.]

The resolution of the differences [be]tween Mr. Morgado, 51 years old, and M[r.] Morris, 54, comes at a critical jun[c]ture. The Warner Music Group, the large[st] music company in the world, has lo[ng] dominated the U.S. market. Much of [its] success, however, reflected the stability [of] Warner Bros. Records, where Mr. Ost[in] was chief executive for the last 25 year[s.] However, Mr. Ostin's decision to leave t[he] job, and Mr. Waronker's rejection of [the] post, has created concern about the labe[l's] future and its ability to sign new artist[s.]

"One of the reasons that Green D[ay] decided to sign with Warner Bros. Recor[ds] was because of the quality of the peo[ple] and the stability that Mo and Lenny g[ave] the place," said Elliot Cahn, manager [of] the punk rock group.

Hollywood Casino Corp.

Gaming Company Reports Surge in 3rd-Period Earnings

Hollywood Casino Corp., Dallas, [re]ported that its earnings more than doub[led] in the third quarter, sending the gam[...]

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FIRST TRIMESTER PROCEDURES

YOUR TIME HERE . . . . .

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ıber of the national abortion federation

nt to make your time at Surgi-Care as comfortable as possible by giving you some of what will be happening while you are here.

stay in the clinic will be about 4-6 hours. You can anticipate that some of time will be spent just waiting. We try to see all patients as promptly as ble, but some delay is inevitable.

tages of your visit, with rough time approximations:

ompletion of your medical chart, review of al history and preliminary lab work.	30 minutes-1 hour
ayment of fees.	10 minutes
ounseling -- a time to explore your feelings and to our questions answered. Our counselors are profes- l and professionally trained. There will be two to other women in the counseling session with you.	1 hour 3-5 women at a time 5 | 60 min = 12 min each
You will change into a gown and have your vital s (blood pressure, temperature, pulse rate) taken. will wait with the other women in your group for procedure.	30 minutes - 1 hour
Physical examination and the abortion procedure. counselor will be with you during surgery.	15 minutes
R&R in the patient lounge. During this time the sing and counseling staff will review birth control ıods and follow-up care. We will also ask you to plete an evaluation of our services so that we know ve have met your needs and expectations.	30 minutes - 1 hour

THE PARENT/PARTNER/FRIEND WHO ACCOMPANIES YOU. . .

is not essential that someone accompany you to your appointment but support ally is welcome during this time. Because our waiting area is small, friends relatives are encouraged to leave their names with the receptionist and call k in about three hours. By then, we should have a pretty good idea of when will be ready to leave and when they should return.

.en, the person accompanying you is just as nervous as you may be. It should .p you both to know that abortion by vacuum aspiration is the most widely used l safest method of pregnancy termination. Sensations will vary, but they are stly described as cramping or discomfort, which generally subsides within a v minutes after the procedure is over.

hope this provides enough information to ease your mind and allay possible ncerns. Let us know . . .

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

CH 3
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rehensive
health
associates

ber of the national abortion federation

Trimester

PATIENT INFORMATION - ADVANCED PROCEDURES

Comprehensive Health provides outpatient abortion care for women who are in the second trimester of pregnancy. We have prepared the following information to answer patient questions about our program and about how your time at our clinic will be spent.

The D&E Option: The kind of abortion you will be having is called "dilatation and evacuation. It is a relatively new procedure which is replacing the induction types which required two to three days of hospitalization and a mini-labor process. A D&E is safer than an induction procedure and involves much less patient discomfort. It is the only kind of advanced abortion that can be done on an outpatient basis.

CHA has been providing the D&E option for four years. The clinic is housed in a licensed ambulatory surgery center regulated by the State of Kansas.

Appointments: Patients are seen by appointment only. Call Monday through Friday, 9 a.m. - 5 p.m., Saturday, 9 a.m. - 3 p.m.

Fees: Payable on the day of your first visit to the clinic. We accept cash, travelers' checks or money orders. No personal checks are accepted.

15-18 weeks LMP - $490
19-22 weeks LMP - $640
23-24 weeks LMP - $840

These fees are all inclusive except for Rh negative patients who need Rhogam injections, which cost an additional $40.

Hotels: Overnight accommodations recommended for out-of-town patients are available. Ask when calling for your appointment. Please note that patients who live more than an hour's drive from the clinic are required to spend the night(s) prior to surgery in the immediate area.

LMP: These initials stand for "last menstrual period." Pregnancy length is calculated in weeks based on the first day of a woman's last normal menstrual period. Appointments are made for women based on this date; thus it is important to be as accurate as possible when providing this information to the appointment staff.

Schedule for Patients Who Are 23-24 Weeks LMP

TUESDAY will be your first visit to the clinic. You will be here for approximately four to five hours. Your time will be spent as follows:

C.H. 1

3-20

2nd trimester

Step 1: Lab work
Step 2: Initial interview
Step 3: Sonogram (an absolutely painless and effective way of determining the length of pregnancy using an ultrasound machine
Step 4: Physical examination
Step 5: Payment of fees
Step 6: Counseling
Step 7: Laminaria insertion. Laminaria are small pieces of sterile seaweed. Two or more will be inserted into your cervix to begin the process of dilating it prior to the procedure itself on Thursday. Laminaria are the safest possible way to achieve cervical dilatation. Mild to moderate cramping may be present for a few minutes.
Step 8: Medications and instructions for the next appointment are given. You also will be given a medical emergency phone number to call should problems arise during the night.

WEDNESDAY will be your second visit to the clinic. At this time, the laminaria inserted on Tuesday will be removed and new ones will be put in place to continue the process of cervical dilatation. You should be here no more than an hour.

THURSDAY will be the day of your procedure. Your total time here on Thursday will be about four to five hours. The abortion will take about 10-15 minutes under local anesthesia. You will be in the recovery area for about two hours.

Schedule for Patients 19-22 Weeks

TUESDAY will be your first visit to the clinic. You will be here approximately four to five hours in the morning during which time you will follow the same eight steps listed above. In addition, you will return later in the afternoon for a second laminaria insertion. The laminaria inserted that morning will be removed and new ones put in place to continue the process of cervical dilatation. You should be here no more than one hour for the second laminaria insertion.

WEDNESDAY will be the second day of your procedure. Please see the information given under THURSDAY above.

Schedule for Patients 15-18 Weeks

TUESDAY will be your first visit to the clinic. You will be here approximately four to five hours. You will follow the same eight steps listed under TUESDAY above.

WEDNESDAY will be the day of your procedure. Please see the information given under THURSDAY above.

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American Medical
NEWS
American Medical Association
JULY 12, 1993

Abortion providers share inner conflicts

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON — The women and men who fill the conference rooms are involved in a political war, but they aren't waving banners or shouting slogans.

Instead, they have checked their bumper stickers at the door. And when it closes behind them, they speak quietly and movingly of their work on the frontline of America's most controversial battlegrounds: abortion clinics.

The discussions take place at workshops sponsored by the National Abortion Federation. And they illuminate a rarely heard side of the abortion debate: the conflicting feelings that plague many providers who are seeking to balance the rights and needs of patients with the reality of terminating pregnancies.

"Ambivalence is not a dirty word," says Terry Beresford, who trains abortion counselors for Planned Parenthood and other groups. "We're not ambivalent about women's right to choose abortion. And we are not ambivalent about the need for safe, legal abortion.

"But abortion is not a simple-minded decision. It is a complex one. Everybody has mixed feelings."

The notion that the nurses, doctors, counselors and others who work in the abortion field have qualms about the work they do is a well-kept secret.

But among themselves — at work, or at meetings with other providers — they talk about how they really feel. About women who come in for "repeat" abortions. About women whose reasons for having abortions aren't ones they consider valid. About their anger toward women who wait until late in their pregnancies to have elective abortions. And about the feelings they have toward the fetus, especially as gestational age increases.

They wonder if the fetus feels pain. They talk about the soul and where it goes. And about their dreams, in which aborted fetuses stare at them with ancient eyes and perfectly shaped hands and feet, asking, "Why? Why did you do this to me?"

Oddly enough, many of the issues that disturb abortion foes also seem to trouble providers. Ultimately, however, they have different moral balance sheets. For providers, the bottom line is the woman's life and the particular circumstances that drive her to choose abortion. For opponents, the bottom line is what actually happens during an abortion: a human life is taken.

> *'Abortion is not a simple-minded decision. ... Everybody has mixed feelings.'*
>
> ***Terry Beresford***

Over the years, the National Abortion Federation has hosted numerous workshops to help providers deal with their conflicted feelings. Here is a sampling of issues they've raised and some of the ways they deal with them.

Repeat abortions

According to the Alan Guttmacher Institute, a research organization affiliated with Planned Parenthood, 43% of the estimated 1.6 million abortions done annually in the United States are performed on women who have had previous abortions.

Not all providers have problems with "repeaters." The problem, they say, is that many women are reluctant to use chemical forms of birth control, and that other forms are frequently messy or inconvenient. They note that a fertile woman has numerous opportunities to become pregnant in her reproductive life and say abortion is a better alternative than an unwanted child.

But some are uncomfortable when "repeat abortions" seem to become a habit. A counselor from Connecticut told of a 31-year-old woman who came to her clinic for her 14th abortion.

"There was a feeling among some of the counselors that we should not continue to see this patient," she told the group. "A feeling that we were in fact reinforcing this behavior."

Another told of a client who came in for three second-trimester abortions in less than 18 months. "She waits til she's almost 21 weeks," then she comes in for an abortion, said the counselor from Utah.

Then there was the Colorado woman who became pregnant every time she "fell in love," hoping it would lead to marriage. She has had seven abortions.

The discussion got down to the issue of how many abortions is too many.

"I had to work through my own issues with women who had multiple abortions," one counselor said. "And I did become moralistic and judgmental. My first cut-off was two. It's gone up to four.

"I'm going to be honest and say

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bortion

Continued from page 3

that's hard for me. I really wish I could get past the four. . . . If it was 14, I know I would have a very hard time sitting across from this woman and trying to be as pleasant as possible."

A discussion facilitator asked, "Is 14 too many? Well, what's the right number? . . . Is 10 too many? Is five too many? ...

"I haven't seen where the woman's uterus falls out after the eighth abortion or anything like that.

"I'm wondering if it's something within the person thinking that it's not quite morally right. And maybe there's some leftover business that they need to tend to," she said.

"I don't think her problem is pregnancy or her problem is repeat abortions. But she has a problem. This is self-destructive behavior," another counselor added.

Maybe the woman is making the decision "not to contracept," said another counselor. "Isn't that valid?"

Another responded: "Would we call this woman self-destructive if she had 14 children? We continue to buy into this view."

For one counselor, the issue was not one of morality but risk. "Abortion is a procedure not without consequences," she said. "And so to subject yourself to risk 20 times is like mountain climbing on a peak without a rope. Twenty times is more risky than once."

Late-term abortions

When it comes to abortion, probably nothing is more gut-wrenching than the issues raised by late-term procedures, those done in the second and third trimesters.

Those attending these workshops do not argue about whether human life begins at conception. For them and other abortion rights advocates, the critical issue is "personhood." And some have definite ideas about when this happens: When brain activity begins. At quickening. At viability. At birth. When the woman decides she wants to have the baby.

But most support the notion that the fetus is not a "person" — at least at the point that the abortion is performed.

Abortion opponents, on the other hand, take issue with the focus on "personhood." Most consider it a highly subjective religious or philosophical concept designed to avert attention from the biological fact that human life begins at conception. From the moment a genetically distinct human life is created, they say, it has moral standing and deserves full legal protection.

Beresford, who feels that a fetus is not a person at any stage of development, says the "rights lie on the side of the born person." But she acknowledges that many people begin to have different feelings about abortion as the fetus starts to develop.

"Most of the issues in late abortion are not significantly different from the issues in early abortion," she said at a seminar on second-trimester abortions. "It's just that it's very easy not to need to face some of these issues . . . in first-trimester [abortions]."

In the second trimester, she said, one has to deal with the "complications of the medical intervention" and "the fact that the fetus begins to resemble more and more what we think of as a baby."

"So what you're getting is not only the stuff that connects to second-trimester [abortions], but all the stuff that connects to abortion," she said.

Beresford supports the availability of abortion throughout pregnancy, regardless of the woman's reason. "But I'm not saying I'd be any good in a procedure room past a certain point," she acknowledged.

Not all providers do late-term abortions, and those that do have varying degrees of comfort with them.

"This may sound like repression; however, it does work for me," said a counselor from Kansas. "When I find myself identifying with the fetus, and I think the larger it gets, that's normal . . . then I think it's OK to consciously decide and remind ourselves to identify with the woman. The external criteria of viability really isn't what it's about. It's an unwanted pregnancy and that's the bottom line."

A Seattle nurse talked about watching her first late-term abortion, done by a dilation and evacuation method.

"I was watching the doctor struggle with the cannula, trying to pull it out," she said. "I didn't understand what the resistance was all about. And I was very alarmed and all of the sudden the doctor pulled the cannula out and there, as I was at the woman's side, I looked down at the cannula and there was a foot sticking out.

"I will never forget the feeling I had in my chest as the doctor pulled that cannula out. And it almost took the breath out of me. Because the reality of this was very hard for me."

The nurse said it took weeks for her to process the issue. "This sounds terribly cavalier, I suppose, but within about a month, like everything else we do after a while, it just becomes pretty routine and it has never bothered me since then."

A New Mexico physician said he was sometimes surprised by the anger a late-term abortion can arouse in him.

On the one hand, the physician said, he is angry at the woman. "But paradoxically," he added, "I have angry feelings at myself for feeling good about grasping the calvaria, for feeling good about doing a technically good procedure which destroys a fetus, kills a baby.

"I don't think I've ever heard anybody talk about that. But there is a good feeling to doing a good job. Even with the destruction of a pregnancy as the outcome."

An Arizona clinic administrator said her clinic gradually had increased the gestational age at which they performed abortions from 12 to 16 weeks. Along the way, she said, the staff needed to deal with conflicting feelings. "One of the things that we've done is talked about where does the soul go."

It helps when the staff can sit down and say things like, "Yeah, that's what disturbed me about seeing that little face. . . . I know I'm not going to burn in hell anymore. But I'm still kind of concerned about how it all fits together."

A physician assistant from New York said she does ultrasounds to determine gestational age on women with advanced pregnancies.

"When I can identify the four chambers of the heart, I start feeling miserable. And when I put my hands on somebody to feel how big they are and I get kicked, I'm barely able to talk at that minute.

"I want to say to that woman so badly: 'What went on here? Why weren't you here six weeks ago?' "

'Everybody in the world is ambivalent about abortion. Abortion is about life, death and sex. And except for eating, that's everything that matters to us.

Terry Beresford

Beresford said it is quite common for the counselor to identify more with the woman and the nurse to identify more with the fetus. "One of the things that those of us who do counseling get that often the doctor or the nursing staff don't get," she said, "is we get the lives of these women. We know what they're dealing with, we know what their issues are, we know how hard it was for them to make the decision, or why they came late.

"We're more easily able to identify with that woman on the table, even when the doctor is pulling out fetal parts of an advanced pregnancy."

Tough questions; tough answers

One of the most vexing problems providers face is their feelings about procedures done for reasons that make them — or others — uncomfortable.

Sometimes it's "sex selection" — the patient wants a boy and is carrying a girl. Sometimes the woman tried unsuccessfully for years to become pregnant, then changed her mind when it finally happened.

One counselor talked about a couple who had been married for 12 years and had "an absolutely wonderful life." When they became pregnant, they were confused. They loved children, but never consciously decided one way or another to have them. They went to the abortion clinic for advice: Would having this baby make their lives better or worse? They ultimately chose abortion.

The counselor said the case was one of her most difficult, because usually "there is some factor that's really bending the person's decision." In this case, she said, the couple made a choice with no concrete reason.

"Damn it," responded one discussion leader. "This is where the opposition has had an effect on us. Stop and think: Where did you get this notion that there has to be some very special, particular, some sort of reason that's better than some other sort of reason? I think you got it from the anti-abortion movement in America. They have so little to hang their hat on, that one of the things they've chosen to hang it on is that there are all these women out there who are having abortions for frivolous reasons.

"People's lives are complicated. . . . And those people would have a baby or have an abortion for a multiplicity of reasons, not one that stands out that you put on a bumper sticker," she said.

"The truth of it is, none of us is nonjudgmental," Beresford said. "And . . . different patients push different buttons for different people.

"Even though we say, 'No woman should have to justify her abortion,' 'Any reason is an adequate reason,' in your heart you know that you are more sympathetic at this time in your life to certain reasons than you are to certain others. And it changes for us over time."

One thing that doesn't change over time, however, is the kinds of questions patients ask. Questions that sometimes stump the staff.

Like whether the fetus feels pain during the procedure.

"This is a big concern" for both staff and patients, said a clinic employee from Massachusetts. After all, she said, "it *is* a dismembered body."

She deals with the issue by comparing it to the saline abortion she had years before, performed because of a fetal anomaly.

"In all of the choice movement, there is a balance between the fetus and the woman," she said. "And between my experience with a saline abortion where I suffered, vs. the option of a D&E where yes, the fetus may suffer, I always choose the woman."

Patients also sometimes ask to view the fetal remains. A Toronto physician said she didn't know "how and whether we [should] protect the patient from the reality of procedure." She said she regularly hid the ultrasound screen and "whisked away" the "fetal products."

"She's probably not prepared for what she's going to see," she said of the patient.

Beresford said that before that particular workshop, someone had asked her what they could say to staff "to make them not look so shocked when they look at a 20-week fetus."

"The answer is: There isn't any one thing you can say," she said. "And there's nothing that you can say once that will do the trick. This is ongoing business for people who work in abortion. It has to do with doctors. It has to do with nurses. It has to do with counselors and lay personnel.

"It has to do with who carries the instruments out of the room and who bags the fetal remains and who carries the bags to wherever you carry them. It has to do with every single person in a clinic. It has to do with the bookkeeper whose mother wants to know why she doesn't keep books in some nice little business that can be mentioned at the dinner table."

It's hard being in a profession "where you have a hard time answering the questions that other people ask you about what you do," she said. "You come to not feel so good about what you're doing even when you thought you were doing something wonderful."

'Everybody is ambivalent'

Sometimes these feelings surface with patients.

A nurse who had worked in an abortion clinic for less than a year said her most troubling moments came not in the procedure room but afterwards. Many times, she said, women who had just had abortions would lie in the recovery room and cry, " 'I've just killed my baby, I've just killed my baby.'

"I don't know what to say to these women," the nurse told the group. "Part of me thinks, 'Maybe they're right.' "

Such self-doubt is not uncommon in the abortion field, Beresford said.

"People have different feelings at different times. And they get scared. They start to think they're not really pro-choice because they're feeling sort of icky about some of what they're seeing." But such ambivalence is normal, she said.

"Everybody in the world is ambivalent about abortion. Abortion is about life, death and sex. And except for eating, that's everything that matters to us. So it's no wonder we've got issues."

#4

Jane Doe #3

The expediency of abortion encourages women to be weak, dependent, and incapable of dealing with unexpected challenges. This mentality tells women they must depend on abortion to solve their problems for them. Abortion has been sold to women under false premises. We have been lied to, manipulated, and exploited. For too long we have remained silent, too ashamed to speak out. No longer am I willing to be silent.

Scared and unaware of what to do at the time of my crisis pregnancy, my boyfriend and I took the abortion pamphlet offered to us by the health clinic nurse and scheduled an appointment. I used the identity and birth date of someone else when scheduling and recieving the abortion. To my surprise very little information was asked of me and very little was given to me. Prior to my abortion, no attention as given to alternatives, what the procedure entailed, or fetal development. No time was offered to consult with the doctor about the nature of the physical and emotional risks of abortion.

When the abortion was over and I was able to go to the waiting room, my boyfriend asked me if the doctor told me if the baby was a boy or girl. It was at that moment I began to realize the magnitude of my decision. This uninformed decision, this "right", was now filled with sufferings and regret. What was aborted during that procedure I later discovered, was far more that a product of conception. This "product of conception" at the time was approximately 2 1/2 to 3 1/2 inches long, weighed roughly 1\2 to 1 1\2 ounces, had fingers, toes, and nails. This "product of conception" also had a heart beat I knew nothing about.

Physically, I have healed from the abortion, despite not returning for follow up care. Unfortunately, the emotional trauma has been excruciating and has ranged from depression and hellish nightmares to utter grief. There is no way you can feel the pain or emptiness I feel knowing I made the wrong decision. What a difference simple information like that proposed by House Bill 2269 would have made.

House Judiciary
Attachment 4
2-13-97

To my knowledge, abortion is the only surgery for which the surgeon is not obligated to inform the patient of the exact nature of the procedure. We need to ask ourselves why. Since abortion is provided as a commodity not as a medical necessity, it's only logical that abortionists or others who profit from it would reject medical standards. The abortion industry like some big businesses resist government regulations for fear it might reduce profits.

How then, can we in good faith support an industry that presents itself under the guise of medicine but repudiates the obligations, codes, and oaths of medicine, specifically informed consent?

The destruction of human life is an irreversible event which has negatively altered my life and countless others. What a tragedy to make a life changing decision such as this without all the facts. There is no liberty in a society that encourages irresponsibility through the concealment of important information like that in House Bill 2269 .

This is not about being pro-choice or pro-life, for both sides agree that the expected outcome of abortion is <u>always</u> death. <u>This</u> is about the value of truth. I would ask you to have the courage, honesty, and conviction to pass this bill. To do anything less will be demeaning and destructive to women and children.

#5

Any politician who opposes Pro-woman legislation and intives can rightly be described as truly anti-woman. Those who oppose safeguards against coersion are the enemies of freedom. If they oppose our pro-woman initiatives it is they who belong in a box labeled "Uncompassionate Anti-woman Ideologues."

Four reasons why legislation is needed. They are:

1. Protecting women from being coerced in to an unwanted abortions 30% Guttmacher 55% Elliott Inst

2. Guarenteeing the right of women to make free & fully informed decisions about abortion (know all aspects)

3 Protecting the woman most likely to be injured by abortion by requiring physicians to Properly screen patients for characteristics which would place them at higher risk of physical or psychological complications and

4. Expanding the rights of injured patients to recover fair compensation for physical or psychological harm resulting from abortion.

Governor Graves had the audicity to Veto the Right to know bill last year. This says loudly to the people that He is willing to risk the welfare of women for the sake of preserving the abortion industry's profit margins because the Right To know bill doesn't outlaw abortion but simply makes abortion providers properly responsible for the problems which are occuring, or at very least, may occur.

For those who are truly pro-choice and those who are Pro-life we share a common concern and a common ground on which to build toward a reasonable solution to the abortion problems. Together we can cooperate in trying to protect women and not judge them. Together we can begin to make abortion more rare, not by restricting womens rights, but instead by expanding their rights to ensure that their choices are truly free & fully informed.

Nancyjo Mann

House Judiciary
Attachment 5
2/13/97

ONCE AGAIN it's time to draw public attention and awareness to the facts that women have the Right To Know and to be protected.

WE believe the basic right's given women in Roe VS. Wade have not been upheld nor complied with by the Supreme Court, Many Physician's, and abortion medical facilities throughtout this country.

Why do our women suffer from such medical procedures from which legal and medical codes deny the patient the right to information and/ or informed concent?

Most abortionist's reject All obligations, codes, and oathes of medicine that through the centuries have given medicine a place of honor.

WE NEED TO support legislation for not only the Women's Right To Know bills, but any and all legislation that helps inform women of possible risks involved for each type of abortion procedure.This includes the psychological and physical complications. This does not wittle away at women's rights but indeed empowers them to make a clear andinformed decision about what they are possibly and probably going to experience.
Planned Parenthood Vs. Danforth 428 US 51, 67, 1975, states "In forming a medical reccomendation, the PHYICIAN is OBLIGATED to develop this opinion " in light of all factors- physically, emotional, psychological, and the womens age-relevant to the well being of the patient." And in ALL cases,the weighing of all factors should operate "for the benifit, not the disadvantage, of the pregant women.
Doe VS Bolten.
410 US 179, 192, 197 1973.
These laws were made to PROTECT women.But where is the protection? We NEED to ensure women protection and remedy the flaw that prevents women to sue and recover damages from their abortionist's. believe in the right to civil action law suits.

Abortionist's and abortion providers need to be held accountable. Women deserve to be given the highest degree of medical care and receive complete information on the reasons for her physicians recomendation, her alternatives, her risks, and any other information that may influence her decision to follow or reject a recommendation to abort.

Examples, such as the fact sheet: The Emotional Effects of Induced Abortion:[New York Planned Parenthood of America 1993]

There are well established predisposing risk factors in the medical and psychiatric literature which are PREDICTIVE of a greater likelihood of regrets or other adverse emotional reactions to abortion. These risk factors include, but are not limited to , the following: feelings of being pressured to have the abortion; feelings of attachment to the unborn child; a history of prior psychological illness or emotional instability; strong religious convictions against abortion; lack of support from partner or parents; a second or third-trimester pregnancy; low expectations of coping well.

Again, we have the Right To Know physical complications that can occur on any of the abortion procedures. Full information pertaining to our physical well being should be given to us.

the age of 17 during her Junior year in high school Nancyjo became pregnant. Refusing to abort the baby Nancyjo married the father. After graduating from high school they had their second child.

Rebounding from the divorce and thinking she was "safe" on the pill, she got pregnant with her 3rd child and 4 months later, married again. On October 30, 1974, not even 2 months into the marriage, her second husband decided 3 kids were more than he could handle and walked out. In her distress she turned to her family for support. Instead, she found scorn. Her mother said, *"Nancy, you'll never amount to anything. No man will want you with 3 children, let alone the 2 you already have. You'll be on welfare the rest of your life.* ***You've got to have an abortion."***

Two hours later, she sat in Dr. Fong's office, terrified, not wanting to abort her child but seeing no alternative. The doctor didn't bother to examine her. When she asked him what he was going to do, he answered, ***"I'm going to take a little fluid out and put a little fluid in. You'll have severe cramps and you'll expel the fetus."*** She was told to go to the hospital, get admitted and he would be over in an hour. As she sat waiting for him, she thought about what he'd said, picturing a regular sized shot. When he pulled out a 4" needle with a 6-8 inch cylinder, everything within Nancyjo wanted to scream, but she was paralyzed with terror.
She lay there frozen, as the doctor prepped her and using the syringe, took out 60 cc's of amniotic fluid. Immediately after he injected the 210 cc's of 20% saline solution. **He left and her baby began to thrash around violently.** Nancyjo talked to her daughter the hour and a half it took her to die begging for forgiveness. Nancyjo still remembers the last weak kick against her lower left side. The nightmare of what was happening seemed unbearable. Nancyjo was never told what would happen to her - **never told she'd feel her baby die.** The severe cramps were in reality, hard labor.

After the baby died, nurses came in, started an I-V of pitosin to induce labor, then left. Nancyjo tried to summon help, pleading for someone to be with her, but no one came. **It took 12 pain filled hours, but she finally delivered her own daughter, alone.** She was 14" long and weighed a pound and a half. She had a head full of hair and her eyes were opening. Nancyjo held her for a minute before the nurses rushed in, grabbed her out of Nancyjo's arms and threw her into a bed pan. Nancyjo heard her tiny head hit the cold metal. Then they yanked on the umbilical cord, jerked the placenta out and left. **Nancyjo lay there tormented by guilt and grief.** Bleeding and infections continued for the next four months. Too ashamed of her abortion to go to her regular ob/gyn, she returned to Dr. Fong for a D & C. Three weeks later she was running a 105 degree fever and doubled over with pain.

She went to the bathroom and expelled over 20 yards of black packing the doctor neglected to remove after surgery. She was rushed to the hospital and the examining doctor exclaimed, ***"My God, Nancy, who has butchered you like this?"*** Full of shame, she refused to tell him anything. He said, ***"Nancy, he has cut off your cervix and you have an open uterus. You will never stop bleeding. Who has done this to you?"*** She still refused to tell him saying he only had to make her well. So at 22 years of age, she underwent a complete hysterectomy because of her ***"safe, clean, legal, hospital performed abortion."***

#6

Advice & Aid Pregnancy Center

February 13, 1997

Dear Committee Members and Chairperson;

Thank you for allowing me to share with you. I am testifying in defense of the "Woman's Right to Know" bill. My concern for this bill is partially due to the fact that I work with women in crisis pregnancies and post abortive women every day, as director of Advice and Aid Pregnancy Center in Overland Park.

The abortion clinics and our center see the same women... women in crisis. Crisis makes any person more vulnerable. It is hard to think straight when you think your world is falling apart. I make a point to ask these girls if they have been to a doctor and received accurate information. Few have, and even those who have already set appointments for abortions or have had them, say they did not receive much information. They are handed a piece of paper to read and they sign their name.

I have had clients tell me they aborted their baby or were thinking of aborting because they got drunk once or twice and were afraid their baby would be deformed. I have had women argue with me after going through fetal development literature and seeing the pictures, because they were told at the abortion clinic that it was a mass of blood cells or fetal tissue. We are not medical professionals nor do we pretend to be, so we are not qualified to answer some of our clients questions. These are questions their doctors should be answering.

I have also had an abortion. My dentist took more time to tell me about a cavity, then my abortionist did to tell me about a procedure that would affect me the rest of my life. After my abortion I also had a cryo, which is a procedure done to freeze abnormal cells that had developed in my uterus. My doctor told me afterwards, that that was quite common after an abortion. Afterwards I also learned more facts on fetal development and options. That devastated me more than the pregnancy ever would have. If this was such a choice, why wasn't I given all the information?

Frankly, I have a hard time trying to figure out why this even has to be a bill. It would seem that it is common sense, say nothing of professionalism, for a woman's doctor to take the time to help her come to the best decision for her. She is not able to do that if vital information is witheld. And it is my experience that very few are getting that vital information.

I am enclosing a copy of a survey done last year representing 1,410 post abortive women. The survey addresses the issue addressed in the "Woman's Right to Know' bill. Please look at this information and consider it in your decision. This bill hurts no one. It will only do good for women in crisis. We need advocates. This bill would help to insure that.

Dawn McClelland

PHONE:
913/385-3484

24 HOUR HOTLINE:
913/385-3485

9948 W. 87th St. Ste. B, Overland Park, KS 66212

House Judiciary
Attachment 6
2-13-97

#7

My name is Teri Reynolds and I am the president of the board and interim director of Pregnancy C.A.R.E., of Olathe, KS.. I have been a lay counselor volunteering at the center for four and a half years. At the center, we do free pregnancy tests, offer education on abortion and alternatives, and provide referrals to area agencies and services related to the needs of the client.

I came to this ministry work as a result of my own abortion experience fourteen years ago - in Wichita, KS.. At the time, because of a pregnancy that was unplanned, I chose to abort. There was only nominal disclosure and counsel available to me at the abortion clinic, and I was not made aware of the risks to my future emotional health, the true and accurate fetal development my baby had achieved and the preliminary paperwork was cursory at best, in helping me with the decision I was making.

I believe that the clients I see regularly, at the center I work, are not getting the kind of education that they get at our center, with regard to the risks associated with abortion, anywhere else. The dismay with which women who are postabortive learn of their baby's development, the grief that they continually live with and the problems that stem directly from their abortions are extremely overwhelming. A law that requires these women considering abortion be given full disclosure about risks and alternatives would no doubt be in their best interest. It may prevent these women from chosing abortion, to be sure. But they have the right to make informed decisions and have the facts.

I believe that my decision to abort may have been altered had I been better informed.

House Judiciary
Attachment 7
2/13/97

Teri Reynolds

#8

Stretching Forth
with Open Arms

"She stretches forth her hand to the needy." Prov. 31:20

Abortion Information Survey

The Open Arms' "Abortion Information Sheet" (AIS) Project is an on-going post-abortion statistical survey which began in 1986. The early surveys were primarily gathered from women who had contacted Open Arms for post-abortion help and support.

Currently, several crisis pregnancy centers (CPCs) are asking their post-aborted clients to participate in the survey. This brings a balance to our sampling because these clients are typically coming to the pregnancy center to find out if they are pregnant, not for post-abortion counseling.

Although the survey is not conducted under strict scientific methods, it offers evidence of trends to look for in the post-aborted. We first released our survey results in January of 1993, with data collected from 650 women. Now, three years later, our data represents 1,410 women.

Total Number of Surveys		**1,410**
Averages:		
Age when they filled out the survey		29
Age when they had their abortion		21
Weeks along when abortion was performed		10
Cost of abortion		$311
Type of Abortion:		
Suction	949	67%
D & C	143	10%
D & E	29	2%
Saline	39	2%
Hysterotomy	4	.5%
Other	21	2%
Can't Recall	216	15%
Number of Abortions:		
One	1001	71%
Two	244	17%
Three	76	5%
Four or more	41	3%
Reason for Abortion:		
Social	1155	82%
Economic	120	9%
Health	67	5%
Life	16	1%
Rape	18	1%
Incest	5	.5%
Abortion Paid By:		
Mother of baby	487	35%
Father of baby	443	31%
Grandparents of baby	308	22%
Government	118	8%
Insurance	91	6%
Other	82	6%
Client's Income Bracket (Family's):		
Low (Under 15K)	576	41%
Middle (15K-35K)	343	25%
Upper (Above 35K)	62	5%

Could remember doctor's name:		
Yes	300	21%
No	826	59%
Felt were adequately informed about the baby:		
Yes	509	36%
No	811	58%
Not Sure	35	3%
Felt were adequately informed about complications:		
Yes	534	38%
No	761	54%
Not Sure	46	3%
Would have liked pro-life information then:		
Yes	805	57%
No	323	23%
Not Sure	122	9%
Was the abortion illegal:		
Yes	77	5%
No	1397	99%
If Not—Would they have an illegal abortion:		
Yes	127	9%
No	927	66%
Not Sure	135	10%
Would they have this abortion again:		
Yes	207	15%
No	1047	74%
Not Sure	60	4%
Did the relationship with the father of the baby end soon after abortion:		
Yes	776	55%
No	611	43%
If the relationship did not end, how was it affected:		
Became closer together	78	13%
Increased their problems	297	49%
Did not have any effect	168	28%

(Continued on p.4, see "Abortion Survey")

House Judiciary
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Abortion Survey

(Continued from p.1)

Psychological/Emotional Problems:

Guilt	1104	78%
Lower self esteem	766	54%
Nightmares	417	30%
Crying/depression	949	67%
Regret/remorse	972	69%
Frigidity	281	20%
Hostility/hatred of men	397	28%
Promiscuity	291	21%
Feeling dehumanized	379	27%
Abusive to Children	48	3%
Despair/helplessness	588	42%
Eating Disorders	242	17%
Can't make decisions	449	32%
Suicidal impulses	335	24%
Can't forgive self	827	59%
Preoccupied w/ death	230	16%
Anger/rage	661	47%
Preoccupied w/aborted baby	438	31%
Drug/alcohol abuse	390	28%
Desire to get pregnant again	484	34%
Desire others to abort	67	5%
Suicide attempts	184	13%
Thwarted maternal feelings	175	12%
Other	130	9%

Physical Complications Reported:

Hemorrhage	130	9%
Infection/high fever	107	8%
Neo-natal death & Stillbirth	21	1%
Perforated Uterus	12	1%
Long/difficult labor	133	9%
Cervical Lacerations	21	1%
Sterility	22	2%
Damage to Bowels	12	1%
Infertility	101	7%
Peritonitus	2	0%
Cervical Damage	33	2%
Shock/Coma	27	2%
PID-tubal Infection	37	3%
Blood Clotting Defect	57	4%
PID-uterine infection	64	5%
Intense pain	347	25%
PID-tubal/ovarian abcess	27	2%
Incomplete abortion	39	3%
PID-unspecified	68	5%
Adherent Placenta	17	1%
Scarred uterus	64	5%
Placenta previa	27	2%
Menstrual Disorders	211	15%
Tubal Pregnancy	18	1%
Rh problems	18	1%
Abdominal pain	232	16%
Premature birth	62	4%
Miscarriage	193	14%
Other	110	8%

News Briefs

Livers For Monkeys

Researchers took liver tissue from aborted preborn children and implanted it in the fetuses of baboons to test "transplantation engraftment," which occurred in one animal. "All the animals survived the in utero procedures," reported the study. —The babies died. *(communique, January 12, 1996)*

Ohio Barrs Late-Term Abortions

Ohio became the first state to pass a law barring late-term abortions. The law forbids abortions after 21 weeks of gestation if the fetus can survive outside the mother's body. A test to determine fetal viability would be required unless the abortion is necessary to save the mother's life or preserve her physical health. *(Religion Report, September 4, 1995)*

D.C. Abortions Restricted

The House Appropriations Committee voted "to impose the tightest restrictions ever on abortion in D.C." *(communique, January 12, 1996)*

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Shawnee Mission KS 66207

#9

February 13, 1997

I would like to thank the committee for allowing me to speak today, My name is Donna Voigts, from Olathe.

I am here in support of the "Woman's Right to Know" bill. In 1973, as a 17 year old high school senior, I became pregnant. It was an extremely shameful position for me to be in. So with very little thought and absolutely no instruction or counseling, I checked myself into a hospital and I had an abortion. Since then I have been married & divorced twice. Both husbands were alcoholic and physically and verbally abusive.

In 1988, I began seeking help for my mental and emotional problems, but because my guilt was so intense, it was1995 before I was able to speak of the abortion. Since then I have been involved in a support group for post abortive women. I've learned about post abortion trauma and have realized some of my emotional instability over the years has stemmed from aborting my child back in 1973. This bill could prevent some of the emotional and mental anguish I have had to suffer.

Yes, I am very much a pro-life advocate, but I am here today because I am especially a pro-woman advocate. Our government has allowed us the right, if we so choose, to take the life of our unborn child and that may never change, but please allow us the right to all the facts prior to making that decision. We are informed on every other medical need. Why is complete and accurate information being withheld on abortion? We women are intelligent creatures. Please allow us the information to make a healthier choice.

Donna Voigts
1117 N. Cooper
Olathe, KS 66061

Donna Voigts

House Judiciary
Attachment 9
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#10

Kansans for Life

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

KANSANS FOR LIFE SUPPORTS HB 2269

Twenty-four years ago, the Supreme Court in *Roe v. Wade* was based on the assumption of dignity and professionalism of physicians who would be authorized to make abortion decisions. In the era of television's Dr. Welby, the Court never envisioned abortion as the assembly line industry it has become today.

Roe and subsequent cases unnaturally linked the rights of women with the rights of abortionists. However, what is in the best interests of the abortionists is not always what is best for the mother and her child. The Woman's Right to Know Act is in line with the expectations of *Roe* in regard to women's rights. The physician's rights are not significant except as they are adjunct to the patient's rights.

The provisions of HB 2269 advocate women's authentic rights by avoiding abortions that are unwanted, uninformed, unscreened as to risks and uncompensated for injuries.

Everyone admits that coersion is happening. Studies show that from 30 to 70 percent of women say they aborted for someone else. See page 12a. Abortion often suits irresponsible lovers and embarrassed parents more than women. Abortionists must be held legally responsible for insuring that a woman's choice to have an abortion is totally her own and that she is not being pressed into this decision by others.

Roe assumed physicians would properly screen patients for any characteristics which would predict that the patient is at risk of experiencing physical or emotional harm after the abortion. Unfortunately, the abortionists' profit margins clash with counseling sessions of adequate length and sufficient reflection periods.

The aggressive defense of patient's rights is essential to curtailing the shoddy practices which are occurring in the abortion industry today. As Justice Blackmun wrote in *Roe*, "If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional are available."

The Woman's Right to Know Act seeks to address the abuses in the physician/patient relationship in the abortion industry. Extensive research is documented in the accompanying handout. I ask that the Committee find HB 2269 favorable for passage.

Respectfully yours,

Jeanne L Gawdun

Jeanne L. Gawdun
Kansans for Life Lobbyist

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Evaluation of the Patient/ Physician Relationship

The obligations of abortionists and the rights of women as defined by the Supreme Court, professional medical standards & common law

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In the Supreme Court's search to find a rational basis for restricting state regulation of abortion, the Court discovered the "abortion liberty" in the realm of a private relationship between a woman and her doctor. This "liberty" is predicated upon an idealized model of "the competent, conscientious, and ethical physician," who has specific obligations with regard to protecting the woman's well-being.

Though a woman is always free to *seek* an abortion, she does not have an absolute right to procure one. The physician retains the right and duty to refuse to provide an abortion which, in his best judgment, given the patient's unique physical, psychological, and social circumstances, may be injurious to her health. This is precisely the way in which the physician retains his medical discretion and exercises his "basic responsibility" for the abortion decision.[1]

However, the Court has never given the physician this same veto power with regard to childbirth. In other words, while a physician can refuse to perform an abortion for health reasons, he has no right to require or pressure a woman into consenting to an abortion because of the health risks associated with childbirth. In the same vein, he has no right to conceal alternative management options or health risks of abortion in order to "guide" her to choose abortion over childbirth.[2] Indeed, the Supreme Court itself has found that abortion involves such emotional and psychological risks that a decision to forego a previously desired abortion may generally be the safest course of action.[3]

This division of rights can be simply summed up in the following way. The physician is responsible for determining whether or not an abortion is contraindicated and is likely to be injurious to a woman's health. On the other hand, the woman is entitled to be fully informed about risks and alternatives so that she can make the ultimate decision, on the basis of all relevant information, of whether or not to accept the physician's recommendation to abort.

PUTTING *ROE* IN CONTEXT

The *Roe* decision was results-oriented. Indeed, the reasoned principle on which *Roe* was formulated was first suggested by Justices William O. Douglas and Potter Stewart in dissents to the 1970 ruling *United States v. Vuitch*. Both were of the opinion that criminal abortion laws should not apply to physicians acting in their best medical judgment to preserve the health of their pregnant patients.

This argument for the autonomy of physicians had a special appeal to Nixon appointee Harry Blackmun. Before his appointment as a federal judge, Blackmun had been a "doctor's lawyer" for the prestigious Mayo Clinic. Programmed to defend the medical establishment, Blackmun always objected to any "undue" interference with the medical profession.[4] The arguments of Stewart and Douglas appealed to his world view. Whenever a doctor believes an abortion is necessary for a patient, Blackmun believed, the ability of the state to interfere should be severely limited. Indeed, in one of his summary statements in *Roe*, Blackmun writes: "[This] decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention." [5]

This "doctors know best" approach appeared reasonable and appealing for several reasons. First, there are inherent dangers to abortion. The safety of women is clearly better served by physicians with years of medical training than by radical feminists and bold entrepreneurs who have completed a four-hour workshop on abortion technique. Second, the decision to abort in a time of personal crisis involves a complex interplay of medical, social, psychological and moral issues unique to each woman. The professional opinion of a trained physician who could assist the woman in making a fully free and informed choice is essential to prevent hasty or ill-considered decisions which might result not only in regrets but also in grave physical injuries. Third, the medical profession was highly respected and exercised a great deal of political and social power. In the absence of constitutional principles, a decision based on the dignity and professionalism of physicians would carry with it a sense of reasonableness. In an era when doctors were epitomized by television's competent and compassionate Dr. Welby, placing abortion decisions under the authority of physicians was seen as a practical solution to the abortion question, one which would both prevent abusive profiteering and ensure the safety of women.

A CONFLICT OF INTERESTS

It is in this context that *Roe* and its progeny are best understood. Though doctors have no special constitutional right to be free of state regulation, it was because of its appeal to the integrity of physicians that the Court's abortion solution had a claim to being reasonable.

This is the cornerstone upon which the "abortion liberty" was built, and its edifice was constructed by a convenient intertwining of the rights of women and the duties of physicians. But this intertwining of rights and duties also resulted in certain conflicts between the woman's and the abortionist's interests. Unlike the co-dependent interests of a woman and her child, the abortion liberty's entwining of a woman's rights with her physician's rights is an unnatural one. While the best interests of the woman and child are always the same, the best interests of a woman and her abortionist are not.

The key, then, to unraveling the "abortion liberty" is to expand the legitimate rights of women so that they are clearly superior to the imputed rights of abortionists. These legitimate rights of women include (1) the right to be protected from contraindicated procedures which would endanger their health, (2) the right to receive the best choice of care options, (3) the right to be fully involved in all aspects of medical decisions affecting their health, and (4) the right to receive full financial compensation for any injuries they incur as a result of an abortionist's failure to respect their rights.

It is noteworthy that abortion was legalized only after pro-abortionists succeeded in promoting their argument that when there is a conflict between the rights of a woman and the rights of her unborn child, the rights of the woman must prevail. Learning from this same strategy, we can apply it here as well. In short, we must promote the argument that whenever there is a conflict between the rights of the woman and those of her abortionist, the rights of the woman must still prevail.

4. Bob Woodward & Scott Armstrong, The Brethren (1979) 175, 416. John Noonan Jr., A Private Choice (1979), 45
5. Roe, 165
6. Roe, 153-154. Matheson,419. P.P v Danforth 428 U.S. 51(1975), 60. P.P. v Casey L Ed 2nd 674 (1992), 709.
7. Medical, emotional and psychological consequences of abortion are serious & can be long lasting. Danforth,67. Casey 698-699.
8. Casey, 698. 9. Roe,163-166. 10.Roe,166

The Standard of Care for Abortion Recommendations

The above analysis is very important to the issue of medical malpractice. Abortion practitioners are not free to abandon all responsibility for the abortion decision. They may not justify provision of a dangerous abortion on the grounds that "I just gave her what she wanted." They must be able to articulate some basis for arriving at a recommendation for abortion which would reflect due consideration of all the health needs of the woman and the health risks of abortion.

In short, the Supreme Court has set in place specific requirements on the standard of care for abortion providers. It is the burden of the physician to make a medical judgment "in the light of all factors—physical, emotional, psychological, and the woman's age—relevant to well-being."[15] From this it can be argued that the Court clearly intended the physician to become familiar with the patient's health history, problems, and needs. Conversely, the failure to form a medical basis for an abortion recommendation constitutes negligence which endangers a patient's health, and abuse of this medical privilege to provide abortions is a cause for legal action.[16]

In addition, under the Supreme Court rulings, physicians clearly retain the right and duty to refuse an abortion which is contraindicated. This right and duty is also recognized by the Committee on Professional Standards of the American College of Obstetricians and Gynecologists (ACOG), which has reiterated that:

> It is recognized that although an abortion may be *requested* by a patient or recommended by a physician, the final decision as to performing the abortion must be left to the medical judgment of the pregnant woman's attending physician, in consultation with the patient.[17] [Italics added.]

A physician has the right and duty to refuse to perform an abortion which is likely to exacerbate a woman's *physical, psychological, or social problems*. At the very least, a competent physician would insist on delaying an abortion until pre-existing medical or psyehological conditions had been treated.[18]

15. Doe v Bolton, 192. Colautti v Franklin, 439 U.S. 379(1979),394
16. Roe, 166.
17. ACOG Committee on Professional Standards (1981). Also exec. board statement of policy (1977),p.2

The Typical Abortion Clinic

Abortion should not be carelessly dispensed as a panacea. While the Supreme Court has allowed physicians to use abortion as one of their tools in treating crisis pregnancies, it has never suggested that physicians are free to use this tool indiscriminately. Indeed, Chief Justice Burger's statements at the time of *Roe* clearly reflect that it was his personal expectation that physicians would resort to abortion only sparingly.[19] By the time he retired, however, Chief Justice Burger had come to the opinion that, in practice, *Roe* had resulted in the unmitigated disaster of abortion on request. Still, his earlier views do reflect that there was a hope, at least in some quarters of the Court, that responsible physicians would never exploit the despair of women in crisis just to earn a quick buck.

Unfortunately, when a quick buck can quickly turn into an extra hundred thousand, or two, per year, just by working on Fridays and Saturdays, some physicians quickly formed the "medical" opinion that every crisis pregnancy is treatable by abortion. In doing so, they have negligently abandoned their duty and violated the civil rights of women as defined by *Roe*.

In contrast to the Supreme Court's Dr. Welby model of a physician who is familiar with his or her patient's history and needs and who compassionately discusses with her the difficulties and options she faces, most abortionists are extremely distanced from their patients and work at a hectic pace. According to Dr. Edward Allred, owner of a chain of clinics performing 60,000 abortions per year:

> Very commonly we hear patients say they feel like they're on an assembly line. We tell them they're right. It is an assembly line....We're trying to be as cost-effective as possible, and speed is important....We try to use the physician for his technical skills and reduce the one-on-one relationship with the patient. We usually see the patient for the first time on the operating table and then not again....[20]

18. Warren Hern, Abortion Practice (1990) p.86
19. Woodward & Bernstein, The Brethren, 236-7
20. "Doctor's Abortion Business Is Lucrative," San Diego Union (8/12/80)

At least 90 percent of abortions are provided in non-hospital facilities. Abortion providers advertise aggressively in the Yellow Pages, offer 800 numbers and discount coupons, and frequently employ a referral network which includes family planning clinics. Often, free pregnancy tests are offered as a way of attracting potential clients who can be counseled toward and scheduled for abortion.

Abortion clinics are essentially self-policing, since the federal courts have rejected most state regulatory efforts, largely on the basis that they infringe on the autonomy of the physician and the privacy of the patient. Thus, there are seldom any substantial requirements for emergency equipment or advanced transfer arrangements to the nearest hospital in the event of a life-threatening complication. Indeed, when complications do occur, many clinics refuse to use ambulance services to transport the patient in order to avoid bad publicity. Instead, the patient is transported in a clinic person's car, often without the aid of a trained medical person during transit.

Under the dictates of *Roe*, any licensed physician may perform abortions. Thus, though many abortionists are obstetricians with extensive training in women's reproductive health, many others are from unrelated fields such as dermatology, psychiatry, or urology.

Unlike other medical practices, abortion clinics universally require payment for the full amount of the abortion prior to rendering any services, unless the costs of the abortion are clearly guaranteed by an insurer. Generally, only cash or certified checks are accepted. There are two reasons for this cash-in-advance rule. First, it shifts the balance of power to the clinic and serves as a deterrent against women who want to change their minds. This is especially powerful in cases where the woman is having an abortion to satisfy the demands of her parents or her boyfriend or husband. She knows that their fury will only be doubled if she goes home not only still pregnant, but also without her money, or with only a partial refund. Second, clinic staff are all too familiar with the outburst of tears, regrets, and anger which sometimes follow an abortion. Some women immediately blame the clinic staff for what they are feeling. If they were not required to pay until after the abortion, such women might refuse to do so.

4-11

ABORTION COUNSELING

Typically, there are no licensing requirements for staff persons who are responsible for patient counseling or post-operative care. Qualifications and training are at the sole discretion of clinic owners, though at least theoretically, medically related tasks such as screening, counseling, and informed consent are under the supervision of the responsible physician.

Pre-abortion counseling is usually performed by a clinic-trained staff person. Counseling sessions for groups of three to 20 women are not uncommon, though many clinics do offer individual counseling sessions. Group counseling sessions may last from fifteen minutes to half an hour or more, while individual counseling sessions seldom last more than ten to fifteen minutes.

Most abortion counselors are trained to recognize the fact that the decision to undergo an abortion is difficult, stressful, and often a marginal one. Therefore, to avoid increasing the stress on the patient (and losing a client), counselors are trained to avoid answering questions or providing information which will aggravate the concerns or doubts of a patient. Instead, pre-abortion counselors generally concentrate on reassuring the woman that abortion is her best option. The counselor is trained to take the role of a compassionate friend to help the aborting woman face the unknown and overcome her doubts. The problems which have motivated a woman to seek an abortion may be discussed in a casual manner, so as to provide the woman an opportunity to air her feelings, but they are seldom explored. Alternative methods of problem resolution, such as marital counseling or job relocation service, are rarely discussed at all.

Frequently, a patient's questions and concerns are sidestepped or answered in trivial ways so as to avoid arousing unresolved doubts or fears. When a patient volunteers a statement such as, "I really wish I could have this baby," abortion counselors will generally attempt to refocus her attention on reasons why the abortion is "for the best." As will be discussed later, such ambivalence is a major risk factor for psychological problems post-abortion and may be a contraindication for continuing with the abortion. When a counselor fails to assist patients

to fully explore such feelings, that counselor is not only guilty of ignoring a "red flag" for post-abortion sequelae, she is also clearly engaged in the "selling" of abortions to an overtly reluctant patient.

Discussion of abortion-related risks is generally brief, with an emphasis on only a few of the immediate physical risks. Reproductive health risks are minimized, and increased cancer risks are almost certainly never mentioned at all. If psychological aftereffects are discussed at all, women are generally told that they may experience only temporary feelings of mild depression. Emphasis will be placed on the fact that "most" women are not significantly affected and are able to "get on with their lives." The fact that serious psychological sequelae are experienced by at least a significant minority of women (15 to 25 percent) is almost never discussed, even though these complication rates are at least equal to, and probably greater than, the risks associated with most physical complications.

DEVIATIONS FROM THE ROE IDEAL

Pre-abortion screening is generally non-existent. Most abortion counselors are not trained to identify all of the pre-existing characteristics which would place a woman at higher risk of negative physical or psychological reactions. Proper screening for risk factors, much more follow-up counseling to explain and resolve these risk factors, is a time-consuming task which most abortion clinics shun. Also, extensive pre-abortion screening does not contribute to the number of patients serviced, and would be most likely to result in some patients changing their minds. This lack of screening for known risk factors is symptomatic of a "routine driven" service industry which neglects the individual circumstances of patients.

Another area where many clinics cut corners in order to speed up the process is in the dilatation of the cervix prior to the abortion. The safest technique involves the insertion of laminaria, fibrous seaweed sticks which slowly swell, dilating and softening the cervix. This is the safest and least painful method of dilatation, and it reduces the risks of cervical injury.[21] The alternative is manual dilatation, which mechanically forces the cervix open with a series of progressively

larger cone-like dilators. This method involves more pain and tearing of cervical muscles, but it is preferred by many abortion providers because it is faster, involves only one visit, and reduces the amount of time in which the patient can attempt to change her mind.

Since sonograms are rarely used, or even available, the abortion itself is a blind procedure, meaning the physician must work by feel alone. Experienced abortionists with large case loads may work quickly, completing an abortion in ten minutes or less. Local anesthetics are generally preferred to general anesthesia. Afterwards, the patient is held in a recovery room until her post-operative bleeding is under control. Before leaving, the patient will generally be given instructions regarding any warning signs of which she should be aware, such as excessive bleeding, fever, or passing of large clots. Unfortunately, many abortion providers do not keep their patients under observation in post-operative recovery for sufficient time, missing the opportunity to diagnose conditions like uterine atony, which may not be evident until up to an hour after the abortion.[22]

Good follow-up care is considered very important to the prevention of major post-operative complications.[23] But while some clinics offer follow-up examinations one to three weeks post-abortion, many do not.

According to the most widely used textbook on abortion services, "Properly performed in the best setting, abortion offers a second chance....Poorly done, abortion leaves physical and emotional scars for life."[24]

Tragically, all too many abortions are poorly done. This is because the pursuit of high profit margins has displaced concern for the welfare of patients. This is why the aggressive defense of patient's rights is essential to curtailing the shoddy practices which are occurring. For as Justice Blackmun wrote in *Roe*, "If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available."[25]

21. Hern, Abortion Practice, 106, 108, 126-7
22. Ibid., 185
23. Ibid., 108
24. Phillip Stubblefield, M.D. Forward to Hern, vii.
25. Roe, 166
26. Matheson, 411
27. Hern, 67-74, 106.

11-5

While there is intense controversy among researchers regarding how frequently women experience post-abortion psychological sequelae, there is general agreement concerning the pre-identifying factors which can be used to predict an increased risk of significant post-abortion psychological distress. Indeed, most of the research on pre-identifying risk factors has been published by abortion proponents, and so these findings are immune from the charge of bias.

The risk factors for post-abortion psychological maladjustments can be divided into two general categories. The first category includes women for whom there exist significant emotional, social, or moral conflicts regarding the contemplated abortion. The second category includes women for whom there are developmental problems, including immaturity, or pre-existing and unresolved psychological problems. A summary list of established risk factors includes: conflicting maternal desires; moral ambivalence; feeling pressured to abort by others; feeling the decision is not her own, or is her "only choice;" feeling rushed to make a decision; immaturity or adolescence; prior emotional or psychological problems, including poor development of coping skills or prior low self-image; a prior history of abuse or unresolved trauma; a history of social isolation as indicated by having few friends or lack of support from one's partner or family; a history of prior abortions; or a history of religious or conservative values which attach feelings of shame or social stigma to abortion. Readers may refer to pages 13-15 for a more complete list of these pre-identifying risk factors.

These risk factors clearly suggest that the majority of women are predictably at risk of experiencing adverse psychological reactions. The conscientious physician would be legally and ethically bound to consider these risk factors in forming a recommendation, to advise the woman of the existence of these risk factors, and, in at least some cases, to refuse to perform an abortion until these risk factors had been alleviated through appropriate counseling.[30]

Proper pre-abortion counseling should include screening for all of the high-risk factors listed above, notification to the patient of any existing risk factors, and appropriate counseling or referral to care and counseling resources outside the clinic where these risk factors can be addressed or treated.[31] Furthermore, after the intake screening,

30. Sylvia Stengle, NAF exec. dir., Wall St. Journal(10/28/94)B12:1
31. Hern, 84,86-7

patients should routinely be instructed about *all* pre-existing risk factors, even those which the patient does not report, because it is well known that abortion patients may conceal a history of prior abortions, coercion, or other relevant information. In anticipation of such concealment, routine disclosure of all risk factors is necessary for the purpose of ensuring that the patient at least has the opportunity to make an informed self-evaluation of her risk profile. Inadequate psychosocial screening endangers patients' health and should be considered sufficient to establish negligence.

A Look at Motivations Behind This Research

This issue of inadequate pre-abortion screening is one which pro-abortion researchers have virtually handed to us on a silver platter. This was not their intent, of course.

Instead, the real reason pro-abortion researchers have published so much on risk factors is that they have been seeking a way to dismiss the complaints of the troublesome "minority" of women who clearly have post-abortion maladjustments within even a few weeks after the abortion. In order to dismiss these patients, pro-abortion researchers have tried to identify how these women are different from those who appear to be "unaffected" by abortion. Having identified these pre-existing factors, they then argue that it is not abortion which causes these women to have problems; their distress is instead the result of some other pre-existing problem. This "politically correct" view of post-abortion trauma contains a kernel of truth, but it is mostly coated with a lot of "blaming the victim."

It is certainly true that women who are suffering from mental disorders or have previously suffered psychological trauma are more likely to subsequently report more severe negative post-abortion reactions. Indeed, if one thing is clear from post-abortion research over the last forty years, it is that abortion is contraindicated when a woman already has mental health problems.This is true because abortion is always stressful. How well a person copes with this stress depends on the individual's resiliency and the conditions under which the stress occurs. When a woman's psychological state is already fragile, the stress of an abortion can more easily overwhelm her. But the fact that she was more vulnerable to stress than others does not mean that the abortion is not the cause of her psychological injuries.

and the risk factors associated with these adverse reactions; (2) provide adequate pre-abortion screening using the criteria outlined above to identify women who are at risk of negative post-abortion reactions; (3) provide individualized counseling to high-risk patients which would more fully explain why the patient is at risk, along with more detailed information concerning possible post-abortion reactions; and (4) assist women who have pre-identifying high-risk factors in evaluating and choosing lower-risk solutions to their social, economic, and health problems.

The Duty to Look Deeper

In evaluating a patient's psychological risks, the idealized standard of care established by the medical community does not allow abortion counselors to rely simply on whatever the patient volunteers. Instead, counselors should actively look for "red flags" which would indicate the presence of risk factors. Uta Landy, a former executive director of the National Abortion Federation, encourages counselors to be aware of the fact that:

> Some women's feelings about their pregnancy are not simply ambivalent but deeply confused. This confusion is not necessarily expressed in a straightforward manner, but can hide behind such outward behavior as: (1) being uncommunicative, (2) being extremely self- assured, (3) being impatient (how long is this going to take, I have other important things to do), or (4) being hostile (this is an awful place; you are an awful doctor, counselor, nurse; I hate being here).[33]

Landy also admits that because women seeking abortion are experiencing a time of personal crisis, their decision-making processes can be temporarily impaired. This crisis-related disability may lead them to make a poor decision which will subsequently result in serious feelings of regret. Landy defines four types of defective decision-making observed in abortion clinics. She calls the first defective process the "spontaneous approach," wherein the decision is made

33. Landy, Clinics in Obs/Gyn., 13(1):33-41 (1986) 34. Ibid.
35. E. Friedman et al, Obstetrical Decision Making (1987): Borton, 44, and Stewart, 30.
36. Belsey, 71-82. Miller, J. Soc. Iss. 48(3)67-93. 37. Hern, 80-1

too quickly, without taking sufficient time to resolve internal conflicts or explore options. A second defective decision-making process is the "rational-analytical approach," which focuses on the practical reasons to terminate the pregnancy (financial problems, single parenthood, etc.) without consideration of emotional needs (attachment to the pregnancy, maternal desires, etc.). A third defective process is the "denying-procrastinating" approach, which is typical of women who have delayed making a decision precisely because of the many conflicting feelings they have about keeping the baby. When such a "denying-procrastinator" finally agrees to an abortion, it is likely that she has still not resolved her internal conflicts, but is submitting to the abortion only because she has "run out of time." Fourth, there is the "no-decision-making approach" wherein a woman refuses to make her own decision but allows others, such as her male partner, parents, counselors, or physician, to make the decision for her.[34]

The standard of care for pre-abortion screening is further described in *Obstetrical Decision Making*. In the section regarding induced abortion, it clearly states:

> It is essential for the gravida [pregnant woman] to be *fully informed* about alternative resources and options and about the safety and risks of the procedure. Psychosocial assessment and counseling are done at the very first visit [see section on psychosocial assessment]. In addition to the medical history, an *in-depth* social history, including relationships with others, attitudes about abortion, and support systems *must be obtained* at this time....No decision should be made by the gravida *in haste, under duress, or without adequate time and information*. Special attention should be given to feelings of ambivalence, guilt, anger, shame, sadness, and sense of loss....Patients requesting abortion *must also be screened* to uncover any serious medical or psychiatric conditions."[35][Italics added.]

Under the section on psychosocial assessment, the obstetrician is also told that "he or she needs to be alert to gravid women who are at *greatest risk*, such as those who were victims of child abuse or neglect themselves and those with a history of psychologic impairment, drug dependency, or behavioral problems." [Italics added.]

At least one pro-choice researcher suggests that pre-abortion screening should be used to distinguish those patients who need in-

depth counseling from those who need only supportive counseling. Using just five screening criteria—(1) a history of psychosocial instability, (2) a poor or unstable relationship with her partner, (3) few friends, (4) a poor work pattern, and (5) failure to take contraceptive precautions—Belsey determined that 64 percent of the 350 abortion patients she studied should have been referred for more extensive counseling. Of this high risk group, 72 percent actually did develop negative post-abortion reactions within the time frame of the study's follow-up. "From a clinician's point of view," she writes, "this result can be viewed as erring on the right side, for a [pre-abortion screening] system that tends to select more women for counseling than is actually necessary is preferable to the reverse." [36]

Detecting Coercion

Of special concern are cases in which a woman desires to have her child but is submitting to the abortion to satisfy the demands of others. Patients should be carefully questioned, in private, to determine if this risk factor is present, since the abused or coerced patient may attempt to conceal the abuse out of fear. This abuse or coercion can be subtle or overt; for example, her partner or parents may threaten to withhold love or approval unless she "does the best thing." Even lack of emotional support to keep a pregnancy may be experienced as a pressure "forcing" a woman to choose abortion. [37]

Over 70% of women having abortions are doing so against their conscience, with 74% agreeing with the statement, "I personally feel that abortion is morally wrong, but I also feel that whether or not to have an abortion is a decision that has to be made by every woman for herself." (*Los Angeles Times* Poll, March 19, 1989. See also, Zimmerman, *Passages Through Abortion*, and Reardon, *Aborted Women*.) Thirty to 55% report feeling pressured to abort by others, and a similar percentage express some desire to keep their child (Zimmerman, Reardon). Approximately 45% of abortions are done on women with a prior history of abortion, and over one-fourth are performed on teenagers. In addition, some trauma experts estimate that as many as one in three women have been sexually abused in childhood. (See for example, Judith Lewis Herman, M.D., *Trauma and Recovery* (New York: Basic Books, 1992), 30.) It is likely that the percentage of women having abortions who have a prior history of abuse, trauma, or other psychological problems is as high, or higher, than that for the general population. These statistics, regarding only a few of the known high-risk factors, clearly indicate that the majority of aborting women are at high-risk of suffering post-abortion psychological sequelae.

8-11

In addition, pressure from adverse circumstances, such as financial problems, being unmarried, social problems, or health problems, may also make a woman feel she is being "forced" to accept abortion as her "only choice." If her "only choice" is contrary to her maternal desires, she should be assisted in finding resources and alternatives which may provide her with an option which does not violate her emotional, maternal, and moral needs.

The Role of the Male

The attitude of the male partner toward the pregnancy is an important factor in a woman's abortion decision and is also significantly related to how she will adjust after the abortion. Because numerous studies have found support from the partner to be an important predictor of good post-abortion adjustment, researchers were recently startled by the finding that accompaniment to the abortion by the male partner was actually a predictor of *greater* post-abortion depression.

This finding suggests that an outward show of support, such as accompaniment to the abortion clinic, is not an accurate measure of the emotional support a woman *feels*. Instead, accompaniment by the male partner may actually indicate one or more of the following: (1) greater pre-abortion anxiety, which led the woman to insist on accompaniment; (2) overt or subtle coercion on the part of the male, who is "making sure" she does the "right thing;" or (3) a more intimate relationship exists between the partners and this greater intimacy is being stressed by the abortion. In this third scenario, the unplanned pregnancy may be perceived by the woman as a "test" of her partner's commitment to their relationship. She may privately be willing to have the baby, and seal their mutual commitment, *if* he takes this as an opportunity to demonstrate his commitment. Instead, his lack of enthusiasm for, or hostile reaction to, the pregnancy causes her to doubt the depth and endurance of their relationship.

In short, when a woman is accompanied to an abortion by her male partner, the woman is more likely to be choosing abortion because her partner has manipulated her into doing so, or because he has exposed to her a lack of commitment to their relationship. In neither case does she truly feel supported.

Risk Factors Predicting Post-Abortion Psychological Sequelae

While present research is unable to accurately establish what percentage of women suffer from any specific symptom of post-abortion trauma, it is clear that post-abortion psychological disorders do occur. Indeed, the published literature demonstrates that serious emotional and psychological complications following an abortion are probably more common than serious physical complications.

The present literature has also successfully identified statistically significant factors which can be used to pre-identify individuals who are most vulnerable to experiencing post-abortion psychological sequelae. Examination of these risk factors suggests that most women seeking abortion have one or more of these high-risk characteristics.

Based on these findings, most of which have been published by researchers who *favor* legalized abortion, it would appear reasonable to expect, and demand, that abortion providers: (1) provide pre-consent information about the types of psychological reactions which have been linked to a negative abortion experience and the risk factors associated with these adverse reactions; (2) provide adequate pre-abortion screening using the criteria outlined above to identify women who are at higher risk of negative post-abortion reactions; (3) provide individualized counseling to high-risk patients which would more fully explain why the patient is at higher risk, along with more detailed information concerning possible post-abortion reactions; and (4) assist women who have pre-identifying high-risk factors in evaluating and choosing lower-risk solutions to their social, economic, and health needs.

Since these high-risk factors have been well-established for a considerable period of time, abortion providers who fail to utilize this information in their screening and counseling procedures may incur greater liability for subsequent injuries when malpractice suits are brought on these grounds.

b-11

I. CONFLICTED DECISION

A. Difficulty making the decision, ambivalence, unresolved doubts[1,2,11,14,16,17,19,23,27,30,36,39,40]

1. Moral beliefs against abortion
   a. Religious or conservative values[1,17,27,31,35,36]
   b. Negative attitudes toward abortion[7]
   c. Feelings of shame or social stigma attached to abortion[1]
   d. Strong concerns about secrecy[37]
2. Conflicting maternal desires[23,27]
   a. Originally wanted or planned pregnancy[11,17,21,23,39]
   b. Abortion of wanted child due to fetal abnormalities[2,5,11,14,15,20,22]
   c. Therapeutic abortion of wanted pregnancy due to maternal health risk[2,11,14,20,32,36]
   d. Strong maternal orientation[27,35]
   e. Being married[6]
   f. Prior children[19,35]
   g. Failure to take contraceptive precautions, which may indicate an ambivalent desire to become pregnant[4]
   h. Preoccupation with fantasies of fetus, including, sex and awareness of due date.[16]
3. Second or third trimester abortion[20,31,32,36]
   (This generally indicates strong ambivalence or a coerced abortion of a "hidden" pregnancy.)

B. Feels pressured or coerced[11,12,14,27,33,35,39,40]

1. Feels pressured to have abortion
   a. By husband or boyfriend
   b. By parents
   c. By doctor, counselor, employer, or others
2. Feels decision is not her own, or is "her only choice"[14]
3. Feels pressured to choose too quickly[13,18]

C. Decision is made with biased, inaccurate, or inadequate information[13,35,36]

II. PSYCHOLOGICAL OR DEVELOPMENTAL LIMITATIONS

A. Adolescence[3,9,12,13,23,26,32,35]
(Minors are both more likely to have psychological sequelae and to report symptoms of greater severity.)

B. Prior emotional or psychiatric problems[2,4,11,14,17,19,20,27,32]

1. Poor use of psychological coping mechanisms[1,23,27]
2. Prior low self-image[27,33,35,40]
3. Poor work pattern [4,40].
4. Prior unresolved trauma[35]
5. A history of sexual abuse or sexual assault[17,25,38]
6. Blames pregnancy on her own character flaws, rather than on chance, others, or on correctable mistakes in behavior[23,24,29]
7. Avoidance and denial prior to abortion[10]

C. Lack of social support

1. Few friends[4,40]
2. Made decision alone, without assistance from partner[28]
3. A poor or unstable relationship with male partner[4,19,27,33,39]
4. Lack of support from parents and family, either to have baby or to have abortion[1,7,8,14,23,28,40]
5. Lack of support from male partner, either to have baby or to have abortion[1,4,7,8,14,19,23,27,28,32,34,39,40]
6. Accompanied to abortion by male partner[24]

D. Prior abortion(s)[11,33,35,40]

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38. Zakus, "Adolescent Abortion Option," *Social Work in Health Care*, 12(4):87 (1987).

39. Zimmerman, "Psychosocial and Emotional Consequences of Elective Abortion: A Literature Review," in Paul Sachdev, ed., *Abortion: Readings and Research* (Toronto: Butterworth, 1981).

40. Zimmerman, *Passage Through Abortion* (New York: Praeger Publishers, 1977).

41. See also: Adler, David, Major, Roth, Russo, & Wyatt, "Psychological Factors in Abortion: A Review" *American Psychologist*, 47(10):1194-1204 (1992).

Choosing the Best Alternative

When a woman comes to a physician requesting an abortion (a form of treatment), her actual complaint (her health problem) is that she is experiencing a crisis pregnancy. But what, precisely, is this problem for which she is seeking help? Is it the "crisis" or is it the "pregnancy?"

When over 80 percent of women seeking abortions report that they would have desired, or at least been willing, to keep their pregnancies if only circumstances were better, it is clear that the notion of a "health problem" should attach to whatever it is that is making a crisis out of the pregnancy, not the pregnancy itself. Clearly, many women would be extremely happy to keep their pregnancy if only they could be relieved of the crisis associated with it. Most actively desire to have children in the future. These women are self-prescribing the "cure" of abortion only because they do not know how to get rid of their present problems without also sacrificing their babies.[38]

When evaluating a patient who is seeking treatment for a crisis pregnancy, it is the physician's duty to identify the underlying "disease"—meaning whatever it is that is causing the "crisis" associated with her pregnancy. Only after doing this can a physician make a knowledgeable and responsible recommendation which will treat, and hopefully resolve, the crisis in the least dangerous and most effective manner. As we will see, just as the cause of the crisis will be unique to each woman, so will the most effective treatment. Furthermore, we will see why it is precisely because they engage in a "one treatment fits all" type of medicine that assembly-line abortion mills are inherently mistreating women.

An Example of the Failure to Identify the Proper Alternatives

Proper alternatives counseling is perhaps best illustrated by example. This is the true story of "Terri," whose abortion of a wanted pregnancy led to drug abuse and prolonged psychological treatment.

38. Testimonies: Frederica Matthewes-Green, Real Choices (1994)
39. ACOG Standards (1985) 83

Adequate assessment of her crisis would have identified alternat which would have spared her the injuries she and other women h experienced when they felt forced to submit to the "evil necessity" of an unwanted abortion.

Terri had become pregnant by her fiance. Both were happy about it. They had even picked out names and moved up the wedding date. But suddenly, Terri became concerned that her former husband would use the out-of-wedlock pregnancy to take away custody of her two small children. There was no provocation for this fear. Her ex-husband had never even indicated a desire to have custody. Yet this fear that he *might* try to take them reached overpowering proportions and drove her to seek an abortion over the objections of her fiance.

Terri was given an abortion without any screening for the several high-risk factors which are evident even in this short synopsis (a wanted pregnancy, feelings of being pressured to have an unwanted abortion, and objections from her male partner). Nor was her crisis situation accurately identified so that appropriate counseling and care could be provided. In this case, the pregnancy was not her problem; it was fear of the possibility that her ex-husband might seek custody. Proper counseling would have identified the crux of Terri's crisis. She should have been referred for legal counseling and possibly marriage counseling.

What Terri really wanted was a way to keep her pregnancy without losing custody of her other two children. In reviewing her circumstances and options, a competent physician would have helped her to identify this need and find the means to satisfy it. And if no other resolution could be found, the physician, if he decided to recommend abortion at all, would at the very least have discussed the risk factors which exposed her to the greater likelihood of post-abortion problems so that Terri could weigh these risks against the risk of losing custody of her children.

In the end, it was only after Terri was in counseling to recover from her post-abortion psychological disabilities that she discovered that her ex-husband highly valued her as a good mother. He would never have sought to deny her custody of the children. Only in hindsight did she discover that her fears had been groundless.

Alternatives counseling is not a service which abortion providers are free to dismiss; it is a required part of pre-abortion counseling.[39] In the case of Terri, the abortionist failed to identify that Terri's first need was legal counsel.

ASSESSING ALTERNATIVES

Other cases may present different alternatives. For example, when a woman is being pressured into an unwanted abortion by her husband (a high-risk factor), marital counseling would best suit her needs and desires. Similarly, if a teenager is being pressured into an unwanted abortion by her parents, or if she is simply too embarrassed to face her parents alone, interventive family counseling would provide a safer alternative. Is she chiefly concerned about ridicule at her work, or does she fear that she may lose advancement opportunities because of her boss's prejudices? Then she might feel saved from an unwanted abortion simply by being referred to the care of a job relocation service, such as those offered by The Nurturing Network, which would place her into a new and more receptive work environment.

Is she submitting to an abortion only to keep her boyfriend from leaving her? Then she should be helped to understand that the abortion will almost certainly doom their uncommitted relationship anyway (which she will often know already in her heart but be denying in her head), in which case, she will be left with nothing but the regrets. Would any responsible physician subject a patient to the more than 100 physical and psychological risks of abortion simply to satisfy the demands of an irresponsible scoundrel?

Does she want children but simply feel unable to have one now because she has financial problems or concerns about finishing school? Then a referral to the appropriate social services agency might best serve her.

Is she pregnant as the result of sexual assault? Then she should be informed that an abortion is likely to aggravate her feelings of violation and despair, adding trauma on top of trauma.[40] She should be referred to a support group like the Life After Assault League, where she can talk to women who have been in the same situation so that she can learn from their experiences.[41]

All of the patients in the situations described above are actually at high-risk of experiencing severe psychological sequelae from abortion. These women do not want to remain childless. They may even be filled with a longing to have the very baby which is in their womb. But these maternal feelings are being overpowered by pressures from circumstances or people which they feel powerless to resist. They are

submitting to *unwanted* abortions because they feel as if they have no other choice. It is the role of the crisis pregnancy counselor to help the woman identify this distinction and to assist her in finding the support and resources she needs to keep her baby.

While it is true that abortionists see themselves as being in the business of providing abortions, in a legal and professional sense, this is not what their business is really supposed to be. Instead, they are supposed to be health professionals, in the business of helping women manage crisis pregnancies.

As has been previously discussed, the Supreme Court never gave to abortionists the right to indiscriminately dispense abortions on request. It is more accurate to say that the Court insisted that physicians must be allowed to use abortion as simply one of the many treatment options which they may employ. This is an important point because it helps us to clarify precisely what standard for counseling and diagnosis should be applied to crisis pregnancies.

Given the fact that there are more than 100 physical and psychological complications associated with abortion, plus the fact that most women see their unborn child as a living being, the killing of whom involves great moral questions, it is clear that abortion should not be the preferred method of treatment. Instead, it seems obvious under the Hippocratic standard of "first, do no harm," that the physician should, if at all possible, assist the woman in finding a way to keep her child by helping her to find ways to correct the circumstances which make her feel that she has to have an abortion.

At this point, abortionists would object, saying that they are not social workers. They provide abortions, not marital counseling or job placement. But it is precisely because they are artificially limiting the scope of their involvement in their patients' health needs that they are negligent. In *Doe v. Bolton* the Supreme Court declared that the physician's decision to treat a woman's crisis pregnancy by abortion should properly be made "in the light of all factors—physical, emotional, psychological, and the woman's age—relevant to well-being.[42] It is therefore obvious that these same factors must be considered in evaluating and recommending alternatives.

While a physician who treats crisis pregnancies may not be trained to actually provide marital counseling, financial counseling, job placement, or similar services, he or she is presumed to be capable

40. David Reardon, Aborted Women, Silent No More, 188-218

doing a psychosocial assessment of the patient to identify the root causes of her psychosocial problem. One would also presume that a physician who is specializing in crisis pregnancy care would be capable of making appropriate referrals to outside agencies and resources.

Furthermore, the successful practices of thousands of ob/gyns and general practitioners demonstrate that crisis pregnancies can be safely and effectively managed without abortion. These non-aborting physicians have proven themselves capable of screening and counseling women, with appropriate referrals, so that they can resolve their crises without the risks involved in abortion. The professional care that these non-aborting physicians provide women is clearly relevant to the standard of care which all pregnant women in crisis should receive.

Expert Testimony

It is one of our goals in this pro-woman/pro-life strategy to make this issue of alternatives counseling, and the corresponding duty of recommending the best treatment option, an important issue in abortion malpractice suits. Abortionists should not be allowed to state in their defense that "I simply gave her what she wanted—an abortion." Instead, they must be required to show why they believed abortion was the best choice of management options.

In this regard, however, the abortion industry should not be allowed to establish its own standard of care in isolation from the rest of the medical community. Therefore, it is inappropriate for state courts to disallow as "non-expert" the testimony of physicians who do not perform abortions. This is especially so because abortion is not recognized in the law as a distinct medical specialty. Indeed, the Supreme Court has already determined that abortion is within the expertise of any physician. Requirements for specialization are not, nor can be, required.[43] In essence, then, the Court has already determined that the standard of care for abortion is so routine that *any* licensed physician is qualified to meet this standard. Therefore, one would expect that *any* physician should be accepted as an expert on the standard of care for abortion. If a physician is qualified enough to

perform an abortion tomorrow, he or she is certainly qu enough to testify about the proper standard of care today.

Nor should the testimony of a qualified expert be excluded simply because he or she has never found a sufficiently compelling reason to recommend or perform an abortion. Indeed, the testimony of a physician who rarely, or never, performs abortions in the management of crisis pregnancies may be particularly relevant, especially if he or she has found that other options have always been available which pose less of a threat to the physical, emotional, psychological, or social health of the patient than abortion. Such testimony goes directly to the issue of the appropriateness of the defendant physician's recommendation for an abortion. Indeed, the jury may also consider relevant the fact that, while many women complain that they have been exploited by abortionists, there is no evidence of women complaining against physicians who helped them find alternatives which enabled them to keep their children. This fact alone should suggest the preferred course of treatment.

Furthermore, the standard of care for crisis pregnancy counseling, alternatives counseling, and pre-abortion screening can legitimately be separated from the actual surgical procedure of abortion. This is evident from the fact that all ob/gyns and general practitioners routinely counsel women faced with unplanned pregnancies. This professional crisis pregnancy management includes supportive psychological counseling, options counseling, screening for risk factors associated with each option, and disclosure of risks and options to the patient.[44]

These observations provide compelling reason to expand the pool of expert witnesses available for plaintiffs to call upon in suits against abortion clinics. By eliminating the requirement for testimony from experts from within the abortion industry, we will eliminate a major barrier against women seeking redress. Justice is also better served by clearly placing the burden of proving the appropriateness of an abortion recommendation on the abortionist.

41. Life After Assault League, ph.414-739-4489 42.Doe v Bolton,192
43. Roe,165 44. Rosenfeld, Am.Fam.Phys. 45(1):137-140

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RIGHT TO FULL DISCLOSURE

IN *Planned Parenthood v. Casey*, the Supreme Court approved state-mandated informed consent requirements for abortion which are intended to protect the rights of the women as patients.'

But not all informed consent statutes are created equal. Indeed, there is the danger, in some cases, that statutory informed consent requirements may be viewed by the courts as establishing a *sufficient* standard for informed consent rather than a *minimum* standard. In such cases, the statute may be construed to protect the abortionist from liability in cases where the patient may have required *more* information than that specified in the statute. Such would be the case when a woman had physical or psychological characteristics which placed her at higher risk of suffering post-abortion complications than a "normal" patient. In such instances, an ill-drafted informed consent law might actually reduce the injured patient's right to recovery.

VARIATIONS IN DISCLOSURE STANDARDS

There are two prevailing standards for disclosure of risks prior to receiving medical care. The first, the so-called "traditional" or "community" standard, is physician-centered and defined by the common and customary practices in the medical community, namely, by what another physician in the same specialty would reveal in a similar situation. The second standard is patient-centered, and is defined by what a "reasonable patient" would find *relevant* to his or her decision to accept or forego a recommended medical treatment.

The traditional, physician-centered standard is best understood in the context of the trust relationship between the physician and patient: "Where the physician-patient relationship is established, the law imposes on the physician a fiduciary duty of good faith and fair dealing; among other things, this duty requires the physician to inform the patient of the nature of his condition and to obtain informed consent as to future treatment." [45]

The "reasonable patient" standard has evolved in recognition of the fact that whenever any bias about any medical procedure exists, it tends to produce a bias in favor of underdisclosure of risks, thereby making a "community medical standard" for disclosure inadequate.[46] Courts have ruled that, "As the patient must bear the expense,

pain and suffering of any injury from medical treatment, his right to know all material facts pertaining to the proposed treatment cannot be dependent upon the self-imposed standards of the medical profession."[47] "True consent to what happens to oneself is the exercise of a *choice*, and that entails an opportunity to evaluate knowledgeably the *options available* and the *risks* attendant upon each."[48] [Italics added.] Though the physician may feel strongly about the correct course of action, "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests lie," and that requires full disclosure of the nature of the procedure and all the risks and alternatives which a reasonable patient might desire to know in order to make an informed choice.[49] Even complications occurring only one percent of the time must be disclosed.[50]

In all fifteen states and the District of Columbia have adopted the "reasonable patient" standard for informed consent, nineteen have adopted an informed consent doctrine based on the fiduciary relationship of the physician and patient, and ten have combined elements of both.[51]

DANGERS OF INADEQUATE DISCLOSURE

Under both standards for obtaining informed consent, it is not sufficient merely to give a patient a laundry list of potential risks. It is the attending physician's responsibility to make sure that the patient adequately *understands* the relevant risks and options and has *sufficient time* to consider them. These requirements, understanding and time, are especially important in dealing with teenagers who have developmental limitations which may prevent them from fully comprehending and weighing the information as quickly as would an adult.[52] In such cases, the patient may need more detailed explana-

45. Louisell & Williams, Medical Malpractice (1985) sect.8.02. Also Stuart, Ohio Northern Univ. Law Review 14(1):1-20 (1987)
46. Schneyer, Wisc. L. Review (1976) 124. Also Stuart, 120.
47. Cooper v Roberts, 220 Pa. Super Ct., 260,267,286 A 2nd 647,650,(1971) Also Wilkinson v Vesey, 110 R. I. 606,624,295 A.2nd 676, 687 (1972)
48. Canterbury v Spence, 464 F.2nd 772 (D.C. Cir. 1972) 780
49. Ibid. 787-8. 792: Any risk that could affect decision must be disclosed.
50. Ibid. 51. Stuart, 9-10
52. Lewis, Child Dev.52:538-44(1981). Weithorn,Child Dev.53:1589-98(1982)
53. Standards of care require risk disclosure, including medical & psychosocial: alternatives explained; sufficient reflection time: Friedman,

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tions and more assistance in reviewing the benefits, risks, and options. Failure to ensure that the patient fully understands the risks, or has had adequate time to reach an informed choice, may provide an additional basis of negligence.[53]

Uninformed consent may also occur when a patient is not informed of personal physical or psychological characteristics which would pre-identify her as being at higher risk of suffering one or more post-procedural complications. A patient would reasonably expect to be informed of any high-risk factors pertinent to his or her case and to receive counseling with regard to alleviating these risks. If the patient was not informed of these high-risk factors because the physician failed to identify them during pre-procedure screening, the physician might be guilty of negligence.[54]

If there is inadequate disclosure to a patient, *the consent is invalid* and the physician's actions are a form of battery. In such cases, the offenses of negligence and battery are intertwined.[55]

In the majority of cases, women seeking abortion feel some external pressure to do so. Yet at the same time, 60 to 70 percent of women seeking abortions have moral qualms about abortion itself, and over 60 percent are struggling with a maternal desire to protect their pregnancies.

For these women, abortion is not a glorious right by which they are able to reclaim control of their lives; instead, it is an "evil necessity" which they submit to because they "have no choice." Rather than affirming their own values, these women feel forced to compromise their values. Rather than feeling proud of themselves for standing up for their beliefs, even during in difficult circumstances, they feel ashamed of themselves for being "spineless cowards."

This feeling of self-betrayal is a devastating blow to the woman's self-image and her feelings of self-worth. She is internally divided by an emotional "war" within and against her very self. On one side are her original moral beliefs and maternal desires. On the other side is her abortion experience, which represents a choice to act against those feelings. From this internal warfare, unresolved feelings will unpredictably erupt through out the woman's life and will manifest themselves in a wide variety of psychological illnesses.

Therapeutic Privilege and Its Limits

Under both informed consent standards, nondisclosure is justified when the information itself "poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view."[56] For example, it may be reasonable to withhold highly stressful information to a cardiac patient when the information itself can cause the onset of a heart attack.

But even when a treatment is lifesaving, the option of withholding potentially upsetting information, commonly referred to as "therapeutic privilege," is very narrow.[57] This option is narrowed even further in the case of an elective procedure, where, by definition, the patient may decline the proposed treatment without dire consequences.[58] When the information does not pose a significant health risk, there is no "therapeutic privilege." Furthermore, no court has ever held a doctor liable for giving too much information.[59] Therefore, it seems reasonable that physicians should err on the side of full disclosure.

When a procedure is elective, then, the only reasons a physician could give for withholding relevant information would be purely self-serving, that is, either (1) to save time, or (2) to avoid losing the sale of one's services.

The application of these principles to the case of abortion is readily apparent. As opposed to therapeutic abortions necessary to save a woman's life, an *elective* abortion is, by definition, never life-threatening. In the latter case the withholding of information is never justified. A decision to forego a previously desired abortion after learning of possible risks, even remote ones, is always reasonable.[60] Indeed, the Supreme Court itself has found that abortion involves such emotional and psychological risks that a decision to forego a previously desired abortion may often be the wisest course of action.[61]

54. David Reardon, The Post-Abortion Review 1(3):3-6 (1993)
55. Fogal v. Genesee Hosp., 41 A.D.2d 468, 473, 344 N.Y.S.2d 552,559 (1973). Bowers v. Talmage, 159 So.2d888, 889 (Fla. Dist. Ct. App.1963)
56. Canterbury, 789. 57. Ibid.re:physician withholding info
58. Annas, ACLU Guide to Patients Rights (1975) 68 59. Ibid.
60. Freedom is ability to make foolish choices: Harper & James,The Law of Torts (1968Supp.) sect.17.1,61. 61. Matheson, 412-3

PRIMACY OF THE REASONABLE PATIENT STANDARD

Abortion is a unique medical procedure.[62] Certainly no medical procedure has involved more Supreme Court rulings which have defined its legal nature and the attendant duties and obligations of the physician. On one hand, the aborting physician is responsible for ensuring that his recommendation to abort will benefit the patient, given her unique circumstances and her physical and emotional makeup. On the other hand, the physician is also responsible for helping the patient to fully understand the basis for his recommendation, attendant risks, and alternatives so that she can independently reevaluate the situation in the light of his disclosures.

With regard to this latter responsibility, the Court has clearly presumed that the informed consent standard which should be applied is the reasonable patient standard. "The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and *imperative* that it be made with *full knowledge* of its nature and consequences." [63][Italics added.]

This highest standard, which the Court calls "imperative," has been defined as applying to abortion in order to fully protect both (1) the freedom of women, and (2) the health of women. These are precisely the two basic rights in which the Court has found a basis for creating the abortion liberty. Any informed consent standard that is less comprehensive than the reasonable patient standard would jeopardize the rights of women as envisioned by the Court.

Thus, regardless of the prevailing standard for informed consent in a particular state, the Supreme Court has determined that a patient-centered standard must be applied in abortion cases, if not in general, because this standard for full disclosure is integral to the "abortion liberty."

Provision of this information is necessary to "insure that the pregnant woman retains control over the discretion of her consulting physician."[64] The content of disclosure is to be measured not by what the physician deems important but by the right of the woman to make a fully knowledgeable choice, for "What is at stake is the woman's right to make the ultimate decision, not a right to be insulated from all others in doing so."[65]

To make this "ultimate decision," women must have access to all of the relevant information. It is not the right of the physician to "screen" information for her, but rather, it is his duty, in consultation

with her, to help her fully understand his recommendation for abortion so that she can make an informed choice to accept or refuse his recommendation. To apply a standard based on anything other than the primacy of a woman's right to make a fully informed and free abortion decision undermines the constitutional framework in which the Court has labored to define the abortion right.

Law professor Joseph Stuart, J.D., argues that:

> While several states do not accept the "reasonable patient" standard [in general], it seems clear that whatever standard was applied by a state court [in the case of a suit involving abortion] could not fall below the requirements of the abortion right. Furthermore, it would be reasonable to conclude that no standard could ignore the "imperative" of the Court that the abortion decision be made with "full knowledge of its nature and consequences," and that the pregnant woman retain control over the physician's discretion.
>
> To take this line of reasoning a step further: if the factors to be considered should operate for the benefit of the woman and if she should have "full knowledge of the nature and consequences" of an abortion, then it seems that the needs of the patient-pregnant woman would determine the substance of the information disclosed. Therefore, a standard that held a physician only to some common medical practice (whatever that might be) or to some reasonable practice under the circumstances could very well fall short of the consultative model developed through the abortion cases.[66]

If the abortion right is to be construed for the benefit of women, it is difficult to see how a woman's rights are harmed by use of the reasonable patient standard; on the other hand, it is abundantly clear that a woman's rights may be infringed upon by the self-serving "community standard" of the abortion industry. Without the freedom to be fully informed, a woman's right to choose is rendered meaningless. The withholding of information, therefore, is a violation of her civil rights as defined by the Supreme Court.

In their defense, abortion providers may argue that provision of detailed information regarding risks and alternatives is too burden-

62. Casey, 698
63. Danforth, 67. Also, the physician's rights are not significant except as they are adjunct to patient's rights: Kapp, Am. J. Ob/Gyn, 144(1):1-4 (1982)
64. Ibid. 66 65. Casey, 715 66. Stuart

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some. But because the right to choose is held by the woman, not the physician, "the fact that a duty 'makes his work more laborious' is not relevant. The determination that the information given is particularly dissuasive or persuasive is, likewise, not significant, since the duty is to inform and the assumption is that the woman can make the decision for herself."[67]

The Scope of Disclosure

As a general rule, the more complex the treatment options and the more dramatic the risks, the more demanding are the disclosure requirements. This is especially true for elective procedures. For example, it may be reasonable to accept a physician's choice of a particular antibiotic without a lengthy explanation of every risk and alternative to that prescription. But in the case of prostate cancer, which can be treated by drugs, surgery, or non-intervention, the patient would properly expect to receive much more precise and detailed disclosure of the risks and alternatives.

Because abortion is a unique medical procedure, involving a very complex decision which encompasses more medical, psychological, familial, social, and moral issues than any other form of surgery, the requirements for disclosure in this case are higher than for any other medical procedure. Indeed, the Court has raised the standard for disclosure to "full knowledge of [abortion's] nature and consequences."[68] This highest standard, which the Court calls "imperative," has been applied to abortion in order to fully protect both the freedom and health of women, which are exactly the two basic rights in which the Court has found a basis for the abortion liberty.

The scope of health risks which should be discussed prior to an abortion should also be consistent with the broad definition of health reasons upon which the abortion right was established, and so should include physical, psychological, familial, and social complications.[69] Indeed, to be fully informed, the Court notes, disclosure should even include the effects of abortion on the fetus. This is evident in the 1992 *Casey* decision, in which the Court stated:

> It cannot be questioned that psychological well-being is a facet of health. Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision.... [This information] 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.[70]

Furthermore, since abortion is an elective procedure, an abortion practitioner's opinion that one or another risk is not yet firmly established, or has not yet been adequately measured, does not relieve him of the responsibility to disclose to the patient that members of the medical community are concerned about this disputed risk. This is especially true because the abortion practitioner may be biased against believing in the reality of a certain class of risks, no matter how strong the evidence may be, due to his personal and financial interests in advocating for the abortion option. It is the reasonable patient's right to weigh the evidence for or against a contested abortion complication without paternalistic "screening." Indeed, because it is an elective procedure, women are entitled to the full disclosure of even theoretical risks, such as would be given in the case of experimental drugs.

Finally, it should be noted that all disclosures relating to potential risks should include reported complication rates for women undergoing multiple abortions. It is well known that the probability of both physical and psychological sequelae increases with each subsequent abortion. Since over 40 percent of abortions are for women who have previously had an abortion, this information is immediately relevant for a large number of patients. It is also relevant to women having their first abortion since they too may someday be in a position where they will be compelled to consider a subsequent abortion. They must understand that their decision today will affect the risks they may face if they subsequently choose to abort again. Furthermore, it is well known that many women seeking abortions will, out of shame, conceal a previous abortion from their counselors. A standard routine of disclosing risks for multiple abortions is the only way to insure that such "concealers" receive accurate information about the risks they face.

67. Stuart, 14 68. Danforth, 67. Also Casey, 718.
69. Jipping, Case Western Law Review, 38:329-386 (1987/88)
70. Casey, 718-9. Also Stuart, 18-9.

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Review of Moral Considerations

Because the Court recognizes the relevance of fetal development information to a woman's future psychological health,[71] we can also infer that abortionists might also be obligated to discuss the relevant moral issues of abortion with a woman. This may be especially true in cases where women have not fully explored their own moral views, and even more true when a woman's decision to abort is clearly contrary to her belief system.

According to bio-ethicist Daniel Callahan, a noted supporter of legalized abortion, reflection on the moral issue of abortion is, in fact, central to the idea of freedom of choice. "How can it make sense to favor the right of choice, but to be morally indifferent about the use of that right?" asks Callahan. While insisting that each woman must be free to make her own decision, he also insists that we must recognize the "moral seriousness of the abortion choice." Indeed, Callahan admits, "Nothing has so baffled me over the years as the faintly patronizing, paternalistic way in which, in the name of choice, it has been thought necessary to protect women from serious moral struggle. Serious ethical reflection ...requires thinking carefully about the moral status of the fetus, and about the best way to live a life and to shape a set of moral values and ideals."[72]

Such serious ethical reflection can be considered an important prophylactic against post-abortion psychological sequelae. It is well known that women who have pre-existing moral conflicts with an abortion decision are significantly more likely to experience post-abortion maladjustments. It is entirely reasonable and, I would maintain, necessary to the purpose of reducing post-abortion sequelae to insist that women considering an abortion recommendation confront and work through any moral ambivalence they have prior to the abortion. Unless the woman is able to honestly reconcile an abortion choice with her own moral beliefs, she is certain to experience post-abortion sequelae.

Even the director of the National Abortion Federation, Sylvia Stengle, has admitted in an interview with *The Wall Street Journal* that one in five women having abortions is doing so in violation of her own moral consciences. (This estimate is almost certainly low.) Stengle says these women are a "very worrisome subset of our patients," and admits, "Sometimes, ethically, a provider has to say, 'If you think you are doing something wrong, I don't want to help you do that.'"[73] Stengle does not say how often, if ever, NAF abortionists actually take this ethical stand. Still, it is nice to have a NAF official admit that it is ethically necessary to refuse to do some abortions.

More Reasons for Full Disclosure

Women seeking abortions are often in a state of emotional turmoil, often under conditions of duress from other people, and lacking in knowledge of abortion's risks. Because of the intense urgency of their circumstances, it is all too easy to make a hasty choice just to "get it over with." This tendency toward haste, which too often leads to post-abortion sequelae,[74] can only be corrected by ensuring that women take the time needed to learn every bit of information relevant to their decision.

Full disclosure is especially important for women who are very ambivalent about the abortion choice. Because the decision to abort is often tentative, or even undertaken solely to please others, "upsetting" information may be *exactly* what a woman is looking for as an excuse to keep her child when everyone else is pressing her into an unwanted abortion. In some cases, it may be far easier for a reluctant woman to resist a boyfriend who is pushing for an abortion by claiming that "the doctor says abortion is dangerous." She may rightly feel that this argument, even if exaggerated, will be more effective than, "I want this baby, even if you don't."

The right of women to be fully informed is further accentuated by the fact that abortionists have historically shifted "basic responsibility" for the abortion decision to the patient. Rather than making informed medical recommendations based on case-by-case risk-benefit analyses, abortionists have tended to provide abortions simply on request. Since abortionists cannot be trusted to do a complete risk-benefit analysis, especially if the patient is withholding relevant information, the importance of each patient doing her own risk-benefit analysis is much further amplified. In order to do this evaluation, the patient needs *all* of the relevant information which is available.

71. Casey, op cit.
72. Daniel Callahan, Commonweal,(11/23/90) 685-6.
73. Junda Woo, Wall ST. Journal (10/28/94)B12 74. Landy,op.cit.
75. Zimmerman, Passage through Abortion, 139

The Danger of Bias in the Informed Consent Process

Research conducted at abortion clinics has also found that the majority of women seeking abortion have little or no prior knowledge about the abortion procedure, its risks, or fetal development. For most women, the counseling they receive at the clinic is the only information they will receive about abortion and alternatives.

Research also shows that persons involved in crises are especially vulnerable to being influenced, for good or ill, by third parties. This reliance on others, especially an authority figure who appears capable of providing the stressed person an escape from her crisis, is called heightened psychological accessibility.[75]

Because a woman faced with a crisis pregnancy is more vulnerable to the influence of authority figures, she is also more exposed to their prejudices. Thus, the only way to minimize the biases of abortion counselors is to hold them to the highest standards for full disclosure. If counselors instead introduce their own biases, the results can be tragic.

In a retrospective survey of 252 women who experienced post-abortion sequelae, we found that 66 percent of the women said their counselors' advice was very "biased" toward choosing abortion. This is especially important since 40 to 60 percent describe themselves as not having been certain of their decision prior to counseling, and 44 percent stated they were actively hoping to find an option other than abortion during their counseling sessions. Only five percent reported that they were encouraged to ask questions, while 52 to 71 percent felt their questions were inadequately answered, side-stepped, or trivialized. In all, over 90 percent said they were not given enough information to make an informed decision. These omissions are especially relevant since 83 percent said that it was very likely that they would have chosen differently if they had not been so strongly encouraged to abort by others, including their abortion counselor.[76]

Reports of biased counseling are abundant. For example, when asked about clients who express a desire to keep their child, abortion counselor Betty Orr says, "I ask them who is going to take care of the baby while they're in school. Where are they going to get money for clothes?"[77] Other counselors bluntly tell the woman to forget the motherhood fantasy and "get realistic. Medical bills for having a baby will run over three thousand dollars. Do you have that kind of money? Raising a child is even more expensive. It costs over two hundred thousand dollars to raise a child right. Where are you goin[g] get that kind of money?" This kind of "counseling" is little more t[han] a way of reinforcing a young woman's feelings of powerlessness.

Faced with such antagonism, from parents, boyfriends, and their "health-care" advisors, is it any wonder that young women cave in to the unrelenting pressures to abort even when 60 to 80 percent of them would actually prefer to keep their babies?[78] Pressured into "choosing" abortion by Planned Parenthood counselors at the age of 13, Kathy Walker charges, "I felt like my family had no control over anything. My parents felt as deceived as I was; we never really made an informed decision. Planned Parenthood railroaded us.... But nobody ever really asked me what I wanted to do."[79]

In another case, an Indiana Planned Parenthood affiliate ignored the warnings of Kathleen Kitchen's own physician, who believed an abortion could be fatal because she suffered from certain birth defects. Evading two court orders blocking the abortion, counselors procured a dangerous out-of-state abortion for the girl, which resulted in hospitalization for abortion-related complications.[80] These events demonstrate that a pro-abortion bias may overcome even the most basic evaluation of abortion's dangers for high-risk patients.

When physicians or counselors withhold information because they fear the information will lead to an "unreasonable" choice for childbirth, they are inserting their own bias into the decision-making process, a bias that has no medical basis. Such bias is of special concern since the majority of abortion patients are ambivalent about their choice, with up to 84 percent saying they would have kept their pregnancies under better circumstances.[81]

Furthermore, biased pre-abortion counseling can, in itself, be injurious. Substantial evidence suggests that inadequate, inaccurate, or biased counseling increases the occurrence and severity of negative post-abortion psychological reactions.[82]

76. Reardon, Aborted Women, 18-19
77. Linda Bird Franke, The Ambivalence of Abortion (1978) 179
78. Zimmerman,op cit. Also Reardon, op cit.
79. Kuppelian, New Dimensions(10/91) 143
80. Bond, Nat'l Rt. to Life news (10/86)6 81.Zimmerman,op cit.
82. Franz & Reardon, Adolescence, 27(105): 161-172

11-30

Understanding the Cause of Counseling Bias

There are many reasons for bias in abortion counseling. Some abortion counselors have a financial bias. They see themselves as being in the "business" of selling abortions.[83] Some act paternalistically, honestly believing that abortion is the best solution to every problem pregnancy.[84] Still others have a psychological need to see other women choose abortion as they once did, thus seeking affirmation of a choice which still troubles them on some deeper level.[85]

Even more troublesome are those who see abortion as a tool for social engineering. Whether they seek to use it to reduce welfare rolls, to eliminate the "unfit," or to save the world from overpopulation, these social engineers see some "greater good" which is served by abortion, and this greater good may be deemed more important than "a little guilt" or "a few torn uteruses" among the women whom they abort.

Some abortion providers of the social engineering mindset also have misogynist and racist attitudes. Such persons want to promote abortion to prevent "unfit" persons from raising "unfit" children. For example, Dr. Edward Allred, owner of the largest chain of abortion clinics in California, is a staunch advocate of abortion as a method of controlling the population of minority groups:

> Population control is too important to be stopped by some right-wing pro-life types. Take the new influx of Hispanic immigrants. Their lack of respect of democracy and social order is frightening. I hope I can do something to stem that tide; I'd set up a clinic in Mexico for free if I could....When a sullen black woman can decide to have a baby and get welfare and food stamps and become a burden to all of us it's time to stop.[86]

Most of those who are ideologically committed to population control, however, are more circumspect in their rhetoric. But there is no denying the fact that the primary purpose of many "family planning" groups, such as Planned Parenthood Federation of America, is to promote a policy of population control. Any health care services it provides are subservient to that goal.[87]

Persons or organizations who advocate coercion, privately or publicly, would certainly not hesitate to conceal or understate the risks of abortion. Indeed, such population control zealots have frequently defended the use of dangerous or insufficiently tested birth control

technologies on the grounds that injured women are a "secondary" concern compared to "overpopulation." [88]

Since PPFA's organizational mandate is to reduce birth rates here and abroad, especially among the poor, its "family planning" services are simply a means to that "all-important" end. It is no wonder, then, that patients report that Planned Parenthood's abortion counseling services are even more biased toward abortion than counseling at non-PPFA clinics.[89]

If a few women, or even 80 percent, suffer minor to severe post-abortion trauma, population controllers may deem this a small price to pay for world peace, prosperity, and environmental purity. Abortion is an essential tool for population control, and many are willing to promote it even if it means hiding its risks from their patients.[90]

83. Zeckman & Warrick, Abortion Profiteers,Chgo. Sun Times (1978)
84. Reardon, op cit. 85. Ibid.
86. Doctor's Abortion Business Lucrative, San Diego Union (10/12/80) B1:1
87. Jacqueline Kasun, The War against Population (1988). Also A.Chase, The Legacy of Malthus (1977)
88. Alan Guttmacher, New York Times (2/26/70) 50:3. Also Mendelsohn, Male Practice (1981) 120.
89. Reardon, op cit.
90. Hardin, Science (12/68) 1243-8.

#12

KANSAS ABORTIONISTS

1. Dale Leonard **Clinton**,M.D. license no.11150 (genl.practice) issued 1956 *active*
residence 3026 Nathan Drive, Lawrence,KS,66049; phone 913-841-7680
office 15 E 7th Suite103, Lawrence,KS,66044; phone 913-841-5716
news article reveals Clinton aborted teen without parental notice

2. Robert Dale **Crist**,M.D. license no.13176 (gyn) issued 1964 *active*
residence 5720 Foster, OverlandPark,KS,66202;
office POBox 575, ShawneeMission,KS,66201; phone 913-236-5388
license renewal form shows adverse judgment during1/90-6/91

3. Mark Alan **Curry**,D.O. license no.22317 (ob/gyn) issued 1988 *active*
residence12326 S. Auff Lane,Olathe,KS,66213; phone 913-764-6571
office 5520 College Blvd., Suite120, Overland Park,KS,66211; phone 913-345-2322(see**Katz**)

4. Glen S. **Hara**,M.D. license no.15456 (ob/gyn) issued 1973 *active*
residence 12810 W. 82nd St., Lenexa,KS,66215; phone 913-492-6279
office KUMC, 3901 Rainbow Blvd., Kansas City,KS,66103; phone 913-583-6241(see**Krantz**)
license renewal form shows hospital restriction/suspension during 1/93-6/94

5. Norman R. **Harris**,M.D. license no.12974 (gyn) issued 1963 *active*
residence 1310 Gulf Blvd., Suite 19A, Clearwater,FL,34630; phone 813-596-4904
office 5101 E. Kellogg, Wichita,KS,67218; phone 316-684-5155(see**Tiller**)
license renewa lshows adverse judgment during 1/90-6/91

6. Herbert Charles **Hodes**,M.D. license no.14447 (ob/gyn) issued 1970 *active*
residence 6906 W. 130th, Overland Park,KS,662 ; phone 913-897-5932
office 4840 College Blvd., Overland Park,KS,66211; phone 913-491-6878
license renewal shows adverse judgment during 1/92-6/93

7. Dennis Kerry **Katz**,D.O. license no.22322 (ob/gyn) issued 1988 *active*
residence 10115 W. 101st, Overland Park,KS,66212; phone 913-888-3677
office 5520 College Blvd., Suite120, OverlandPk.,KS,66211; phone 913-345-2322(see**Curry**)
license renewal hint sat adverse judgment during 1/93-6/94

8.William Malcolm **Knarr**,D.O. license no.19184 (genl.practice) issued 1981 *suspended*
residence 7023 Bradshaw Ct., Mission,KS,66206; phone 913-268-0538
office #1:720 Central, Kansas City,KS,66102; phone 913-321-3343 (see**Rajanna,Zaremski**)
office#2: 5020 SW 28th, Topeka,KS,66614; phone 913-273-3004(see**Neuhaus**)
large disclipinary file; suspended 3/12/94 for 2years but retains his 2 offices; adverse settlements (Cummins, Phillips) during 1/93-6/94

9. Kermit E. **Krantz**, M.D. license no.12291 (gyn) issued 1959 *active*
residence 6711 Overhill Rd., Mission Hills, KS,66208; phone 913-362-8440
office KUMC, 3901 Rainbow Blvd., Kansas City,KS,66103; phone 913-583-6201(see**Hara**)
license renewal shows adverse judgment during 1/92-6/93

(continued)

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10. Joseph Walter **Manley**,M.D. license no.14812 (ob/gyn) issued 1971 *canceled*
residence 6810 W. 52 Pl., Apt.2B, Mission,KS,66202; phone 913-384-9744
office 6400 Glenwood, Suite104, OverlandPark,KS,66202; phone 913-831-1551
large disciplinary file;18month revocation 12/93, conditional reinstatement

11. Dennis W. **Miller**,M.D. license no.19490 (ob/gyn) issued 1982 *active*
residence 7408 W. 54th St.,OverlandPark,KS,66202;
office 600Nebraska, Suite102, KansasCity,KS,66101; phone 913-621-4001
restricted location 1/89-12/89; adverse judgment & hospital restriction 1/90-6/91

12. Ann Kristin Eisenbise **Neuhaus**,M.D. lic.no.21596 (genl.practice) issued 1986 *active*
residence 1228 Westloop #127, Manhattan, KS,66506; phone 816-283-9142
office#1: Wichita Family Planning Clinic,KS; phone
office#2: 5020 SW 28th, Topeka,KS,66614; phone 913-273-3004(see**Knarr**)

13. Krishna **Rajanna**,M.D. license no.15624 (genl.practice) issued 1972 *active*
residence 838 W. 39th Terr., Kansas City, MO,64111; phone 816-531-4422 (or-1849)
office 720 Central, KansasCity,KS,66102; phone 913-321-3343 (see**Knarr,Zaremski**)
insurance expired 2/95

14. John Bertram **Robb**,M.D. license no.18015 (emer.med) issued 1979 *active*
residence 1509 S. Eton, Perryton, TX,79070;
office 15072 N West St.,Wichita,KS,67203;
insurance expired 12/94

15. George R. **Tiller**,M.D. license no.14025 (gyn) issued 1968 *active*
residence 16066Citation, Wichita,KS,67230; phone 316-733-2828
office 5101 E. Kellogg, Wichita,KS,67218; phone 316-684-5255(see**Harris**)
2 year alcohol probation period;insurance expired1/95

16. Ronald N. **Yeomans**,M.D. license no.1015 (ob/gyn) issued 1968 *active*
residence 9234 Kessler Lane, Overland Park,KS,66212; phone 913-341-3829
office 4401 W. 109th, Shawnee Mission, KS,66211; phone 913-345-1400

17. Sherman Charles **Zaremski**, license no.13172 (pulmonary) issued 1964 *active*
residence 9931 Lee Ct., Leawood,KS,66206; phone 913-621-0808
office 720 Central, Kansas City, KS,66102; phone (see **Knarr**)
2 week suspension, fine and censure for drug & record keeping fraud

#13

Testimony
of
The Rev. Lynn NewHeart
Planned Parenthood of Mid-Missouri and Eastern Kansas
February 13, 1997
before the
House Judiciary Committee
of the Kansas Legislature
in opposition to
House Bill No. 2269

I am the Reverend Lynn NewHeart, Chaplain/Patient Advocate at Planned Parenthood of Mid-Missouri and Eastern Kansas. I have been with Planned Parenthood for almost seven years. A large portion of my job involves working with, and counseling with women who are seeking abortion services. I am also an ordained minister of the Christian Church (Disciples of Christ).

Upon reading HB2269, I was immediately struck by several inaccuracies in the first section. The bill states, about women who seek abortions, "They do not return to the facility for post-surgical care." This sounds as if post-surgical care is neither available nor utilized, both are incorrect. Follow-up visits, two to three weeks after an abortion, are strongly encouraged in most clinics, even provided free of charge in some, and many woman do make and keep these appointments.

The bill also states that there is "little opportunity to receive counseling concerning her decision," and, "Many abortion facilities or providers hire untrained and unprofessional counselors whose primary goal is to sell abortion services." Once again, in my experience in a clinic in which abortion is one of the services provided, and being affiliated with other clinics which do the same, both of these statements are inaccurate. In our particular clinic, many of the women providing counseling have Bachelors degrees and several have, or are working towards, Masters degrees. Extensive training is provided to staff so that they are equipped with all the pertinant information for ensuring informed consent. Our protocols, standards and guidelines demand that we offer compassionate, medically sound and unbiased information to all patients.

Women seeking abortion often call into the clinic to obtain information, discuss their options and speak about the emotions of having to make such a decision. Some, who do not resolve their decision after a phone call, will schedule to come into the clinic to speak further about their concerns before making a decision. Always, for every woman who comes into the clinic for an abortion, we sit down with her after she has read and filled out the paperwork, seen a video tape of the information on the procedure, risks and aftercare instructions, we then go over any questions she may still have, confirm her decision (after verifying that she is aware of all of her options) and discuss any issues she may wish to discuss.

If at any time the woman indicates that she may need more time to make her decision, additional counseling time is offered. There have been times when the staff have not felt good

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with the level of comfort a woman has expressed regarding her decision and so the staff member sends the woman home, refusing to do the abortion that day, so that she has more time to resolve the issues. Sometimes those women do come back for an abortion and sometimes they do not. As Chaplain, I have talked with women who were sure of their decision to have an abortion but just wanted to talk about the religious aspects of making that decision. We give every woman every opportunity for counseling for as long as it takes for her to make a decision that she deems is best for her in her particular circumstances. We also provide post-abortion counseling, at no cost, for anyone who desires it. All of the people I have known who work in this area are following these procedures because they are committed to helping empower woman to make good decisions for themselves, not because they are trying to "sell abortion services."

One of the concerns of the bill is that women seeking abortion be given "accurate scientific information", and yet throughout the bill there is language that is not scientifically accurate. Using terminology such as "unborn child" is not scientifically accurate. The term fetus, or embryo when applicable, fits within scientific definitions. The use of value-laden terms like "unborn child" seems to be inconsistent with the desire for medical, scientific accuracy.

Passage of HB2269 would result in making it very difficult to obtain abortion services for some women, impossible for others. Whereas a mandatory trip into the clinic, at least eight hours before an appointment, might be experienced as only a nuisance for a few women, it would serve as a barrier to service for many women who struggle with transportation problems, child care, or missing work. Even without a waiting period, it is often difficult for women to manage the necessary logistics of getting to the clinic for an appointment depending on her financial, family and employment situations. I speak with a different woman, at least weekly, who is spending a great deal of time and energy just trying to make everything work so that she can make it to her appointment. It is challenging enough for women who live in town. To require out-of-town patients to make an additional visit to the clinic often will mean an additional day of work missed, possibly payment for a hotel overnight, and the difficult tasks of obtaining child care for a longer period of time. The political climate surrounding abortion necessitates confidentiality like no other surgical procedure. The challenge to maintain privacy, while making these additional arrangements, would present yet another burden.

Another barrier to obtaining abortion services would be created by the increase in cost. Paying a physician to provide the informed consent counseling could very well more than double the price of abortions. The counseling usually takes much longer than the actual abortion itself, so the additional increase in physicians' salary would have to be passed on to the patient just to cover costs. Since most insurance companies do not cover abortion services, and Medicaid will not cover abortion services (except currently for rape or incest victims), the cost of an abortion is usually out of pocket. A single woman with children, dependent on AFDC and foodstamps just to feed and clothe her children, has a very difficult time finding several hundred dollars "out-of-pocket". Many women already struggle to obtain the necessary fees in a timely manner (since the price only increases as they wait to obtain funding). A substantial increase will result in making abortion impossible for many women because of cost alone.

With the terrorist-induced shortage of physicians willing to provide abortion services in the U.S., tying up physician time to provide counseling, a service another adequately trained staff member can well perform, will also serve to make skilled physician availability a much scarcer resource. Ultimately, more women would have reduced access to an important and necessary medical service that is already hard to find in many areas.

Having counselled with women seeking abortion for almost 7 years, it has been my experience that the vast majority of patients have already spent a good deal of time thinking about their decision even before they call to make an appointment. Most have involved people close to them in their decision-making process, taking into account a multitude of factors. Several weeks ago a woman told me that she felt her decision to not have another child was the most loving, caring and decent option for the sake of her existing three children. Another child, she felt, would place a financial, emotional and physical burden on the family that would cheat the others out of the love and care she and her husband wanted desperately to provide. To assume that women cannot make decisions regarding their bodies and regarding the decision to become parents without a physician-delivered lecture from the government is nothing short of misogynistic.

It is also demeaning to women to assume that the difficult and complex decision to terminate a pregnancy would be, or should be, affected by seeing pictures or drawings of fetuses at two-week developmental intervals. Although the decision to terminate a pregnancy might be a simple decision for some women, it is never an easy one. The couple who have just made the heartwrenching decision to terminate a planned and wanted pregnancy because of severe fetal anomalies requires special care and attention. To force them to view pictures of developing fetuses could cause emotional harm that would never exist with a more caring approach to counseling. Although we have this information available in our clinic for those who request it, medically sound informed consent happens for other surgical procedures without such unnecessary, emotionally-evocative visual aids.

In conclusion, HB2269 has within it several factors which are troubling from the standpoint of what is good for the patient. Grossly inaccurate information and value-laden language exists within the text. The proposed conditions for informed consent would un-necessarily tie up physicians' time and produce a cost-inhibitive procedure for many women. And finally, the tone and content of mandated information to be given to women are both unnecessary and potentially harmful to the patient's emotional well being. Please do not allow passage of HB2269.

14

National Council of Jewish Women NCJW
Daring to Make a Difference
2nd Century Celebration

January 13, 1997

Testimony of Barbara Holzmark, Kansas State Public Affairs Chair (SPA)
National Council of Jewish Women
8504 Reinhardt Lane
Leawood, Kansas 66206
(913)381-8222

Dear Members of the House Judiciary Committee,

I am submitting testimony in opposition to HB 2269, an act enacting the Woman's Right-to-Know Act.

Founded in 1893, the National Council of Jewish Women is the oldest women's organization in the country. Our mission is six-fold: To support the NCJW Center for the Child, promoting the well-being of children and families; Supporting the NCJW Research Institute for Innovation in Education is Israel, promoting the well-being of children, youth and families; Promoting comprehensive services that ensure children succeed in school; Ensuring individual and civil rights; Improving the status of women; and Furthering the quality of Jewish life locally, nationally and internationally. In order to improve the status of Women, we have endorsed and resolved to work for comprehensive, confidential, accessible family planning and reproductive health services for all, regardless of age or ability to pay. Therefore, the protection of every female's right to reproductive choice, to safe and legal abortion, and to the elimination of obstacles that limit reproductive freedom are her individual liberties and civil rights.

HB 2269 specifically puts further restrictions and obstacles on women seeking abortion services in all forms. I am not here today to condone abortions, I am here on behalf of WOMEN and their rights. All individuals should have the fundamental right to live with their human rights and dignities guaranteed. You do, and no one questions your decisions. Women should have that same right, to have the choice to a legal procedure. They know what is ahead of them. From the moment of conception, a woman labors over her decisions and her choices. Do you honestly think that the decision is made upon arrival at an abortion clinic? Do you think it is fair to put demands on ALL Doctors, telling them that they have performed an abortion by the use of a medicine, drug, or any other substance that is legally available to them for that purpose? What is happening to our society today? It is only the unborn child that seems to have rights. Women should procreate for men , but should have no rights for their feelings. The National Council of Jewish Women love children, youth, and families and don't put priorities on any of them.

I urge you to oppose HB 2269 and consider how it discriminates against women of all ages, and how it further restricts a woman's right to her choice.

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15

ProChoice Action League

P.O. Box 3622, Wichita, KS 67201
9517 E. Bluestem
Wichita, KS 67207

Phone 316-681-2121
Fax 316-681-2121
Email peggyjj@aol.com

To: Members of the House Judiciary Committee
From: Peggy Jarman, lobbyist for Women's Health Care Services and ProChoice Action League
Re: H.B. 2269

H.B. 2269 will prevent many women from accessing abortion services. It give the impression that physicians are withholding appropriate medical information and counseling to patients. Most insidious of all, sidewalk counselors will be encouraged to harassment and badger patients even more than they do now. Overall, H.B. 2269 is just part of the "Five Year Plan to Stop All Abortions in Kansas." (See Attachment #1)

- **No other medical procedure is so regulated by the legislature as to**

  (A) dictate office protocol,
  (B) demand waiting periods,
  (C) require state prepare consent forms,
  (D) dictate to physicians the method of consent,
  (E) allow civil action not allowed in any other medical malpractice arena,
  (F) requires duplicate reporting,
  (G) deliberately negate anonymity of reporting protocols by adding additional requirements, initiating a stealth attempt at preventing medical abortions,
  (H) deliberately negate judicial by-pass requirements outlined by the U. S. Supreme Court., and
  (I) demand and dictate language to be used by physicians without regard to specific needs or circumstances of their patients.

  Abortion is one of the safest types of surgery. (See Attachment 2). No other surgery is regulated by the legislature in this way. Can you imagine placing these kinds of requirements on any other surgeon practicing today?

- **No other medical procedure is so regulated by the legislature as to**

  (A) force a woman to delay a medical procedure beyond what she and her physician find appropriate.
  (B) force woman to spend more money for care or more time away from her home, children, family, and work.
  (C) force a woman to put herself at the mercy of a group of people whose entire focus is to prevent her from having an abortion by any means they deem appropriate, often as they deem has been dictated by God.

  Women are capable of making health care decisions including the decision whether or not to have an abortion. Women are moral agents and do not need legislators to put barriers up that will make access more difficult for all and impossible for others.

- **Current Kansas law places an enormous burden on teens needing to access the judicial by-pass.**

  (A) H.B. 2269 will create an enormous hardship on teenagers, effectively eliminating their access to the judicial by-pass.

  (B) H.B. 2269 will force children to have children taking opportunities for teens and their parents to make joint decisions of what is appropriate for their particular families away from them.

  The current compromise abortion law is so strict against teens that few are capable now of accessing the judicial by-pass. Add an overnight stay that H.B. 2269 will mandate and the constitutional requirement of judicial by-pass will be a joke.

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A look at the specifics of the bill makes clear its problems. Some are implied, suggestive innuendo. Some problems are about access to abortion services.

1. The name of the act itself..."woman's right to know" implies there have been attempts to deceive women seeking services. Consent forms used by physicians providing abortion services are as extensive as those used with any other surgery. See Attachment #3. **Page 1, Line 23**

2. New Sec 2 (1) why doesn't the Kansas legislature find that it is essential to the physiological and physical well-being of anyone getting any surgery to receive complete and accurate information including the alternatives. It suggests that other surgery is unimportant, immaterial, or perhaps that it doesn't matter if women are uninformed before undergoing heart surgery or brain surgery. **Page 1, Line 25**

(2)Women are already told that under the current Kansas compromise abortion Law. **Page 1, Line 28**

(3) Almost no surgeon has an established personal relationship with the patients they see for surgery. To suggest that physicians providing abortions are different because they do not is misleading and deceiving. Patients are all offered the options of returning to the physician who provided the care. Many do; many return to their primary care physicians. It is simply a matter of choice patients make. It is unlike that the legislature has any proof that patients have "little opportunity for counseling." At Women's Health Care Services for example, we have a master's level counselor on staff who is available to any patient at any time and she spends most of her time with patients in both individual and group counseling sessions. **Page 1, Line 32**

(4) See Attachment #3 **Page 1, Line 40**

(5) No one denies that having an abortion can be upsetting and can cause distress. The most frequent response women report after ending a problem pregnancy is relief and the majority are satisfies that they made the right decision for themselves. The American Psychological Association finds no scientific support or evidence for the so-called "post abortion syndrome." **Page 2, Line 1**

(6,7) no basis of fact. **Page 2, Lines 4 and 6**

2. (b) (2) Purpose of the act is stated to be to "protect unborn children....." A simple straightforward honest statement that supports the goal of stopping all abortions in Kansas. **Page 2, Line 14**

New Sec. 3 - definitions

(a) Abortion - Definition has changed. See Attachment #4. This definition could lead to waiting periods for taking birth control pills, getting IUDs. **Page 2, Line 21**

(b) Problematic due to that fact that the definition is misleading. Fertilization, in biology, sexual reproductive process involving the union of two unlike sex cells (gametes)—the ovum, or egg (female), and sperm (male)—followed by fusion of their nuclei. Conception, the process by which a fertilized egg implants in the uterine lining. The new definition could lead to waiting periods for taking birth control pills, getting IUDs. **Page 2, Line 28**

(i) Seems to assign personhood to a fetus from moment of fertilization. Sets uneasy precedent. Needs lawyers interpretation. **Page 3, Line 2**

New Sec. 4 (a) This forces women who do not live near the health care provider to spend another night away from home, work, and family. This adds emotional and physiological stress and a financial burden. Out of 105 counties, there are less than 10% that have physicians providing abortion services. The need and desire for most women is to have someone accompany her to the procedure. Adding this requirement will force many women to come alone, adding again to the emotional and physiological stress of the woman. **Page 3, Line 13**

(1-7) and (b) Six of the seven are already included in consent forms. (See Attachment #3).
4(A) - Is it appropriate to tell a woman carrying a fetus that has no kidneys, a conditions incompatible with life, or any of the horrible anomalies that her fetus has that "the unborn child may be able to survive outside the womb"? (B) Is currently being done. **Page 3, Lines 11-33**

(b - 4) - "the woman is free to withhold or withdraw her consent...at any time before or during the abortion....." (my emphasis). Medically this is impossible without enormous risk to the life of the woman. **Page 4, Line 4**

The reporting requirements represent a duplication of reporting. A comprehensive reporting bill was passed and signed into law in 1995. It is designed specifically to provide both the appropriate information AND preserve confidentiality of both patients and physicians. In this emotionally charged health care service, it is imperative that is maintained. **Page 4, Line 20-23**

Available of material is by request meaning anyone providing abortion services will have to ask for supplies removing the anonymity perfected in the current reporting law. **Page 5, Lines 35-37**

Most of what Sections 4 and 5 do is dictate to the physician that s/he must give the consent and under what conditions it is to be done. This is absurd and condescending. This legislative body would not dream of giving any other physician such duties. These physicians, like all other physicians in this state, set up and operate their offices under the rules and regulations of the Kansas Board of Healing Arts. They are as regulated as any other physician in this state, subject to the same requirements from advertising to staffing. To suggest otherwise is either pure ignorance or deliberately misleading. In addition this section requires state prepared information for distribution. At what cost, for what purpose? To "protect the unborn."

Additional sections deal with legal issues that also need to be examined for content, implication, and whatever new standards might be set in medical malpractice civil cases and the appropriateness of those actions.

In conclusion, this legislation is unnecessary, inappropriate, and biased against physicians, women, and teenagers. I urge you to defeat H.B. 2269.

ProChoice Action League

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Email peggyjj@aol.com

Attachment # 3 - Consents Used by Women's Health Care Services

1. Eight-hour consent form.

2. Oral contraceptive consent

3. Consent for Pregnancy Termination Beyond 14 Weeks

    a. Laminaria Consent
    b. Digoxin Consent
    c. D and E Complication Explanation and Consent

4. Consent to Induction Abortion including

    a. Purpose of Abortion
    b. Laminaria
    c. Procedure
    d. Risks
    e. Laboratory
    f. Additional Procedures Due to Complications
    g. Emergency
    h. Follow-Up

5. Consent for Abortion Treatment, Anesthetic and Other Medical Services including the following complications:
    a. Perforation
    b. Laceration
    c. Bleeding
    d. Infection
    e. Failure to Terminate Pregnancy
    f. Tubal Pregnancy
    g. Hysterectomy
    h. Cervical Incompetency
    i. Emotional Distress

Women's Health Care Services, P.A.
George R. Tiller, M.D., DABFP, Medical Director
5107 E. Kellogg, Wichita, Kansas 67218
(316) 684-5108
1-800-882-0488

Dear Prospective Patient:

I am Dr. George Tiller, a 1967 graduate of the University of Kansas School of Medicine, a diplomat of the American Board of Family Practice. My medical practice has included legal and safe abortion services for thousands of women since 1973 here in Wichita, Kansas.

The 1992 Kansas abortion law requires that I provide certain written information to patients seeking abortion services at least eight hours before an abortion is performed. This document will satisfy the basic notification requirement. We will provide you with additional detailed information before your procedure, as we have always done.

1) The nature of an abortion procedure is to medically induce the termination of a pregnancy.

2) The alternative to abortion is vaginal delivery or caesarean section at the end of the pregnancy.

3) The risks of an abortion are related to the duration of the pregnancy. Generally speaking, an abortion performed early in a pregnancy is safer than one performed later in the pregnancy. The generally recognized minor (non-hospitalization) complications such as infections, laceration, and incomplete or retained material in the uterus vary in occurrence from one to five per one hundred abortions (1/100 to 5/100) at five to six weeks up to as much as five to ten per one hundred abortions (5/100 to 10/100) at later stages.

   The major (hospital type) complications of transfusion, hemorrhage, amniotic fluid embolism, laceration, infection, and uterine perforation vary in occurrence from one per eight hundred abortions (1/800) at five to six weeks up to two major complications per one hundred abortions (2/100) at the latest gestation. We believe that, in the vast majority of patients, abortion is safer than full term delivery at all legal stages.

4) Based on the first date of your last menstrual period or an ultrasound evaluation, the gestation of your pregnancy is estimated to be _____, plus or minus 11 to 14 days.

5) The generally recognized medical risks associated with carrying the pregnancy to full term delivery or caesarean section at term include but are not limited to the following: unplanned major surgery, hemorrhage, transfusion, blood clots in legs, blood clots in the lungs, hysterectomy, major infection, cervical laceration, vaginal laceration, rectal laceration, perforation of the uterus, injury to bowel/bladder, major and minor emotional problems, amniotic fluid embolism, cervical incompetence, major and minor depression, and even death.

   The types of medical risks (listed above) associated with abortion, are, in general, the same as those associated with carrying the pregnancy to term. The medical risks of an early abortion (5-12 weeks) and a second trimester abortion (13-26 weeks) occur at a lower rate than at full term delivery or caesarean section. The medical risks of an abortion in the third trimester may occur at about the same rate as full term delivery or caesarean section. The death rate for abortion is less than the death rate for full term delivery.

6) Community resources available to support a woman's decision to carry a pregnancy to term include Lutheran Social Services, Planned Parenthood of Kansas, YWCA, Self-Help Network of Kansas, Family Consultation Service, United Way First Call for Help, United Way Center, Childcare Association of Wichita, Kansas, Children's Service League, Episcopal Social Services, and United Methodist Urban Ministry.

By signing below, you acknowledge that you have read and understood the information above, and that you have received this information eight hours prior to your abortion.

SIGNATURE: _____

Note to Patient: Please see the back of this form for important information about your visit.

15-5

Women's Health Care Services
Visit Checklist

All patients

___No one will be allowed in the clinic without photo identification.
___Bring your signed Informed Consent (the other side of this sheet).
___Arrive with a full bladder.
___Drink no alcohol 24 hours prior to your visit.
___No children are allowed in the clinic.
___The fee will be collected prior to the procedure.
___No personal checks will be accepted.
___Remember to park in our fenced parking lot.
___Our security staff will be on duty and will scan you electronically and check in all handbags prior to allowing you into the clinic.
___Minors: You will need a parent to accompany you **OR** have a notarized Waiver of Notification and be accompanied by person 21 years of age or older.

One-day patients

___If your appointment time is at 12:00 noon or after, eat nothing after 8:00 a.m. the morning of your appointment. After 8:00 a.m., you may drink only coffee, tea, or water.
___If your appointment is on Saturday morning, eat nothing after 12:00 midnight the night before your appointment. After midnight, you may drink only coffee, tea, or water.
___We request that you bring only one person with you.
___The person accompanying you will be asked to wait outside while we do your sonogram and collect your fee, unless you are a minor. We will then invite him/her inside.
___You will need to have a person accompanying you to receive the preoperative medication which relaxes you for your surgery.
___Plan to be in the clinic for 3-4 hours.

Two-day patients

___You may eat a light breakfast the first day.
___Bring along $10.00 for your prescription.
___Plan to be in the clinic for 3-4 hours the first day.

Out-of-town patients

___You must stay in Wichita until you are released from our care. Call us for hotel information, if you wish.
___If you use a cab, use American Cab Company. They are pro-choice. Their number is (316) 262-7511.
___Bring a supply of sanitary pads.
___No luggage is allowed in the clinic.

Four-to-five-day patients

___Bring along $50.00 for your prescriptions.

MEDICAL HISTORY

This questionnaire is part of your medical record and is used by the staff to anticipate any problems you might have relating to an abortion. Please answer the questions as fully as possible. This record is strictly confidential.

Name _____ **Birthdate** ___/___/___ **Age** _____

Address _____
Street **City** **State** **Zip**

Telephone (___) ___-_____ **Occupation** _____ **Religion** _____

Education (check one)
___ Under 12 years
___ 12 years or G.E.D.
___ College
___ Graduate School

Marital Status
___ Single
___ Married
___ Separated
___ Divorced
___ Widowed

Ethnic Group
___ Caucasian
___ African American
___ Asian
___ Hispanic
___ Other:_____

Do you have a doctor who knows about the abortion? ___Yes ___No

Pregnancy History

Number of pregnancies (including this pregnancy): _____

Live births:	_____	Date of last:	_____
Stillbirths:	_____	Date of last:	_____
Miscarriages:	_____	Date of last:	_____
D & C's:	_____	Date of last:	_____
Abortions:	_____	Date of last:	_____
Living children:	_____	Age of youngest:	_____

Dates (month and year) of abortions, if any: _____

Was your last period normal? ___Yes ___No

What was the first day of your last normal menstrual period? _____

Bleeding during your periods is usually: ___Light ___Medium ___Heavy

Do you have cramps with your periods? ___Yes ___No

If so, is the cramping: ___Light ___Moderate ___Heavy

Are your periods regular? ___Yes ___No

What was the date of your last pap smear (if any)? _____

Have you ever had any complications or hemorrhaging with previous pregnancies, abortions, or deliveries? ___Yes ___No

If yes, please explain: _____

_____

Please mark any of the following methods of birth control you have used:

___foam ___rubbers ___pills ___diaphragm ___IUD ___rhythm

___withdrawal ___other: _____

Describe any problems you have had with any methods: _____

_____

Are you allergic to any drugs or medications? ___Yes ___No

If yes, check which ones:

___ Novacaine
___ Iodine
___ Penicillin
___ Aspirin
___ Codeine

PLEASE LIST ANY OTHER MEDICATIONS YOU ARE ALLERGIC TO:

_____

_____

_____

Have <u>you or anyone in your immediate family</u> had any of the following: (check yes or no)

YES	NO		YES	NO	
___	___	Migraine Headaches	___	___	Sickle Cell Disease
___	___	Breast or Uterine Cancer	___	___	Varicose Veins
___	___	Diabetes	___	___	High Blood Pressure
___	___	Blood Clots in Veins	___	___	Breast Tumors
___	___	Uterine Fibroid Tumors			

If yes to any, please explain: _____

_____

_____

Have <u>you</u> ever had any of the following: (check yes or no)

YES	NO		YES	NO	
___	___	Anemia	___	___	Liver Disease
___	___	Cancer	___	___	Mononucleosis
___	___	Chest Pain/Angina	___	___	Painful or Bloody Urination
___	___	Dizziness/Fainting Spells	___	___	Psychiatric Treatment
___	___	Heart Disease	___	___	Nervous Disorder

YES	NO		YES	NO	
___	___	Inflammation of Veins	___	___	Rheumatic Fever
___	___	Pelvic Inflam. Disease	___	___	Shortness of Breath/Asthma
___	___	Jaundice/Hepatitis	___	___	Thyroid Disease or Goiter
___	___	Kidney Disease	___	___	Tuberculosis
___	___	Blood Clotting Problems	___	___	Venereal Disease/Herpes
___	___	Vaginal Infections	___	___	Hypoglycemia (Low Blood Sugar)
___	___	Epilepsy/Convulsions			

Please list any operations you have had, and the approximate date. Describe any specific severe injuries or medical problems you have had or now have: _____

_____

_____

Have you taken birth control pills in the past three months? ___Yes ___No
If yes, what brand name? _____

Are you currently taking any medications? ___Yes ___No
If so, please list them all. _____

Have you had a positive pregnancy test? ___Yes ___No

When you first thought you were pregnant, did you consider abortion? ___Yes ___No

Is anyone with you today? ___Yes ___No
What is their relationship to you? _____

Will someone be with you when you leave the clinic? ___Yes ___No

Do you have medical insurance? ___Yes ___No

Where can we reach you for the next two days? _____

The information given above is true to the best of my knowledge.

_____
Signature

Women's Health
Care Services, P.A.

5107 East Kellogg • Wichita, Kansas 67218 • (316) 684-5108

Name: _____

Birthdate: _____

ORAL CONTRACEPTIVE ADDENDUM CONSENT

Complete spaces and initial applicable paragraphs.

I have chosen oral contraceptives as my method of birth control. I am _____ years old and I smoke approximately _____ cigarettes a day.

_____ I have been informed of the increased risk of heart attack, stroke, and damage to blood vessels due to age (over 35) and oral contraceptive use.

_____ I have been informed of the increased risk of heart attack, stroke, and damage to blood vessels due to heavy smoking (10 - 15 cigarettes a day) and oral contraceptive use.

_____ I understand that I can minimize these risks by the limitation or cessation of smoking.

I am aware of and fully understand the above information. Nevertheless, I request and consent to the use of birth control pills. I release WHCS, the attending clinicians, their staff and assistants from any liability or responsibility for any condition that may result from the use of oral contraceptives.

Signed _____ Date _____

Witness _____

15-10

I, _____, understand that neither Women's Health Care Services nor any motel or hotel association will be held responsible for any spontaneous miscarriage that could take place outside this clinic. I have been given the clinic phone number for an emergency.

Women's Health Care Services will not be held responsible for any money or valuables lost or stolen here at the clinic during my stay.

_____ _____

Date Signature

_____

Witness

Additional Consent for Pregnancies Beyond 14 Weeks

Date_____

Laminaria Consent

It has been explained to me that a local anesthesia may be administered, and that one or more Laminaria (which has been shown to me) may be inserted into the cervix in order to open it gently and slowly. I understand that once the Laminaria are inserted, the abortion procedure has begun and therefore I MAY NOT CHANGE MY MIND. I will not leave the Wichita area or care of Women's Health Care Services until I am discharged by the medical staff. The Laminaria absorb moisture and enlarge the opening of the cervix, and this may cause cramping, bleeding, or infection. The benefit of Laminaria is to make the abortion easier and reduce the possibility of other complications.

_____ _____ _____

Patient Significant Other Staff Witness

Digoxin Consent

In our experience, after the pregnancy has developed to 18 or 19 weeks, the abortion procedure is made easier and safer by injecting the fetus with a medication called Digoxin. The purpose of this injection is to cause fetal demise, to prevent a live birth, and to help prepare the woman's body for the abortion process. This medicine is injected inserting a needle directly into the fetus through the lower abdomen. We have used this process over 7,000 times at Women's Health Care Services without a serious complication and feel the process is safe. However, possible complications include, but are not limited to, infection, shock, allergic reaction, and even death. After the injection of Digoxin, the procedure to end and remove the pregnancy has begun. I understand that the fetus will be non-viable and I MAY NOT CHANGE MY MIND. I will not leave the Wichita area or the care of Women's Health Care Services until I am discharged by the medical staff.

_____ _____ _____

Patient Significant Other Staff Witness

D&E Complications

An abortion at later stages of pregnancy (over 14 weeks) carries greater risks to the patient's physical well-being than at earlier stages of pregnancy. These risks involve the unlikely possibility of perforation of the uterus, injury to bowel, bladder or intestines, infection, allergic reaction, disfiguring paralysis, paraplegia, quadriplegia, brain damage, or even cardiac arrest, and death. I understand and accept these risks, and request that an abortion be performed on me.

_____ _____ _____

Patient Significant Other Staff Witness

f:\docs\surgi\additional.con

WOMEN'S HEALTH CARE SERVICES, P.A.
CONSENT TO INDUCTION ABORTION

Date: _____

I, _____, age _____, hereby give my consent to, and request and authorize Dr. George R. Tiller, and assistants of his choosing to perform an abortion on me. I warrant that the first day of my last normal menstrual period was _____ (date).

Initial boxes as you read

Patient Parent/ Guardian

PURPOSE OF ABORTION: I have been advised and have had explained to me what an induction abortion is and what it is for. I understand that tests and/or examinations performed on me indicate that I am more than twenty (20) weeks pregnant. I have requested the doctor to perform an abortion procedure so that my pregnancy will be terminated by inducing premature labor. I know that I have the right to continue this pregnancy to its full term but it is my personal choice to end it now. All of my questions have been answered.

☐ ☐ **LAMINARIA**: It has been explained to me that a local anesthesia may be administered and that laminaria (which has been shown to me) will be inserted into the cervix (the opening of the uterus or womb) and that as moisture is absorbed, the laminaria will dilate, or open, the cervix gently and slowly. I understand that once the laminaria are inserted, the abortion procedure has begun and therefore **I MAY NOT CHANGE MY MIND**. I understand the risks of local anesthesia range from minor to severe including convulsions, cardiac arrest, and possibly death.

☐ ☐ **PROCEDURE**: I understand that the procedure for the abortion involves the insertion of a needle through the lower wall of my abdomen into the fetus. The fetus will be injected with a medication called Digoxin to cause fetal demise, to prevent a live birth, and to help prepare the woman's body for the abortion process. Amniotic fluid may be withdrawn for testing or other purposes. At some time later, oxytocin and prostaglandin, as well as other medications, may be administered to me to activate contractions of the uterus causing the fetus to be expelled. I have viewed the video film, which explains this procedure and its possible complications.

☐ ☐ **RISKS**: I understand that because this abortion procedure is to be performed in the second or third trimester it has greater risks than an earlier abortion. The risks are about the same as childbirth. Some of the risks of abortion at this stage of pregnancy are similar to those of continuing the pregnancy. They include but are not limited to hemorrhage, uterine rupture, retained placenta, shock, cardiac arrest, amniotic fluid embolism, and even death. I understand that there is a risk that I might have an adverse reaction to the drugs which might result in complications from minor to severe including the rare event of death. Other possible risks include: infection - in order to help avoid this possible complication, I understand that I am responsible for taking the precautions explained to me in the post-operative instruction sheet titled "Instructions After a Miscarriage Abortion". Incomplete abortion - if the abortion is incomplete, it may be necessary to dilate the cervix and use an evacuation procedure which may necessitate anesthesia for which I hereby consent. I understand that where an abortion is incomplete, I may have a fever, heavy bleeding and/or cramping. If any of these symptoms appear, I should go to a hospital or see a doctor at once or immediately contact Women's Health Care Services. I understand that infection or other complications might require a D&C Procedure (cleaning out the uterus), a hysterectomy, or may result in death. I understand that if I have a multiple pregnancy, the chance of complications is increased; cervical incompetency - I understand that the abortion procedure may result in cervical incompetency which means that I may have problems maintaining a pregnancy in the future (possible miscarriage, stillbirth), low birth weight, premature delivery, or other complications in pregnancy. There is also the possibility of the live birth of the fetus, and that the patient will be responsible as parent for all medical care rendered which will include all steps necessary in the judgment of the physician to maintain life, including the possibility of the transfer of the fetus to a neonatal intensive care facility. Emotional distress - such as depression or other psychological consequences may occur. **I ACCEPT ALL THESE RISKS AND TAKE RESPONSIBILITY FOR THEIR CONSEQUENCES.**

☐ ☐ **LABORATORY**: I consent to the disposal of any tissue or other parts of the contents of my uterus (womb) which may be removed during the abortion. I also consent to the administration of RhoGam (or equivalent) should my blood be Rh negative. I understand that the doctor or hospital may need to contact me or my emergency contact regarding additional laboratory findings and consent thereto.

☐ ☐ **ADDITIONAL PROCEDURES**: If during the course of the abortion procedure, any unforeseen conditions or complications arise, and the doctor in his/her professional medical judgement decides that different or additional procedures including but not limited to anesthesia or blood transfusion or the association of another doctor, or hospitalization at another hospital are necessary, I give my consent to such. I assume all financial responsibility for payment for any additional services set forth above. I give my permission for my parents (or legal guardian where applicable) or other person (name set forth below) to be notified by the doctor or hospital. The correct identity, address, and phone number of my emergency contact is below.

☐ ☐ **EMERGENCY**: I have been given an emergency telephone number which I can call 24 hours a day for assistance. I agree to notify the hospital in the event of a problem. My failure to give notice within 72 hours releases the doctor, clinic and hospital from any responsibility to me for emergency care.

☐ ☐ **FOLLOW-UP**: I have been advised to return to my doctor, clinic (or Women's Health Care Services) for two follow-up examinations; one at one week and one at three to four weeks after the procedure. I understand that I should have these follow-up examinations in order to be sure that no complications or other problems have appeared, that I am not still pregnant, and that the healing process has gone on properly. My failure to obtain follow-up care relieves the doctor, clinic, and hospital of any further responsibility to me.

☐ ☐ I have read and understand fully this form. All blanks have been filled in before I signed my name. All information given herein and in my Medical History are true and correct and I realize that the doctor and clinic have relied on such information. My consent has been freely and voluntarily given. I have rejected the alternatives to abortion and this procedure is being performed at my request.

Notify in Emergency or Regarding Lab Findings

Name _____

Address _____

City/State/ZIP _____

Phone _____

Patient's Signature

Name _____

Address _____

City/State/ZIP _____

Phone _____

Adult's Consent: I am the _____ to the patient whose signature appears above. I have read and had explained to me the matters set forth in the above and hereby request and give my consent thereto as her _____. I agree to pay for medical expenses incurred in this procedure.

Parent or Guardian's Signature

NURSE WITNESS _____ _____

NOTICE TO PATIENT: STOP! YOU HAVE COMPLETED ALL OF THE PAPERWORK. THE REMAINING PAPERWORK ATTACHED IS FOR MEDICAL STAFF USE ONLY.

Patient and/or significant other had no questios remaining on the film, risks, and/or complications of an abortionprocedure.

_____
STAFF MEMBER SIGNATURE

15-14

LAB AND INSERT:

Name.....Date.....age.....

BP.....Pulse.....Temp.....Weight.....

Heart.....Lungs.....Other.....

Allergies:.....

Major Illnesses .....

PELVIC EXAM:

Vagina.....Cervix.....

Uterus.....Adnexa.....

BPD:.....Weeks.....rh FACTOR.....HGB.....

IMPRESSION:.....IUP.....PLAN....D&C....D&E....INDUCT....MA....

INSERT:

1 Time.....Date.....Xylo.....Dil.....Lams.....FSD/PK

MEDS:.....

Remarks.....

.....

2.Time.....Date.....Xylo.....Dil.....Lams.....FSD/PK

MEDS.....

Remarks.....

.....

3.Time.....Date.....Xylo.....Dil.....Lams.....FSD/PK

MEDS.....

Remarks.....

.....

4. Time.....Date.....Xylo.....Dil.....Lams.....FSD/PK

MEDS.....

Remarks.....

.....

Surgery Sheet Six

NAME.....AGE.....DATE.....

WKS.....RH.....ALLERGIES.....

PRE-OP MEDICATIONS:

1. VERSED:..... 2.5mg..... 5.0mg.....IV.....TIME.....DATE.....

2. NUBAIN..IV.....10mg.. .20mg.....30mg....40mg..Time.....Date.....
   10mg....20mg.....other.....Time Date.....

3. 1/2 VAN IV.....TIME/DATE.....TIME/DATE.....

4. ROCEPHIN/OTHER IM:.....
   .....

5. DIGOXIN....1MG.....2MG...IF..DATE.....:0 FHT's.....

IV FLUIDS:..500CC.....1000CC.....NS.....TIME STARTED.....
1. ROCEPHIN / ANCEF ADDED.....
2. OXYTOCIN ADDED.....
3. TIME STOPPED.....

SURGERY: D&C / D&E

1. 30-45-60-CC 1/2% XYLO. P.C. BLOCK WITH / WO VP.....

2.BREVITOL:.....OTHER:.....

3. METHERGINE: 1...2...CC INTRACERVICAL: RHO GAM: NOT GIVEN.....

4. RHO GAM: given..:where:.....time/date.....
   LOT #.....INITIALS:.....

5. EVACUATION: Complete/Incomplete Time:_____ Date:_____

6. TISSUE: Placenta Parts

7. Dil: Lams/Direct 21 / 23 / 25 / 27 / 29 / 31

SSC MSC LSC Hem Finks Sopher Ring _____ Other

Size Cannulae 6 7 8 10 12 14

NOTES/COMPLICATIONS: SONO FCCI CONT. OXIMETRY W.E.L. - T.W.

OTHER_____

SIGNATURE_____

15-16

POST-OP AND RECOVERY ROOM

NAME _____ DATE _____

AGE _____

ALERGIES _____

Rh FACTOR _____

MAJOR ILLNESSES _____

TIME	BP	P	BLEEDING	FUNDUS	INITIAL

COMPLICATIONS _____

SYMPTOMS AND SIGNS _____

NAUSEA _____

VOMITING _____

CRAMPS _____

MEDICATION GIVEN:

	TIME	MEDICATION	INITIAL
1.			
2.			

ORAL AND WRITTEN INSTRUCTIONS _____

INSTRUCTION SHEET

1. BCP
2. Tetracycline 500 mgs. P.O. Q.I.D. x 5
3. Methergine #8 P.O.
4. Ampicillin 500 mgs. P.O. Q.I.D. x 5
5. Flagyl 250 mgs. Q.I.D. x 7
6. Others
7. Evaluation Sheet
8. Check chart - completely filled out

TIME OF DEPARTURE: _____ SIGNATURE: _____

MEDICAL HISTORY

This questionnaire is part of your medical record and is used by the staff to anticipate any problems you might have relating to an abortion. Please answer the questions as fully as possible. This record is strictly confidential.

Name_____ Birthdate__/__/__ Age___

Street_____ City _____ State ___ Zip _____

Telephone: (__)_____ Occupation_____ Religion_____

Education (check one)
___ Under 12 years
___ 12 years or G.E.D.
___ College
___ Graduate School

Marital Status
___ Single
___ Married
___ Separated
___ Divorced
___ Widowed

Ethnic Group
___ Caucasian
___ African American
___ Asian
___ Hispanic
___ Other:_____

Do you have a doctor who knows about the abortion? _____ Yes _____ No

Pregnancy History

Number of pregnancies (including this):____
Live births___ date of last__/__/__
Still births__ date of last__/__/__
Miscarriages__ date of last__/__/__
D & C's __ date of last__/__/__
Abortions __ date of last__/__/__
Living children__ age of youngest__
Date(s) of abortion(s) (if any):
Month and year_____

Was your last period normal?____
When was the first day of your last menstrual period?____
Bleeding during your periods is usually (circle):
light medium heavy
Do you have cramps with your periods?____
light moderate heavy
Date of last pap smear (if any)?__/__/__
Are your periods regular?___

Have you ever had any complications or hemorrhaging with previous pregnancies, abortions, or deliveries?____ If yes, please explain

_____

_____

Please circle any of the following methods of birth control you have used:
foam rubbers pills diaphragm IUD rhythm withdrawal
other_____

Describe any problems you have had with any methods:_____
_____
_____

Are you allergic to any drugs or medications? ( ) Yes ( ) No
If yes, check which ones:
( ) Novocaine
( ) Iodine
( ) Penicillin
( ) Aspirin

PLEASE LIST ANY OTHER MEDICATIONS YOU ARE ALLERGIC TO:
_____
_____

Have you or anyone in your immediate family had any of the following? (check YES or NO):

YES	NO		YES	NO	
( )	( )	Sickle Cell Disease	( )	( )	Breast or Uterine Cancer
( )	( )	Varicose Veins	( )	( )	High Blood Pressure
( )	( )	Diabetes	( )	( )	Breast Tumors
( )	( )	Blood clots in veins	( )	( )	Uterine fibroid tumors

If yes to any, please explain:_____
_____
_____

Have you ever had any of the following? (Check YES or NO or circle appropriate condition on all):

YES	NO		YES	NO	
( )	( )	Anemia	( )	( )	Liver Disease
( )	( )	Cancer	( )	( )	Mononucleosis
( )	( )	Chest pain/Angina	( )	( )	Painful or bloody urination/bladder infection
( )	( )	Dizziness/fainting spells	( )	( )	Psychiatric treatment
			( )	( )	Nervous disorder
( )	( )	Heart Disease	( )	( )	Depression
( )	( )	Inflammation of Veins	( )	( )	Rheumatic fever
( )	( )	Shortness of breath/ Asthma	( )	( )	Migraine Headaches
			( )	( )	Pelvic Inflammatory Disease
( )	( )	Thyroid disease or Goiter	( )	( )	Jaundice/Hepatitis
			( )	( )	Tuberculosis
( )	( )	Kidney Disease/Infection	( )	( )	Venereal Disease/Herpes
( )	( )	Blood clotting problems	( )	( )	Hypoglycemia (low blood sugar)
( )	( )	Vaginal infections	( )	( )	Epilepsy/convulsions

Please list any operations you have had, and the approximate date. Describe any specific severe injuries or medical problems you have had or now have:_____

_____

_____

_____

_____

Have you taken birth control pills in the past 3 months?___
If yes, which one?_____
Are you currently taking any medications?___
If so, what?_____
Have you had a positive pregnancy test?_____
When you first thought you were pregnant, did you consider abortion?___

Is anyone with you today? ___ What is their relationship to you?_____ Name_____

Will someone be with you when you leave the clinic?_____

Where can we reach you for the next two days?

Hotel_____ _____ Tele. #_____
Room #_____ Home #_____ Friend #_____

The information given above is true to the best of my knowledge.

_____
SIGNATURE

I, _____. understand that neither Women s Health Care Services nor any motel or hotel association will be held responsible for any spontaneous miscarriage that could take place outside this clinic. I have been given the clinic phone number for an emergency.

Women's Health Care Services will not be held responsible for any money or valuables lost or stolen here at the clinic during my stay.

_____ _____

Date Signature

_____

Witness

ORAL CONTRACEPTIVE ADDENDUM CONSENT

Complete spaces and initial paragraphs. Please initial paragraphs even if you do not smoke. If you are over 35 years of age, or over 30 years of age and a smoker, we will not be able to give you birth control pills. If we find you have a medical contraindication, we will not be able to fill your request for birth control pills.

_____ I have chosen oral contraceptives as my method of birth control. I am _____ years old and I smoke approximately _____ cigarettes a day.

_____ I have been informed of the increased risk of heart attack, stroke, and damage to blood vessels due to age (over 35) and oral contraceptive use.

_____ I have been informed of the increased risk of heart attack, stroke, and damage to blood vessels due to heavy smoking (10-15) cigarettes a day) and oral contraceptive use.

_____ I understand that I can minimize these risks by the limitation or cessation of smoking.

I am aware of and fully understand the above information. nevertheless, I request and consent to the use of birth control pills. I release WHCS, the attending clinicians, their staff and assistants from any liability or responsibility for any condition that may result from the use of oral contraceptives.

Signed_____ **Date**_____

Witness_____

Additional Consent for Pregnancies Beyond 14 Weeks

Date_____

Laminaria Consent

It has been explained to me that a local anesthesia may be administered, and that one or more Laminaria (which has been shown to me) may be inserted into the cervix in order to open it gently and slowly. I understand that once the Laminaria are inserted, the abortion procedure has begun and therefore I MAY NOT CHANGE MY MIND. I will not leave the Wichita area or care of Women's Health Care Services until I am discharged by the medical staff. The Laminaria absorb moisture and enlarge the opening of the cervix, and this may cause cramping, bleeding, or infection. The benefit of Laminaria is to make the abortion easier and reduce the possibility of other complications.

_____ _____ _____

Patient Significant Other Staff Witness

Digoxin Consent

In our experience, after the pregnancy has developed to 18 or 19 weeks, the abortion procedure is made easier and safer by injecting the fetus with a medication called Digoxin. The purpose of this injection is to cause fetal demise, to prevent a live birth, and to help prepare the woman's body for the abortion process. This medicine is injected inserting a needle directly into the fetus through the lower abdomen. We have used this process over 7,000 times at Women's Health Care Services without a serious complication and feel the process is safe. However, possible complications include, but are not limited to, infection, shock, allergic reaction, and even death. After the injection of Digoxin, the procedure to end and remove the pregnancy has begun. I understand that the fetus will be non-viable and I MAY NOT CHANGE MY MIND. I will not leave the Wichita area or the care of Women's Health Care Services until I am discharged by the medical staff.

_____ _____ _____

Patient Significant Other Staff Witness

D&E Complications

An abortion at later stages of pregnancy (over 14 weeks) carries greater risks to the patient's physical well-being than at earlier stages of pregnancy. These risks involve the unlikely possibility of perforation of the uterus, injury to bowel, bladder or intestines, infection, allergic reaction, disfiguring paralysis, paraplegia, quadriplegia, brain damage, or even cardiac arrest, and death. I understand and accept these risks, and request that an abortion be performed on me.

_____ _____ _____

Patient Significant Other Staff Witness

f:\docs\surg\additional.con

WOMEN'S HEALTH CARE SERVICES, P.A.
INFORMED CONSENT FOR ABORTION TREATMENT, ANESTHETIC AND OTHER MEDICAL SERVICES

Patient Name: _____

Address: _____

Birth Date: _____

Today's Date: _____

AS YOU READ, PLEASE PUT YOUR INITIALS IN THE LEFT BOX TO SHOW THAT YOU UNDERSTAND. THE PERSON WITH YOU (PARENT, GUARDIAN, FRIEND, ETC.) MUST INITIAL THE RIGHT BOX TO SHOW THAT THEY ALSO UNDERSTAND. THESE ARE LEGAL DOCUMENTS - PLEASE DO NOT MARK THROUGH ANY ERRORS.

I (patient name) _____, request and consent to the performance upon me of a pregnancy termination procedure by vacuum aspiration or dilatation and evacuation at Women's Health Care Services by Dr. George R. Tiller, his associate physicians, and whomever he may designate as his assistants. ☐ ☐

I further consent to the taking of cultures and the performance of reasonably indicated tests and procedures, whether or not relating to presently known conditions, if my medical attendants find these necessary or advisable in the course of evaluation or treatment for pregnancy termination or management of complications. ☐ ☐

I have fully and completely disclosed my medical history including allergies, blood conditions, prior medications or drugs taken, and reactions I have had to anesthetics, medicines or drugs. I consent to my physician's relying on this disclosure as complete. ☐ ☐

I consent that the physician or associates may administer such anesthesia and medications as may be deemed necessary or advisable, with the exception of _____. ☐ ☐

I understand that local anesthetics do not always eliminate all pain, that in a small number of cases local anesthetics cause severe reactions or even shock or death, and that no guarantee to the contrary has been made. ☐ ☐

I understand that the duration of my pregnancy will be based on the sonogram test conducted on me at Women's Health Care Services, and not on the basis of my last menstrual period. ☐ ☐

I fully understand that the purpose of this procedure is to terminate this pregnancy, and I affirm this to be my personal choice in light of the alternative of continuing the pregnancy to term. No one has forced or compelled me to make this decision. ☐ ☐

I understand that the complications associated with pregnancy termination are generally much less severe and less frequent than with childbirth. Nonetheless, I realize, as is true of childbirth and any kind of surgery, that there are inherent risks of minor and major complications and death which may occur without the fault of the physician. No guarantee or assurance has been made to me as to the results which may be obtained. ☐ ☐

The risks and possible complications of the abortion procedure most likely to occur, though only in a small number of cases, are as follows:

Perforation: Occasionally an instrument used in the abortion may go through the wall of the uterus. When this happens, hospitalization may be necessary for completion of the abortion and repair and/or observation of the perforation and any internal injuries resulting therefrom.

Laceration: In rare cases the cervical opening and/or cervical canal may be torn. A few stitches to repair the tear is usually all that is necessary.

Bleeding: More bleeding sometimes occurs than is normally expected. This may require an immediate repeat of the abortion procedure, or hospitalization for observation and treatment. If the excessive bleeding occurs some hours or days after the abortion, hospitalization may be necessary, and dilation and curettage may have to be done to remove material retained in the uterus. Heavy bleeding may require a transfusion.

Infection: Infection, caused by the presence of bacteria in the vagina or uterus, is not an infrequent occurrence. Such infections usually respond to antibiotics, but in a few cases hospitalization is necessary.

Failure to Terminate Pregnancy: Although the possibility is remote, the abortion procedure may fail to end the pregnancy. It is this possibility, among others, that makes a post-abortion examination essential. In such a case, another abortion must be recommended, since the first one may have affected normal development of the pregnancy.

Tubal Pregnancy: A tubal pregnancy occurs when the fertilized egg implants in the fallopian tube instead of in the uterus. If this condition is unchecked, the fetus develops in the tube until it is large enough to burst the tube. Although the chances of a tubal pregnancy are small, the risk of death from a ruptured tubal pregnancy is very great. For this reason, all tubal pregnancies must be surgically removed. The abortion procedure cannot terminate a tubal pregnancy. I understand that this is a preexisting medical condition for which the Women's Health Care Services assumes no medical or financial responsibility.

Hysterectomy: I understand that as a result of certain preexisting conditions or some complications (such as perforation, bleeding or severe infection) a hysterectomy may be necessary. If a hysterectomy is necessary, I understand I will never be able to become pregnant again.

Cervical Incompetency: I understand that the abortion procedure may result in cervical incompetency which means that I may have problems maintaining a pregnancy in the future (possible miscarriage, stillbirth), low birth weight, premature delivery, or other complications in pregnancy.

Emotional Distress: Such as depression or other psychological consequences may occur.

I ACCEPT ALL OF THESE RISKS AND TAKE RESPONSIBILITY FOR THEIR CONSEQUENCES.

LABORATORY: I also consent to the disposal of any tissue or other parts of the contents of my uterus (womb) which may be removed during the abortion. I also consent to the administration of RhoGam (or equivalent) should my blood be Rh negative. I understand that the doctor or clinic may need to contact me or my Emergency contact regarding additional laboratory findings and consent thereto.

ADDITIONAL PROCEDURES: If during the course of the abortion procedure, any unforseen conditions or complications arise, and the doctor in his/her professional medical judgement decides that different or additional procedures including but not limited to anesthesia or blood transfusion or the association of another doctor or hospitalization may be necessary, I give my consent to such. I assume all financial responsibility for payment for any additional services set forth above. I give my

permiss r my parents (or legal guardian if applicable) or other person (name set forth below) to be notifi. y the doctor or staff of the clinic. The correct identity, address and phone number of my emergency contact is set forth below.

EMERGENCY: I have been given an emergency telephone number which I can call 24 hours a day for assistance. I agree to notify the clinic in the event of a problem. My failure to give notice within 72 hours releases the doctor and clinic from any responsibility to me for emergency care.

FOLLOW-UP: I have been advised to return to my doctor, clinic or Women's Health Care Services for a follow-up examination within three weeks after the procedure. I understand that I should have this follow-up examination in order to be sure that no complications or other problems have appeared, that I am not still pregnant, and that the healing process has gone on properly. My failure to obtain follow-up care relieves the doctor and clinic of any further responsibility to me.

I have read, had explained to me, and understand fully this form. All blanks have been filled in before I signed my name. All information given herein and in my Medical History are true and correct and I realize that the doctor and Women's Health Care Services have relied on such information. My consent has been freely and voluntarily given. I have rejected the alternatives to abortion and this procedure is being performed at my request.

Patient's Signature **Date**

WHO TO NOTIFY IN THE EVENT OF AN EMERGENCY:

Name Address

City, State, ZIP Phone

In my judgement, the above-signed patient understands the nature of, risks of, and alternatives to abortion, and she has chosen the abortion without coercion.

Witness - Significant Other Date

Witness - Staff Member Date

For my patient to receive pre-operative medication I understand that I must remain on the premises of WHCS throughout the entire procedure and provide transportation home for my patient.

Signature - Significant Other Date
(If someone is here with you they need to sign.)

IF THE PATIENT IS A MINOR ACCOMPANIED BY A PARENT OR GUARDIAN:

I am the parent/guardian of the above-signed patient. I understand the nature of, risks of and alternatives to abortion. I believe the patient I am accompanying has chosen abortion without coercion and also understands the nature of, risks of and alternatives to abortion.

Signature - Parent/Guardian Date

NOTICE TO PATIENT: STOP! YOU HAVE COMPLETED ALL OF THE PAPERWORK. THE REMAINING PAPERWORK ATTACHED IS FOR MEDICAL STAFF USE ONLY.

Patient and/or significant other had no questions remaining on the film, risks and/or complications of an abortion procedure.

STAFF MEMBER SIGNATURE

LAB AND INSERT:

Name.....Date.....age.....

BP.....Pulse.....Temp.....Weight.....

Heart.....Lungs.....Other.....

Allergies:.....

Major Illnesses .....

PELVIC EXAM:

Vagina.....Cervix.....

Uterus.....Adnexa.....

BPD:.....Weeks.....rh FACTOR.....HGB.....

IMPRESSION:.....IUP.....PLAN.....D&C.....D&E.....INDUCT.....MA.....
DIGOXIN:.....1MG.....2MG.....IF.....Date..... 0 FHT'S .....Time ..... Date

INSERT:

1 Time.....Date.....Xylo.....Dil.....Lams.....FSD/PK
MEDS:.....
Remarks.....
.....

2. Time.....Date.....Xylo.....Dil.....Lams.....FSD/PK
MEDS.....
Remarks.....
.....

3. Time.....Date.....Xylo.....Dil.....Lams.....FSD/PK
MEDS.....
Remarks.....
.....

4. Time.....Date.....Xylo.....Dil.....Lams.....FSD/PK
MEDS.....
Remarks.....
.....

Surgery Sheet Six

NAME.....AGE.....DATE.....

WKS.....RH.....ALLERGIES.....

MAJOR ILLNESSES:.....

1. VERSED:..... 2.5mg..... 5.0mg.....IV.....TIME.....DATE.....

2. NUBAIN..IV.....10mg....20mg.....30mg....40mg....Time.....Date.....
10mg....20mg.....other.....Time.....Date.....

3. 1/2 VAN IV.....TIME/DATE.....TIME/DATE.....

4. ROCEPHIN/OTHER IM:.....
.....

IVFLUIDS:..500CC.....1000CC.....NS.....TIMESTARTED.....
1. ROCEPHIN / ANCEF ADDED.....
2. OXYTOCIN ADDED.....
3. TIME STOPPED.....

SURGERY: D&C / D&E

1. 30-45-60-CC 1/2% XYLO. P.C. BLOCK WITH / WO VP.....

2.BREVITOL:..... .....OTHER:.....

3. METHERGINE: 1/2....1...2...CC INTRACERVICAL: RHOGAM NOT GIVEN:

4. RHO GAM: GIVEN .:where:.....time/date.....
LOT #.....INITIALS:.....

5. Dil: Lams/Direct 21 / 23 / 25 / 27 / 29 / 31

SSC MSC LSC Hern Finks Sopher Ring _____ Other

Size Cannulae 6 7 8 10 12 14

6. TISSUE: Placenta Parts

7. EVACUATION: Complete/Incomplete Time:_____ Date:_____

NOTES/COMPLICATIONS: SONO FCCI CONT. OXIMETRY W.E.L. - T.W.
SaO2%>.....

OTHER_____

SIGNATURE_____

15.27

POST-OP AND RECOVERY ROOM

NAME_____ DATE_____
AGE_____
ALLERGIES_____
Rh FACTOR_____
MAJOR ILLNESSES_____

TIME	BP	P	BLEEDING	FUNDUS	INITIAL

COMPLICATIONS_____

SYMPTOMS AND SIGNS_____

NAUSEA_____

VOMITING_____

CRAMPS_____

MEDICATIONS GIVEN

	TIME	MEDICATION	INITIAL
1.			
2.			

ORAL AND WRITTEN INSTRUCTIONS_____

INSTRUCTION SHEET

1. BCP - Loestrin Fe. 1.5/30 - TriLevlen 1/28 Script given Other
2. Ampicillin 500mg x3 #12
3. Doxycycline #10 - 100mg. P.O. BID X 5
4. Methergine #3 given Script #12 given
5. Benadryl #10 25mgs given
6. Loratab 5 #200 - #30 Talwin #20 - #30 Script called in
7. Check chart - completely filled out

DISCHARGE CRITERIA

Y N

1. The patient is awake, and alert, and oriented to name, place, and time.

2. The patient's vital signs are stable and at levels consistent with the patient's age, condition, surgical procedure performed, and preanesthetic vital signs.

3. The patient's protective reflexes (i.e., cough and gag reflexes) have returned to normal.

4. The patient displays minimal nausea or vomiting, for example, nausea or vomiting has not occurred within the period of 15 minutes prior to discharge. The patient who has received an IV antiemetic medication has been observed for at least 30 minutes for change in vital signs.

5. There are no signs of respiratory distress.

DISCHARGE PROCEDURE

1) Assure compliance with discharge criteria -- fill out checklist
2) The patient must be able to ambulate appropriately and demonstrates voiding without difficulty when indicated.
3) Give appropriate medication (antibiotics--Methergine script--BC pills--)
4) Give written and oral instructions
5) Fill out (and have patients sign) appropriate consent forms for oral contraceptives and follow-up forms
6) Walk patient to front desk. Dismiss to significant other
7) An adult must be available to escort the patient home. Patient who receive local anesthesia do not need an escort home.
8) Patient does not meet discharge criteria #'s_____--left against medical advice.

TIME OF DISCHARGE_____

SIGNATURE_____

f:\docs\surgi\discharge.cri

.atute # 65-6701
Chapter 65.--PUBLIC HEALTH
Article 67.--ABORTION
Title Definitions.

Attachment 4

As used in this act:

(a) "Abortion" means the use of any means to intentionally terminate a pregnancy except for the purpose of causing a live birth. Abortion does not include: (1) The use of any drug or device that inhibits or prevents ovulation, fertilization or the implantation of an embryo; or (2) disposition of the product of in vitro fertilization prior to implantation. *

(b) "Counselor" means a person who is: (1) Licensed to practice medicine and surgery; (2) licensed to practice psychology; (3) licensed to practice professional or practical nursing; (4) registered to practice professional counseling; (5) licensed as a social worker; (6) the holder of a master's or doctor's degree from an accredited graduate school of social work; (7) registered to practice marriage and family therapy; (8) a registered physician's assistant; or (9) a currently ordained member of the clergy or religious authority of any religious denomination or society. Counselor does not include the physician who performs or induces the abortion or a physician or other person who assists in performing or inducing the abortion.

(c) "Minor" means a person less than 18 years of age.

(d) "Physician" means a person licensed to practice medicine and surgery in this state.

(e) "Unemancipated minor" means any minor who has never been: (1) Married; or (2) freed, by court order or otherwise, from the care, custody and control of the minor's parents.

(f) "Viable" means that stage of gestation when, in the best medical judgment of the attending physician, the fetus is capable of sustained survival outside the uterus without the application of extraordinary medical means.

History

History: L. 1992, ch. 183, S. 1; July 1.

Case Annotations

65-6701.

Case Annotations

CASE ANNOTATIONS 1. Whether trial court erred by construing 65-6705 more restrictively than legislature intended examined; judicial procedure discussed. In re Doe, 19 K.A.2d 204, 209, 866 P.2d 1069 (1994).

#16

Planned Parenthood®
Of Kansas, Inc.

House Judiciary Committee
Testimony in Opposition of HB 2269
Feb. 13, 1997

Submitted by: Monica Neff
(913)-842-6496

Honorable Chair and Distinguished Members of this Committee:

As one can see, there are numerous provisions to HB 2269. The framework from which this bill's sponsors have described its intent has been very clever, but entirely misleading. We cannot allow ourselves to be distracted and in any way acquiesce to the political spin of the dangerous contents within this bill.

Planned Parenthood of Kansas strongly oppose HB 2269. We oppose this bill because if enacted into law it will **severely restrict, if not end, access** to physicians and medical services for large numbers of women seeking reproductive health care.

The gravity of this bill cannot be understated. To understand the provisions of HB 2269, one must look at the **practical application** of such inappropriate governmental mandates and **its impact on the practice of medicine and the delivery of services.**

HB 2269 includes inappropriate governmental interference in the practice of medicine. It mandates **unnecessary requirements on a physician's time, dictates the method of medical informed consent and debilitates clinic management** in such a way that would **critically decrease a physician's ability to provide direct medical services.**

- According to HB 2269 medical informed consent can only be achieved by requiring that orally and person the physician in addition to another highly educated professional meet with a woman eight hours prior to an abortion procedure to be performed.
- Two separate and individual private counseling sessions must occur utilizing contents of a uniform packet of governmentally published mandated materials.

This realistically would enforce a 24 hour waiting period, demanding a 2-day minimum process.

This creates further delays to accessing an abortion procedure for women in addition to increasing the risks to their health. **It has been estimated by clinic administrators that possibly 50% of the patients now being seen would no longer be able to see a physician or access medical services.**

House Judiciary
Attachment 16
2/13/97

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

Clinics would no longer be able to provide for effective, efficient and affordable medical service delivery to half of those in need of services.

- **In fact, for many Kansas women, there would be no access. In reality the Kansas Legislature through HB 2269 will have indirectly, but effectively, imposed a ban against abortion services for hundreds of women.**

- **Needless to say,** this bill is **about hindering access and abolishing our rights to abortion. Let us not allow religious political extremists to skillfully enact legislation that would effectively eliminate Kansas women's rights.**

Attached to these excessive mandates are exaggerated penalties for noncompliance thus possibly hindering a physician's right to professional medical discernment and judgment. Inherently, this increases the hostile and threatening environment these physicians already face as they provide women health services and legal reproductive choice in Kansas.

Fortunately Gov. Graves studied the contents of a similar bill, last year and understood its harmful and far reaching ramifications. He **vetoed SB 352 on May 15, 1996.** As he so clearly stated in his veto message, **"The United States Constitution protects a woman's rights to access abortion, and we should therefore recognize that the Kansas Legislature does not have the authority to ban abortions."**

Each section in HB 2269 is flawed and is truly extreme in its consequences against women. I ask you to vote against HB 2269 in any form in order to preserve the privacy of Kansas women and their families to access health care and make their own reproductive decisions.

Thank you for your attention and thoughtful consideration.

#17

Planned Parenthood®
of Mid-Missouri and Eastern Kansas

Testimony Opposing KS House Bill 2269
Judiciary Committee
Thursday, February 13, 1997

Ladies and Gentlemen of the Committee:

HB 2269

House Bill 2269 has been given the misleading title of the "Women's Right to Know" act. This title is misleading in that it indicates that women are not currently receiving information on their options before terminating a pregnancy. Additionally, the authors of this bill mistakenly believe that the information that is required by this bill is suitable for a doctor to distribute to a patient in order to obtain true informed consent.

In large part, this bill seeks to set a standard of informed consent that would be applied only to abortion providers under Kansas law. There is not a single other medical procedure for which the statute lists out what a physician must do to obtain informed consent. This bill sets a dangerous precedent of infringing on a physician's medical judgement within the informed consent process.

Informed Consent

The authors of this bill have a misperception of what true informed consent really is and seem to confuse informed consent with decision counseling. This bill seeks to hold doctors who perform abortions accountable for things that are beyond their area of expertise, training, and experience. This bill would require informed consent to go cover not only the medical risks of an abortion procedure, but also information not applicable to the patient's current circumstance, information on social service agencies, and information on availability of legal and monetary benefits--regardless of their expressed needs or desires.

True informed consent is a well-established legal and medical doctrine. Doctors who provide abortions belong to many different professional organizations which all have guidelines for their members on informed consent. The National Abortion Federation (NAF) states "it is the responsibility of each abortion provider to ascertain prior to the performance of an abortion that the patient understands and has freely chosen to terminate her pregnancy." The American College of Obstetrics and Gynecologists (ACOG) requires physicians treating a patient with an unwanted pregnancy to counsel her "about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy." Planned Parenthood Federation of America requires of it's doctors that "informed consent must be obtained in writing from all women...prior to the procedure."

House Judiciary
Attachment 17
2/13/97

The AMA advises that "health care professionals should inform their patients or their

sur es of their clinical impressions or diagnosis; alternative treatments and consequences of treatments, including the consequences of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient."

As noted by the AMA standard, informed consent is a flexible doctrine, which depends on the discretion of the health care professional, the circumstances of the patient and the risks of the procedure.

Consistent with this principle, abortion providers obtain the valid consent of every woman before a procedure is performed. This bill changes informed consent from a discussion of the risks and benefits of a specific procedure to a litany of the social services available in the state of Kansas.

In the 1982 report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research, four major principles of informed consent were enunciated:

- Patients "are entitled to accept or reject a health care intervention on the basis of their own personal values and in furtherance of their own personal goals."
- Truly informed consent "is a process of shared decision making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form."
- Physicians must discuss all alternative treatments, "including those he or she does not provide or favor, so long as they are supported by respectable medical opinion."
- Patients should be provided with complete and unbiased information. "Manipulation has more and less extreme forms...Of particular concern in health care contexts is the withholding or distortion of information in order to affect the patient's beliefs and decision."

Decision Counseling

In addition to establishing informed consent, abortion providers also offer decision counseling. The National Abortion Federation's *Standards for Abortion Care* describes decision counseling in the following way: [it] "seeks no pre-determined outcome, but encourages exploration of all possible alternatives, the final choice resting entirely with the woman." The process should explore the woman's feelings about her pregnancy, her circumstances and her options, and should assist with implementing her final choice.

The content of decision counseling and informed consent may overlap, but the two processes are distinct--the first assists with decision-making, while the second informs about the medical procedure selected. This bill would seem to confuse the two.

Conclusion

These requirements for informed consent are currently followed by doctors who provide abortions. "Informed consent" as it is detailed in this bill goes well beyond the scope of true "informed consent." The authors of this bill are operating under a false sense of the nature of "informed consent" in general and are unaware of the efforts made by abortion providers to ensure that a woman's decision to abort is made of her own free will and is aware of her alternatives.

Requiring physicians to give all patients a specific litany of information like that required in this bill does nothing to foster the goal of informed consent. For example, nine in ten abortions are performed in the first trimester of pregnancy. There is no reason to subject a woman seeking an early abortion to a lengthy discussion of the risks entailed in an abortion later in pregnancy. These risks are irrelevant to her situation. Similarly, fetal

development changes as pregnancy progresses; a discussion of fetal development in the later stages of pregnancy is irrelevant to the medical treatment of a woman seeking an abortion at eight or nine weeks.

There are many different reasons why this bill should be defeated. However, the erroneous concept of "informed consent" is the most glaring. This bill would hold doctors who perform abortions to standards of informed consent that go well beyond what is currently contained in Kansas law for doctors who perform other procedures. The information that doctors are required to give their patients goes well beyond the scope of their training, expertise, and experience. It is nothing short of harassment to force doctors to be responsible for such information under threat of malpractice suits and loss of license. Especially when the information is disturbing, insulting, or irrelevant for the woman forced to receive it.

Ellen W. Brown
Public Affairs Coordinator

#18

AMERICAN CIVIL LIBERTIES UNION

OF KANSAS AND WESTERN MISSOURI

1010 West 39th Street, Kansas City, Missouri 64111 (816) 756-3113

Testimony in Opposition to HB 2269
House Judiciary Committee -- February 13, 1997

Members of the Committee: The bill before you is an attack on the fundamental and constitutionally protected right of women to have access to safe and legal abortion services in this state. HB 2269 represents a significant step toward the ballyhooed goal of anti-choice extremists to ban all abortions in Kansas, no matter the risk to the lives and health of women.

The specific focus of ACLU's testimony is on the two-visit requirement, separated by eight hours (in practical application, hardly different from an outright 18-hour or 24-hour requirement). Other provisions of the bill are equally onerous and will be addressed in other testimony.

A similar two-visit requirement is part of a challenge to a 1995 Indiana law now advancing through the courts. The U.S. District Court order granting a preliminary injunction in the Indiana case, *A Woman's Choice v. Newman*, reviewed the two-visit ("in the presence") requirement in detail and found, based on a factual analysis of Mississippi's documented experience with an in-place two-visit requirement, that Indiana also would be likely to prove it creates an unconstitutional undue burden.

The difficulties encountered by women traveling from the far western corners of Kansas to Wichita, for example, are already more burdensome than in some other states. The sparse availability of abortion services in Kansas argue strongly against any additional burdens of time or expense beyond those found in the current law.

Please consider whether the following statement, by the U.S. District Court in Indiana, could be applied to Kansas if HB 2269 were passed:

> The evidence before the court, which goes well beyond the evidence presented in *Casey* on this issue, shows that the [two-visit] requirement of the Indiana law is likely to have effects in Indiana comparable to the effects of the similar law in Mississippi. That is, the number of Indiana women obtaining abortions is likely to drop by approximately 11 to 14 percent, and this effect is likely to be the result of the burdens of the law rather than the persuasive effect of the required information and delay. That effect means that for a large fraction of women seeking abortions, the law is likely to operate as a substantial obstacle to a woman's choice to undergo an abortion. Under *Casey*, therefore, the "in the presence" requirement of the Indiana law appears reasonably likely to impose an undue burden that is unconstitutional. [emphasis added]

In other words, although the Pennsylvania case, *Planned Parenthood v. Casey*, found that two-visit requirements are not necessarily unconstitutional, this provision can be found by a court to be unconstitutional based on the preponderance of the burden it causes to women in a specific state. ACLU contends that the demographics of Kansas are such that a constitutionally significant "undue burden" would be demonstrated if HB 2269 were enacted.

Kansas already has a law on the books, passed in 1992, which mandates a waiting period after a woman receives written information about her alternatives to abortion, the procedure, community resources available and the gestational age of her fetus. This bill is another attempt by extremists to prevent as much access to abortion services as possible. Please oppose this legislation and all other attempts to restrict women's constitutionally protected I right to full reproductive choice.

Written and Submitted by Carla Mahaney

House Judiciary
Attachment 18
2/13/97

Betty Armstrong #19

COMPREHENSIVE
health for women

Testimony in Opposition to HB 2269

House Judiciary Committee

February 13, 1997

Comprehensive Health for Women, a provider of abortion services in Overland Park, is opposed to HB 2269 as it is an attempt to limit access to abortion by placing undue burdens on women. It is not about "a woman's right to know."

All women at Comprehensive Health receive complete and personal information and counseling and no woman receives an abortion until the counselor and medical staff determine she is absolutely sure of her decision. Patients are sent home every day to reconsider because of ambivalence.

To mandate a woman to have this meeting with the physician 8 hours before her appointment would require all women from out-of-town to spend a night or additional night in Kansas City, therefore increasing the cost to her of lodging, meals, babysitting, time off work or school, etc. The 8-hour requirement is no improvement over the 24-hour bill last year. It remains an undue burden to women.

The state does not mandate to physicians performing any other surgical procedure what they must say to patients and in what time frame, and to fail to do so "intentionally or by neglect" face civil penalties.

The decision to end a pregnancy is always a difficult and personal one and should be left to the families involved, not the government.

House Judiciary
Attachment 19
2/13/97

4401 WEST 109 STREET
OVERLAND PARK, KANSAS 66211
TEL (913) 345-1400
1 800 227-1918

#20

Kansas NOW
working for equality for women

PO Box 15531
Lenexa, KS 66285-55531

To: **House Judiciary Committee**

Submitted By: **Jana L. E. Gryder**
Kansas National Organization for Women

Date: **February 13, 1997**

Re: **Testimony in Opposition to HB 2269**

The Kansas Chapter of the *National Organization for Women* stands in opposition to **HB 2269**. This is a redundant and unduly confining bill that is disguised under the "*woman's right to know*."

Kansas already has a narrow informed consent law that places obstructive barriers to a woman's right to make a very personal and private decision. **HB 2269** places even more mandated restrictions that require a generic form that is state prepared and enforced upon doctors. This results in the state telling doctors how to practice medicine. It constricts doctors from reading their patients and knowing what that patient needs to hear. Each patient, I am sure, varies in their needs and doctors are trained and should be allowed to provide to those needs. Under this bill, if a doctor varies from the guidelines at all, he or she faces serious consequences. This bill places doctors in the position of practicing defensive medicine.

The information mandated is hypocritical and deceptive. It does not follow with welfare reform. It misinforms women about the sufficiency of assistance to support children. State programs have been seriously restricted and reduced by current legislation and child support payments are almost impossible to recover.

I truly believe that the proponents of this bill could care less about a woman's right to know. They are trying to enforce their political and religious beliefs upon others through legislation. Politicians decide what should and should not be told to a patient in no other medical procedure. Women have the ability to decide who they want to consult with and what information that they need on every other medical procedure. They do not need legislated information from the state to make a personal medical decision.

Woman are not ignorant. They know what an abortion is and do not make an impulsive decision about having one. It is a difficult decision with much time spent on thought and consideration of all options. We all can make an informed choice without government intervention. All people are capable of deciding their own health options ethically,

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knowledgeably, emotionally, and spiritually - according to their own ethical, moral and spiritual beliefs - not the Legislature's.

The right to an abortion is a Constitution right that can not be placed under an undue burden. *Planned Parenthood v. Casey*. The intent of **HB 2269** is not to fully inform the woman of her current options. It's purpose is to even more fully harass women who are seeking to exercise their Constitutional right. Do not try to demean women by disguising restrictions under a protective "*right to know*."

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Amend HB 2269 on page 2 by striking lines 20 through 43 and on page 3 by striking lines 1 through 5, and then add the following:

Sec. 3. K.S.A. 65-6701 is hereby amended to read as follows:

65-6701. Definitions. As used in this act:

(a) "Abortion" (strike existing language and insert the following:) means the use or prescription of any instrument, medicine, drug or any other substance or device with the intent to terminate the pregnancy of a woman. Such use or prescription is not an abortion if done with the intent to (1) save the life or preserve the health of an unborn child, (2) remove a dead unborn child, or (3) deliver an unborn child prematurely in order to preserve the health of both the mother and her unborn child.
(b) "Conception" means the fusion of a human spermatozoon with a human ovum.
(c) "Counselor" (old (b), same as current law)
(d) "Department" means the department of health and environment.
(e) "Gestational age" means the time that has elapsed since the first day of the woman's last menstrual period.
(f) "Medical emergency" means that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman s to necessitate the immediate abortion of her pregnancy to overt her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.
(g) "Minor" (old (c), same as current law)
(h) "Physician" (old (d), same as current law)
(i) "Pregnant" or "pregnancy" means that female reproductive condition of having an unborn child in the mother's body.
(j) "Qualified person" means an agent of the physician who is a psychologist, licensed social worker, registered professional counselor, registered nurse or physician.
(k) "Unborn child" means the offspring of human beings from conception until birth.
(l) "Unemancipated minor" (old (e), same as current law)
(m) "Viable" (old (f), same as current law)
(n) "Aggrieved party" means any woman who obtains, seeks to obtain, or believes she has obtained, an abortion, and includes her personal representative.

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f such payment and proof is received more han one year after the date of expiration of he registration.

(d) A duplicate registration shall be issued by the board upon receipt of a $20 fee.

History: L. 1992, ch. 184, § 3; July 1.

65-6604. Refusal to issue or renew, suspension, limitation or revocation of registration; grounds; applicability of Kansas administrative procedure act. (a) The board may deny, refuse to renew, suspend, limit or revoke any registration pursuant to this act if the registrant or applicant:

(1) Has obtained or attempted to obtain registration by means of fraud, misrepresentation or concealment of material facts;

(2) has been convicted of a crime found by the board to have a direct bearing on whether the registrant or applicant can be entrusted to serve the public in the position of alcohol and other drug abuse counselor;

(3) has used any advertisement or solicitation which is false, misleading or deceptive to the general public or persons to whom the advertisement or solicitation is primarily directed; or

(4) has violated any lawful order or rule and regulation of the board.

(b) Suspension, limitation, revocation or refusal to issue or renew registration pursuant to this section shall be in accordance with the Kansas administrative procedure act.

History: L. 1992, ch. 184, § 4; July 1.

65-6605. Advisory committee; purpose; composition; expenses; expiration. The board shall appoint an advisory committee for the purpose of assistance in adopting rules and regulations pursuant to this act. The advisory committee shall be composed of 3 members who are registered alcohol and other drug abuse counselors under this act or are qualified for registration as alcohol and other drug abuse counselors under this act. Members of the advisory committee shall receive amounts provided for in subsection (e) of K.S.A. 75-3223 and amendments thereto for each day of actual attendance at any meeting of the advisory committee or any subcommittee meeting authorized by the advisory committee, and such amounts shall be paid from the behavioral sciences regulatory board fee fund. The provisions of this section shall expire on the date the original permanent rules and regulations of the board become effective.

History: L. 1992, ch. 184, § 5; July 1.

65-6606. Citation of act. K.S.A. 65-6601 to 65-6605, inclusive, and amendments thereto, shall be known and may be cited as the alcohol and other drug abuse counselor registration act.

History: L. 1992, ch. 184, § 8; July 1.

Article 67.—ABORTION

65-6701. Definitions. As used in this act:

(a) "Abortion" means the use of any means to intentionally terminate a pregnancy except for the purpose of causing a live birth. Abortion does not include: (1) The use of any drug or device that inhibits or prevents ovulation, fertilization or the implantation of an embryo; or (2) disposition of the product of *in vitro* fertilization prior to implantation.

(b) "Counselor" means a person who is: (1) Licensed to practice medicine and surgery; (2) licensed to practice psychology; (3) licensed to practice professional or practical nursing; (4) registered to practice professional counseling; (5) licensed as a social worker; (6) the holder of a master's or doctor's degree from an accredited graduate school of social work; (7) registered to practice marriage and family therapy; (8) a registered physician's assistant; or (9) a currently ordained member of the clergy or religious authority of any religious denomination or society. Counselor does not include the physician who performs or induces the abortion or a physician or other person who assists in performing or inducing the abortion.

(c) "Minor" means a person less than 18 years of age.

(d) "Physician" means a person licensed to practice medicine and surgery in this state.

(e) "Unemancipated minor" means any minor who has never been: (1) Married; or (2) freed, by court order or otherwise, from the care, custody and control of the minor's parents.

(f) "Viable" means that stage of gestation when, in the best medical judgment of the attending physician, the fetus is capable of sustained survival outside the uterus without the application of extraordinary medical means.

History: L. 1992, ch. 183, § 1; July 1.

65-6702. Drugs or devices for birth control or fertilization lawful; political subdivisions prohibited from limiting abortion. (a) The use of any drug or device that inhibits or prevents ovulation, fertilization or implantation of an embryo and disposition of the product of *in vitro* fertilization prior to implantation are

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