Approved: 5-3-97
Date

MINUTES OF THE SENATE COMMITTEE ON FEDERAL AND STATE AFFAIRS.

The meeting was called to order by Senator Lana Oleen at 11:00 a.m. on March 13, 1997 in Room 254-E of the Capitol.

All members were present.

Committee staff present: Mary Galligan, Legislative Research Department
Theresa Kiernan, Revisor of Statutes
Midge Donohue, Committee Secretary

Conferees appearing before the committee:
Senator Nancey Harrington
Senator Karin Brownlee
Mr. Clyde Graeber, Governor's Office
Patrick R. Herrick, MD, Ph.D., Olathe Medical Center & Overland Park Medical Center, Olathe
Ms. Jeanne L. Gawdun, Kansans for Life, Wichita
Ms. Beatrice E. Swoopes, Program Coordinator, Kansas Catholic Conference, Merriam
Mr. Brad Brown, Student Intern for Senator Nancey Harrington
Ms. Jalen O'Neil, Washburn University School of Law, Topeka
Ms. Rachael K. Pirner, Attorney at Law, Wichita
Ms. Jan Messerli, Law Student, Topeka
Ms. Peggy Jarman, Pro-Choice Action League & Women's Health Care Services, Wichita
Representative Susan Wagle

Others attending: See attached list

Senator Oleen advised that the time allotted for testimony on the bills scheduled for hearing before the committee today would be divided equally between the two sides, and the hearings were opened on:

SB 230: **An act establishing requirements for informed consent relating to abortions.**
SB 234: **An act prohibiting partial-birth abortions.**
HB 2269: **An act concerning abortion; relating to certain requirements before the performance thereof.**

Senator Nancey Harrington, a sponsor of **SB 230** and **SB 234**, recalled testimony given yesterday by clergymen who felt the language of the bills had religious connotations, and she told the committee the language could be adjusted, if the committee wanted to amend.

Senator Harrington first addressed the proposed legislation concerning informed consent (Attachment #1) and explained its purpose. She advised that current Kansas law does not conform with the U.S. Supreme Court decision in the Planned Parenthood versus Casey case regarding oral counseling in person. She directed attention to the fiscal note that had been provided on **SB 230** and questioned the estimated cost for the printing of materials the bill would require. Senator Harrington referred to testimony from women who have suffered Post Abortion Syndrome who indicated that, had they been truly informed of the alternatives and services available, they would not have chosen to have an abortion. She asked the committee to favorably pass the bill to the full Senate.

Senator Harrington provided written testimony on the issue of partial birth abortions (Attachment #2).

CONTINUATION SHEET

MINUTES OF THE SENATE FEDERAL & STATE AFFAIRS COMMITTEE, Room 254-E- of the Capitol, at 11:00 a.m. on March 13, 1997.

Senator Karin Brownlee, one of the sponsors of **SB 234**, addressed the committee as a proponent of the bill that would ban partial birth abortions (Attachment #3) She called attention to responses to President Clinton's veto message on the partial-birth abortion ban act and asked the committee to take the time to read them. She directed the committee's attention to misinformation that had been provided during debate of the issue in Washington and the ABC Nightline transcript attached to her written testimony.

Mr. Clyde Graeber, Legislative Liaison, Governor's Office, appeared on behalf of the Governor regarding "Woman's Right to Know" legislation (Attachment #4) Mr Graeber said the Governor had concerns about the current versions of this proposal. He explained what the Governor would consider acceptable legislation and presented a draft of a proposed substitute bill for **SB 230** and **HB 2269** (Attachment #5) for consideration by the committee.

Mr. Graeber then discussed the Governor's position on **SB 234**, partial-birth abortion (Attachment #6) which he said is a procedure the Governor finds personally abhorrent. Mr. Graeber stated that, although the Governor is convinced that few partial-birth abortions occur in Kansas, he supports efforts to enact a state law to ban the procedure.

Patrick R. Herrick, M.D., Ph.D., Olathe Medical Center and Overland Park Medical Center, addressed the committee as a proponent of **SB 230** and **SB 234** (Attachment #7). Dr. Herrick stated that a patient is dependent upon the physician for information upon which to make a decision and has the right to expect the physician to provide the needed information.

Dr. Herrick discussed the changes that would be mandated in current law by the proposed legislation if enacted. He said the decision about abortion is so momentous it is best made with as much information as possible, and he questioned the advisability of limiting the material available to women in a situation which will have a profound lasting effect.

Dr. Herrick then addressed the issue of partial-birth abortion and described the procedure in detail (Attachment #8). He stated that the situation where the mother's life is at stake if she were to continue the pregnancy is no longer a clinical reality; that, given the state of modern medicine, a pregnant woman with a medical affliction can now be managed successfully to the natural conclusion of the pregnancy which is the birth of a healthy child.

Ms. Jeanne Gawdun, lobbyist for Kansans for Life, addressed the committee as a proponent of **SB 230** and **HB 2269** (Attachment #9). She described the legislation as "pro-woman", saying it would ensure that women receive unscientifically unbiased, medically sound facts about abortion. She said "choice" is meaningless when information is withheld. Ms. Gawdun advised that women continue to make it known that they have been coerced, not fully informed, not carefully evaluated for risk and injured without just compensation in regard to abortion. She asked the committee to favorably pass the Women's Right to Know Act".

In the interest of time, Ms. Gawdun did not present verbal testimony on **SB 234**, partial-birth abortion ban; instead, she asked that her written comments in support of the bill be entered into the official record (Attachment #10).

Ms. Beatrice E. Swoopes, Program Coordinator, Kansas Catholic Conference, Merriam, appeared as a proponent of **SB 230**, **SB 234**, and **HB 2269** (Attachment #11), focusing primarily on **SB 230** and **HB 2269** which deal with informed consent. Ms. Swoopes advised that the Kansas Catholic Conference represents the Roman Catholic Bishops of Kansas which supports and encourages the passage of legislation enabling women who are anticipating abortion to be educated and informed about the medical and psychological consequences of their actions as well as feasible alternatives. She said either bill was a good approach because both would guarantee a woman's thorough understanding of the physical and mental aspects of the abortion procedure she is contemplating.

In regard to partial-birth abortion, Ms. Swoopes advised that the Catholic Bishops of Kansas have made this one of their targeted legislative objectives and act in concert with the United States Bishops in seeking to end this technique. She urged the committee to favorably consider passage of **SB 234**.

Mr. Brad Brown, a legislative intern for Senator Nancey Harrington and a law student at the University of Kansas School of Law, addressed the committee in support of informed consent bills (Attachment #12). Mr. Brown stated he had been assigned the task of researching the informed consent requirement in the proposed bills as part of his internship and, as a result of that research, concluded that: the bills are within present constitutional limits.

CONTINUATION SHEET

MINUTES OF THE SENATE FEDERAL & STATE AFFAIRS COMMITTEE, Room 254-E- of the Capitol, at 11:00 a.m. on March 13, 1997.

Ms. Jalen O'Neil, Associate Professor of Law, Washburn University School of Law, Topeka, appeared as an opponent to **SB 230** and **HB 2269** (Attachment #13). Mr. O'Neil stated that passage of either bill would result in fewer women having full information on the options available to them when faced with an unwanted or dangerous pregnancy. Instead, she said the bills would act as a government-forced "slow-down strike" against abortion providers which would result in fewer abortions being performed but at a higher cost, thus limiting the procedure to wealthy women, or women impregnated by wealthy men. She pointed out that the bills were especially discriminatory against poor rural women who would have an unsurmountable burden placed on them when facing at least one overnight stay, arranging for child care and absence from her job. Ms. O'Neil said the present informed consent law on abortion strikes a good balance in that it gives the woman the information she needs to make an informed decision but does so in a way that allows her to maintain confidentiality and actually obtain a legal abortion if that is her ultimate decision.

Ms. Rachael K. Pirner, Attorney at Law, Wichita, addressed the committee as an opponent of **SB 230** (Attachment #14) and discussed the penalty provisions contained in the bill. She pointed out that failure to comply with the requirements of the act would: provide a basis for civil malpractice action, provide a basis for professional disciplinary action under the Kansas Healing Arts Act, and provide a basis for recovery for the woman for the death of her unborn child, whether or not the unborn child was viable at the time the abortion was performed or was born alive. Ms. Pirner cited a ruling by the Kansas Supreme Court in regard to wrongful death actions and told the committee that adoption of the wrongful death provision in **SB 230** would represent a significant shift in public policy in Kansas.

Ms. Jan Messerli, Topeka, a third year law student representing the women of western Kansas, spoke as an opponent to the proposed informed consent legislation (Attachment #15). Ms. Messerli pointed out that the eight hour waiting period would result in a twenty-four hour delay for women from western Kansas, a delay that would cost not only money but personal integrity. She said passage of this legislation would send a message that it doesn't really matter how much it costs in dollars or integrity as long as there is one last chance to change the decision to have an abortion. She told the committee she is not afraid of being informed but is afraid of their version of information.

Ms. Peggy Jarman, Lobbyist, ProChoice Action League and Women's Health Care Services, Wichita, spoke in opposition to **SB 230**, **SB 234**, and **HB 2269** (Attachment #16). In regard to informed consent, Ms. Jarman challenged the assertion that women in the state were having abortions without consent and without knowing what they are doing. She presented an example of consent forms used by Women's Health Care Services in Wichita to support her claim (Attachment #17). She told the committee that no woman in the state is having an abortion without full knowledge that she is ending a pregnancy, and that all medical requirements in the proposed legislation are already being met by physicians providing abortions in the state. She referenced letters, copies of which were attached to her written testimony (Attachment #18), from women who had abortions and were pleased with the services provided. Ms. Jarman referenced also copies of news clippings included with her written testimony (Attachment #19) which she said show there is a five-year plan to stop abortions in Kansas. She urged the committee to report **SB 230** and **HB 2269** unfavorably, saying there are many problems with the bills which she had outlined in her written testimony (Attachment #20).

Ms. Jarman then spoke on the issue of partial birth abortion, **SB 234** (Attachment #21). She told the committee she had asked the sponsors of the bill to adopt language that would make an exception to save the life of a woman and to clearly identify this procedure. She said it was clear from the response she received that the bill is about politics rather than banning a procedure and she urged the committee to report it unfavorably.

Senator Oleen recognized Representative Susan Wagle, one of the sponsors of **HB 2269**, who had just arrived. Although the allotted time for testimony had elapsed, Senator Oleen invited her to offer a few brief comments (Attachment #22). Representative Wagle explained that she had been instrumental in getting the House in 1992 to pass the present informed consent statute relating to abortion. She advised that the proposed legislation before the committee today was patterned after current Pennsylvania law. Representative Wagle said she hoped the committee would support **HB 2269**.

The hearings were closed on **SB 230**, **SB 234**, and **HB 2269** with Senator Oleen acknowledging additional written testimony that would be included in the official record:

Betty Armstrong, Director of Community Relations, Comprehensive Health for Women, Overland Park (Attachment #23)
Ms. Amy C. Bixler, Attorney at Law, Topeka (Attachment #24)
Ms. Sheila Kostas, Director of Counseling, Comprehensive Health for Women, Overland Park (Attachment #25)
Iris A. Brossard, M.D., & Burtram J. Odenheimer, M.D., (Attachment #26)

CONTINUATION SHEET

MINUTES OF THE SENATE FEDERAL & STATE AFFAIRS COMMITTEE, Room 254-E- of the Capitol, at 11:00 a.m. on March 13, 1997.

Jana L. E. Gryder, Kansas National Organization for Women (Attachment #27)
Ms. Ellen W. Brown, Public Affairs Coordinator, Planned Parenthood, Kansas City, Missouri (Attachment #28)
Ms. Patricia C. Brous, President, Planned Parenthood, Kansas City, Missouri (Attachments #29 & 30)
The Reverend Mr. Lynn NewHeart, Planned Parenthood of Mid-Missouri & Eastern Kansas (Attachment #31)
Ms. Carla Mahany, Associate Director, American Civil Liberties Union, Kansas City, Missouri (Attachments #32 & #33)
Ms. Mary Beth Blake, Kansas City, Kansas (Attachment #34)

Senator Oleen announced that tomorrow the meeting would be on call of the chairman.

The meeting adjourned at 12:06 p.m.. The next meeting is scheduled for March 17, 1997.

SENATE FEDERAL & STATE AFFAIRS COMMITTEE
GUEST LIST

DATE: 3-13-97

NAME	REPRESENTING
Alice Brown	Pro-Choice
Kara Green	Pro-Choice
Amy Scarborough	PRO-CHOICE
Laurie Beuke	Pro-Life
Melissa Goss	
Sarah Williamson	Pro-Choice
Que Lam	
Molly Malone	Pro-CHOICE
Grant Denny	Sen. Goodwin's office
Terri Clark	Pro-Life
Heidi Turner	Pro choice
Charity King	
Amy Houston	
Jerry Fiebenk	
Rachael K. Pirner	pro choice
DAN STALKER	
Amy Zimmerman	pro choice
A. Huelskamp	PRO-LIFE
Rebecca Mize	SRS

SENATE FEDERAL & STATE AFFAIRS COMMITTEE
GUEST LIST

DATE: 3-13-97

NAME	REPRESENTING
Shirley Lusco-Strong	Intern for Sen Jones
J. Mike Carlin	SEN. LANA OLEEN
Benton Oleen	SEN. OLEEN (PAGE/SON)
Ryan J Weigel	Sen Oleen (friend of the fam)

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SENATE CHAMBER

COMMITTEE ASSIGNMENTS
VICE CHAIR: FEDERAL AND STATE AFFAIRS
MEMBER: ENERGY AND NATURAL RESOURCES
JUDICIARY
TRANSPORTATION AND TOURISM

Testimony Before the Senate Federal and State Affairs Committee
Proponent for Women's Right to Know, SB 230, HB 2269
March 13, 1997
By Senator Nancey Harrington

Thank you Chairman Oleen and members of the committee.

The Women's Right to Know Act: Informed Consent would enact legislation that would require physicians to inform a woman seeking an abortion in person 8 hours prior to the procedure the name of the doctor performing the abortion, description of the procedure to be used, risks of the abortion procedure compared to childbirth, detailed information about the development of the unborn child, information on adoption, the father's liability for child support should the women desire to disclose the name of the father if she chooses to keep the baby, and support available from the community.

Current Kansas law does not conform with the U.S. Supreme Court decision in Planned Parenthood vs Casey 112 S. Ct. 2791 (1992) in the following areas: The woman is not required to be counseled orally and in person. She is not told:

a. The name of the abortion doctor
b. The availability of medical assistance benefits
c. The liability of the father for child support
d. Information describing the child's development

Civil penalties for failure of the doctor performing the abortion to obtain truly informed consent are not unreasonable. If a woman suffers with health complications as a result of having had an abortion, current law has no enforcement mechanism for violation - no criminal or civil penalty.

This legislation does not increase the current statute of limitations for medical malpractice of 2 years for abortion. The statute of limitations for other medical malpractice cases is 5 years.

A fiscal note has been provided for SB 230. The amount is questionable. The fiscal note provides a cost anywhere from $172,000 to $276,000 for printing of materials provided, a trained nurse for consultations and to develop medical and referral information. The State of Louisiana published this printed material for .50¢ a copy or booklet. The State of Kansas should check with Louisiana for possible cost savings. Trained nurses would not be necessary for developing a list of services, since a list is already available. Also, a

nurse would not be necessary to provide counseling services, since the woman's own doctor or the abortion clinic are to be providing the woman with the counseling.

The 24 hour toll line is to provide information of available community services, a women may leave a message for the information to be mailed to her. A nurse is not necessary for this position, as well. A phone message service would not require the toll free line to be manned 24 hours a day.

In a recent article the Kansas Children's Services League, which handles special needs adoption services and foster care placements, said it has quit taking applications for newborn adoptions in July of 1992 because the availability of children fell very low. One of the reasons is that counselors seem not to steer teens toward adoption, more are choosing abortion.

Women who have suffered from Post Abortion Syndrome have testified that had they been truly informed to the alternatives and services available, they would have chosen not to have had an abortion. Every women has not, or will not suffer from Post Abortion Syndrome. This bill will not affect them. For the women who will suffer, passage of Women's Right to Know would enable those women to make a well informed health choice, that will benefit them for the rest of their lives.

On October 22, 1990, Congress passed the "Student's Right to Know and Campus Security Act". Considered a "consumer rights statute, the Act requires college universities to report graduation rates of all students, as well as those of student athletes. In addition, the institutions must report certain campus crime statistics and campus security procedures. I ask you to consider the Women's Right to Know Act to be a consumer rights statute.

I respectfully ask the committee to pass Women's Right to Know on to the full Senate.

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SENATE CHAMBER

COMMITTEE ASSIGNMENTS
VICE CHAIR: FEDERAL AND STATE AFFAIRS
MEMBER: ENERGY AND NATURAL RESOURCES
JUDICIARY
TRANSPORTATION AND TOURISM

Senate Federal and State Affairs Committee
Written Testimony, Proponent for SB 234
March 13, 1997
Senator Nancey Harrington

Chairman Oleen and members of the committee, thank you for receiving written testimony concerning SB 234, a bill to prohibit partial-birth abortions in Kansas.

SB 234 is good policy for Kansas and Kansans. Consider the recent admission of Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers, that he had "lied" about the number of partial birth abortions being performed in the United States.

Abortion on demand was never the intent of the Supreme Court's decision in Roe v. Wade. Mr. Fitzsimmons now admits that thousands of these abortions are elective and committed every year, not just in the last three months of pregnancy, but from 20 weeks onward. With this revelation, legislators, the Governor, Kansans and even the nation must ask that this type of abortion service be prohibited.

One should also question if any, or all, of the information the abortion industry provides is accurate, or even truthful. Most abortion providers have a monetary interest to protect.

I have attached recent newspaper articles concerning this issue.

I ask for this committee's support of SB 234.

Sen. Federal & State Affairs Comm.
Date: 3-13-97
Attachment: # 2

:nds fund-raising

Associated Press

nt Clinton said White
events for donors were
iate and perfectly legal.

ıg the events. And the guide-
made it clear that there was
price tag on the events."
he past two years, the De-
Party raised $27 million
people who attended the ses-
companies that were repre-
ere.
resident's use of the White
r party fund-raising events
have hit a nerve with av-
mericans, Republicans and
ny Democrats.
ven for people who believe
ors expect some kind of ac-
politician in return for their
here's something off-putting
ontributors being offered a
the Lincoln Bedroom.
a Kelly thinks Clinton doesn't
ie White House, she said, be-
the people, not to him. And
ing big contributors there
introducing moneychangers
mple of democracy.
eps saying it was OK," Kelly
sing to catch her breath out-
ie White House fence
lay. "It wasn't OK. It was an
idea.
ys Republicans did it too,"
cheery registered Democrat
incy, Mass. "Well, honey, you
ght with your hand in the
r this time. It's your turn. Say
'I did something wrong' if you want to end it."

It's important to understand the attitude at the White House in 1995, when the decision to offer Pennsylvania Avenue premiums to donors was made. At that time, Republicans were in control of Congress and Clinton was, as one Washington columnist put it, "dogmeat."

Bob Dole and Colin Powell were beating him soundly in polls. More important, Dole was drubbing Clinton as a fund-raiser. Republicans as a party were outraising Democrats 2-to-1.

Democrats — already getting nearly half of their money from donors of $50,000 or more — needed more, bigger contributors fast. So the Democratic Party, with encouragement from Clinton and chief Clinton-Gore fund-raiser Terry McAuliffe, created new donor clubs for top-dollar contributors.

One was for the party's "trustees," who, for giving $50,000 or raising $100,000, would be rewarded with dinners with Clinton, Gore and other Democratic luminaries. Another club was created for "managing trustees" — those who contributed $100,000 or raised $250,000. They got double the number of dinners and prestigious events.

Unresolved was what Democrats called "the problem of the jumbos" — what to do for donors and fund-raisers of much bigger sums. That's why the Lincoln Bedroom had so many guests, and why donors of outsized sums not only drank coffee with Clinton but enjoyed so much White House access.

The law doesn't prohibit these kinds of visits, so long as money isn't solicited in the White House and there are no promises of action in return for donations.

Contributing: Eagle Washington bureau

Abortion-rights backer admits he lied about controversial procedure

Associated Press

WASHINGTON — A prominent abortion-rights supporter conceded Wednesday he lied when he said a type of late-term abortion is performed rarely and only to save a mother's life or to abort malformed fetuses.

He now says the procedure is performed far more often than his colleagues acknowledged, and on healthy women bearing healthy fetuses.

But Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers in Alexandria, Va., a coalition of 200 independently owned clinics, said he still supports the procedure and does not regret waiting almost a year and a half to recant his lie.

"It's concerned me that I'd known more about this procedure than is being reported about it," Fitzsimmons said Wednesday.

"The fact is that we have absolutely no apologies about this procedure, that it's performed for very good reasons on women, and we shouldn't be apologizing."

Fitzsimmons said he intentionally misled in previous remarks about the procedure, called intact dilation and evacuation by those who believe it should remain legal and "partial-birth abortion" by those who believe it should be outlawed, because he feared that the truth would damage the cause of abortion rights.

But he is now convinced, he said, that the issue of whether the procedure remains legal, like the overall debate about abortion, must be based on the truth.

In an article in American Medical News, to be published March 3, and an interview Tuesday, Fitzsimmons recalled the November 1995 night when he appeared on "Nightline" and "lied through my teeth" when he said the procedure was used rarely and only on women whose lives were in danger or whose fetuses were damaged.

Fitzsimmons said that after that interview he stayed on the sidelines of the debate for a while, but with growing unease. As much as he disagreed with the National Right to Life Committee and others who oppose abortion under any circumstances, he said he knew they were accurate when they said the procedure was common.

In the procedure, a fetus is partly extracted from the birth canal, feet first, and the brain is suctioned out.

Last fall, Congress failed to override a presidential veto of a law that would have banned the procedure, which abortion opponents insist borders on infanticide and some abortion rights advocates also believe should be outlawed as particularly gruesome. Polls have shown that such a ban has popular support.

Abortion rights groups have been arguing strongly that the procedure is uncommon. They claim about 500 such abortions are carried out every year — and performed only on women with unhealthy fetuses.

But Fitzsimmons put the number at 3,000 to 4,000 every year, out of about 1.3 million total abortions in the United States each year.

Contributing: New York Times News Service

APHICS
•COMPUTER VINYL
•CUSTOM PAINTING

—LAURA L. MOORE, Topeka.

Tribune Media Services

News media, others swallowed abortion lie hook, line and sinker

■ It isn't the first big lie that the media have bought and resold.

Mike Royko

Chicago beat

When I started this job a few decades ago, a veteran columnist at the next desk offered advice. One rule was: "Never write about a subject when you're mad. Wait until you calm down."

Sensible words, and I usually try to follow them.

But on this day, there weren't nearly enough hours left until my deadline for me to calm down about a whopper of a lie that a public figure named Ron Fitzsimmons has finally admitted telling.

Fitzsimmons runs the National Coalition of Abortion Providers.

And he says his conscience has nagged him into admitting "lying through my teeth" when he made public statements in 1995 that the controversial "partial birth abortion" was rarely used. And that it was used only when a woman's life was in danger or the fetus was already severely damaged.

You probably remember the big debate on this issue. Those against this late-term procedure wanted it outlawed because they said it killed healthy, normal fetuses that were well into full development.

And the procedure is barbaric, they said. The fetus is partially delivered feet first, then a device is used to suck its brain out to collapse the head.

Fitzsimmons now admits that most such abortions are done on women who are healthy and fetuses that are healthy, not because the woman is in danger or the fetus is unhealthy.

The abortion is performed for the same reason as other abortions: the woman wants it.

Fitzsimmons says he and others lied because the truth might have hurt the cause of abortion rights.

They were right. If it hadn't been for those lies, eagerly accepted and passed along as gospel by the printed press and broadcast news, President Clinton would not have dared veto a bill that outlawed the procedure. And Congress wouldn't have failed to override his veto.

That's what is so infuriating: the silence of those in the medical field who knew it was a lie but failed to thunderously refute it.

And the willingness of the press to accept the lie and pass it along as fact.

A few physicians spoke up. Two wrote a piece for the op-ed page of the Wall Street Journal that shredded the line peddled by people like Fitzsimmons. But they were ignored, probably because the Journal's opinion sections are viewed by the rest of journalism as hopelessly conservative.

The press swallowed the lies like worms by a bass because the lies fit so neatly into what is sometimes referred to as a "world view" that is shared by those in the mainstream news media.

Part of that view seems to be that anyone who questions the need for the vast number of abortions performed each year is some kind of right-wing, bomb-tossing, gun-toting religious nut.

It isn't the first big lie that the media have bought and resold.

Some years ago, gay organizations and public health people launched an intense "We're All at Risk" campaign. This meant that we were all equally vulnerable to the threat of AIDS.

Common sense and evidence said otherwise: If you didn't have anal intercourse with a man or borrow a needle from a dopehead, what put you at risk?

But those who launched the propaganda campaign later admitted that they believed the fear would create sympathy for gays and spur increased spending on AIDS research.

Eventually, a few skeptical reporters shot holes in the campaign. But not until others who questioned it had been labeled bigots and homophobes.

More recently, there was the media hysteria over the burning of black churches. Remember? Night riders were thought to be galloping all over the country, burning black churches. A massive racist conspiracy, possibly inspired by the oratory of political conservatives like Pat Buchanan.

Proposals were made to use federal funds to rebuild churches. Do-gooders kicked in money to organizations that made the most victimization noise.

Turned out it was more smoke than fire. After the nation's press spread the arson story, calmer heads took a closer look. Most of the fires weren't arson. No conspiracy. Black arsonists as well as white arsonists were arrested, proving that a nut is a nut, regardless of color. It was as if no one in an American newsroom knew that an old wooden rural church can actually have bad wiring.

Now we have Fitzsimmons blowing the whistle on himself. His conscience? Or was it that the truth was going to come out anyway?

Maybe from people such as the antiabortion physician who will be the subject of my next column.

Tribune Media Services

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TOPEKA

SENATE CHAMBER

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JOINT COMMITTEES:
ARTS & CULTURAL RESOURCES
CLAIMS AGAINST THE STATE

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SENATE FEDERAL AND STATE AFFAIRS COMMITTEE

TOPIC: Support for SB 230, SB 234, & HB 2269 March 13, 1997

Thank you for the privilege of participating in possible the greatest debate of our time--the debate on the value of human life as it relates to the practice of abortion.

Part of today's debate is about banning the partial birth abortion procedure. Is this procedure good medicine or is it extreme? I won't describe it for you as you are already familiar with it. In today's American culture we have extensive rules and regulations on the humane treatment of animals in biomedical research. These regulations mandate "avoidance or minimization of discomfort, distress, and pain," and specify "surgical or other painful procedures should not be performed on unanesthetized animals paralyzed by chemical agents." (1)

We treat our laboratory animals with such a delicate touch. Yet when it comes to an unwanted child, in the words of Congressman Henry Hyde (R-Ill.), we do (with this procedure) what "we would not do to a mangy coyote or a wild animal." How can we reconcile this incongruity? I would suggest that we cannot and we must not. (Please see Congressman Hyde's attached testimony.)

Is a partial birth abortion good medicine? When the debate on this procedure took place in Washington, D.C. last year, a number of Doctors came forward to correct the falsehoods which had been perpetrated on the American people. These doctors quite boldly stated that "partial-birth abortion is never medically indicated to protect a woman's health or her fertility." Some of the risks from the procedure include incompetent cervix (this leads to premature delivery), "tearing the uterus, scissor injury to the mother, massive bleeding and the threat of shock or even death to the mother." (2)

Unfortunately, this procedure has prompted some of those involved in this debate to be untruthful in their defense of it. I have attached a transcript from an ABC Nightline program on which Ron Fitzsimmons admitted the falsehoods he had communicated nationally.

Sen. Federal & State Affairs Comm.
Date: 3-13-97
Attachment: #3

Before I end, I would like to touch on another aspect of the abortion debate. Few people talk about the economic impact of abortion except as it relates to the profits of an abortionist. The Rockford Institute took it upon themselves to study the economic consequences of having 35 million workers absent from the American workforce in 2014. These 35 million people (children aborted from about 1970-1995) could generate almost $2 trillion into the American economy. Of this amount, about $450 billion would be paid in taxes and $274 billion in FICA tax revenue. (3)

I would never measure the value of one human life strictly on economic output. However, America's most valuable natural resource is her people. Our future is in our children. My prayers are with you, my dear colleagues, as the future lives of these precious children rest on your magnanimous decision.

(1) The Wall Street Journal, "Review and Outlook: Who Are the Extremists", Apr.25,1996.
(2) The Wall Street Journal, "Partial-Birth Abortion is Bad Medicine." Drs. Romer, Smith, Cook and DeCook, Sept. 19, 1996.
(3)The Family in America: "The Economic Consequences of Abortion: A Speculation" The Rockford Institute, Vol. 9, Number 11, Nov. 1995.

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PARTIAL-BIRTH ABORTION BAN ACT OF 1995--VETO MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 104-198) (House of Representatives - September 19, 1996)

Mr. HYDE. Mr. Speaker, I beg the indulgence of my colleagues not to ask me to yield because I cannot and will not and I would appreciate their courtesy. I also want to say briefly that those who have charge us with politics, invidious politics, for delaying this debate ought to understand that Americans cannot believe this practice exists and it has taken months to educate the American people and it will take many more months to educate them as to the nature and extent of this horrible practice. That is one reason it has taken so long.

The law exists to protect the weak from the strong. That is why we are here.

Mr. Speaker, in his classic novel `Crime and Punishment,' Dostoyevsky has his murderous protagonist Raskolnikov complain that `Man can get used to anything, the beast!'

That we are even debating this issue, that we have to argue about the legality of an abortionist plunging a pair of scissors into the back of the tiny neck of a little child whose trunk, arms and legs have already been delivered, and then suctioning out his brains only confirms Dostoyevsky's harsh truth.

We were told in committee by an attending nurse that the little arms and legs stop flailing and suddenly stiffen as the scissors is plunged in. People who say `I feel your pain' are not referring to that little infant.

What kind of people have we become that this procedure is even a matter for debate? Can we not draw the line at torture, and baby torture at that? If we cannot, what has become of us? We are all incensed about ethnic cleansing. What about infant cleansing? There is no argument here about when human life begins. The child who is destroyed is unmistakably alive, unmistakably human and unmistakably brutally destroyed.

The justification for abortion has always been the claim that a women can do with her own body what she will. If you still believe that this four-fifths delivered little baby is a part of the woman's body, then I am afraid your ignorance is invincible.

I finally figured out why supporters of abortion on demand fight this infacticide ban tooth and claw, because for the first time since Roe v. Wade the focus is on the baby, not the mother, not the woman but the baby, and the harm that abortion inflicts on an unborn child, or in this instance a four-fifths born child. That child whom the advocates of abortion on demand have done everything in their power to make us ignore, to dehumznize, is as much a bearer of human rights as any Member of this House. To deny those rights is more than the betrayal of a powerless individual. It betrays the central promise of America, that there is, in this land, justice for all.

The supporters of abortion on demand have exercised an amazing capacity for self-deception by detaching themselves from any sympathy whatsoever for the unborn child, and in doing so they separate

themselves from the instinct for justice that gave birth to this country.

The President, reacting angrily to this challenge to his veto, claims not to understand why the morality of those who support a ban on partial birth abortions is superior to the morality of `compassion' that he insists informed his decision to reject Congress' ban on what Senator Moynihan has said is `too close to infanticide.'

Let me explain, Mr. President. There is no moral nor, for that matter, medical justification for this barbaric assault on a partially born infant. Dr. Pamela Smith, director of medical education in the Department of Obstetrics and Gynecology at Chicago's Mount Sinai Hospital, testified to that, as have many other doctors.

Dr. C. Everett Koop, the last credible Surgeon General we had, was interviewed by the American Medical Association on August 19, and he was asked:

Question: `President Clinton just vetoed a bill on partial birth abortions. In so doing, he cited several cases in which women were told these procedures were necessary to preserve their health and their ability to have future pregnancies. How would you characterize the claims being made in favor of the medical need for this procedure?'

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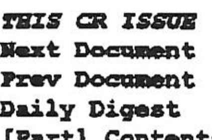


PARTIAL-BIRTH ABORTION BAN ACT OF 1995--VETO MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 104-198) (House of Representatives - September 19, 1996)

Answer: Quoting Dr. Koop, `I believe that Mr. Clinton was misled by his medical advisors on what is fact and what is fiction in reference to late term abortions.'

Question: `In your practice as a pediatric surgeon, have you ever treated children with any of the disabilities cited in this debate? Have you operated on children born with organs outside of their bodies?'

Answer: `Oh, yes, indeed. I've done that many times. The prognosis usually is good. There are two common ways that children are born with organs outside of their body. One is an omphalocele, where the organs are out but still contained in the sac composed of the tissues of the umbilical cord. I have been repairing those since 1946. The other is when the sac has ruptured. That makes it a little more difficult. I don't know what the national mortality would be, but certainly more than half of those babies survive after surgery.

`Now every once in a while, you have other peculiar things, such as the chest being wide open and the heart being outside the body. And I have even replaced hearts back in the body and had children grow to adulthood.'

[Page: H10628]

[TIME: 1345]

Question: And live normal lives?

Answer: Living normal lives. In fact, the first child I ever did with a huge omphalocele much bigger than her head went on to develop well and become the head nurse in my intensive care unit many years later.'

The abortionist who is a principal perpetrator of these atrocities, Dr. Martin Haskell, has conceded that at least 80 percent of the partial-birth abortions he performs are entirely elective; 80 percent are elective. And he admits to over a thousands of these abortions, and that is some years ago.

We are told about some extreme cases of malformed babies as though life is only for the privileged, the planned and the perfect. Dr. James McMahon, the late Dr. James McMahon, listed nine such abortions he performed because the baby had a cleft lip.

Many other physicians who care both about the mother and the unborn child have made it clear this is never a medical necessity, but it is a convenience for the abortionist. It is a convenience for those who choose to abort late in pregnancy when it becomes difficult to dismember the unborn child in the womb.

Well, the President claims he wants to solve a

problem by adding a health exception to the partial-birth abortion ban. That is spurious, as anyone who has spent 10 minutes studying the Federal law, understands. Health exceptions are so broadly construed by the court, as to make any ban utterly meaningless.

If there is no consistent commitment that has survived the twists and the turns in policy during this administration, it is an unshakable commitment to a legal regime of abortion on demand. Nothing is or will be done to make abortion rare. No legislative or regulatory act will be allowed to impede the most permissive abortion license in the democratic world.

The President would do us all a favor and make a modest contribution to the health of our democratic process if he would simply concede this obvious fact.

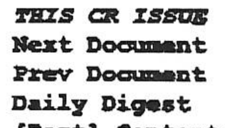
In his memoirs Dwight Eisenhower wrote about the loss of 1.2 million lives in World War II, and he said:

`The loss of lives that might have otherwise been creatively lived scars the mind of the civilized world.'

Mr. Speaker, our souls have been scarred by one and a half million abortions every year in this country. Our souls have so much scar tissue there is not room for any more.

And say, what do we mean by human dignity if we subject innocent children to brutal execution when they are almost born? We all hope and pray for death with dignity. Tell me what is dignified about a death caused by having a scissors stabbed into your neck so your brains can be sucked out.

We have had long and bitter debates in this House about assault weapons. Those scissors and that suction machine are assault weapons worse than any AK-47. One might miss with an AK-47; the doctor never misses with his assault weapon, I can assure my colleagues.



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It is not just the babies that are dying for the lethal sin of being unwanted or being handicapped or malformed. We are dying, and not from the darkness, but from the cold, the coldness of self-brutalization that chills our sensibilities, deadens our conscience and allows us to think of this unspeakable act as an act of compassion.

If my colleagues vote to uphold this veto, if they vote to maintain the legality of a procedure that is revolting even to the most hardened heart, then please do not ever use the word compassion again.

A word about anesthesia. Advocates of partial-birth abortions tried to tell us the baby does not feel pain; the mother's anesthesia is transmitted to the baby. We took testimony from five of the country's top anesthesiologists, and they said it is impossible, that result will take so much anesthesia it would kill the mother.

By upholding this tragic veto, those colleagues join the network of complicity in supporting what is essentially a crime against humanity, for that little, almost born infant struggling to live is a member of the human family, and partial-birth abortion is a lethal assault against the very idea of human rights and destroys, along with a defenseless little baby, the moral foundation of our democracy because democracy is not, after all, a mere process. It assigns fundamental rights and values to each human being, the first of which is the inalienable right to life.

One of the great errors of modern politics is our foolish attempt to separate our private consciences from our public acts, and it cannot be done. At the end of the 20th century, is the crowning achievement of our democracy to treat the weak, the powerless, the unwanted as things? To be disposed of? If so, we have not elevated justice; we have disgraced it.

This is not a debate about sectarian religious doctrine nor about policy options. This is a debate about our understanding of human dignity, what does it mean to be human? Our moment in history is marked by a mortal conflict between culture of death and a culture of life, and today, here and now, we must choose sides.

I am not the least embarrassed to say that I believe one day each of us will be called upon to render an account for what we have done, and maybe more importantly, what we fail to do in our lifetime, and while I believe in a merciful God, I believe in a just God, and I would be terrified at the thought of having to explain at the final judgment why I stood unmoved while Herod's slaughter of the innocents was being reenacted here in my own country.

This debate has been about an unspeakable horror. While the details are graphic and grisly, it has been helpful for all of us to recognize the full brutality of what goes on in America's abortuaries day in and day out, week after week, year after year. We are not talking about abstractions here. We are talking about

life and death at their most elemental, and we ought to face the truth of what we oppose or support stripped of all euphemisms, and the queen of all euphemisms is `choice' as though one is choosing vanilla and chocolate instead of a dead baby or a live baby.

Now, we have talked so much about the grotesque; permit me a word about beauty. We all have our own images of the beautiful; the face of a loved one, a dawn, a sunset, the evening star. I believe nothing in this world of wonders is more beautiful than the innocence of a child.

Do my colleagues know what a child is? She is an opportunity for love, and a handicapped child is an even greater opportunity for love.

Mr. Speaker, we risk our souls, we risk our humanity when we trifle with that innocence or demean it or brutalize it. We need more caring and less killing.

Let the innocence of the unborn have the last word in this debate. Let their innocence appeal to what President Lincoln called the better angels of our nature. Let our votes prove Raskolnikov is wrong. There is something we will never get use to. Make it clear once again there is justice for all, even for the tiniest, most defenseless in this, our land.

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ABC NEWS

SHOW: ABC NIGHTLINE (11:35 pm ET)

FEBRUARY 26, 1997

Transcript # 97022601-J07

TYPE: SHOW

SECTION: NEWS

LENGTH: 3940 words

HEADLINE: THE DEBATE OVER PARTIAL BIRTH ABORTIONS REIGNITES

GUESTS: RON FITZSIMMONS, KATE MICHELMAN

BYLINE: JACKIE JUDD, TED KOPPEL

HIGHLIGHT:
INTERVIEW WITH RON FITZSIMMONS AND KATE MICHELMAN

BODY:

ANNOUNCER: February 26th, 1997.

TED KOPPEL, ABC News : (voice-over) It's a controversial procedure -- partial birth abortion.

Pres. WILLIAM J. CLINTON: This is not about the pro-choice or life debate.

TED KOPPEL : (voice-over) And it was an equally controversial decision by the president to support it.

Pres. WILLIAM J. CLINTON: There are a few hundred women every year who have personally agonizing situations.

TED KOPPEL : (voice-over) But did the president get bad information?

Rep. CHRISTOPHER SMITH, (R), New Jersey: He just passed it off as very rare and 500 per year as though the others, and that is unmitigated nonsense.

TED KOPPEL : (voice-over) This abortion rights activist says I lied through my teeth on Nightline about what clinics are doing.

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RON FITZSIMMONS, National Coalition of Abortion Providers: I would say that there are probably total the number of these abortions maybe 3,000, 4,000 a year.

TED KOPPEL : (voice-over) Tonight, the debate over partial birth abortions reignites.

ANNOUNCER: This is ABC News Nightline. Reporting from Washington, Ted Koppel.

TED KOPPEL: You can bet it caught our attention this morning when the executive director of the National Coalition of Abortion Providers was quoted in the New York Times as saying that he had lied through his teeth during a November 1995 appearance on Nightline.

The subject had been late term abortions and Ron Fitzsimmons said he felt physically ill because he had left people with the impression that the procedure was used rarely and only on women whose lives were in danger or whose fetuses were damaged. That, he now wants everyone to know, is not true.

We were concerned on two levels. One, if the truth about late term abortions has been concealed, that's an important piece of information and we should help get it out. And two, if this program was used to spread false information, we should correct it.

Let me take the second and easiest part first. Mr. Fitzsimmons appeared twice on the program in question. During the opening, he was heard and seen for about five seconds. Here's how that went.

ABORTION RIGHTS ACTIVIST: Partial birth abortion kills a little baby boy or a girl.

RON FITZSIMMONS: What they really want, of course, is to outlaw abortion ultimately.

TED KOPPEL: Later, during a Dave Marash report, Mr. Fitzsimmons reacted to the term partial birth abortion when he said this.

RON FITZSIMMONS: We're not talking about the birth of a child here. We're talking about, in fact, just the opposite when we're talking about late term abortions.

TED KOPPEL: That was it. That was all we used of our interview with Mr. Fitzsimmons. The material that would later so upset him was never shown on Nightline. But that doesn't address the more important issue. If President Clinton vetoed a bill that would have outlawed partial birth abortions because pro-choice advocates like Mr. Fitzsimmons are spreading false information, that is an issue we need to address and tonight, we will.

We begin with this report from Jackie Judd.

JACKIE JUDD, ABC News : (voice-over) As head of an organization representing 200 abortion clinics, Ron Fitzsimmons largely worked in the background of the abortion rights movement. Today, he single- handedly reignited the issue of late term abortions.

(on camera) His part of the story begins in 1995. In portions of an interview with Nightline which were not broadcast, Fitzsimmons said that annually, 450 abortions in which a fetus is essentially sucked out of the birth canal took place in women very late in their pregnancies. These third trimester abortions, he said then, were almost always done to save the mother's life or because the fetus could not survive outside the womb.

(voice-over) That part of Fitzsimmons' story did not change today, but he has added to it. Fitzsimmons says based on conversations with doctors and the clinics he represents, there are several thousand more of these procedures performed annually in the latter part of a woman's second trimester, in some cases, when a fetus is viable and could survive outside the womb.

RON FITZSIMMONS: The majority of these procedures are performed in the late second trimester on healthy women and healthy fetuses. That's -- the law allows that. Women come in at that point unfortunately, for whatever reason, seeking abortion services.

JACKIE JUDD : (voice-over) That, coupled with newspaper articles in which Fitzsimmons suggested the pro-choice movement had known and deliberately ignored this information, lit the match to a debate that had ended last year with a presidential veto.

Pres. WILLIAM J. CLINTON: This terrible problem affects a few hundred Americans every year.

JACKIE JUDD : (voice-over) Citing statistics that the abortions were extremely rare and done only in dire emergencies, President Clinton vetoed the bill that would have completely banned the procedure.

Pres. WILLIAM J. CLINTON: This is not about the pro-choice, pro-life debate. This is not a bill that ever should have been injected into that.

Rep. CHRISTOPHER SMITH: The abortionist here is pulling the child all the way out of the womb and into the birth canal.

JACKIE JUDD : (voice-over) Next week, abortion opponents plan to introduce the bill again. So Ron Fitzsimmons' comments, from their point of view, could not have come along at a better time.

DOUG JOHNSON, National Right To Life Committee: Our hope is that as the American public comes to recognize that these brutal abortion procedures are, indeed, performed thousands of times a year on healthy babies of healthy mothers that there will be enough public outrage that we will be able to override the president's veto.

JACKIE JUDD: The nuance in Fitzsimmons' comments talking about second trimester and not third trimester abortions was ignored today by abortion opponents.

Rep. CHRISTOPHER SMITH: I think this was several steps forward for the pro-life movement, because again, out of the ranks of the pro- abortionists has come someone who's said, a whistle blower, if you will, it's not what we said it was. It's untrue.

3-11

Grim Arithmetic

As an exercise in the spirit of Petty, Farr, Bolliol, and Dublin, we might ask, "What would be the impact of 1.5 million additional lives on the U.S. economy?"

To derive a number, let us make a few arbitrary assumptions:

(1) Children not aborted would have become "wanted," either by the decision of the mother to keep the child or through adoption.

(2) When projecting an individual's earnings into the future, cancel out two factors: (a) an expectation that real earnings will, on average, rise by 2 percent per year; and (b) an average annual discount rate of 2 percent.

(3) In determining average future annual money income, utilize figures provided by the U.S. Census Bureau. In 1992, the median money income of a U.S. male with income, 25-34 years old, was $26,533; for those ages 35-44, $34,945. For U.S. women, the comparable figures were $21,999 for those ages 25-34, and $24,189 for those ages 35 to 44. These figures include all adult persons in the relevant age categories, regardless of whether they are engaged in full or part-time employment, and regardless of their race and marital status. The folk conjured up here are, in short, to be thoroughly average. To translate 1992 figures into 1995 dollars, assume an adjustment of 4 percent a year, delivering figures of: men (ages 25-34), $29,846; women (ages 25-34), $24,745; men (ages 35-44), $39,308; women (ages 35-44), $27,209.

It appears that the long-term negative economic impact of abortions performed in the United States since 1970 approaches $2 trillion annually.

(4) Among the age cohorts considered here, .497 are men, and .503 are women.

(5) A conservative economic multiplier, measuring the stimulative effect of an individual's economic activity on others, would be 2.0 (a figure which assumes a marginal propensity to consume of 0.50).

The calculated impact on national income of 1.555 million economically active lives, if born in 1980, would in the year 2010 be $84,841,412,840. (See table 1.)

Of course, such additional persons draw on certain forms of social support, including public education and Social Security. In a 1[illegible] paper, economist Marvin DeVries calculated that an additional 1.5 million people would run up total social welfare costs (in 1983 dollars) of $240.9 billion during their first 18 years and after retirement at age 65.[20] Adjusted into 1995 dollars, at the rate of 5 percent a year, and to the 1.555 million number, the figure becomes $432 billion. Divided by a working life span of 47 years, we secure the figure of $9.66 billion to be deducted each year. For the year 2010, this leaves a net increase in national income of approximately $75.9 billion, even after the phantom children have paid for their own public education and socially funded retirement.

A more interesting number comes as we look at the cumulative impact of abortion. Between 1970 and 1995, approximately 35 million legal abortions occurred in the United States. Of these, 9,347,167 occurred in the 1970-79 period, and 25,147,000 in the 1980-95 period.[21] For the year 2014, the economic effect of these additional 35 million Americans would be $1,993,097,186,600. (See table 2.)

This figure approaching $2 trillion offers interesting extensions. If the government's budget deficit is a concern, for example, and if one assumes that 25 percent of income goes toward federal taxes of one sort or another, this lost population would have generated an additional $448 billion in tax dollars in 2014 alone. If one looks only at Social Security, additional wage or self-employed income of this magnitude would be taxed at a total rate of at least 15.30 percent, which represents a lost $274 billion in payroll tax revenue in that year alone.

Such calculations, of course, are merely illustrative, and subject to many caveats. Nonetheless, they suggest the magnitude of the usually overlooked economic consequences of abortion.

Table 1:

Men: $ 29,846 x .497 x 1,555,000 x 2.0 = $ 46,132,066,820

Women: $ 24,745 x .503 x 1,555,000 x 2.0 = $38,709,345,840

Total additional national income, in 2010 (using 1995 dollars) = $ 84,841,412,840

Table 2:

Ages 35-44:

Men: $34,308 x .497 x 9,347,167 x 2.0 = $365,213,929,600

Women: $27,209 x .503 x 9,347,167 x 2.0 = $255,853,029,200

Ages 25-34:

Men: $24,846 x .497 x 25,147,000 x 2.0= $746,034,137,800

Women: $24,745 x .503 x 25,147,000 x 2.0= $625,996,090,000

TOTAL = $1,993,097,186,600

3 -12

STATE OF KANSAS

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OFFICE OF THE GOVERNOR

TESTIMONY REGARDING "WOMENS RIGHT TO KNOW"
SENATE FEDERAL & STATE AFFAIRS COMMITTEE
THURSDAY MARCH 13, 1997
CLYDE GRAEBER, LEGISLATIVE LIAISON

Madame Chair and members of the Senate Federal & State Affairs Committee, I appreciate the opportunity to appear before you today on behalf of Governor Graves to share with you his thoughts regarding the proposed "Woman's Right to Know" legislation.

No doubt, each of you have read or seen accounts where the Governor has indicated his concerns about the current versions of this proposal. Some of the provisions in the 1996 bill which he expressed concern about in his veto message remain prominent in this year's proposals.

Governor Graves believes it is his responsibility to spell out what he would find acceptable in legislation such as this. First, the Governor believes women must have a right to a face-to-face meeting with the actual physician who would perform the procedure. Some attorneys who have spoken with the Governor on this subject advise him that women currently have that right. Nonetheless, Governor Graves has no objection to delineating that right in statute so there is no question that such a right is protected by law and required in both written and verbal instructions provided when a woman first inquires about the procedure.

Second, the legislation may require the physician at such a meeting to discuss with the patient: (1) facts concerning the procedure, possible alternatives, and available options; and (2) the availability of community resources to help bring the baby to term and assist her after the birth. The legislation may then permit the patient to acknowledge -- on forms provided by the Kansas Department of Health & Environment (KDHE) -- when the meeting occurred, who was present, what topics were discussed, and what information was provided to the woman regarding the procedure. This face to face meeting must be held at least 8 hours before the abortion procedure is begun.

In those situations where the patient does not request or desire to have the face-to-face meeting, the same information required by the proposed legislation must be delivered to her at least eight hours before the procedure takes place. Delivery of the information could be acknowledged on forms approved and provided by KDHE. This way there could be no question that comprehensive, necessary information is provided for and received by the patient.

Sen. Federal & State Affairs Comm.
Date: 3-13-97
Attachment: # 4

The Governor is also greatly concerned with the extraordinary liability that would be placed on the performing physician. This same concern was expressed in his veto message last year. Kansas statutory and common law places very stringent duties and responsibilities on our physicians. If they fail to honor those duties and responsibilities, they are subject to severe personal, professional and legal scrutiny and liability (KSA 65-2801; Funke v. Fieldman, 212 Kan. 524[1973]). As a matter of public policy there is simply no justification for imposing greater or lesser liability strictures on doctors who perform this procedure.

Governor Graves encourages you, the members of the Senate Federal & State Affairs Committee, to consider the substitution of this concept of 'Woman's Right to Know" for HB 2269 and SB 230. Copies in draft form of this legislation have been delivered to your committee secretary.

####

PROPOSED SUBSTITUTE BILL NO. ____

By

AN ACT concerning abortion; relating to certain requirements before the performance thereof; amending K.S.A. 65-6706 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-6706 is hereby amended to read as follows: 65-6706. (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, orally and in writing ~~not less than eight hours before the abortion~~, of the right of such woman to request a meeting with the physician who is to perform the abortion. If a meeting is requested, the meeting shall be held not less than eight hours before the abortion. At such meeting, pregnancy and counseling information shall be provided. Such information and counseling shall include:

(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.

Sen. Federal & State Affairs Comm
Date: 3-13-97
Attachment: #5

A woman may waive, in writing, the right to meet with the physician who is to perform the abortion. If a woman waives the right to a meeting, written materials containing the information specified in paragraphs (1) through (4) of this subsection shall be provided to the woman not less than eight hours before the abortion.

A woman shall certify in writing on a form provided by the department of health and environment, prior to the abortion, that the information required to be provided by paragraphs (1) through (4) of this subsection has been provided.

A woman may withdraw consent to an abortion at any time prior to the abortion.

(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.

(d) A physician shall be held to the same duties and responsibilities and standard of care in the performance of an abortion as in the performance of any other medical procedure. Nothing in this section shall be construed as imposing any liability in addition to the liability for which a physician would otherwise be liable for any other medical procedure.

Sec. 2. K.S.A. 65-6706 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

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TESTIMONY REGARDING SB 234
SENATE FEDERAL & STATE AFFAIRS COMMITTEE
CLYDE GRAEBER, LEGISLATIVE LIAISON TO THE GOVERNOR
THURSDAY, MARCH 13, 1997

Madame Chair and members of the Senate Federal & State Affairs Committee, Governor Graves appreciates the opportunity to share his concerns with you on a matter of public policy important to the people of Kansas.

Before the 1997 session of the Kansas Legislature convened, the Governor expressed publicly that he would be willing to sign into law properly worded legislation that would outlaw partial birth abortion in the state of Kansas.

That position has not wavered, and now that the issue is before the Legislature, he is grateful for the chance to further delineate his views.

Governor Graves has devoted a great deal of time and thought to this issue, and has sought the counsel of many Kansans with an interest in this policy question.

The Governor concurs with the language of the current legislation which would allow this procedure only in those rare and extreme circumstances when it is deemed necessary to save the life of the mother.

Governor Graves has stated that this procedure is personally abhorrent to him, and while he is convinced that few occur in Kansas, he supports the efforts to enact a state law which would ban this procedure in our state.

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Sen. Federal & State Affairs Comm
Date: 3-13-97
Attachment: #6

Testimony Regarding S.B. 230
Informed Consent

Patrick R. Herrick, M.D, Ph.D.

Training:

Medical Scientist Training Program, an NIH-sponsored program at the University of Iowa, 1986-92.
Successfully completed doctoral thesis in Biomedical Engineering, 1992.
Residency at the University of Missouri-Columbia Department of Family & Community Medicine, 1992-95.
Chief Resident, 1994-95.
During that year, this department was rated #2 in the country by Newsweek.

Practice:

Board-certified Family Physician at Associates in Family Care, Olathe.
Medical Staff, with privileges including Obstetrics; Olathe Medical Center and Overland Park Medical Center.
Volunteer, Johnson County Health Partnership Clinic and medical support for Johnson County Pregnancy Center.

Informed Consent

"Informed consent is rooted on the principle that a patient who is competent has the *right to decide* the medical treatment rendered. However, since the patient is presumably unschooled, the patient is dependent upon the physician for the information upon which to make the decision, and has the *right to expect* the physician will competently provide the needed *information*." (1) (emphases mine)

"The current, most common standard, introduced in 1972, is the 'reasonable man' standard of material risk, which means that physicians must tell a patient what a reasonable person in the patient's position would want to know, and that risks that are not serious or are unlikely are not considered material. Most courts expect the disclosure before a procedure to include diagnosis, the nature of the proposed procedure, risks and benefits of the procedure, available alternatives and their risks and benefits, and the consequences of not having the procedure." (2)

"There is rarely an exception to the rule that all procedures should be preceded by the patient's consent." (2)

David Reardon, in 1987, published the results of his survey of over 250 women belonging to an post-abortion support group, with results germane to informed consent (3):

- 81% felt "rushed to have an abortion".
- 82% felt the abortion decision was not "well thought out".
- 93% felt they did not have "all the necessary information to make the decision".
- 91% said the clinic, doctor, or counselor did not "help you explore your decision".
- 80% were not "encouraged to ask questions".
- 81% believed "there was information you were not given, or were misinformed about".
- 81% said "risks and dangers" were not discussed.

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The proposed legislation changes current law (4) by mandating the following:

- **personal** counseling (Section 2.a). "Informed consent is not someone else's responsibility. It is the duty of the physician ordering or performing the treatment to see that the information is supplied and the informed consent obtained." (1)
- **oral** counseling (Section 2.a). "Give the patient the necessary information. This includes *discussing* (emphasis mine) with the patient (i) the nature and purpose of the proposed treatment, (ii) its expected outcome or probability of success, (iii) disclosure of the material risks associated with the treatment course of action, (iv) alternative possible courses of treatment, and (v) the effect of not having any treatment, the effect of absence of treatment on outcome and the material risks of going without treatment." (1)
- the **name of the abortion doctor** (Section 2.a.1). See Figure 1.
- the **availability of medical assistance benefits** (Section 2.b.1). "The following essentials must be observed: 1. Determine the patient's capacity to give informed consent, i.e., the patient's ability to (i) comprehend the relevant information, (ii) *consider the available choices and relate them to his particular circumstances* (emphasis mine), and (iii) communicate his decision." (1)
- the **liability of the father for child support** (Section 2.b.3). See above.
- **information describing her child's development** (Sections 2.a.3, 2.b.2, & 4.a.5). Destroying one's offspring, when it has a beating heart and the easily recognizable form of a human baby, is undeniably serious; therefore it is a material risk of the abortion procedure, and required for consent. See Figures 2-5.
- **penalty for violation** (Section 6). The Reardon data show the failure of self-policing in regard to the abortion procedure. (3)

The decision about abortion is so momentous that it is best made with as much information as possible. One must question the advisability of limiting the material available to women in a situation which will have profound lasting effect.

1) T.G. Kokoruda & K.J. Goza. Malpractice Prevention: A Lawyer's Perspective. Syllabus for Risk Management Seminar presented by Research Medical Center of Kansas City, 1996.

2) J.G. Moy. Informed Consent. In: Procedures for Primary Care Physicians. J.L. Pfenninger & G.C. Fowler, eds. Mosby, 1994.

3) D. Reardon. Aborted Women: Silent No More. As reported on Ohio Right to Life Web site, forwarded by Human Life International. 1987.

4) J.E. Koehler. Kansas Abortion Law: Fact Sheet. Kansans for Life.

5) K.L. Moore. The Developing Human: Clinically Oriented Embryology, 3rd ed. W.B. Saunders.

6) M.H. Klaus & A.A. Fanaroff. Care of the High-Risk Neonate. W.B. Saunders, 1993.

BOX 134–2. PATIENT CONSENT FORM

I came to the office of Dr. ____________ on ____________ [date] for evaluation and treatment of the following condition:

(description of diagnosis, etiology, and differential diagnosis)

We discussed the different treatments possible, and discussed the risks of not treating the condition. Based upon the advice given by Dr. __________ and my own judgment, I agree to undergo the following procedure:

(description of anesthetic, procedure, and dressing)

We discussed the different outcomes that could occur, and most of the possible complications. I am aware that other complications could occur that we could not foresee. I agree to follow the instructions for self-care after the procedure, and to return for follow-up care on: ____________________.

I will call the office or answering service if any problems arise before the scheduled follow-up visit.

______________________ ______________________

Patient signature Date and time

______________________ ______________________

Witness signature Physician's signature

One copy for chart, one copy for patient

Figure 1 (2)

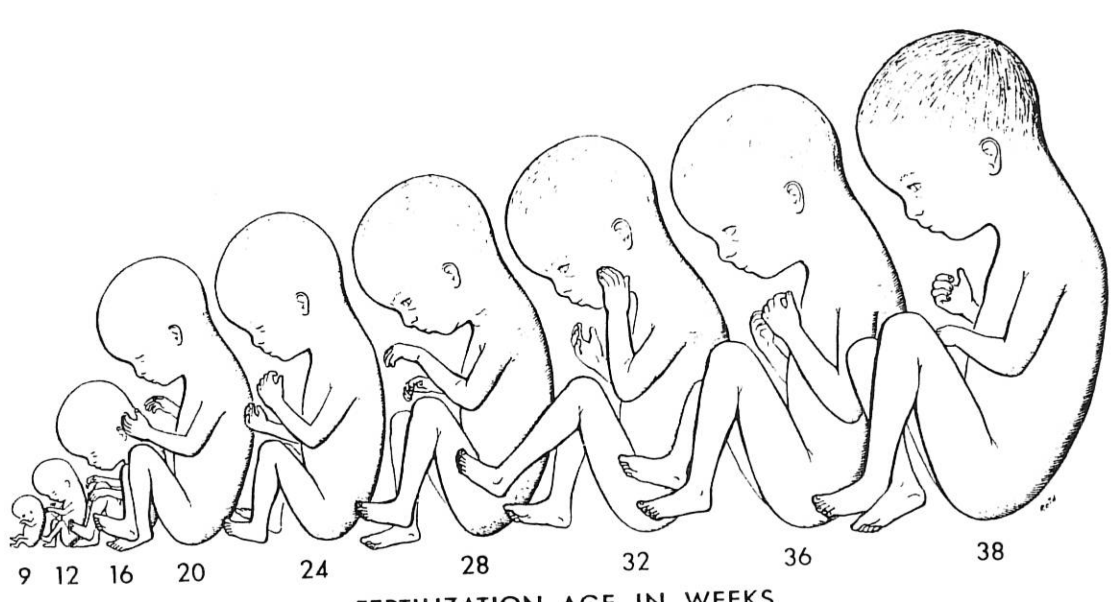


Figure 6–1 Drawings of fetuses, about *one-fifth actual size.* Head hair begins to appear at about 20 weeks. Eyebrows and eyelashes are usually recognizable by 24 weeks, and the eyes reopen by 26 weeks. Fetuses born prematurely (22 weeks or more) may survive, but intensive care is required. The mean duration of pregnancy is 266 days (38 weeks) from fertilization, with a standard deviation of 12 days. *In clinical practice,* it is customary to refer to full term as 40 weeks from the first day of the last menstrual period (LMP), assuming that conception occurs two weeks after the onset of menses. Thus when a doctor refers to a pregnancy of 20 weeks, the true duration or actual age of the fetus is only 18 weeks. (5)

Figure 2

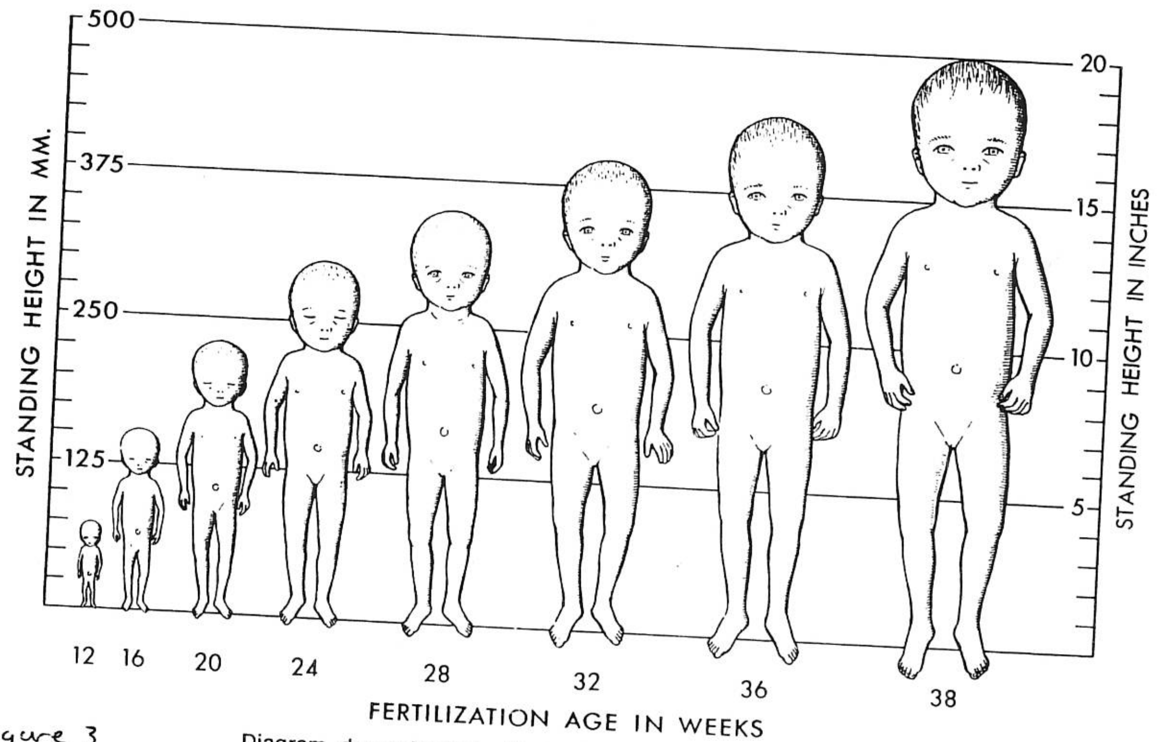


Figure 3
Diagram, drawn to scale, illustrating the changes in size of the human fetus. (5)

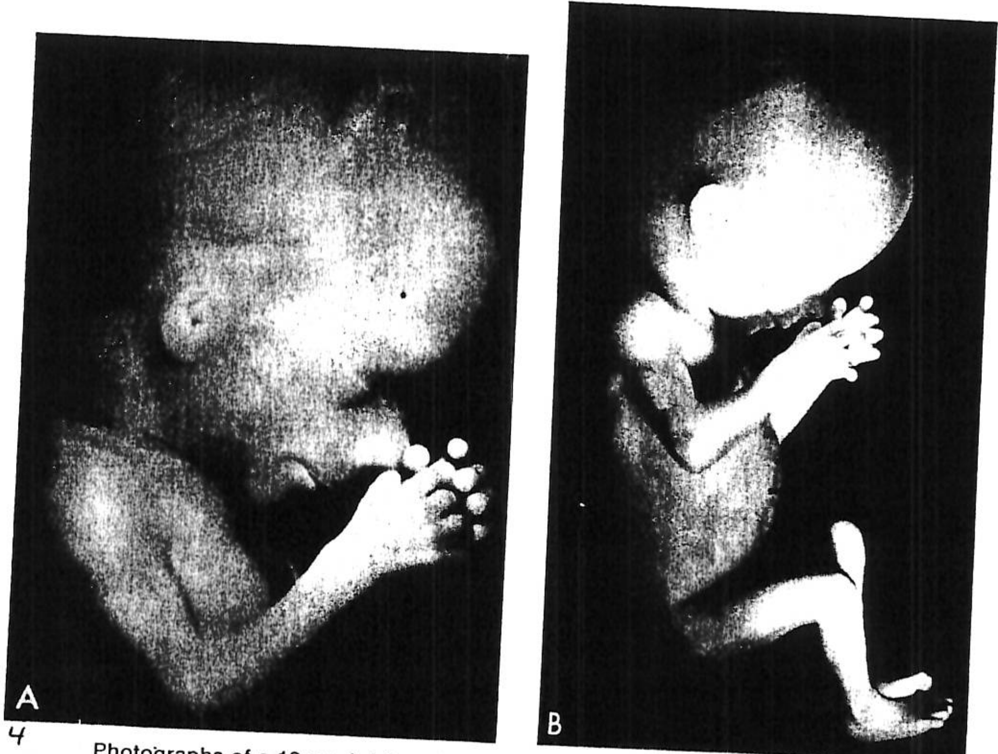
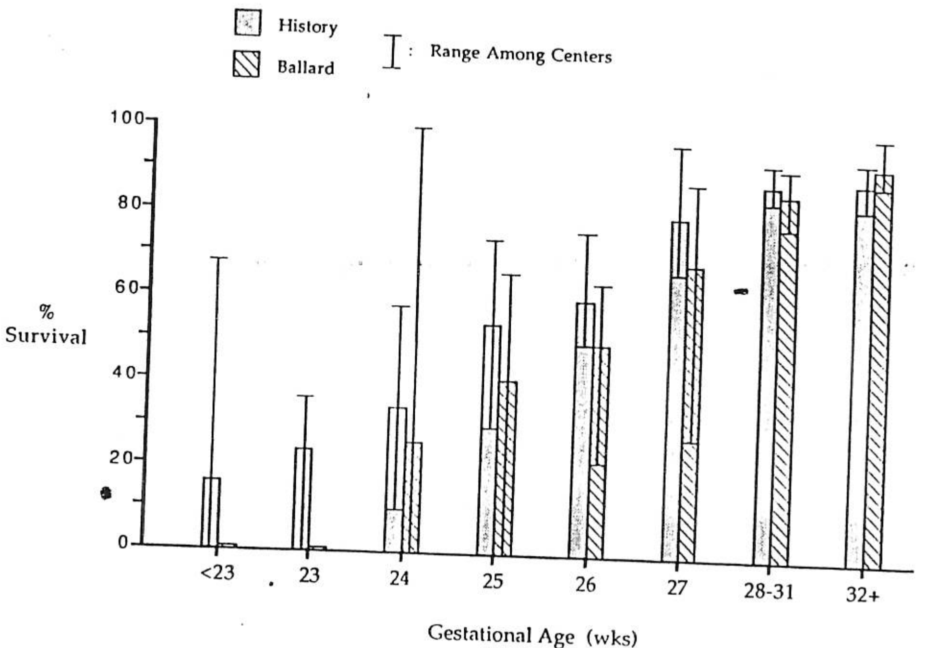


Figure 4
Photographs of a 13-week fetus. *A*, An enlarged photograph of the head and shoulders of this fetus that appears on the cover of this book (×2). *B*, *Actual size.* (Photographed by Professor Jean Hay, Department of Anatomy, University of Manitoba, Winnipeg, Canada.) (5)

Appendix H–2*
Percent Survival by Gestational Age According to the Obstetric Parameters and Physical Component of the Ballard



*From Hack M, Horbar JD, Malloy MH, et al: Very low birth weight outcomes of the National Institute of Child Health and Human Development Neonatal Network. Pediatrics 87:587, 1991. Reproduced by permission of Pediatrics.

Figure 5 (6)

Testimony Regarding S.B. 234
Partial-Birth Abortion

Patrick R. Herrick, M.D, Ph.D.

Partial-Birth Abortion

Brings the body of a living fetus through the birth canal, only to destroy it before its head is delivered. See Figure 6.

The procedure is executed after the 16th week of pregnancy. (2)

According to its proponents, partial-birth abortion is:

- not the only method available to commit abortion at any gestational age. (2)
- performed on a "purely elective" basis 80% of the time. (3)
- not rare; 1500 in New Jersey alone each year. (4)

"The situation where the mother's life is at stake were she to continue a pregnancy is no longer a clinical reality. Given the state of modern medicine, we can now manage any pregnant woman with any medical affliction successfully, to the natural conclusion of the pregnancy: the birth of a healthy child." (5)

"Truly, I say to you, as you did it to one of the least of these my brethren, you did it to me." (6)

1) Partial-Birth Abortion fact sheet. Kansans for Life.

2) ACOG Statement of Policy: Statement on Intact Dilatation and Extraction. The American College of Obstetricians and Gynecologists, 1997.

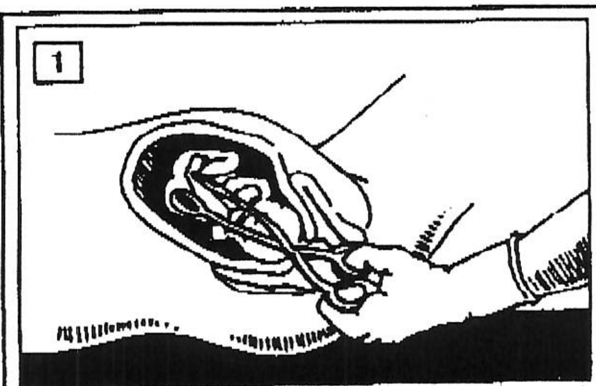
3) M. Aiello. Some Key Facts on Partial-Birth Abortions. Cites Dr. Martin Haskell interviews with American Medical News, 7/5/93 & 11/20/95. National Federation of Catholic Physicians' Guilds Newsletter, June 1996.

4) Ruth Padawer. As related by Dr. Michael Aiello. The Record (a N.J. newspaper), 9/16/96.

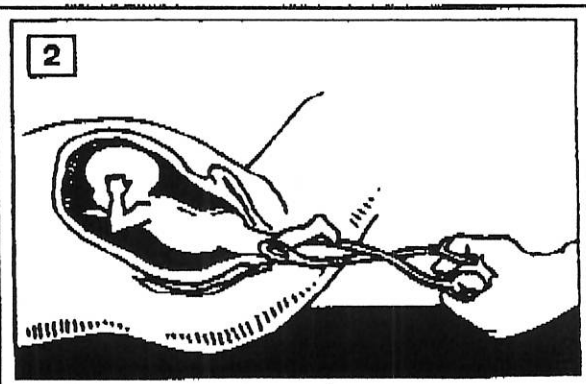
5) B.N. Nathanson. Letter to Idaho State Representative Pam Bengson, 2/16/90.

6) Gospel of Matthew, 25:40.

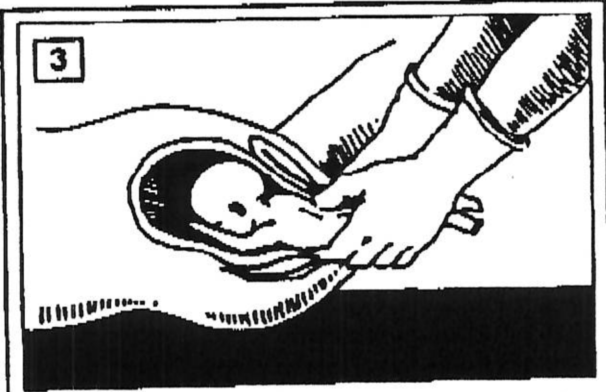
PARTIAL-BIRTH ABORTION



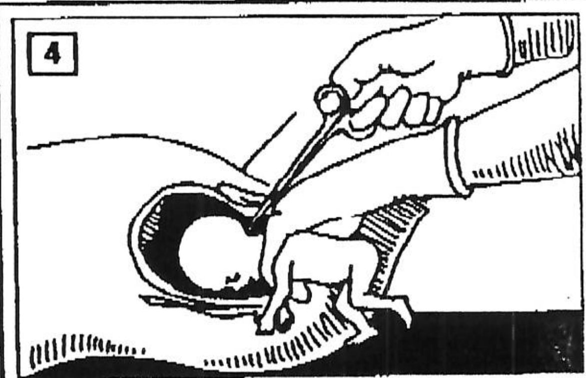
Guided by ultrasound, the abortionist grabs the baby's leg with forceps.



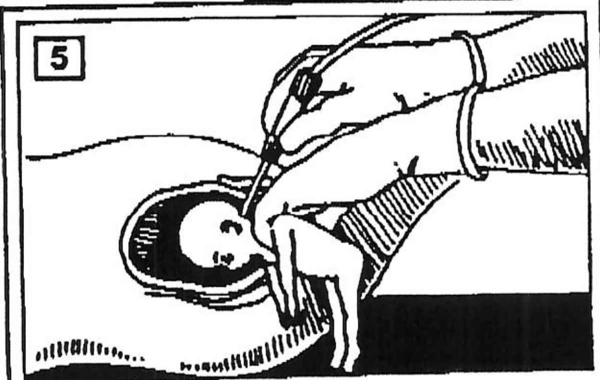
The baby's leg is pulled out into the birth canal.



The abortionist delivers the baby's entire body, except for the head.



The abortionist jams scissors into the baby's skull. The scissors are then opened to enlarge the hole.



The scissors are removed and a suction catheter is inserted. The child's brains are sucked out, causing the skull to collapse. The dead baby is then removed.

Figure 6 (1-KFL)

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; **and**
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

continued. . .

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920 • Washington, DC 20090-6920 Telephone 202 638 5577

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Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the **only** option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. **The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.**

Approved by the Executive Board
January 12, 1997

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3/13/97

KANSANS FOR LIFE SUPPORTS HB 2269 and SB 230
The Woman's Right to Know Act

This legislation is Pro-Woman. It simply advocates an end to situations where women are prevented from informed decision-making. This bill would insure that women receive scientifically unbiased, medically-sound, facts about abortion, because "choice" is meaningless when information is withheld.

Testimony from the opposition has not stayed on point, stealing valuable legislative time to talk about anything other than the bill's provisions. We can only assume that's because they don't want the public to know that their interest is in protecting the abortion industry no matter what the price paid by abortion-injured women. If abortion was already safe and not predatory, this act wouldn't frighten them.

Women continue to tell us, in counseling and in surveys, that with regard to abortion, they have been: coerced, not fully informed,
not carefully evaluated for risk, and injured without just compensation.

Now, of course, all of those things work to the advantage of a streamlined, assembly-type abortion industry-- something the Supreme Court never envisioned. Roe and subsequent decisions have NOT given abortionists the right to be free of state regulation. Thus Kansas should put an end to abortions that are UNWANTED, UNINFORMED, UNSCREENED and UNCOMPENSATED.

This is a situation of justice, not paternalism. Even the most autonomous person has times when a crisis or unexpected situation makes them stressed and vulnerable. As many as 55% of aborted women report that their decision was not their own; 75% say they violated their own conscience.

It is an authentic role for the state to institute safeguards and penalties to insure that profit-driven businesses do not prey on pregnant women. Lawmakers should not believe that the best interests of women and abortionists are the same. In fact, they are most often in conflict.

This conflict of interest has been attested to by devastated post-aborted women at legislative committee hearings the past few years. Women have regrets, anger and resentment for being misled, rushed, and coerced. They have been mishandled, grievously damaged and even killed during abortion.

The fact is, there are women, whose decision-making was compromised. Don't they deserve the guaranteed protection this act provides?

I ask that the committee find the Women's Right to Know Act favorable for passage.

Jeanne Gawdun, lobbyist

Kansas affiliate to the National Right to Life Committ

Sen. Federal & State Affairs Comm.
Date: 3-13-97
Attachment: #9

9-2

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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Abortion counseling 6b
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Screening for risk factors 8b
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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 previouslv 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.

In treating a woman faced with a crisis pregnancy, it is the physician's duty to help her find the best solutions to her physical and psychosocial health problems. It is superficial, and negligent, to assume that the pregnancy itself is always the real problem, or that aborting it will always solve a woman's problems without causing additional physical or psychosocial problems. As with any medical condition, there are many alternatives for managing a crisis pregnancy. A proper recommendation must be based on an understanding of the precise factors which make up the underlying cause of this health crisis.

The failure to consider alternative options of care is medical negligence. The failure to provide alternatives counseling is also a denial of the patient's right to full disclosure of risks and alternatives and may invalidate the patient's consent. In the event of a civil suit by an injured patient, abortionists can and should be required to defend their recommendation to abort against the standard of medical care provided by non-aborting physicians. The obligation of proving that a medical treatment is safer or more effective than allowing nature to take its course always rests on those who advocate that form of treatment. The promoters of abortion have failed to meet this obligation.

Informed consent standards for abortion must follow the reasonable patient standard. Furthermore, a woman's right to *all* information relevant to an abortion decision cannot be limited by "therapeutic privilege," because abortion is an elective procedure. Indeed, since full disclosure is an integral part of a woman's "abortion liberty" as defined by the Supreme Court, this right must be treated as a basic civil right. Therefore, violation of this right is a violation of a woman's civil liberties and is itself injurious and should be considered grounds for a civil suit.

The importance of maintaining a rigorous standard for full disclosure is demonstrated by reviewing the many biases of abortion providers. Abortion counseling is biased by financial self-interest, paternalism, psychological need, and social concerns which extend beyond the personal needs of the individual patient. When these biases result in directive counseling and the withholding of relevant information, the well-being and autonomy of women is endangered.

Few abortionists adequately screen patients for the known risk factors which pre-identify women as being at higher risk of experiencing psychological maladjustments post-abortion. This lack of adequate screening is due to (1) a desire to streamline abortion services

and avoid extensive pre-abortion evaluations, and (2) a desire to deny that there are *any* post-abortion problems.

In their efforts to dismiss the "minority" of women, 15 to 25 percent, who are known to have post-abortion sequelae, pro-abortion researchers have thoroughly established that there are pre-identifying factors which can be used to predict negative post-abortion reactions. Proper use of these factors in pre-abortion screening would require much more extensive counseling and care than is normally provided today for 70 percent, or more, of all patients requesting abortion.

In terms of civil action against abortion providers, either the failure to identify known risk factors, the failure to notify the patient of potential risk factors, or the failure to refuse an abortion which was contraindicated may provide grounds for a suit claiming malpractice or reckless endangerment.

The business of abortion has evolved into a streamlined service industry which is far removed from the highly professional model of medical care upon which *Roe* was formulated. To reduce the level of involvement by physicians, clients are allowed to self-diagnose their problems and prescribe their own treatment. To further reduce the cost of counseling, and to avoid time-consuming introspection, risk disclosure is minimized, screening for risk factors is non-existent, and alternatives counseling is presumed to be mostly unnecessary. The result is that women are being exposed to dangerous abortions which are injurious to their best interests.

This substandard level of care has evolved, and thrived, because there are artificial legal obstacles which prevent most women from being able to successfully sue their abortionists. Reform will occur only when abortionists become fully liable for protecting women's health and are held fully responsible for ensuring that a woman's consent to an abortion recommendation is fully free and informed.

1. Roe v Wade, 410 U.S. 113(1973) 166 vindicates the right of a physician to administer treatment according to his judgment
2. Maher v Roe 432 U.S. 464, 472 n.7
3. H. L. v Matheson 450 U.S. 397(1980) 412-413

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

Basic Responsibility for the Decision Rests on the Physician

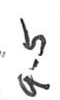
Contrary to popular notions, abortion is not a constitutional right which women are free to exercise autonomously. As *Roe* makes clear, "Some *amici* argue that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree." [6]

A woman's request for abortion is always subject to the review and recommendation of a physician, who bears full responsibility for making that recommendation. This is so because the Supreme Court has repeatedly found that abortion has serious health risks, both mental and physical.[7] Therefore, abortion is not an arbitrary right of women but is rather a medical right which derives from her health needs and can therefore only be exercised after appropriate and sufficient consultation with a "responsible physician." It is by thus intertwining the rights of the patient and the duties of the physician that the Court has attempted to simultaneously advance and *protect* the health of women.

Abortion is best described as a medical procedure which women have a protected liberty to *seek* because of their unique health needs.[8] But this liberty is limited by three factors: (1) the physician's duty to protect the woman's health, (2) the state's interest in protecting the woman's health, and (3) the state's interest in protecting "potential human life." [9]

In describing the duties and obligations of the physician, the Court has been very clear. Physicians are free to provide abortion when, in consultation with their patients, it is *medically determined* to be in their patient's health interests. This is not an arbitrary decision; it is a medical decision. This important distinction was made in *Roe* when the Court concluded its decision with the emphatic statement that "the abortion decision in all its aspects is inherently, and primarily, a medical decision, and *basic responsibility* for it must rest with the physician.[10] [Italics added.]

Furthermore, the Court has consistently held that physicians are obligated to make this medical decision in light of a broad range of health issues, including physical, mental, social and family planning concerns.[11] Thus, as a health issue, "*the attending physician*, in consultation with his patient, is free to determine, without regulation by the State, that, *in his medical judgment*, the patient's pregnancy *should* be terminated."[12] [Italics added.]



In order to reach a "medical judgment" that a pregnancy "should" be aborted, the physician is clearly obligated to thoughtfully weigh on a case-by-case basis, the risks, benefits, and alternative forms of care. This requirement to make an informed medical judgment is intended to protect women from profiteers and to preclude the prostitution of medical skills, which would occur if an abortion were simply provided on request. The role of the physician as a thoughtful protector of the woman's health was further substantiated when the Court emphasized that its "consistent recognition of the critical role of the physician in the abortion procedure has been based on the model of the competent, conscientious, and ethical physician."[13]

Clearly, a competent and conscientious physician would never allow a patient to self-diagnose her own health problems, much less prescribe her own treatment. In reserving to the physician the final judgment of when an abortion may be performed, the Court requires the physician to protect the patient from the grievous harm which can result from her own ignorance of potential risks and alternatives. And in all cases, the recommendation for an abortion, formed on the basis of her broadly defined health needs, should be "for the benefit, not the disadvantage, of the pregnant woman." [14]

To summarize up to this point, while a woman may initiate a request for an abortion, it is the physician's responsibility, in consultation with the patient, to weigh *all* the risks and benefits of every option and make an appropriate medical recommendation. This important, but generally neglected, safeguard in the Court's rulings reflects the fact that the distress of an unplanned pregnancy may lead a woman to make a hasty, rash, ill-informed, or even dangerous decision. It is the physician's role, then, to bring a calm mind to this medical problem, to evaluate the patient's problems, needs, and risks, and to offer her the best care possible given all the complex factors involved. Just as a cancer patient is not free to procure chemotherapy without the review and recommendation of a physician, so a crisis pregnancy patient is not free to procure an abortion without the review and recommendation of a physician who will accept responsibility for what is "inherently, and primarily, a medical decision."

11. In light of all circumstances, psychological, emotional,physical Danforth, 66. Roe 153. Harris v McRaie, 448 U.S. 297(1980),325
12. Roe, 163
13. Abortionists can be held more liable for injuries with this ideal: Akron v Akron Ctr. Reprod. Health, 462 U.S.416 (1983), 448
14. Doe v Bolton, 410 U.S. 179(1973), 192

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 psychological con-ditions 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.

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 th[illegible]st and least painful method of dilatation, and it reduces the ris[illegible] 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.

Avoiding Liability

When critically examined, the typical practices of the abortion industry clearly violate the idealized standards established by *Roe* and the subsequent abortion cases. Instead of "competent, compassionate, and ethical physicians" making informed recommendations for abortion, and fully disclosing to patients all that is relevant to their decisions, we find incompetent, compassionless, unethical technicians dispensing abortions on request without review of risks or consideration of better treatment options.

The abortion industry survives not because it is competent, but because the women it injures are generally so ashamed of what they have done that they don't dare to complain, much less face public humiliation in a lawsuit. This is especially true in the short period of time during which the statute of limitations normally allows malpractice victims to file suit, because it is during this time—immediately after the abortion—that women are most ashamed and most want to put the abortion experience behind them.

The abortion industry is also being protected by laws and judicial standards pertaining to malpractice which tend to favor physicians. For example, in some states, the normal standards for disclosure of risks are interpreted according to the "customary" norms of the medical community. This "community standard" will generally eliminate most opportunities to sue for lack of informed consent. Another example is the requirement placed on the plaintiff to obtain the cooperation of another abortionist to provide expert testimony against the defendant. Since abortionists are loathe to condemn each other, this requirement may pose a major obstacle to recovery.

Furthermore, in all states, malpractice suits are among the most expensive and difficult cases to litigate. Since such cases are usually taken on contingency, attorneys are likely to refuse even a good case if they cannot be confident that they will win a large enough award to cover their expenses. Because of these and other legal hurdles, many women who have suffered injuries for which they would justly be entitled to an award are simply denied the opportunity to have their cases heard.

These hurdles, however, can be removed. Some can be removed by statutes expanding the rights of women injured by abortion, and others can be removed by a more complete adherence to the precedents established in *Roe* and its progeny.

Identifying High-Risk Abortion Patients

The duty to properly screen patients prior to abortion is derived both from the physician's obligation to form a treatment plan which safeguards his patient's health and from the woman's right to be given all of the information relevant to her decision to accept or reject his recommendation.

The failure to adequately screen patients for pre-identifying factors constitutes negligence. Additional negligence occurs if a risk factor is identified and not mitigated by proper treatment, referral, or additional counseling. In addition, the failure to tell a woman or, in the case of a minor, the minor's parents of identifiable risk factors is concealment of relevant information and a violation of the patient's right to full disclosure. Thus, the need to hold the abortion industry accountable for proper pre-abortion screening is undisputable.

In determining the risks and benefits of management options for a crisis pregnancy, a physician is clearly obligated to make an assessment of risk factors associated with specific physical and psychological adverse reactions.[26] Risk factors for physical complications include uterine abnormalities, multiple gestation, cardiovascular disease, renal disease, asthma, epilepsy, diabetes, venereal infection, intoxication or being in a drugged state, obesity, and other pre-existing conditions.[27]

While the physical risks of abortion are significant, the published literature demonstrates that emotional and psychological complications following an abortion are far more common. While there is wide variation among what researchers define to be "significant" emotional complications, all studies show that at least some women are negatively affected by abortion. Even the most dedicated pro-choice researchers generally admit that "[t]here is now virtually no disagreement among researchers that some women experience negative psychological reactions postabortion.[28] The lowest estimate for adverse outcomes is six percent, with typical reports ranging from 12 to 25 percent, and the highest estimates ranging up to 80 percent.[29]

28. Wilmoth, Journal of Social Issues (3):1-17. Also Anne Baker "Counselor's Corner" Hope Clinic for Women (12/94).p.2-4
29. 49% show post abortion maladjustments: Belsey et al. Soc. Sci. & Med., 111:71-82 (1977). 11 studies avg. 15% long, short term negative effects: Dagg. Am. J. Psych. 148:5 (5/91)578-585.

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.

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's psyche determines the *extent* of post-abortion injuries, it is the abortion itself which is the *direct cause* of those injuries.

Pro-abortion researchers, on the other hand, insist that post-abortion maladjustments must be blamed on the character flaws of the individual. This "blame the victim" strategy 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.[32]

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 women for being "whiners" or "dysfunctional." This judgment is a result of their *a priori* belief that abortion "empowers" women. This bias is so strong that some pro-abortion researchers even argue that women should not be told of any 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. Essentially, these pro-abortion researchers are arguing that the suffering of a "few" misfits should not be used to raise doubts among the many.

32. Judith Lewis Herman. Trauma & Recovery(1992) 30.

The Strategic Importance of Screening Requirements

The biases of pro-abortion researchers, however, are not nearly as important as their findings. When examined as a body of literature, the information they have handed us actually demonstrates that the vast majority of women fall into one or more statistically significant high-risk categories. The pro-abortionists themselves have clearly established the importance of adequate screening.

These findings have inadvertently placed the abortion industry in a "Catch-22." Failure to screen makes them liable for negligence. Adequate screening, on the other hand, will demand from them far greater attention to evaluation of each case and a much higher standard of counseling to alleviate the risk factors which are identified. In addition, it must be remembered that the physician has a right and duty to refuse to do a contraindicated abortion. If he performs an abortion despite the presence of known risk factors, and the woman subsequently experiences negative emotional consequences, his recommendation to perform a contraindicated abortion would itself be evidence of either incompetence or negligence.

In short, proof that high-risk factors were present at the time of the abortion, whether identified at that time or not, increases the liability of the abortionist. If they were left unidentified, he is guilty of negligence. If they were identified, and the abortionist persisted in recommending abortion, there was again negligence. Whether the abortion caused the subsequent emotional problems or whether it simply triggered the worsening of previously existing emotional problems is mostly a philosophical issue. The relevant fact is that the abortionist knew, or should have known, that the woman's psychological health was at risk.

Another way of looking at the issue of pre-identifying risk factors is to examine how this knowledge *should* affect the standard of care for abortion. A competent physician would properly be expected to (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 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 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-

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

...pth 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.

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.

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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.

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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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 alternatives which would have spared her the injuries she and other women have 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 abor- These women do not want to remain childless. They may even led 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 of

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 qualified 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

9-19

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, therefore 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, 44.

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]

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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

9-22

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, 14

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 evi-

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.

dent 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.

8-23

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 in five women having abortions is doing so in violation of her 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.

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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 hun-

dred thousand dollars to raise a child right. Where are you going to get that kind of money?" This kind of "counseling" is little more than 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]

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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

9-26

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 [illegible]nded 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.

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KANSANS FOR LIFE SUPPORTS SB 234 (PARTIAL-BIRTH ABORTION BAN)

Partial-birth abortions are generally performed in the fifth and sixth months of pregnancy, and sometimes even later. In a partial-birth abortion, the abortionist pulls a <u>living</u> baby feet-first out of the womb into the birth canal, except for the head, which the abortionist purposely keeps lodged just inside the cervix (the opening to the womb). The abortionist punctures the base of the skull with a long surgical scissors or other surgical instrument. He then inserts a catheter into the wound, and removes the baby's brain with a powerful suction machine, after which he completes the delivery of the now-dead baby.

The abortion industry has manufactured a great deal of misinformation about partial-birth abortion, including sweeping assertions that these abortions are very rare and are performed only when the mother's life is in jeopardy and/or the baby suffers from disorders incompatible with sustained life outside the womb. Based on interviews with abortionists and other substantial evidence, at least several thousand partial-birth abortions occur annually in the United States--and the overwhelming majority of these are performed on healthy babies of healthy mothers. Dr. Martin Haskell (the author of a paper with detailed step-by step instructions on how to perform the procedure) has admitted that 80% of the partial-birth abortions he performs are "purely elective."

Recently, Ron Fitzsimmons, the executive director of the National Coalition of Abortion Providers (an organization of 200 abortion clinics) admitted that he "lied through my teeth" when he, along with the entire abortion lobby, told the American people that partial-birth abortions were rarely performed and done only to save women's lives or in the cases of seriously malformed babies. Mr. Fitzsimmons lied because he feared that the truth would hurt the cause of abortion rights. What are we to conclude from this other than the fact that truth means little to people committed to protecting the abortion industry at all costs?

A group of over 400 physician-specialists, including former Surgeon General C. Everett Koop, have formed an organization called the Physicians Ad Hoc Coalition for Truth (PHACT) in an effort to tell the public the truth about partial-birth abortions. They say that "partial-birth abortion is never medically necessary to protect a mother's health or future fertility. On the contrary, this procedure...can pose a significant threat to both her immediate health and future fertility."

SB 234 prevents a gruesome procedure that is more infanticide than abortion from being performed on unborn children in the state of Kansas. Even those who are loathe to bestow personhood on the unborn child should, at the very least, be incensed at a procedure that is so outrageous that we would not allow it to be performed on an animal.

Jeanne L. Gawdun
Lobbyist

Kansas affiliate to the National Right to Life Committ

Sen. Federal & State Affairs Comm.
Date: 3-13-97
Attachment: #10

In Partial Birth Abortion, Why is the Baby Delivered Feet First?

By Alexander F. Metherell, M.D., Ph.D., Laguna Beach, CA.

There are three peculiar things to note about how a partial birth abortion is performed:

1. In a third trimester pregnancy the position of the baby in the womb is more often than not in the vertex, or head down, position. This is why most deliveries are done head first. It is also safest for the baby and the mother. Why then, does the abortionist turn the baby around in the womb into the double footling position where both feet come out first?

2. When a physician operates on a patient the area being operated on is **always brought into view** so that the surgeon can see what he or she is operating on. For example, when doing an appendectomy the abdomen is opened to bring the appendix into view so that it can be safely removed. Why then, does the abortionist turn the baby around by grabbing the baby's leg inside the womb with a clamp and then pull the baby out feet first exposing every part of the baby **except** the head, which is the part of the baby that the procedure is performed upon?

3. It would seem to be far easier, quicker, and humane to suction out the brains of the baby by allowing the head to come out first and then to insert the suction cannula through the top of the baby's head (through the soft fontanel where the baby skull has not joined.) Because the abortionist can see better and the route to the mid brain and brain stem is much more direct, the baby would be essentially dead in one second. This would eliminate the pain and suffering to the baby of having the feet crushed by the clamp used to pull him or her out feet first, and would save the terrible pain of having the surgical scissors thrust into the back of the neck and spread to allow the cannula to be driven up through the base of the skull before the brains can be sucked out. Why go to this extraordinary effort to keep the head inside the mother when the baby is killed? Answer: *Because the baby would scream.*

In the way it is done now, the baby screams as soon as the leg is crushed by the clamp — and continues to scream until the head is evacuated of the brains — but those screams are silent because the lungs and trachea remain full of amniotic fluid. Sound from the vocal chords is not generated until air passes by them. This cannot happen until the head comes out of the birth canal and the baby takes his or her first breath. If the abortionist allows the head to come out first, the screams of the baby would be too psychologically upsetting to the mother and the nurses assisting in the procedure. To eliminate the **sounds** of the screams, the baby is put through increased torture and the mother's womb and birth canal are more traumatized by the process of inserting the forceps into the womb and turning the baby — just to prevent the baby's screams from becoming audible.

TESTIMONY

S.B. 230, H.B. 2269, S.B. 234

SENATE FEDERAL AND STATE AFFAIRS COMMITTEE
Thursday, March 13, 1997 - 11:00 a.m. - Room 254-E

KANSAS CATHOLIC CONFERENCE
Beatrice E. Swoopes, Program Coordinator

Chairwoman Oleen, members of the 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 the above mentioned bills. My primary focus will be **S.B. 230 and H.B. 2269** which deal with Informed Consent.

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

Sen. Federal & State Affairs Comm
Date: 3-13-97
Attachment: #11

S.B. 230 and H.B. 2269 which addresse a "woman's right to know" are good approachs. Either bill 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 strongly support S.B. 230 and H.B. 2269.

****

As regards the partial birth abortion ban, the Catholic Bishops of Kansas have made this one of their targeted legislative objectives. They act in concert with the United States Bishops in seeking to end this "inhumane abortion technique that is more like infanticide".

We strongly urge this committee to vote favorably S.B. 234.

Senate Hearing Testimony

Regarding Informed Consent Bills

My name is Brad Brown. I am a legislative intern for Senator Nancey Harrington. I am a law student at the University of Kansas School of Law. My educational background includes an MBA degree from Purdue University and a management degree from Friends University. I have no emotional involvement in the subjection of abortion. Although I am a Christian, my personal religious belief does not condemn legal abortion. I do not believe that legal abortions are a sin or are immoral. My religious belief neither compels nor opposes these bills regarding informed consent prior to performing abortions. I had devoted almost no consideration to the issues relating to abortion prior to working in my present position as intern to Senator Harrington. I have never been involved in any organization or association which supports either a pro-life or pro-choice position regarding abortion.

My present belief is that determination of the legality or illegality of abortion is a State function which must weigh the various interests of society; such as, the interest of an individual in being protected from intrusion by the government, and the government's responsibility to protect the health and welfare of its citizens and prospective citizens. The State of Kansas determines when the killing of another human being constitutes a punishable offense and when it does not. For example, the right to kill another in self-defense has been recognized since ancient times. The statutory recognition of a woman's right to an abortion when her life is threatened by her unborn child is an extension of this right. This determination of the legality of killing is properly a function of the legislature. This determination necessarily must be based on the various beliefs and interests of the citizens constituting the State of Kansas, as well as the possible economic and societal effects of the decision.

As part of my function as an intern, I have been assigned the task of researching the informed consent requirement in the proposed bills. I have researched the constitutionality of the proposed bills, performed a personal public opinion survey to give an indication of the likely reception of the bill by the public, and developed a model to estimate the likely economic effect of the bill on the State of Kansas. My conclusion is that the proposed informed consent bills are well

within present constitutional limits, that an informed public is likely to support or at least not oppose, the proposed bills, and that these bills would increase the State Domestic Product by an estimated $10,912,500 per year per year as of 2015 for a period of approximately 35 years and negatively impact abortion providers by $400,000 per year by 1998.

Constitutionality

My research regarding constitutionality has consisted of reviewing several hundred of the 3,931 citations to Roe v. Wade, 410 U.S. 113 (1973) as of February of this year. I have examined all of the Kansas cases which have cited Roe. I have also examined several hundred of the 779 secondary sources, such as law reviews and law reports, that have cited Roe. The citations that I did not examine were those in reference to issues in Roe that are unrelated to abortion. My research also included a personally conducted survey of a convenience sample of twelve females who self-identify as "strongly pro-choice" regarding their support or opposition to the provisions of the informed consent bills.

The conclusion that I have reached is that the present informed consent bills are well within the limits of constitutionality as presently determined by the United States Supreme Court in regard to abortion. "Roe did not declare an unqualified 'constitutional right to an abortion' . . . " Planned Parenthood v. Casey, 505 U.S. 833, 874 (1992). Subsequent to viability, the State can regulate abortion in any manner even to the extent of completely prohibiting abortions except in cases which threaten the life or health of the mother. Id. at 870. In 1992, the United States Supreme court decided in Casey to expressly overrule the trimester framework established by Roe, and established that the State has an interest in its prospective citizens represented by pre-viable fetuses, see id. at 881, and declared that "[n]ot all burdens on the right to decide whether to terminate a pregnancy will be undue," id. at 876.

Regulations which are designed to persuade a woman to choose childbirth over abortion are not an undue burden. See id. at 877-78. The Supreme Court expressly overruled the earlier cases Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) and Thornburgh that had prohibited requirements to provide truthful information to women seeking abortions. Casey at 882. The requirement that a licensed physician provide the information personally was held not to be a substantial burden. Casey at 884-85. A twenty four hour waiting period does not constitute an undue burden even when it requires women who live in remote parts of a state to make two trips to an urban provider and exposes them to "the harassment and hostility of

anti-abortion protesters demonstrating outside a clinic." Casey at 885-86. The Supreme Court also determined that a 48 hour waiting period is constitutional for minors and suggested in dicta that even a five day waiting period would not be a substantial burden. Hodgson v. Minnesota, 497 U.S. 417, 449 (1990). See also Casey, at 895. A State requirement of written informed consent prior to abortion is constitutional. Casey at 881.

Regulations designed to foster the health of a woman seeking an abortion are valid even if they have an incidental effect of making it more difficult or expensive to procure an abortion. Casey at 874. Regulations requiring the collection and reporting of data that are reasonable directed to the preservation of maternal health are constitutional even when they result in some increased cost of abortions. Danforth, 428 U.S. at 80. See also Casey at 900-01. The requirement that viability tests be conducted in a hospital prior to an abortion is constitutional. Webster v. Reproductive Health Services, 492 U.S. 490, 515 (1989). The State can also establish a rebuttable presumption that a fetus is viable at 20 weeks gestational age, after which time a physician is required to rebut the presumption of viability by medical tests prior to performing an abortion. Webster at 515. The State can also require that pre-viability abortions be performed in a licensed medical facility. Simopoulos v. Virginia, 462 U.S. 506, 516-17 (1983).

In conclusion, the provisions of the Kansas informed consent bills are well within the constitutional limits presently established by the United States Supreme Court. Roe v. Wade represented the high water mark for abortion rights. Virtually every subsequent Supreme Court decision has resulted in a retreat from the provisions of Roe, not necessarily as a result of a fundamental change in philosophy regarding abortion, but in an apparent attempt to return power back to the states that had been usurped by Roe. In Casey, Justice O'Connor made a seemingly strident defense against overruling Roe on the grounds of stare decisis, that is, the doctrine that previous decisions should be left standing, 505 U.S. at 864-65, but Justice Blackmun in his concurrence noted that four Justices are waiting for the one additional vote necessary to overrule Roe in its entirety, 505 U.S. at 923, and return the power to the States to completely regulate abortion even prior to viability.

Public Opinion

The result of the survey of females self-identifying as "strongly pro-choice," indicates that even though the provisions of the informed consent bills may result in some women choosing not to complete their intended abortion, the decision to have an abortion is of such a serious nature

and tends to be made under conditions of such extreme emotional stress that a woman should be required to take time to contemplate her decision. I conducted this survey by personally contacting a convenience sample of forty five women between the ages of twenty-two and thirty that are presently attending the University of Kansas School of Law. I asked these women how they would characterize themselves in regard to their position on abortion. Thirty three women identifying themselves as "pro-life," "neutral," or "moderately pro-choice" were not selected for this survey. Twelve women self-identifying as "strongly pro-choice" were selected for further discussion regarding their position on the proposed informed consent bills. No one identifying as "strongly pro-choice" was excluded from the survey and no attempt was made to bias the selection of the sample. Every single participant of the "strongly pro-choice" sample responded that they did not oppose an eight hour waiting period even if it required the women to make two visits on different days, even for women living in rural areas, and even if the intended purpose of the informed consent provision was to reduce the number of abortions being performed.

Although the size of this sample is small, the deliberate sampling bias resulting from taking the sample in the traditionally liberal environment of a law school and sub-selecting to a population self-identifying as being likely to oppose legislation placing restrictions on abortion access, supports a conclusion that the majority of the population of the State of Kansas is likely to either support or not oppose the proposed informed consent legislation. It is likely that the only opposition to this legislation will come from abortion providers whose revenues may be adversely affected by this legislation.

Economic Effect on Kansas

My estimation of the economic effect of these proposed bills is based on a simple model using readily available information. This model predicts that this bill would increase the State Domestic Product by $10,912,500 per year per year as of 2015 and negatively impact abortion providers by $400,000 per year by 1998. No other affected groups have been identified.

The increase in State Domestic Product per year per year is estimated by multiplying the present $21,825 Kansas annual per capita income figure reported in the 1997 World Almanac by 500 persons, the number of abortions per year estimated to be avoided as a result of this bill. This figure of 500 persons is determined by multiplying 5,000 which is an estimate of the number of abortions performed per year in Kansas by 10% which is the estimated number of abortions that will be avoided per year as a result of the proposed legislation.

This is a simple and conservative model. It ignores the effect of emigration and immigration. It ignores the time value of money. It ignores childhood mortality. It ignores possible fundamental changes in birth rates or utilization rates of abortion providers. It discounts income of the putative citizen until age eighteen. The figure of 500 persons is suspect since both the number of annual abortions and the prospective percentage of avoided abortions are speculative; however, the figure is expected to be close enough to identify the magnitude of the effect on State Domestic Product. That is, it is unlikely that there are more than 10,000 or less than 2,500 abortions performed in Kansas per year. It is also unlikely that the proposed legislation will avoid more than 20% or less than 5% of the number of abortions performed per year. Consequently, the effect on State Domestic Product is unlikely to be more than \$20 million or less than \$5 million per year. This figure is estimated per year per year because the income resulting from these individuals will be cumulative over the estimated working life of these individuals.

Per capita income is used as a basis for this model because the majority of these individuals are likely to be born into middle and upper class families. Available information suggests that the cost of abortion is high enough that lower income mothers are unlikely to be affected substantially by this legislation. In addition, Kansas has held illegitimate children equal to legitimate children as a matter of law since 1898. Consequently, illegitimate children have the same income and employment opportunities as legitimate children. Furthermore, it is speculated that abortions are disproportionately obtained by urban mothers relative to rural mothers while urban per capita income is higher than rural per capita income supporting an assumption that these individuals are likely to have an average income at least equivalent to per capita income. This use of per capita income is also supported by the fact that Kansas has traditionally had unemployment rates in the range of 4.4% which is considered full employment. As a State, it is sparsely populated and has considerable demand for workers. Thus, these individuals will presumably be able to participate fully in the economy of the State.

The negative impact to abortion providers is estimated by multiplying the 500 persons identified above by \$800 which is the estimated average cost per abortion. This estimate is also subject to similar errors as above. The negative impact to abortion providers is estimated per year since the revenues lost as a result of the avoided abortions is non-cumulative.

WASHBURN UNIVERSITY
School of Law

To: Federal & State Affairs Committee
Senator Oleen, Chair
Senator Harrington, Vice-Chair
Senator Becker
Senator Bleeker
Senator Schraad
Senator Vidrisksen
Senator Jones
Senator Biggs
Senator Gooch

From: Jalen O'Neil
Vis. Assoc. Professor of Law

Date: March 13, 1997

Re: Opposition to SB 230 &
HB 2269

Dear Senators:

When I first heard of Senate Bill 230 and House Bill 2269, I was inclined favorably towards them, as they were explained as bills that would ensure that a woman was given full accurate information about her various legal options when faced with an unwanted or dangerous pregnancy. This would accord with the basic principles of bioethics, one of the courses I teach at Washburn Law School. Upon reading the bills, however, I found that they are designed to have the opposite effect. Passage of either of these bills will result in fewer women having full information of the options available to them when faced with an unwanted or dangerous pregnancy.

Sen. Federal & State Affairs Comm.
Date: 3-13-97
Attachment: #13

1700 SW College Avenue • Topeka, Kansas 66621-1140 • 913•231•1060
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The bills would act as a sort of government-forced "slow-down strike" against abortion providers. In requiring that a physician orally inform a woman, in person, eight hours before an abortion about a varied mass of information, the bills ensure that many fewer abortions will be performed, at much higher cost. This limits the procedure to wealthy women, or to women impregnated by wealthy men, taking us back to the status quo of thirty years ago.

The bills are especially discriminatory against poor rural women because they will absolutely be faced with at least one over-night stay. This will often be an unsurmountable burden for a poor working woman who must arrange for child care and absence from her job. If she is in the type of abusive situation the United States Supreme Court recognized in Casey, she will not, in some situations, be able to keep her decision confidential.

The irony of these bills are that they work against all that a bioethicist would wish. A bioethicist would hope that if an abortion is sought, that it would be done as early in the pregnancy as possible, both for the sake of the mother's health, and from respect for the fetus. Bioethicists generally see tremendous differences in the loss of potential human life at different times throughout the pregnancy. An average woman without birth control will conceive at least 100 times in her life. That is a very different figure from the approximately 60 embryos that will

actually implant in her uterine wall. That, again, is different from the approximately ten fetuses to reach "viability," which is still again different from the approximately five babies actually born alive. See Furrow, et al., Bioethics: Health Care Law and Ethics 42-45 (West 1991 & 1996 Supp.).

When poor rural women are told on the phone that they must come to the abortion provider and receive state-mandated education personally from a physician, and that they then face at least an overnight stay, they will most likely take one of two paths. One woman, in spite of all obstacles and possible abuse and lack of confidentiality, will, despite great burden to herself, somehow come up with the additional money to provide for her absence from work, for child care, for increased expense of the abortion, and for overnight accommodations. Anyone who has seen such a woman try to fit in even a dental appointment knows, however, that she will not be able to overcome this burden in a short amount of time.

Another woman faced with the same burden will simply give up and conclude that the state has de facto outlawed abortion for someone in her situation. This, of course, is the true purpose of these bills. But forcing a woman to "choose" not to have an abortion in this way violates fundamental precepts of bioethics. Her "choice" will not be a true choice; nor will it be an informed choice.

Our present informed consent law on abortion, K.S.A. 65-6706, strikes a good balance in that it gives the woman the information she needs to make an informed decision, but does so in a way that allows her to maintain confidentiality and actually obtain a legal abortion if that is her ultimate decision.

I support K.S.A. 65-6706 as a reasonable interpretation of United States Supreme Court decisions that is unlikely to lead to litigation and adheres to the basic principles of bioethics.

Thank you for your consideration.

Very truly yours,

Jalen O'Neil

Jalen O'Neil
Vis. Assoc. Professor of Law

Testimony of Rachael K. Pirner, attorney at law, before the Federal and State Affairs Committee March 13, 1997

Re: SB 230

Sec. 7 In addition to whatever remedies are available under the common or statutory law of this State, failure to comply with the requirements of this Act shall:

(a) Provide a basis for a civil malpractice action. Any intentional violation of this Act shall be admissible in a civil suit as prima facie evidence of a failure to obtain an informed consent. When requested, the court shall allow a woman to proceed using solely the woman's initials or a pseudonym and any close any proceeding in the case and enter other protective orders to preserve the privacy of the woman upon whom the abortion was performed.

> Currently, Kansas common law clearly recognizes the doctrine of informed consent. Except in unusual, limited circumstances, every person has a right not to be touched or treated medically. Cruzan v. Director, Missouri Department of Health, 110 S. Ct. 2841 (1990). Further, at common law, the Kansas Supreme Court recognized: "Anglo-American law starts with the premise of thorough going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery or other medical treatment." Natanson v. Kline, 186 Kan. 393 (1960). [1] Other Kansas cases clearly establish that the failure to adequately inform a patient about the nature and risk of a procedure forms the basis for the patient to bring a medical malpractice action against the health care provider. Funke v. Fieldman, 212 Kan. 524 (1973)[2];Leiker v. Gafford, 245 Kan. 325 (1989).[3]
>
> With this well established case law in place it is readily apparent that this particular provision of SB 230 is in the nature of a penalty. I caution this committee that severe and/or excessive penalties violate the 14th amendment to the United States Constitution as confiscatory and unreasonable. In all respects a penalty is unconstitutional where it subjects an individual to an arbitrary and unreasonable exercise of the powers of government by assessing a penalty greatly out of proportion to the actual damages sustained. In this instance, it is made clear, by the duplicative nature of recovery and the specific identification of the

[1] A copy of the Natanson decision is attached hereto for convenience, as is a summary of the case.
[2] A copy of the Funke decision is attached hereto for convenience, as is a summary of the case.
[3] A copy of the Leiker decision is attached hereto for convenience, as is a summary of the case.

abortion procedure that this bill penalizes the physician who performs abortions. This civil liability section is punitive and intended to intimidate doctors, thereby discouraging them form doing abortions. It shows that the real purpose of SB 230 is not to improve the process by which women decide whether to terminate a pregnancy, but to prevent the women of Kansas from being able to exercise a constitutionally protected right by attempting to drive providers out of business.

(b) Provide a basis for professional disciplinary action under the Kansas healing arts act(sic).

The Board of Healing Arts is empowered to investigate and discipline certain health care providers essentially for fraud, or misrepresentation in certain instances, an act of professional incompetency, unprofessional conduct and fraudulent or false advertising, conviction of certain crimes, unlawful drug distribution or substance addiction, violation of the Healing Arts Act and some other circumstances. This bill proposes to legislate information which must be distributed to a woman prior to the time that she obtains an abortion. This information may or may not be proper, enough or too much under the particular circumstances of a given case. Physicians are required to go to medical school to make these decisions and they are governed by rules of professional conduct. This provision is not directed at ensuring that the public is "protected against unprofessional, improper, unauthorized and unqualified practice of the healing arts and from unprofessional conduct by persons licensed to practice. . ." in Kansas. K.S.A. 65-2801. Rather, this portion of the bill clearly singles out those physicians who provide abortion services and as such this provision amounts to little more than a near naked attempt to single out those doctors who provide abortions for disciplinary action.

(c) Provide a basis for recovery for the woman for the death of her unborn child, whether or not the unborn child was viable at the time the abortion was performed or was born alive.

SB 230 permits a woman who has received an abortion in violation of the mandatory delay and biased counseling requirements to maintain an action for wrongful death, "whether or not the unborn child was viable at the time the abortion was performed." Adoption of this provision would permit wrongful death actions in the context of abortion that are not allowed for any other tort resulting in the death of a fetus.

The Kansas Supreme Court has ruled that wrongful death actions may be maintained for causing the death of a viable fetus.[4] For purposes of first degree murder, "human being" does not include a viable fetus. Adoption of the wrongful death provision in SB 230 would therefore represent a significant shift in public policy in Kansas.

[4] Wrongful death actions are allowed when a third party's actions cause a viable fetus' stillbirth. *Hale v. Manion*, 368 P.2d 1, 3 (1962). An unborn unviable fetus is not a person within the wrongful death statute; viability is a condition precedent to liability for wrongful death. *Humes v,. Clinton*, 792 P.2d 1032 (1990).

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1. Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960).
   Case and Case Summary

2. Natanson v. Kline, 187 Kan. 187, 354 P.2d 670 (1960).
   Case and Case Summary

3. Funke v. Feldman, 212 Kan. 524, 512 P.2d 539 (1973).
   Case and Case Summary

4. Leiker v. Gafford, 245 Kan. 315, 778 P.2d 823 (1989).
   Case and Case Summary

Case Summary
Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960)

In Natanson, the plaintiff was overradiated during her radiation therapy for cancer. As a result of the overradiation, the entire chest, skin, cartilage and bone in the areas radiated were completely destroyed. The evidence demonstrated that the plaintiff and her husband were not informed by the defendant of any risk associated with cobalt radiation. The jury granted a verdict in favor of the defendant. Plaintiff appealed.

The Kansas Supreme Court granted plaintiff a new trial and outlined the parameters of the informed consent doctrine in Kansas. The Court noted that the doctor and his patient have a fiduciary relationship, and the doctor has an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness. Natanson, 186 Kan. at 403-04.

The Court then stated that anglo-American law starts with the premise of self-determination, which means that each person of sound mind is the master of his own body and may expressly prohibit the performance of life-saving surgery or other medical treatment. Natanson, 186 Kan. at 406-07. Because of self-determination, the law prohibits a doctor, through artifice or deception, to substitute his own judgment for that of his patient. Natanson, 186 Kan. at 407. Based upon these principles, the patient must give informed consent.

Moreover, the Court stated that:

> So long as disclosure is sufficient to insure an informed consent, the physician's choice of possible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.

Natanson, 186 Kan. at 409-10.

Then the Court specifically held:

> At the time the appellant went to Dr. Kline as a patient, there was no immediate emergency concerning the administration of cobalt irradiation treatment such as would excuse the physician from making a reasonable disclosure to the patient. We think upon all of the facts and circumstances here presented, Dr. Kline was obligated to make a reasonable disclosure to the appellant of the nature and probable consequences of the suggested or recommended cobalt irradiation treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which

> were incident to, or possible in, the treatment he proposed to administer.
>
> Upon the record here presented, Dr. Kline made no disclosures to the appellant whatever. He was silent. This is not to say that the facts compel a verdict for the appellant.

Natanson, 186 Kan. at 410.

The Court also held that the physician must disclose in simple and understandable language the following items:

1. The nature of the ailment;

2. The nature of the proposed treatment;

3. The probability of success or of alternatives; and

4. Perhaps the risks of unfortunate results or unforeseen conditions within the body.

Natanson, 186 Kan. at 410.

The Court then reversed the district court because it did not instruct on the doctor's failure to inform his patient. Natanson, 186 Kan. at 411.

No. 41,476

IRMA NATANSON, *Appellant,* v. JOHN R. KLINE and ST. FRANCIS HOSPITAL AND SCHOOL OF NURSING, INC., *Appellees.*

(350 P. 2d 1093)

SYLLABUS BY THE COURT

1. PHYSICIANS AND SURGEONS—*Action for Malpractice—Injury Resulting from Radiation Therapy—Evidence Failed to Establish Negligence as a Matter of Law.* In an action for damages founded on malpractice against a hospital and the physician in charge of its radiology department to recover for injuries sustained as a result of radiation therapy with radioactive cobalt, alleged to have been given in an excessive amount, it is *held:* As more particularly set forth in the opinion, the evidence did not establish negligence against the defendants as a matter of law.

2. TRIAL—*Procedure—Instructions.* The code of civil procedure requires the trial court to give general instructions to the jury, with or without request having been made for the same (G. S. 1949, 60-2909, *Fifth*). Under this provision of the code the court must define the issues and state at least generally the law applicable thereto.

3. PHYSICIANS AND SURGEONS—*Duty to Instruct on Law of Case.* In an action for damages founded on malpractice, upon request it is the duty of the trial court to instruct the jury with respect to the law governing the case, explaining the precise questions at issue upon which there has been evidence presented.

4. SAME—*Extent of Physician's Duty to Advise Patient.* Where no immediate emergency exists, a physician violates his duty to his patient and subjects himself to liability for malpractice, upon facts and circumstances more particularly set forth in the opinion, if he makes no disclosure of significant facts within his knowledge which are necessary to form the basis of an intelligent consent by the patient to proposed cobalt irradiation treatment.

5. SAME—*Physicians Subject to Doctrine of Respondeat Superior.* Physicians, like other persons, are subject to the doctrine of *respondeat superior.* Where the physician has the actual or potential right to control the servant, the doctrine applies whether the person administering the treatment, or having a part therein, be a layman, a physician or a nurse.

6. SAME — *Injury from Cobalt Irradiation — No Presumption of Negligence.* Where a patient suffers injury from cobalt irradiation therapy, no presumption of negligence of the physician is to be indulged from the fact of injury or adverse result of his treatment of the patient.

Appeal from Sedgwick district court, division No. 1; WM. C. KANDT, judge. Opinion filed April 9, 1960. Reversed with directions.

Wayne Coulson, of Wichita, argued the cause, and *Homer V. Gooing, Paul R. Kitch, Dale M. Stucky, Donald R. Newkirk, Robert J. Hill, Gerritt H. Wormhoudt, Philip Kassebaum, John E. Rees, Robert T. Cornwell* and *Willard B.*

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Thompson, all of Wichita, were with him on the briefs for the appellant; *Hugo T. Wedell,* of Wichita, of counsel.

William Tinker, of Wichita, argued the cause, and *Getto McDonald, Arthur W. Skaer, Hugh P. Quinn, William Porter, Alvin D. Herrington, Darrell D. Kellogg, Richard T. Foster, W. D. Jochems, J. Wirth Sargent, Emmett A. Blaes, Roetzel Jochems, Robert G. Braden, J. Francis Hesse, James W. Sargent, Stanley E. Wisdom, Vincent L. Bogart, Cecil E. Merkle, John W. Brimer* and *Harry L. Hobson,* all of Wichita, were with him on the briefs for the appellee, St. Francis Hospital and School of Nursing, Inc.

W. A. Kahrs, of Wichita, argued the cause, and *Robert H. Nelson* and *H. W. Fanning,* both of Wichita, were with him on the briefs for the appellee, John R. Kline.

The opinion of the court was delivered by

SCHROEDER, J.: This is an action for malpractice against a hospital and the physician in charge of its radiology department to recover for injuries sustained as the result of radiation therapy with radioactive cobalt, alleged to have been given in an excessive amount.

The plaintiff (appellant), Irma Natanson, suffering from a cancer of the breast, had a radical left mastectomy performed on May 29, 1955. At the direction of Dr. Crumpacker, the surgeon who performed that operation, the plaintiff engaged Dr. John R. Kline, a radiologist, for radiation therapy to the site of the mastectomy and the surrounding areas.

Dr. Kline, a licensed physician and specialist in radiation therapy, was head of the radiology department at St. Francis Hospital at Wichita, Kansas. The plaintiff seeks damages for injuries claimed to have been sustained as a result of alleged acts of negligence in the administration of the cobalt radiation treatment. Dr. Kline and the hospital were named as defendants (appellees).

The case was tried to a jury which returned a verdict in favor of both defendants. The plaintiff's motion for a new trial having been denied, this appeal followed specifying various trial errors.

The questions controlling the decision herein relate to the giving of instructions by the trial court.

It will be unnecessary to relate in detail all the facts presented by the evidence as abstracted, consisting of more than three hundred pages, to dispose of the issues on appeal.

The jury was submitted two special questions. In the first it found that the defendants were not guilty of any act or acts of negligence which were the proximate cause of plaintiff's injury.

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The jury having found in the negative on the first, the second question required no answer.

It must be conceded, insofar as the evidence is concerned, that all presumptions are, and must be, in favor of the verdict. All issues of fact have been resolved in favor of the defendants. (*Lord v. Hercules Powder Co.*, 161 Kan. 268, 167 P. 2d 299; and *Beye v. Andres*, 179 Kan. 502, 296 P. 2d 1049.)

The appellant contends, however, the uncontradicted evidence shows the defendants negligent as a matter of law.

Dr. Kline was called by the plaintiff to testify in the trial court and in great detail counsel examined Dr. Kline to educate the court and jury concerning cobalt radiation therapy in the treatment of cancer. A short summary in rough will serve as a basis for further discussion.

The purpose of any irradiation therapy is to destroy tissue. The theory of destruction of cancer by irradiation therapy is that when treatment is given in a series of doses (fractionation in medical terms), the greater ability of normal tissue to recover from irradiation effects enables it to survive while the cancerous tissue is destroyed.

Dosages of irradiation are expressed in roentgen. All forms of irradiation have some point of maximum, or one hundred per cent, dosage and diminish as they penetrate deeper into the body. In the case of X rays the point of maximum dosage is in the skin. In the case of cobalt irradiation the maximum dosage is received at a point about five millimeters beneath the outer surface of the skin. The primary advantages of cobalt irradiation over X ray irradiation are deeper penetration and less skin injury. The amount of X ray which can be administered is governed in a large measure by the amount which the skin can tolerate. The amount of cobalt irradiation which can be administered is governed by the tolerance of the tissues lying five millimeters below the outer surface of the skin.

By "equilibrium" dose in relation to radioactive cobalt is meant the maximum dose, which occurs about five millimeters below the outer surface of the skin. "Tumor" dose means the quantity received at the known or assumed depth of the tumor.

Dr. Kline ordered the administration of cobalt irradiation for the appellant in "routine fashion." To him and to his assistant, Dr. Somers, this meant a tumor dose of 4,400 roentgen delivered to the supraclavicular area in a period of sixteen days. For this purpose

the tumor was assumed to extend from outer surface in front to outer surface behind. "Routine fashion" also meant a dosage of 4,800 roentgen delivered over the outer two centimeters of the remainder of the left chest from a point at the rear portion of the left side of the patient's body around past the breast bone in a period of twenty-three days. It also meant an approximately equal dosage to the outer two centimeters over the breast bone including the chain of lymph nodes running longitudinally along each side of the breast bone.

Material to further discussion is the fact that the prescription or outline of treatment called for 4,800 roentgen to be delivered to the outer two centimeters of the chest wall. It also directed that this treatment be delivered by means of a rotating beam. According to the testimony of the appellant's husband the rotational equipment had not been installed and ready for use at the time of the appellant's first treatment. It was installed and ready for use soon thereafter.

A radiologist, who administers cobalt irradiation treatment with rotational equipment, must have the assistance of a specialist in physics. Dr. Kline's assistant was a hospital employee by the name of Darter who determined by necessary computations how to administer the desired quantity of radiation, ordered by Dr. Kline, by means of a moving beam. Darter had graduated from Wichita University with a B. S. degree the preceding spring and had a six months' special course on irradiation therapy at Massachusetts Institute of Technology. His actual experience with radioactive cobalt therapy began with the installation of the unit at the St. Francis Hospital on January 29, 1955, some four months before the appellant's treatment began.

Highly summarized, the evidence upon which the appellant relies is that the radioactive cobalt beam was delivered at an angle to the chest wall in an effort to avoid injury to the lungs. In making the calculations to achieve the tumor doses (one and one-half to two centimeters deep), the equilibrium doses (five millimeters deep) were not calculated by Darter.

Dr. Paul A. Roys, an assistant professor of physics at Wichita University, who was a specialist in the field of nuclear physics of which radiation physics is a part, was called to testify concerning his calculations of the roentgen delivered to various parts of the appellant's chest wall in accordance with the time chart and dosages

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administered to the appellant as a result of Darter's calculations. From Dr. Roys' calculations the equilibrium doses administered at several segments of the chest wall were from 5,670 roentgen to 6,260 roentgen at a depth of five millimeters. It was in these segments where the appellant's injuries were sustained.

Dr. Kline had previously testified that the soft tissues of the chest wall could tolerate about 5,000 roentgen in twenty-four or twenty-five days; that the cartilage could tolerate about 5,500 roentgen over a period of twenty-eight days, and ordinarily bone would stand a larger amount. The appellant argues the effect upon her of the administration of amounts ranging from 5,670 roentgen to 6,280 roentgen certainly corroborates Dr. Kline's testimony. The entire chest, skin, cartilage and bone were completely destroyed in those areas.

There was other evidence which contradicted the appellant's theory, however. When Dr. Kline was called as a witness on his own behalf, he stated the prescribed dosage of 4,400 roentgen was intended as a minimum dosage, and was the smallest dosage which would be effective and had to be given, even though he knew that portions of the chest would receive a much higher dosage. He testified that a doctor has to take a chance in the treatment of cancer, that he knew there was danger of injury from such treatment, but that he took a calculated risk. This risk is determined to a large extent by the tolerance of the individual concerned. Some patients have a much higher tolerance than others. He further testified that he had treated approximately seventy-five breast and cancer cases since the treatment of the appellant, all of which were treated in the same manner with the same number of roentgens directed to be given.

Dr. Hare, a radiologist from Los Angeles, was called to testify for the appellees. He said that for five years he had been using 6,000 roentgen up to 9,000 roentgen on the treatment of cancer cases.

At the time treatment started the appellant had an ulcer about the size of a quarter under her left arm which remained from the mastectomy. It had not stopped draining. After treatment started the drainage increased and, according to the appellant, she understood the treatment was to shrink the area but instead it seemed to be growing larger.

There is no issue presented by the record as to the relationship

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between Dr. Kline and the St. Francis Hospital. The petition pleaded that the defendants were engaged in a joint adventure or in the alternative that the defendant physician was acting within the scope of his employment as agent, servant and employee of the defendant hospital. The answer of the defendant hospital admitted that the defendant physician "was in charge of its radiology department." Moreover, the pleadings raised no issues between the defendants.

Upon the foregoing evidence on the state of the record presented herein, it cannot be said the appellees were guilty of negligence as a matter of law. At best it may be said, upon all the facts and circumstances presented by the record, there was evidence from which a jury could find that the proximate cause of the appellant's injury was the negligence of the defendants. On the other hand a jury, *properly instructed,* would be justified in finding for the appellees.

We shall next consider whether the jury was properly instructed.

The code of civil procedure requires the court to give general instructions to the jury, with or without request having been made for the same. (G. S. 1949, 60-2909, *Fifth.*) This provision has frequently been interpreted to require the court to define the issues and state at least generally the law applicable thereto. (*Bushey v. Coffman,* 109 Kan. 652, 201 Pac. 1103; *Knox v. Barnard,* 181 Kan. 943, 317 P. 2d 452; and *Schmid v. Eslick,* 181 Kan. 997, 317 P. 2d 459.) The trial court in summarizing the pleadings for the jury in its instructions was quite brief. Aside from general factual recitations the material portions of this summarization given in instruction No. 1 are as follows:

"In this case the plaintiff Irma Natanson . . . alleges . . . *that Dr. Kline and personnel of St. Francis Hospital administered to the plaintiff a series of cobalt radiation treatments in such a negligent manner* that the skin, flesh and muscles beneath her left arm sloughed away and ribs of her left chest were so burned that they became necrotic, or dead; . . .

"The defendants then filed their answers in the case in which they allege that the treatments were properly administered and that they were not guilty of any negligence toward the plaintiff." (Emphasis added.)

Then followed the usual instruction (No. 2) that the foregoing statement taken from the pleadings set forth the various claims and contentions of the parties against each other, and that such claims and contentions are to be considered only as they may have been proved by evidence presented during the trial of the case.

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Instruction No. 3 reads in part:

"This is a lawsuit based upon negligence. In the conduct of human affairs, the law imposes upon us the obligation to use due and proper care to avoid hurt or injury to others. Thus, negligence may be defined as a violation of the duty to use due and proper care. The term, 'due and proper care' means, in this case, such care as medical specialists in radiology in this community would ordinarily and reasonably use under the same or similar circumstances."

The court then instructed that negligence is never presumed—it must be proved by a preponderance or greater weight of the evidence; it defined preponderance or greater weight of the evidence and instructed that negligence may be established by circumstantial evidence.

Instruction No. 4 given by the court reads:

"The law does not require that treatments given by a physician to a patient shall attain nearly perfect results. He is not responsible in damages for lack of success or honest mistakes or errors of judgment unless it be shown that he did not possess that degree of learning and skill ordinarily possessed by radiologists of good standing in his community, or that he was not exercising reasonable and ordinary care in applying such skill and learning to the treatment of the patient. And if among radiologists more than one method of treatment is recognized, it would not be negligence for the physician to have adopted any of such methods if the method he did adopt was a recognized and approved method in the profession at the time and place of treatment."

On this appeal the court is not concerned with the general instructions on negligence or instruction No. 4, which correctly states the law. The cases upon which the appellees rely to substantiate these instructions are sound law. (*Erastus Tefft v. Hardin H. Wilcox*, 6 Kan. 46; *Sly v. Powell*, 87 Kan. 142, 123 Pac. 881; *Paulich v. Nipple*, 104 Kan. 801, 180 Pac. 771; *James v. Grigsby*, 114 Kan. 627, 220 Pac. 267; *Riggs v. Gouldner*, 150 Kan. 727, 96 P. 2d 694; *Cummins v. Donley*, 173 Kan. 463, 249 P. 2d 695; and *Goheen v. Graber*, 181 Kan. 107, 309 P. 2d 636.)

The amended petition pleaded negligence in eight specific particulars, one or more of which presented issues which the jury was required to determine on the basis of the evidence presented. It was proper for the trial court to exclude those specific allegations of negligence enumerated in the amended petition concerning which there was no evidence, but it should have set forth those specific allegations of negligence concerning which there was evidence. The general summarization, consisting of the italicized

portion of instruction No. 1 heretofore quoted, was insufficient to meet this obligation of the trial court.

The answers filed by both of the defendants in the lower court denied the specific allegations of negligence alleged in the amended petition and pleaded "the plaintiff assumed the risk and hazard of said treatment."

One of the alleged grounds of negligence, concerning which there was evidence before the jury, was that Dr. Kline failed to warn the appellant the course of treatment which he undertook to administer involved great risk of bodily injury or death.

The appellant requested and the trial court refused to give the following instruction:

"You are instructed that the relationship between physician and patient is a fiduciary one. The relationship requires the physician to make a full disclosure to the patient of all matters within his knowledge affecting the interests of the patient. Included within the matters which the physician must advise the patient are the nature of the proposed treatment and any hazards of the proposed treatment which are known to the physician. Every adult person has the right to determine for himself or herself whether or not he will subject his body to hazards of any particular medical treatment.

"You are instructed that if you find from the evidence that defendant Kline knew that the treatment he proposed to administer to plaintiff involved hazard or danger he was under a duty to advise plaintiff of that fact and if you further find that defendant Kline did not advise plaintiff of such hazards then defendant Kline was guilty of negligence."

There was evidence from which the jury could have found that the appellant fully appreciated the danger and the risk of the radiation treatment. The appellant's husband testified:

"Q. Yes, how did it happen you went there for the conference with Dr. Kline?

"A. We, of course, made a periodic visit to Dr. Crumpacker after the operation, and he told us that as a precautionary measure Mrs. Natanson should go to the St. Francis Hospital and take the cobalt treatment. He explained to us that the cobalt was a new therapy; that it was much more powerful than the x-ray they had used previously. He suggested we see Dr. Kline."

On cross examination he testified:

"Q. Just a question or two. Mr. Natanson, when you and your wife went to see Dr. Crumpacker, did you have a discussion with him about the purpose of the irradiation?

"A. Yes.

"Q. And, was the general objection of irradiation explained to you?

"A. Yes.

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"Q. And, that was when Mrs. Natanson was with you?

"A. Yes.

"Q. Now, did you consult any radiologist other than Dr. Kline in determining anything about this irradiation?

"A. No, sir.

. . . .

"Q. Now, I take it that it was Dr. Crumpacker's thought or suggestion at least to you that Dr. Kline be consulted?

"A. Yes.

"Q. And, up to the time you engaged Dr. Kline, Dr. Crumpacker had been the doctor on the case?

"A. Yes."

There was also testimony from the appellant and her husband that Dr. Kline did not inform the appellant the treatment involved any danger whatever. The testimony of Dr. Kline, a radiologist with special training in cobalt irradiation, was that he knew he was "taking a chance" with the treatment he proposed to administer and that such treatment involved a "calculated risk." He testified there was always a danger of injury in the treatment of cancer. Insofar as the record discloses Dr. Kline did not testify that he informed the appellant the treatment involved any danger. His only testimony relevant thereto was the following:

"Q. Now, tell us what transpired when you first met with the Natansons?

"A. I could not completely recall that meeting. It was such a long time ago.

"Q. Just tell us what you can recall of it?

"A. I remember Mr. and Mrs. Natanson coming in to see me. I can't remember if I met them in my office or whether we were downstairs. I remember in a very vague way. I remember in a vague way that we discussed the treatment, about how long it took, the number of areas we would irradiate. I have a recollection of that. I remember we took her into the treatment room. She was marked out, measured. I believe the marking out and measurement was done by Mr. Darter. Her first treatment occurred the first day she came. I am not sure of that but I think so.

"Q. Have you told us everything you recall?

"A. Yes."

No other evidence appears in the record concerning the subject.

The appellees argue that we are here concerned with a case where the patient consented to the treatment, but afterwards alleges that the nature and consequences of the risks of the treatment were not properly explained to her. They point out this is not an action for assault and battery, where a patient has given no consent to the treatment.

What appears to distinguish the case of the unauthorized surgery

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or treatment from traditional assault and battery cases is the fact that in almost all of the cases the physician is acting in relatively good faith for the benefit of the patient. While it is true that in some cases the results are not in fact beneficial to a patient, the courts have repeatedly stated that doctors are not insurers. The traditional assault and battery involves a defendant who is acting for the most part out of malice or in a manner generally considered as "antisocial." One who commits an assault and battery is not seeking to confer any benefit upon the one assaulted.

The fundamental distinction between assault and battery on the one hand, and negligence such as would constitute malpractice, on the other, is that the former is intentional and the latter unintentional. (*Hershey v. Peake,* 115 Kan. 562, 223 Pac. 1113; and *Maddox v. Neptune,* 175 Kan. 465, 264 P. 2d 1073.)

We are here concerned with a case where the patient consented to the treatment, but alleges in a malpractice action that the nature and consequences of the risks of the treatment were not properly explained to her. This relates directly to the question whether the physician has obtained the informed consent of the patient to render the treatment administered.

The treatment of a cancer patient with radioactive cobalt is relatively new. Until the use of atomic energy appeared in this country, X ray was the type of radiation treatment used for such patients. Radioactive cobalt is manufactured by the Atomic Energy Commission in a neutron pill by bombarding the stable element of cobalt in its pure state. This makes the cobalt unstable and by reason thereof it is radioactive. The radioactive cobalt emits two homogeneous beams of pure energy called gamma rays, very close in character, which are far more powerful than the ordinary X rays. It produces no other rays to be filtered out. This makes it desirable for use in the treatment of cancer patients. The cobalt machine may be compared to a three million volt X ray machine.

Radioactive cobalt is so powerful that the Atomic Energy Commission specifies the construction of the room in which the cobalt unit is to be placed. The walls of the room are made of concrete forty inches thick and the ceiling, also concrete, is twenty-four inches thick. The room is sunken down in a courtyard outside the hospital. A passageway off the control room about ten feet long leads to the treatment room. All controls are placed in the outer control room and, when the radiation treatment is administered to a patient, the

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operator in the outer room looks through a specially designed thick lead quartz glass which gives a telescopic view. A periodic report of radiation outside the room must be made to the Atomic Energy Commission in accordance with regulations. These facts were given by Dr. Kline in his testimony.

These facts are not commonly known and a patient cannot be expected to know the hazards or the danger of radiation from radioactive cobalt unless the patient is informed by a radiologist who knows the dangers of injury from cobalt irradiation. While Dr. Kline did not testify that the radiation he gave the appellant caused her injury, he did state cobalt irradiation could cause the injury which the appellant did sustain.

What is the extent of a physician's duty to confide in his patient where the physician suggests or recommends a particular method of treatment? What duty is there upon him to explain the nature and probable consequences of that treatment to the patient? To what extent should he disclose the existence and nature of the risks inherent in the treatment?

We have been cited to no Kansas cases, nor has our research disclosed any, dealing directly with the foregoing questions. A recent article by William A. Kelly published in the Kansas Law Review entitled "The Physician, The Patient, And The Consent" (8 Kan. L. Rev. 405), reviews many malpractice cases dealing with the consent of the patient, but the article fails to deal with the problem of disclosure involving on one hand the right of the patient to decide for himself and on the other a possible therapeutic ground for withholding information which may create tension by depressing or exciting the patient. This subject has been touched upon in an article by Charles C. Lund, M. D., "The Doctor, The Patient, And The Truth" (19 Tenn. L. Rev. 344 [1946]), and in an article by Hubert Winston Smith, LL. B., M. D., "Therapeutic Privilege To Withhold Specific Diagnosis From Patient Sick With Serious Or Fatal Illness" (19 Tenn. L. Rev. 349 [1946]). Allan H. McCoid, Associate Professor of Law, University of Minnesota, has written two recent articles, one "A Reappraisal Of Liability For Unauthorized Medical Treatment" (41 Minn. L. Rev. 381), published in March, 1957, and the other "The Care Required Of Medical Practitioners" (12 Vanderbilt L. Rev. 549, 586), published in June, 1959.

The courts frequently state that the relation between the physi-

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cian and his patient is a fiduciary one, and therefore the physician has an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness. We are here concerned with a case where the physician is charged with treating the patient without consent on the ground the patient was not fully informed of the nature of the treatment or its consequences, and, therefore, any "consent" obtained was ineffective. An effort will be made to review the cases from foreign jurisdictions most nearly in point with the question presently at hand, although none may be said to be directly in point.

In 1958 the Supreme Court of Minnesota in *Bang v. Charles T. Miller Hospital*, 251 Minn. 427, 88 N. W. 2d 186, had an assault case before it, and though not alleged as a malpractice action for negligence, a new trial was granted on the ground that a fact issue was presented for the jury to determine whether the patient consented to the performance of the operation. There the patient went to a urologist because of urinary trouble and apparently consented to a cystoscopic examination and a prostate operation. He was not informed that part of the procedure of a transurethral prostatic resection would be the tying off of his sperm ducts. In the opinion the court said:

"While we have no desire to hamper the medical profession in the outstanding progress it has made and continues to make in connection with the study and solution of health and disease problems, it is our opinion that a reasonable rule is that, where a physician or surgeon can ascertain in advance of an operation alternative situations and no immediate emergency exists, a patient should be informed of the alternative possibilities and given a chance to decide before the doctor proceeds with the operation. By that we mean that, in a situation such as the case before us where no immediate emergency exists, a patient should be informed before the operation that if his spermatic cords were severed it would result in his sterilization, but on the other hand if this were not done there would be a possibility of an infection which could result in serious consequences. Under such conditions the patient would at least have the opportunity of deciding whether he wanted to take the chance of a possible infection if the operation was performed in one manner or to become sterile if performed in another." (pp. 434, 435.)

A malpractice action was before the Fifth Circuit Court in *Lester v. Aetna Casualty & Surety Company*, 240 F. 2d 676. The patient was given electro-shock treatments prescribed by a psychiatrist and suffered a bad result. In affirming the jury's finding the

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court held the patient's wife gave sufficient legal consent, and said:

"The basic, the fundamental, difficulty which confronts plaintiff on this appeal is that he presents his case as though it were one of a person being deprived by another of due process of law, instead of grounding it upon the well settled principles that a physician must, except in real and serious emergencies, acquaint the patient or, when the circumstances require it, some one properly acting for him, of the diagnosis and the treatment proposed, and obtain consent, thereto express or implied, and, consent obtained must proceed in accordance with proper reasonable medical standards *and in the exercise of due care* . . ." (p. 679.) (Emphasis added.)

The appellees rely upon the Canadian case of *Kenny v. Lockwood* [1932], 1 D. L. R. 507, where a patient alleged the defendants falsely and recklessly, without caring whether it was true or false, and without reasonable ground for believing it to be true, represented the operation to be "simple," and that her hand "would be all right in three weeks." No evidence was presented to suggest fraud or recklessness and the plaintiff's argument proceeded mainly upon the duty which it was said the defendants owed to the plaintiff, due to the peculiar relation set up between a surgeon and his patient. The Ontario trial judge concluded that it was the duty of the defendant doctors to "enlighten the patient's mind in a plain and reasonable way as to what her ailment was, as to what were the risks of operating promptly, what were the risks of delaying the operation, and what the risks of not operating at all. Having discharged that duty, it was their further duty to secure from the patient a decision or consent as to what course is to be followed, and if that decision or consent is not had and the surgeons operate and the operation turns out badly the surgeons are liable. Such a relationship is established between a person of special skill and knowledge and a person of no skill or knowledge upon the facts required for the making of a decision that, unless the person with the special skill and knowledge discharges the duty which he owes of placing the patient in a position to make a decision, that person, when he is employed and paid because of his special skill and knowledge, has failed to perform his duty, and that breach of duty makes him liable in damages for untoward results." (*Kenny v. Lockwood Clinic Ltd.* [1931], 4 D. L. R. 906, 907.)

The trial court found for the plaintiff but on appeal the judgment was reversed, the appellate court saying there was some testimony

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that the doctors had explained all details to the plaintiff, although the extracts contained in the opinion indicate that the doctor admitted to having said that the operation was not a very serious one and that he had not clearly presented the alternatives to the plaintiff. In the court's opinion it was said:

". . . the duty cast upon the surgeon was to deal honestly with the patient as to the necessity, character and importance of the operation and its probable consequences and whether success might reasonably be expected to ameliorate or remove the trouble, but that such duty does not extend to warning the patient of the dangers incident to, or possible in, any operation, nor to details calculated to frighten or distress the patient." (p. 525.)

The court concluded upon the evidence presented:

"That the defendant Stoddart reasonably fulfilled the duty laid upon him arising out of the relationship of surgeon and patient, not being guilty of 'negligence in word' or 'economy of truth' nor of misleading the plaintiff, and so is not liable for breach of the duty . . ." (p. 526.)

In the opinion it was said the duty of a surgeon is to be honest in fact and to express his honest belief, and if he does so he ought not to be judged as if he had warranted a perfect cure nor to be found derelict in his duty on any meticulous criticism of his language.

The conclusion to be drawn from the foregoing cases is that where the physician or surgeon has affirmatively misrepresented the nature of the operation or has failed to point out the probable consequences of the course of treatment, he may be subjected to a claim of unauthorized treatment. But this does not mean that a doctor is under an obligation to describe in detail all of the possible consequences of treatment. It might be argued, as indicated by the authors of the various law review articles heretofore cited, that to make a complete disclosure of all facts, diagnoses and alternatives or possibilities which may occur to the doctor could so alarm the patient that it would, in fact, constitute bad medical practice. There is probably a privilege, on therapeutic grounds, to withhold the specific diagnosis where the disclosure of cancer or some other dread disease would seriously jeopardize the recovery of an unstable, temperamental or severely depressed patient. But in the ordinary case there would appear to be no such warrant for suppressing facts and the physician should make a substantial disclosure to the patient prior to the treatment or risk liability in tort.

Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, ex-

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pressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.

The mean between the two extremes of absolute silence on the part of the physician relative to the treatment of a patient and exhaustive discussion by the physician explaining in detail all possible risks and dangers was well stated by the California District Court of Appeal in *Salgo v. Leland Stanford, Etc. Bd. Trustees* [1957], 154 Cal. App. 2d 560, 317 P. 2d 170. There the court had before it a malpractice action wherein the defendants were charged with *negligence*. The patient, his wife and son testified that the patient was not informed anything in the nature of an aortography was to be performed. Two of the doctors contradicted this, although admitting that the details of the procedure involving injection of a radio-opaque substance into the aorta and the possible dangers therefrom were not explained. As a result of the aortography the patient was paralyzed from the waist down. The trial court gave a rather broad instruction on the duty of the physician to disclose to the patient "all the facts which mutually affect his rights and interests and of the surgical risk, hazard and danger, if any." (p. 578.) On appeal, the instruction was held to be overly broad, the court stating:

". . . A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent . . .

"The instruction given should be modified to inform the jury that the physician has such discretion consistent, of course, with the full disclosure of facts necessary to an informed consent." (p. 578.)

The appellees rely upon *Hunt v. Bradshaw* [1955], 242 N. C. 517, 88 S. E. 2d 762, a North Carolina case. This was a malpractice action against a physician wherein the patient sought damages alleged to have resulted from the negligent failure of the defendant (1) to use reasonable care and diligence in the application of his knowledge and skill as a physician and surgeon, and (2) to exercise his best judgment in attempting to remove a small piece of steel from plaintiff's body. On these allegations of negligence the plaintiff contended, among other things, that the defendant advised the plaintiff the operation was simple, whereas it was serious and involved undisclosed risks. The plaintiff's evidence was sufficient to justify a finding the operation was of a very serious nature. The court after reviewing the evidence said:

". . . Upon Dr. Bradshaw's advice the operation was decided upon. It is understandable the surgeon wanted to reassure the patient so that he would not go to the operating room unduly apprehensive. Failure to explain the risks involved, therefore, may be considered a mistake on the part of the surgeon, *but under the facts* cannot be deemed such want of ordinary care as to import liability.

"Proof of what is in accord with approved surgical procedure and what constitutes the standard of care required of the surgeon in performing an operation, like the advisability of the operation itself, are matters not within the knowledge of lay witnesses but must be established by the testimony of qualified experts . . .

"Plaintiff's expert testimony is sufficient to justify the finding the injury and damage to plaintiff's hand and arm resulted from the operation. But, as in cases of ordinary negligence, the fact that injury results is not proof the act which caused it was a negligent act. The doctrine *res ipsa loquitur* does not apply in cases of this character . . .

"Of course, it seems hard to the patient in apparent good health that he should be advised to undergo an operation, and upon regaining consciousness finds that he has lost the use of an arm for the remainder of his life. Infallibility in human beings is not attainable. The law recognizes, and we think properly so, that the surgeon's hand, with its skill and training, is, after all, a human hand, guided by a human brain in a procedure in which the margin between safety and danger sometimes measures little more than the thickness of a sheet of paper.

"The plaintiff's case fails because of lack of expert testimony that the defendant failed, either to exercise due care in the operation, or to use his best judgment in advising it . . ." (pp. 523, 524.) (Emphasis added.)

Under *the facts* presented by the case it does not appear the allegations of negligence were sufficient to encompass the failure of the physician to inform the patient of the risks.

An X ray case upon which the appellees rely is *Costa v. Regents*

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of Univ. of California, 116 Cal. App. 2d 445, 254 P. 2d 85. This was a malpractice action against a hospital and certain doctors for alleged negligence in the X ray treatment of cancer to the area of the lower jaw which resulted in necrosis of tissue. It was alleged the X ray treatment was too drastic and extensive. While the circumstances were in many respects similar to the case at bar, it did not involve any failure of the physicians to disclose the risks. It was claimed a less drastic and extensive treatment should have been undertaken by the doctors. The court said:

> ". . . The expert evidence showed clearly that the exact extent of the cancer under the surface and the absence of hidden involvements cannot in a case like appellant's be decided with such certainty that it can be safely relied on for the purpose of restricting the treatment within narrow limits. There was no expert evidence whatever that on the data available to defendants they ought in good practice to have restricted the X-ray treatment to a less drastic procedure or that the diagnostic methods now indicated by appellant if used would have yielded certainty and should have led to restriction to less dangerous treatment. Several experts testified that said methods (X-ray pictures and biopsy) could not be relied on for the purpose. In fighting so dangerous a condition as here involved, physicians may take serious risks and in doing so must rely on their judgment in deciding how far to go. See *Callahan v. Hahnemann Hospital,* 1 Cal. 2d 447 [35 P. 2d 536]. To hold them responsible in the cases where the bad chance unfortunately materializes would be evidently unjust and most dangerous if physicians were deterred from going to the extent which gives their patient the best chance of survival." (p. 457.)

The *Costa* case has nothing to do with the duty to inform the patient of the hazardous character of proposed treatment. The more recent case of the same court in *Salgo v. Leland Stanford, Etc. Bd. Trustees,* supra, covers the subject specifically.

In our opinion the proper rule of law to determine whether a patient has given an intelligent consent to a proposed form of treatment by a physician was stated and applied in *Salgo v. Leland Stanford, Etc. Bd. Trustees,* supra. This rule in effect compels disclosure by the physician in order to assure that an informed consent of the patient is obtained. The duty of the physician to disclose, however, is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment. So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances con-

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sidered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.

Turning now to the facts in the instant case, the appellant knew she had a cancerous tumor in her left breast which was removed by a radical mastectomy. Pathological examination of the tissue removed did not disclose any spread of the cancer cells into the lymphatics beyond the cancerous tumor itself. As a precautionary measure the appellant's ovaries and fallopian tubes were removed, which likewise upon pathological examination indicated no spread of the cancer to these organs. At the time the appellant went to Dr. Kline as a patient there was no immediate emergency concerning the administration of cobalt irradiation treatment such as would excuse the physician from making a reasonable disclosure to the patient. We think upon all the facts and circumstances here presented Dr. Kline was obligated to make a reasonable disclosure to the appellant of the nature and probable consequences of the suggested or recommended cobalt irradiation treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which were incident to, or possible in, the treatment he proposed to administer.

Upon the record here presented Dr. Kline made no disclosures to the appellant whatever. He was silent. This is not to say that the facts compel a verdict for the appellant. Under the rule heretofore stated, where the patient fully appreciates the danger involved, the failure of a physician in his duty to make a reasonable disclosure to the patient would have no causal relation to the injury. In such event the consent of the patient to the proposed treatment is an informed consent. The burden of proof rests throughout the trial of the case upon the patient who seeks to recover in a malpractice action for her injury.

In considering the obligation of a physician to disclose and explain to the patient in language as simple as necessary the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body, we do not think the administration of such an obligation, by imposing liability for malpractice if the treatment were administered without such explanation where explanation could reasonably be made, presents any insurmountable obstacles.

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The appellant's requested instruction on the duty of a physician to make a disclosure to his patient was too broad. But this did not relieve the trial court of its obligation to instruct on such issue under the circumstances here presented, since the issue was raised by the pleadings. On retrial the instruction should be modified to inform the jury that a physician has such discretion, as heretofore indicated, consistent with the full disclosure of facts necessary to assure an informed consent by the patient.

On retrial of this case the first issue for the jury to determine should be whether the administration of cobalt irradiation treatment was given with the informed consent of the patient, and if it was not, the physician who failed in his legal obligation is guilty of malpractice no matter how skillfully the treatment may have been administered, and the jury should determine the damages arising from the cobalt irradiation treatment. If the jury should find an informed consent was given by the patient for such treatment, the jury should next determine whether proper skill was used in administering the treatment.

The primary basis of liability in a malpractice action is the deviation from the standard of conduct of a reasonable and prudent medical doctor of the same school of practice as the defendant under similar circumstances. Under such standard the patient is properly protected by the medical profession's own recognition of its obligations to maintain its standards.

The appellant requested and the trial court refused to give the following instruction:

> "You are instructed that under the terms of the contract between defendant Kline and defendant Hospital it was the duty of defendant Kline to supervise the work of all the personnel in the radiology department. If you find that plaintiff's injury was the result of the negligence of personnel in the department your verdict shall be in favor of plaintiff and against both defendants."

Nowhere in the written instructions was there anything to indicate that either defendant could be chargeable with the negligence of anyone other than the negligence of Dr. Kline personally, unless it is to be construed from the generalization of the pleadings contained in the court's instruction No. 1. This generalization at best would be confusing to a jury on this point.

> "A physician is responsible for an injury done to a patient through the want of proper skill and care in his assistant, and through the want of proper skill and care in his apprentice, agent, or employee. The fact that a physician's assistant is a member of the same or a similar profession does not make the

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rule of *respondeat superior* inapplicable, and a physician is liable not only for negligence of laymen employed by him, but also for the negligence of nurses or other physicians in his employ.

. . . .

"Corporations, or persons other than physicians, who treat patients for hire with the expectation of profit are liable for negligence or malpractice on the part of the physicians or nurses employed by them." (70 C. J. S., Physicians and Surgeons, § 54e, pp. 978, 979, and see cases cited therein.)

Although the court did not think it necessary to go into the doctrine of *respondeat superior*, see the facts in *Rule v. Cheeseman, Executrix*, 181 Kan. 957, 317 P. 2d 472.

In *Gray v. McLaughlin*, 207 Ark. 191, 179 S. W. 2d 686, an X-ray specialist or roentgenologist was held liable for injuries caused by the X-ray technician employed by him.

In an action for damages founded on malpractice it is the duty of the trial court to instruct the jury with respect to the law governing the case, explaining the precise questions at issue. This includes, under the evidence presented by the record in the instant case, the responsibility of the physician for the acts or omissions of others under his supervision. (See, 70 C. J. S., Physicians and Surgeons, § 64, p. 1016, and cases cited.)

A party is entitled to have the trial court give an instruction to the jury which is essential to his theory of the case when there is sufficient evidence to support such theory. (*Krch v. Trinkle*, 185 Kan. 329, 343 P. 2d 213.)

In our opinion the refusal of the trial court to give the requested instruction was prejudicial and constituted reversible error. It was Dr. Somers, not Dr. Kline, who prescribed use of rotational therapy. Dr. Somers was an assistant to Dr. Kline. It was the hospital's employee, Darter, referred to by Dr. Kline as his physicist, who made the computations which resulted in administration of a dosage in excess of tolerance limits, if the jury were to give credence to the appellant's theory of the evidence, and Dr. Kline was chargeable with knowledge of the quantity and effect of the irradiation he caused to be administered to the appellant. (*Agnew v. Larson*, 82 Cal. App. 2d 176, 185 P. 2d 851.)

While counsel for the appellees made no objection to the testimony of Dr. Roys, they set forth in detail his testimony in a counter abstract to show he was not a physician but was testifying by virtue of an academic degree. Inferentially this may suggest Dr. Roys, not being a physician of the same school of practice as Dr. Kline.

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was incompetent to establish negligence concerning medical practice and treatment. (*Goheen v. Graber*, 181 Kan. 107, 309 P. 2d 636.)

It is the customary practice, however, for a radiologist to have a physicist make his calculations where cobalt irradiation therapy treatments are given by a rotational beam to patients. This was confirmed not only by Dr. Kline but also by Dr. Hare. In fact, Dr. Kline testified that he did not know how to make the calculations necessary to make the irradiation administered meet the requirements for the radiation prescribed. He said he could not even understand the calculations when they had been made by others. It must be observed this is not unusual because the radiologist is not trained in nuclear physics, a specialty in itself. Dr. Roys was a technician of the same type as Darter, and, in fact, was the professor at Wichita University under whom Darter studied. Thus, there could be no legitimate objection to the competency of Dr. Roys to testify relative to the calculations made.

The appellees contend that no issue was raised in the pleadings or in the evidence at the trial, so far as the jury was concerned, which would exempt the hospital from liability for the acts of Dr. Kline under the doctrine of *respondeat superior* and that by reason thereof no instruction was required. The simple answer is that the appellees are privileged to make this admission, but the jury is entitled by an appropriate instruction to know about it. The appellees argue the appellant does not claim that Darter made any error in computation. While this is true, Darter did not, under the appellant's theory, make enough calculations to know that an excessive equilibrium dosage was administered five millimeters beneath the skin. Under these circumstances, the appellees' argument has no merit.

The appellant contends the trial court erred in failing to instruct that the jury might consider the fact of injury as evidence of negligence, citing *George v. Shannon*, 92 Kan. 801, 142 Pac. 967. On the facts presently before the court this point is not well taken. The appellant alleges injury as a result of burns from cobalt irradiation therapy. This is not a *res ipsa loquitur* case and no presumption of negligence of a physician is to be indulged from the fact of injury or adverse result of his treatment of the patient. (*Cummins v. Donley*, 173 Kan. 463, 249 P. 2d 695, and cases cited therein.)

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In *Costa v. Regents of Univ. of California,* supra, it was contended, among other things, that necrosis did not ordinarily follow treatment from cancer X ray and that this circumstance amounted to proof of negligence. In rejecting the contention the California court said:

". . . The result of the same treatment is not always the same in all cases and on all patients. When the result of a treatment is less favorable or more prejudicial than in the great majority of cases such need not indicate that the treatment was negligently performed, but may as well be the result of individual differences in reaction or the less favorable circumstances of the case . . ." (p. 461.)

The expert testimony in the instant case confirms the correctness of the above statement. (But see, *King v. Ditto,* 142 Ore. 207, 19 P. 2d 1100.)

Upon the record presented it is apparent the appellees were united in interest; therefore, pursuant to G. S. 1949, 60-2907, the appellees were obligated in the exercise of their peremptory challenges in empaneling the jury to challenge jointly.

In conclusion we hold the trial court committed reversible error in the matter of instructing the jury. It has been held when the instructions to the jury define the issues and state the pertinent law with accuracy, the failure of the court to emphasize some particular point of law deemed important by a party litigant does not constitute error, especially when such party does not object to the instructions as given nor ask for a further instruction to supplement them. (*Kiser v. Skelly Oil Co.,* 136 Kan. 812, 18 P. 2d 181.) In the instant case the instructions given to the jury did not define the issues and state the pertinent law with accuracy, and further instructions were requested. By reason of the errors heretofore noted the appellant should be granted a new trial.

The judgment of the lower court is reversed with directions to grant a new trial.

PARKER, C. J., and PRICE, J., dissent.

(REPORTER'S NOTE—For opinion denying motion for rehearing see 187 Kan. 186, 354 P. 2d 670.)

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Case Summary
Natanson v. Kline, 187 Kan. 187, 354 P.2d 670 (1960)

This second Natanson opinion stems from the Kansas Supreme Court denying appellees' motion for rehearing. When denying the motion for rehearing, the Kansas Supreme Court explained part of its original decision on a doctor's duty to warn his patient. In this vein, the Kansas Supreme Court stated:

> A physician violates his duty to his patient and subjects himself to liability for malpractice, where no immediate emergency exists and upon facts and circumstances particularly set forth in the opinion, if he makes no disclosure of significant facts within his knowledge which are necessary to form the basis of an intelligent consent by the patient to the proposed form of treatment.

Natanson, 187 Kan. at 188, citing Syl. ¶ 4 in Natanson v. Kline, 186 Kan. 393.

The Court then held that the appellant was entitled to a reasonable disclosure by Dr. Kline so that she could intelligently decide whether to have cobalt irradiation treatment. Natanson, 187 Kan. at 189. The Court then stated that based upon the record, as a matter of law, Dr. Kline failed to make a reasonable disclosure to his patient, thereby breaching his legal duty. The Court then recognized that:

> Conceivably, in a given case as indicated in the opinion, no disclosures to a patient may be justified where such practice, under given facts and circumstances, is established by expert testimony to be in accordance with that of a reasonable medical practitioner under the same or similar circumstances.

Natanson, 187 Kan. at 189.

The Court then focused on when a plaintiff must produce expert testimony to prove his case. On this point, the Court stated:

> Whether or not a physician has advised his patient of the inherent risks and hazards in a proposed form of treatment is a question of fact concerning which lay witnesses are competent to testify, and the establishment of such fact is not dependent upon expert medical testimony. It is only when the facts concerning the actual disclosures made to the patient are ascertained or ascertainable by the trier of facts, that expert testimony of medical witnesses is required to establish whether such disclosures are in accordance with those which a reasonable medical practitioner would make under the same or similar circumstances.

Natanson, 187 Kan. at 190.

by the trial court, it cannot be said it does not appear from the face of the fourth amended petition that such pleading failed to state a cause of action.

For decisions which, although they cannot be regarded as controlling precedents for the reason they deal with the right and power of trial courts to strike amended petitions and other pleadings from the files because repetitious and requiring the repeated review of what has been previously held and determined, nevertheless support the conclusions here reached and announced see *Fleming v. Campbell*, supra; *Mydland v. Mydland*, 153 Kan. 497, 112 P. 2d 104; *Dwinnell v. Acacia Mutual Life Ins. Co.*, 155 Kan. 464, 126 P. 2d 221; *Fidelity Hail Ins. Co. v. Anderson*, 172 Kan. 253, 239 P. 2d 830; *Farran v. Peterson*, 181 Kan. 145, 309 P. 2d 677; *Rine Drilling Co. v. Popp*, 184 Kan. 13, 334 P. 2d 426; *In re Estate of Manweiler*, supra; *Neuvert v. Woodman*, supra; *Rockhill, Administrator v. Tomasic*, supra.

The judgment is affirmed.

No. 41,476

IRMA NATANSON, *Appellant*, v. JOHN R. KLINE and ST. FRANCIS HOSPITAL AND SCHOOL OF NURSING, INC., *Appellees*.

(354 P. 2d 670)

OPINION DENYING A REHEARING

Appeal from Sedgwick district court, division No. 1; WM. C. KANDT, judge. Opinion denying a rehearing filed August 5, 1960. (For original opinion reversing the judgment of the trial court with directions to grant a new trial, see 186 Kan. 393, 350 P. 2d 1093.)

Wayne Coulson, Homer V. Gooing, Paul R. Kitch, Dale M. Stucky, Donald R. Newkirk, Robert J. Hill, Gerrit H. Wormhoudt, Philip Kassebaum, John E. Rees, Robert T. Cornwell and *Willard B. Thompson*, all of Wichita, for the appellant. *Hugo T. Wedell*, of Wichita, of counsel.

William Tinker, Getto McDonald, Arthur W. Skaer, Hugh P. Quinn, William Porter, Alvin D. Herrington, Darrell D. Kellogg, Richard T. Foster, W. D. Jochems, J. Wirth Sargent, Emmett A. Blaes, Roetzel Jochems, Robert G. Braden, J. Francis Hesse, James W. Sargent, Stanley E. Wisdom, Vincent L. Bogart, Cecil E. Merkle, John W. Brimer and *Harry L. Hobson*, all of Wichita, for the appellee, St. Francis Hospital and School of Nursing, Inc.

W. A. Kahrs, Robert H. Nelson and *H. W. Fanning*, all of Wichita, for the appellee, John R. Kline.

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The opinion of the court was delivered by

SCHROEDER, J.: Within the time allotted after the decision of the court herein was announced the appellees filed motions for rehearing. Thereafter, pursuant to request, leave was granted the Kansas Medical Society on May 12, 1960, to file its brief *amicus curiae* in support of the appellees' motions for rehearing. Finding nothing, upon consideration of the motions for rehearing and the brief of *amicus curiae* in support thereof, which warrants a reconsideration of the case, the motions for rehearing are denied.

Recognizing, however, that this is a case of first impression in Kansas and one establishing judicial precedence of the highest importance to the medical profession, an attempt will be made to clarify Syllabus ¶ 4 and the corresponding portion of the opinion concerning which counsel are apprehensive.

Perhaps in preoccupation over the *legal* obligation of a physician to his patient, the court has not adequately emphasized procedural aspects of the case, or reiterated fundamental doctrine in the law of negligence sufficiently to completely avoid efforts to misconstrue the opinion.

It is charged that the court has confused a malpractice suit, where negligence is an essential element, with an assault and battery case, where negligence is not an essential element, thereby giving rise to a hybrid action which is neither one of negligence nor one of assault and battery, but may be a combination of the two.

It is argued the only way the court's opinion can be justified is to say that the duty of a physician to disclose to his patient the risks and hazards of a proposed form of treatment is an absolute one, and the matter is not to be judged by such disclosures as a reasonable medical practitioner would make under the same or similar circumstances.

In support of the argument, that the court has imposed an absolute duty upon the physician, the following paragraph is isolated from context:

"On retrial of this case the first issue for the jury to determine should be whether the administration of cobalt irradiation treatment was given with the informed consent of the patient, and if it was not, the physician who failed in his legal obligation is guilty of malpractice no matter how skillfully the treatment may have been administered, and the jury should determine the damages

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arising from the cobalt irradiation treatment. If the jury should find an informed consent was given by the patient for such treatment, the jury should next determine whether proper skill was used in administering the treatment." (*Natanson v. Kline,* 186 Kan. 393, 411, 350 P. 2d 1093.)

A casual reading of this paragraph in context would indicate that reference is there being made to the *order* in which the jury is to consider the issues presented on retrial of the case, and not to an enumeration of the various elements which must be established by the evidence to prove each of the issues stated.

The gravamen of the plaintiff's complaint was malpractice or the failure of the defendants to properly perform the duties which devolved upon them—a failure which resulted in the alleged injuries to the plaintiff. Thus it was incumbent upon the plaintiff to prove and establish (1) that the defendants failed to perform their duty; and (2) that the plaintiff's injuries were the direct and proximate result of such failure.

The petition alleged that the injuries were "a direct and proximate result of the defendants' negligence and carelessness" and then set forth eight specific grounds of negligence, including:

"(g) He [Dr. Kline] failed to warn plaintiff that the course of treatment which he undertook to administer involved great risk of bodily injury or death."

The answers of both defendants denied generally the allegations of asserted negligence, and in addition thereto, affirmatively pleaded that the plaintiff "assumed the risk and hazard of the treatment." Thus, at the trial the defendants were fully aware that *the informed consent of the patient to the hazards of the treatment was an issue of fact in the case.* This is true because as a defense assumption of risk is applicable only where the plaintiff is equally competent with the defendant to judge concerning the risks and hazards. (See, *Taylor v. Hostetler,* 186 Kan. 788, 352 P. 2d 1042, and cases cited therein.) These affirmative allegations of the defendants presupposed an informed consent by the patient with full knowledge of the risks and hazards of the treatment.

The court held after reviewing the record presented on this appeal that a physician violates his duty to his patient and *subjects himself to liability for malpractice,* where no immediate emergency exists *and upon facts and circumstances particularly set forth in the opinion,* if he makes *no disclosure* of significant facts within his knowledge which are necessary to form the basis of an intelligent consent by the patient to the proposed form of treatment (Syllabus ¶ 4).

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In other words, on the facts and circumstances presented by the record the appellant was entitled to some explanation concerning the risks and hazards inherent in the administration of cobalt irradiation treatment which Dr. Kline proposed to administer to her. For this treatment she was Dr. Kline's patient and not the patient of Dr. Crumpacker by whom she was referred to Dr. Kline.

The appellant was entitled to a reasonable disclosure by Dr. Kline so that she could intelligently decide whether to take the cobalt irradiation treatment and assume the risks inherent therein, or in the alternative to decline this form of precautionary treatment and take a chance that the cancerous condition in her left breast had not spread beyond the lesion itself which had been removed by surgery. There was no emergency calling for immediate attention. The appellant had recovered from the surgery. In addition to the evidence related in the opinion her husband testified:

"Q. Now, directing your attention to approximately the 5th or 6th day of June, 1955, I would like to have you describe for us the general apparent condition of the health of Mrs. Natanson?

"A. Mrs. Natanson at that particular time was very, very well. She had gone through the two operations and had made a very, very fine recovery. She was able to use her arm because of the therapy; she had almost the complete use of the left arm again. The breast had healed fully. There were actually no scars—just the one large scar but there was a thickness there. We were living a very normal life after the big scare we had.

"Q. Now, directing your attention to the first week of June, 1955, I will ask you whether or not Mrs. Natanson ever recovered to the point where she was able to do her own housework?

"A. Yes, she had."

But contrary to the legal obligation imposed upon a physician to make a reasonable disclosure to his patient of the inherent risks and hazards of a proposed form of treatment, Dr. Kline gave the appellant no explanation whatever. He made no disclosures. He was silent. On this state of the record Dr. Kline failed in his legal duty to make a reasonable disclosure to the appellant who was his patient *as a matter of law*.

Conceivably, in a given case as indicated in the opinion, no disclosures to a patient may be justified where such practice, under given facts and circumstances, is established by expert testimony to be in accordance with that of a reasonable medical practitioner under the same or similar circumstances. But on the state of the record here presented the appellant was not required to produce expert medical testimony to show that the failure of Dr. Kline to

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give any explanation or make any disclosures was contrary to accepted medical practice. To hold otherwise would be a failure of the court to perform its solemn duty.

Whether or not a physician has advised his patient of the inherent risks and hazards in a proposed form of treatment is a *question of fact* concerning which lay witnesses are competent to testify, and the establishment of such fact is not dependent upon expert medical testimony. It is only when the facts concerning the actual disclosures made to the patient are ascertained, or ascertainable by the trier of the facts, that the expert testimony of medical witnesses is required to establish whether such disclosures are in accordance with those which a reasonable medical practitioner would make under the same or similar circumstances.

The question then remains whether such failure on the part of Dr. Kline to make a reasonable disclosure to the appellant was a proximate cause of her injury. As indicated in the opinion the mere fact that Dr. Kline was silent does not compel a verdict for the appellant. It was said:

> ". . . Under the rule heretofore stated, where the patient fully appreciates the danger involved, the failure of a physician in his duty to make a reasonable disclosure to the patient would have no causal relation to the injury. In such event the consent of the patient to the proposed treatment is an informed consent. The burden of proof rests throughout the trial of the case upon the patient who seeks to recover in a malpractice action for her injury." (*Natanson v. Kline,* supra, p. 410.)

Negligence is an essential element of malpractice, and the foregoing statement recognizes that a causal relation must be established by the patient, between the negligent act of the physician and the injury of the patient, to sustain the burden of proof where damages are sought in a malpractice action for injury. Prior to a discussion of the manner in which the court instructed the jury it was said in the opinion:

> ". . . At best it may be said, upon all the facts and circumstances presented by the record, there was evidence from which a jury could find that the proximate cause of the appellant's injury was the negligence of the defendants. On the other hand a jury, *properly instructed,* would be justified in finding for the appellees." (*Natanson v. Kline,* supra, p. 398.)

After making the foregoing statement in the opinion, discussion was directed to the instructions of the court without further specific attention to the issue of proximate cause. If, of course, the appellant would have taken the cobalt irradiation treatments even though Dr. Kline had warned her that the treatments he undertook to administer

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involved great risk of bodily injury or death, it could not be said that the failure of Dr. Kline to so inform the appellant was the proximate cause of her injury. While the appellant did not directly testify that she would have refused to take the proposed cobalt irradiation treatments had she been properly informed, we think the evidence presented by the record *taken as a whole* is sufficient and would authorize a jury to infer that had she been properly informed, the appellant would not have taken the cobalt irradiation treatments.

Two days after the decision of this court was announced, the Supreme Court of Missouri handed down its opinion in *Mitchell v. Robinson,* 334 S. W. 2d 11, on April 11, 1960, wherein the Missouri court reached the same conclusion as this court on the duty of a physician to inform his patient of the hazards of treatment. There the patient had a rather severe emotional illness but was not mentally incompetent. The treatment prescribed was "combined electroshock and insulin subcoma therapy." A sharp conflict developed in the testimony as to whether the patient was informed of the risks of the treatment. Serious hazards incident to shock treatment were admitted, to-wit: fractured bones, serious paralysis of limbs, irreversible coma and even death, and further that there were no completely reliable or successful precautions. The patient as a result of treatment went into convulsions which caused the fracture of several vertebrae and sued the physicians in a malpractice action on the ground that he was not informed of the risks inherent in the treatment. The "essentially meritorious problem" before the court was whether upon the record there was any evidence to support the jury's finding of negligence. In the opinion the court said:

> "In the particular circumstances of this record, considering the nature of Mitchell's illness and this rather new and radical procedure with its rather high incidence of serious and permanent injuries not connected with the illness, the doctors owed their patient in possession of his faculties the duty to inform him generally of the possible serious collateral hazards; and in the detailed circumstances there was a submissible fact issue of whether the doctors were negligent in failing to inform him of the dangers of shock therapy." (p. 19.)

As always, an effort is made by the court to present an opinion in logical sequence, so that consideration of subsequent issues is dependent upon the disposition of issues previously determined, and if opinions are analyzed in this manner misinterpretations will be minimized.

PARKER, C. J., and PRICE, J., are of the opinion the judgment of the trial court should be affirmed, and therefore dissent.

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Case Summary
Funke v. Fieldman, 212 Kan. 524, 512 P.2d 539 (1973)

The plaintiff was paralyzed on her left side after receiving a caudal anesthesia (spinal anesthesia). The night before the plaintiff's operation, the defendant asked the plaintiff what type of anesthesia she would like to receive, to which the plaintiff responded spinal. The defendant stated that this was the best type of anesthesia and the most "you could get from them is a headache and we have medicine for that now." The defendant does not deny this statement. When the defendant attempted to inject the fluid into the plaintiff's spine, the plaintiff stated that she felt a terrible pain down her leg and she said "Oh." Defendant's expert agreed that the only way the partial paralysis would have occurred is if the substance was injected into the conus. The trial was to the Court, who rendered a verdict for the defendant.

When reversing the trial court, the Court restated the rules from Natanson, Williams and Tatro. The Court stated:

> We are not faced with total silence on the part of a physician, or a failure to make a disclosure that would deviate from acceptable medical practice. Here we are confronted with a misleading by Dr. Fieldman upon which Dr. Fieldman knew Mrs. Funke was relying when she gave her consent for the spinal anesthetic. As such, the misleading statement was equivalent to a false statement by Dr. Fieldman and vitiated Mrs. Funke's consent.

Funke, 212 Kan. at 535.

The Court then stated that there must be a causal relationship between the damage to the patient and the physician's failure to divulge the risk. When examining the causal relationship, the Court cited at length and with approval Canterbury v. Spence, 464 F.2d 772 (1972). The Kansas Supreme Court adopted the objective test created by the Court in Canterbury to determine whether the causation element had been met.

When adopting the objective causation test, the Kansas Supreme Court cited the following passage from Canterbury with approval:

> Better it is, we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitable informed of all perils bearing significance. [Citing authorities.] If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not.

Funke, 212 Kan. at 537, citing, Canterbury, 464 F.2d at 790-91.

The Kansas Supreme Court then noted that under the objective test, the patient's testimony is relevant on this issue but is not controlling. Funke, 212 Kan. at 537.

In Funke, the plaintiff presented expert testimony demonstrating that the defendant misled the plaintiff. Throughout these cases, a bright line is beginning to form, which is: if the defendant made any type of disclosures, then the plaintiff must present expert testimony to impinge the adequacy of these disclosures.

No. 46,798

LILLIAN M. FUNKE, *Appellant*, v. E. JAY FIELDMAN, *Appellee*.

(512 P. 2d 539)

SYLLABUS BY THE COURT

1. TRIAL—*Findings as to Controlling Facts—When Findings Will be Set Aside.* Under K. S. A. 60-252(*a*) where trial is to the court the trial judge shall find the controlling facts, and on appellate review the findings of fact by the trial judge shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the witnesses.
2. PHYSICIANS AND SURGEONS—*Malpractice—Expert Medical Testimony Generally Required—Exception Stated.* In malpractice cases expert medical testimony is ordinarily required to establish negligence or lack of skill on the part of a physician or surgeon in his medical diagnosis, his performance of surgical procedures and his care and treatment of patients. An exception to the general rule exists where the results of medical treatment are so patently bad as to be manifest to lay persons or as to come within the common knowledge and experience of mankind generally.
3. SAME—*Duty to Make Reasonable Disclosure—Informed Consent.* In the absence of an emergency a physician or surgeon has a legal obligation to make a reasonable disclosure to his patient of the nature and probable consequences of the suggested or recommended treatment, and to make a reasonable disclosure of the dangers within his knowledge which are incident or possible in the treatment he proposes to administer in order that his patient will have a basis to make an intelligent informed consent to the proposed treatment. But the duty of the physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances.
4. SAME—*Reasonable Disclosure—Informed Consent.* What is a reasonable disclosure upon which an informed consent may rest depends upon the facts and circumstances in each case.
5. SAME—*Administration of Spinal Anesthetic—Misinformed as to Possible Danger—Consent a Nullity.* There does not necessarily have to be negligence in the administration of a spinal anesthetic for there to be resultant nerve damage, this is one of the possible dangers from the administration of such procedure. A patient who is told by the physician who administers the spinal anesthetic that a headache is the only possible danger from such procedure is misinformed, and the patient's consent given as a result thereof is a nullity.
6. SAME—*Liability for Nondisclosure.* For there to be liability of a physician for nondisclosure, the unrevealed risk must materialize, and there must be harm to the patient; there must be a causal relationship between the physician's failure to adequately divulge information and damage to the patient.
7. SAME—*Necessity for Causal Connection Between Nondisclosure and Damage.* A causal connection exists between the physician's nondisclosure to [illegible] the patient's damage when, but only when, disclosure of

significant risks incidental to treatment would have resulted in a decision against it.

8. Same—*Refusing Treatment After Disclosure—Determined Objectively—Patient's Testimony Relevant But Not Controlling.* Whether the patient would have refused the treatment or medical procedure had the physician made adequate disclosure is to be determined objectively. If adequate disclosure could reasonably be expected to have caused the patient to decline the treatment or medical procedure had the patient been informed of the kind of risk or danger which resulted in her harm, causation is shown but otherwise not, and the patient's testimony is relevant on such issue, but should not be controlling.

9. Same—*Claim of Inadequate Disclosure—Burden of Proof.* In the trial of a malpractice action wherein the plaintiff claimed inadequate disclosure of risk information by the physician, the patient has the burden of going forward with evidence tending to establish a *prima facie* cause of action, and ultimately the burden of proof.

10. Same—*When Res Ipsa Loquitur Applicable to Malpractice Actions.* The doctrine of *res ipsa loquitur* applies in a medical malpractice action only where a layman is able to say as a matter of common knowledge and observation, or from the evidence can draw an inference, that the consequences of professional treatment were not such as ordinarily would have followed if due care had been exercised.

11. Same—*Giving Spinal Anesthesia—Nerve Damage—Procedure Beyond Experience of Laymen.* The administration of a spinal anesthesia by a physician anesthesiologist which results in permanent nerve damage to the patient is a procedure so complicated, considering the delicate anatomy of the human spine and the various possibilities of injury from the needle or anesthetic solution, as to lie beyond the realm of common knowledge and experience of laymen as to whether such result would not ordinarily occur in the absence of negligence.

Appeal from Sedgwick district court, division No. 3; B. Mack Bryant, judge. Opinion filed July 14, 1973. Reversed with directions.

Gerald L. Michaud, of Michaud, Cranmer, Syrios and Post, of Wichita, argued the cause, and *Ronald D. Heck*, of the same firm, was with him on the brief for the appellant.

William Tinker, of McDonald, Tinker, Skaer, Quinn & Herrington, of Wichita, argued the cause, and *Norman I. Cooley*, of the same firm, was with him on the brief for the appellee.

The opinion of the court was delivered by

Schroeder, J.: This is an action for malpractice against a physician anesthesiologist to recover for injuries sustained as the result of the administration of a spinal anesthetic alleged to have been negligently performed.

The plaintiff (appellant), Lillian M. Funke, had experienced a

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dull ache in her side for several years prior to 1967. The ache got much worse prior to her menstrual periods. Because of the ache the appellant consulted Dr. Gordon T. Cowles and was placed on birth control pills as a result of the consultation. However, Mrs. Funke subsequently became pregnant and gave birth to her sixth child in August, 1967.

Unforeseen complications prior to the birth of the child resulted in Dr. Cowles' recommending and subsequently administering a caudal anesthesia to Mrs. Funke for the birth. Mrs. Funke had no reaction to the caudal anesthesia and thought it was "marvelous". She continued treatment with Dr. Cowles and eventually was advised to have a hysterectomy. Arrangements were made, and Mrs. Funke entered Wesley Medical Center in Wichita, Kansas, on November 12, 1967, for the scheduled hysterectomy on November 13.

On the evening of November 12, 1967, Dr. Cowles visited Mrs. Funke in her room and advised her that Dr. E. Jay Fieldman (defendant-appellee) was her anesthesiologist and would be in to see her.

Dr. Fieldman visited the plaintiff that same evening. The plaintiff testified that he walked into her room and introduced himself, but only stayed approximately three to four minutes. Dr. Fieldman gave the plaintiff no physical examination but did ask her what kind of anesthetic she wanted. She replied that Dr. Cowles had recommended a spinal to which Dr. Fieldman replied "well, those are the best".

Dr. Fieldman went on to state that he liked to give those and that the most you could get from them is a headache and that "we have medicine for that now".

Before continuing with the facts, a brief discussion of the anatomy and the details of the procedure involved is in order.

The spinal cord runs the length of the back from the brain to approximately the first lumbar vertebra. Below that area the nerves flare out into what is termed the cauda equina (horse's tail). In a caudal anesthetic the anesthetic solution is not placed within the spinal column or subarachnoid space, while in a spinal anesthetic the solution is placed within the subarachnoid space. There is a lateral approach or method of giving a spinal anesthetic which consists of the insertion of the needle through the skin lateral to the midline of the patient's back. The aim in the performance of the spinal anesthetic using the lateral approach is to place the

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needle within the midline or the center of the intervertebral canal.

The cauda equina nerves are hanging free and are bathed in spinal fluids. The spinal cord which ends in a bulbous mass (conus medullaris) normally ends opposite the first lumbar vertebra.

The Anatomical Record, volume 88, published April, 1944, (defendant's exhibit No. 6.), states that termination of the spinal cord ranges from the level of the lower third of the twelfth thoracic vertebra to that of the middle third of the third lumbar vertebra.

Dr. William H. L. Dornette, called as a witness upon behalf of the defendant, testified the purpose of spinal anesthesia is to produce a block of the spinal nerves which will relieve pain and will produce muscular relaxation. Dr. Dornette explained the subarachnoid space is occupied by the spinal cord and other nerves and is filled with spinal fluid which is watery like substance. The nerves leave the spinal cord and transverse varying lengths of the subarachnoid space. Dr. Dornette continued to testify in detail about this part of the anatomy, stating in part that,

> ". . . The spinal cord ends at the upper part of the small of our back, normally you would not expect it to end lower than the body of the second lumbar vertebra. The cord tapers down gradually and at the very bottom there is a slight enlargement which is called the conus medullaris and the cauda equina extends from the conus medullaris and exits through the lower lumbosacral coccygeal foramen.
>
> "The fetus has a spinal cord which extends the entire length of the spinal column. At birth the body is starting to grow much faster than the spinal cord so that the tip of the spinal cord rises within the spinal column until finally in the adult, it is located somewhere in the region of the body of the second lumbar vertebra.
>
> "The nerves that form the cauda equina are approximately one to two millimeters in diameter, which is approximately the diameter of the lead in an old fashioned lead pencil. The nerves that formulate the cauda equina are within the subarachnoid space and are surrounded by and float within the spinal fluid.
>
> "To advance or put the needle through an individual's back into the subarachnoid space in the spinal anesthetic procedure, it would be necessary for the needle to pass through the subcutaneous tissue, supraspinous ligament between the spinous processes, through the interspinous ligament and through the epidural space, the dura and into the arachnoid membrane which fuses together and forms the subarachnoid space."

As for the actual procedure involved, Dr. E. Jay Fieldman was called as a witness on behalf of the plaintiff and on direct examination he testified to the following:

> "I made the initial spinal tap at the L2-3 interspace. [This is the interspace between the second lumbar vertebra and the third lumbar vertebra.] This

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is the highest possible interspace at which the procedure can be safely done because in the average person, the spinal cord comes down to the L1-2 interspace. If the initial tap is done higher than the L2-3 interspace there is a danger of traumatizing the spinal cord which would cause nerve or spinal cord damage that would result in weakness in one of the legs.

. . . .

"I usually aspirate when I attach the syringe, but I cannot recall whether I did in Mrs. Funke's particular case. . . ."

Dr. Fieldman went on to state that while he was not taught at the Mayo Clinic to aspirate, in many instances it is important to aspirate before starting an injection and in some instances it is dangerous. Dr. Fieldman agreed that if the plunger rotates freely but spinal fluid cannot be aspirated freely, the needle is not in the right place. The purpose of aspiration is to ascertain if you are getting a free flow of spinal fluid which indicates the needle is in the subarachnoid space rather than up against or inside a nerve, in which case a free flow of spinal fluid would not be present.

Mrs. Funke testified she was sleepy and drowsy from the pre-operative medication when she arrived at the operating room and was placed on the operating table. She was awake when she was set up but did not see Dr. Fieldman. She does remember hearing his voice when he gave instruction on the anesthetic.

The plaintiff was in a sitting position with her legs straight out and held in a position which caused her to lean over with her head very low.

The plaintiff testified when the needle was first inserted she felt a terrible pain down her leg; that her leg jerked; and she said "Oh". The plaintiff testified that Dr. Fieldman then said "Sit still" and soon thereafter the plaintiff felt another pain and remarked to Dr. Fieldman that, "Something's wrong, my legs aren't going to sleep". Dr. Fieldman then said, "Well, maybe we had better remove the needle". He then reinserted the needle at the L3-4 interspace. Plaintiff then remembers nothing after her legs went to sleep.

Evidence disclosed that about two tenths of a cubic centimeter of anesthetic solution was injected through the needle at the place of its initial insertion before the needle was reinserted at the lower interspace.

Testimony disclosed that when the anesthesia disappeared, paralysis remained on the left side with total anesthesia to pain as well as temperature with reduced sensitivity to touch. Testimony

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also showed that the plaintiff's left leg was so sensitive that doctors could hardly examine it and that a problem with control of bladder and bowels existed.

The plaintiff contends the trial court erred (1) in finding that the defendant was not negligent and in finding generally for the defendant when the evidence was not sufficient to support said findings; (2) in finding plaintiff gave an informed consent to the spinal anesthesia prior to its administration; and (3) in finding that the doctrine of *res ipsa loquitur* was not applicable to this case.

Under K. S. A. 60-252 (*a*) where trial is to the court, as here, the trial judge shall find the controlling facts, and on appellate review the findings of fact made by the trial judge shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the witnesses. (*Short v. Sunflower Plastic Pipe, Inc.*, 210 Kan. 68, 500 P. 2d 39.)

The appellant first contends the appellee was negligent in proceeding to start the injection of the solution after she experienced the sudden severe pain down her leg, rather than removing the needle and repositioning it before injection of the solution; and that the appellee was negligent in not heeding the warning of the first pain, and in waiting until she cried out a second time before removing the needle and repositioning it in the next lower interspace.

The appellant's nerves which were adversely affected are described as L-5, L-4, S-1 and S-2. Dr. Dornette, during his direct examination on behalf of the defendant, stated that in his opinion, "There's just no possible way that you can injure four nerves on one side without an injection into the substance of the conus." Dr. Dornette was cross-examined with the assistance of a work called *Neurological Complications after Spinal Anesthesia and Results from Two Thousand Four Hundred Ninety Three Follow Up Cases*, by Gunnar Thorsen, Stockholm, 1947. The cross-examination began with a paragraph entitled "Injuries via an Assumed Endroneural Injection". An endroneural injection is an injection into a nerve root or into a nerve. When counsel for the appellant began comparison between the plaintiff's case and the case reported by Thorsen, the defendant objected and the court ruled that the plaintiff could finish her cross-examination relative to the reported case but would not be allowed to cross examine Dr. Dornette on any other cases reported in Thorsen's work. Plaintiff

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sought to proffer other similar cases to compare the complaints and residuals of the plaintiff but was not allowed to proffer the information by the court. There was also evidence introduced that 1.8 percent of the population, or one in every fifty-five persons, has a low lying conus medullaris which extends down to the L2-3 interspace.

Suffice it to say evidence in the record establishes there is a possibility of nerve damage from a spinal injection, such as the appellant sustained in the instant case.

The appellant argues that even if her conus medullaris actually does extend down to the L2-3 interspace, if she had a complaint of pain when the defendant put the needle in followed by an injection without repositioning the needle, he departed from standard approved medical practice, which departure caused her injury.

The long standing general rule, consistently adhered to by this court in malpractice cases of this character, is that expert medical testimony is ordinarily required to establish negligence or lack of skill on the part of a physician or surgeon in his medical diagnosis, his performance of surgical procedures and his care and treatment of the patients. (*Collins v. Meeker*, 198 Kan. 390, 394, 424 P. 2d 488 and cases cited therein.) An exception to the general rule exists where the results of medical treatment are so patently bad as to be manifest to lay persons or as to come within the common knowledge and experience of mankind generally. (*Collins v. Meeker*, supra, and cases cited there.)

Without belaboring the point further we hold the record does contain substantial competent evidence in the form of expert medical testimony to support the trial court's finding that the appellee was not negligent in the performance of the spinal anesthetic injection.

We now turn to the appellant's second point—that the trial court erred in finding that she gave an informed consent to the spinal anesthesia prior to its administration.

This court was squarely confronted with the question of a patient's informed consent to a method or a course of treatment by medical personnel in *Natanson v. Kline*, 186 Kan. 393, 350 P. 2d 1093. That was an action for malpractice against a hospital and a physician in charge of its radiology department to recover for injuries sustained as a result of radiation therapy with radioactive cobalt, allegedly given in an excessive dosage. One of the plaintiff's contentions in *Natanson* was that while she consented to the treatment, the treating

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physician failed to warn her the course of treatment he undertook to administer involved great risk of bodily injury or death.

After an extended review of cases from foreign jurisdictions most nearly in point, this court concluded the proper rule of law to determine whether a patient has given an intelligent consent to a purposed form of treatment by a physician was the rule stated and applied in *Salgo v. Leland Stanford Etc. Bd. Trustees* [1957], 154 Cal. App. 2d 560, 317 P. 2d 170. The trial court in *Salgo* gave a rather broad instruction on the duty of the physician to disclose to the patient "all the facts which mutually affect his rights and interests and of the surgical risk, hazard and danger if any". In holding the instruction to be overly broad, the California appellate court stated:

". . . A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent. . . ." (p. 578.)

This court commented further on the doctrine of informed consent in *Williams v. Menehan*, 191 Kan. 6, 379 P. 2d 292. There it was held the parents of a small child who died while a team of physicians was performing a cardiac catheterization had given an informed consent to the procedure. In commenting on the rule as laid down in *Natanson*, supra, it was said:

". . . [I]t is the duty of a doctor to make a reasonable disclosure to his patient of the nature and probable consequences of the suggested or recommended treatment, and to make a reasonable disclosure of the dangers within his knowledge which are incident or possible in the treatment he proposes to administer. But this does not mean that a doctor is under an obligation to describe in detail all of the possible consequences of treatment. To make a

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complete disclosure of all facts, diagnoses and alternatives or possibilities which might occur to the doctor could so alarm the patient that it would, in fact, constitute bad medical practice." (p. 8.)

Summarizing the rule in *Tatro v. Lueken,* 212 Kan. 606, 512 P. 2d 528, the court said in Syllabi 3 and 4:

"In the absence of an emergency a physician or surgeon has a legal obligation to make a disclosure of the risks and dangers incident to a proposed medical or surgical procedure in order that his patient may make an informed consent thereto, but the duty of the physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances.

"What is a reasonable disclosure upon which an informed consent may rest depends upon the facts and circumstances of each case."

Against this historical background of the rule the question now posed is whether or not a reasonable disclosure of the nature and probable consequences of the recommended spinal anesthesia was made to Mrs. Funke, and whether or not a reasonable disclosure was made to Mrs. Funke of the dangers, within the knowledge of Dr. Fieldman, which were incident or possible in the spinal anesthesia he proposed to administer.

At the time of trial the appellant testified:

"I knew before Dr. Fieldman came to see me that Dr. Cowles was a believer in the advantages of spinal anesthesia for the type of surgery I was going to have. I believed in and trusted Dr. Cowles; before when he delivered my child, he recommended a caudal anesthetic, but he didn't talk to me about possible complications and risks of the caudal. I didn't ask him before the delivery and I didn't feel that I should have had more information from him at that time.

"At the time I had the spinal anesthetic I did not feel I needed more information about it. If I had known then what I know about spinals or caudals now, I would never have gone through it.

"When I discussed the spinal anesthetic with Doctor Cowles, I did not have any questions as to the advantages and disadvantages. I always thought the doctor chose the anesthetic and the patient did not ever really have much to say. I was never asked before. Doctor Cowles had recommended the spinal anesthetic and it seemed satisfactory to me and I accepted Doctor Fieldman's recommendation for the spinal anesthetic."

On direct examination Mrs. Funke testified concerning the time Dr. Fieldman came into her hospital room on the evening of November 12, 1967, as follows:

"Q. All right. Now I ask you this question: up to that time had anyone in the world ever told you that a spinal anesthetic could cause a paralysis or a partial paralysis?

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"A. No. I really didn't know anything about spinals. No one had ever told me.

"Q. All right. Had anyone ever told you that such a procedure could injure any part of your nervous system like the spinal cord, the nerve roots, or anything of that nature?

"A. No. The only thing I knew about a spinal was—I had heard women talk about the headaches from them. I was concerned about those.

"Q. Is that the only knowledge you've had is what you told the Court about here? Right now?

"A. Yes, sir.

"Q. When Dr. Fieldman walked into your room that night, did he introduce himself?

"A. Yes. He did. He said he was Dr. Fieldman. I believe we shook hands.

"Q. How long did he stay in the room there that evening?

"A. Well, he couldn't—it wasn't very long. I would say approximately three to four minutes at the most.

"Q. Did he give you a physical examination at that time?

"A. No, sir.

"Q. Did he interrogate you about any of your previous medical history?

"A. No. Not that I recall he didn't.

. . . .

"Q. Tell the Court what you said and what he said.

"A. He came in and introduced himself. I said well, I knew he was coming in. Dr. Cowles had mentioned he would be my anesthesiologist and that he would be in in a few minutes—in that evening. I told him Dr. Cowles had just left and he was very friendly. We exchanged, you know, hello. He asked me how I was and all this. Then he asked me what kind of anesthetic I wanted. I said well, Dr. Cowles had recommended a spinal; and he said, well, those are the best.

"He said I like to give those, too. He said the most you can get from them is a headache; and we have medicine for that now.

"Q. Was that the extent of his complete conversation in describing the procedure and what could happen there from it?

"A. That was about it.

"Q. Did Dr. Fieldman during this conversation at any time mention to you any possible consequence from spinal anesthetic?

"A. No, sir."

Dr. Fieldman takes the position, as the trial court found, that he was entitled to rely on the explanation given the patient by Dr. Cowles.

Dr. Cowles in his testimony was evasive as to what he told Mrs. Funke concerning a spinal anesthetic.

Did Dr. Cowles, the physician in charge, or Dr. Fieldman the anesthesiologist, have a duty to make a reasonable disclosure of the dangers of the proposed spinal anesthetic? We do not find it necessary to answer this question because the record clearly shows

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Dr. Fieldman went to see Mrs. Funke in her hospital room the evening prior to her scheduled operation and *undertook* to tell Mrs. Funkee that "the most you can get from them [spinal anesthetic] is a headache; and we have medicine for that now".

This testimony was never refuted by Dr. Fieldman.

A careful examination of the record affirmatively shows there were other risks associated with the administration of a spinal anesthetic, and that one out of 55 people does have an abnormally low lying conus medullaris which makes such patient vulnerable to nerve injury if a spinal needle is inserted at L2-L3 interspace, rather than at the next lower interspace.

Dr. Fieldman recognized in his testimony, previously quoted, that if the initial tap is done higher than the L2-3 interspace there is danger of traumatizing the spinal cord which could cause nerve or spinal cord damage. With a low lying conus medullaris the same would be true of an initial tap made at L2-3. On the facts in this case the needle was withdrawn from the L2-3 interspace, where it was first inserted and some anesthetic solution injected after the patient twice indicated pain, and reinserted at the L3-4 interspace where the spinal anesthetic was finally administered.

Albert Faulconer, M. D., chairman of the Department of Anesthesiology at the Mayo Clinic in Rochester, Minnesota, replied to the question,

"Q. . . . [W]ouldn't it be a fair statement that that's not the only risk, there is an occasional headache. . . ?

"A. Yes, there certainly are other risks."

Frank M. Tilton, M. D., a physician and specialist in the field of neurology practice in Wichita, Kansas, testified that in his best medical judgment the conus medullaris would not ever go down to the second and third lumbar interspace and that he would not agree with Dr. Faulconer that in about two percent of the people the spinal cord ends below the L-2 interspace. However, after being cross-examined from the anatomical record, Dr. Tilton changed his testimony and agreed that in the big majority of people the end of the spinal cord would be at the L-1 or L-2 level of the spine.

The record establishes that Dr. Fieldman either knew or should have known that spinal anesthesia carried with it more risks than mere headaches for the patient, and that such other risks were greater in severity. When Dr. Fieldman then undertook to tell

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Mrs. Funke that a headache was the only possible danger he misinformed and misled Mrs. Funke. In other words, her consent to the administration of a spinal anesthesia by Dr. Fieldman was not an informed consent. As such, it was a nullity.

In *Collins v. Meeker*, supra, the court said:

> "At no time has this court ventured to say that a physician or surgeon is under obligation to disclose any and all results which might possibly follow a medical or surgical procedure. Nor would we now deny that there may well be circumstances under which it would be bad therapeutic practice to disclose the nature, the procedures and the possible harsh results of treatment. Even though a patient may be relieved of the burden of showing, by expert evidence, that his doctor's silence deviated from acceptable medical practice, there is nothing in this rule which would preclude the doctor, himself, from showing that his silence did, in fact, comply with medical standards under the facts then facing him. . . ." (p. 397.)

But we are not here faced with total silence on the part of a physician, or a failure to make a disclosure that would deviate from acceptable medical practice. Here we are confronted with a misleading statement by Dr. Fieldman upon which Dr. Fieldman knew Mrs. Funke was relying when she gave her consent for the spinal anesthetic. As such, the misleading statement was equivalent to a false statement by Dr. Fieldman and vitiated Mrs. Funke's consent.

While there does not necessarily have to be negligence in the administration of the spinal anesthetic for the resultant damage which Mrs. Funke experienced, the risk was still present.

On the record here presented we find Dr. Fieldman failed to obtain the informed consent of Mrs. Funke to the spinal anesthetic prior to its administration.

No more than breach of any other legal duty does nonfulfillment of the physician's obligation to disclose alone establish liability to the patient. An unrevealed risk that should have been made known must materialize, otherwise the omission, however unpardonable, is legally without consequence. Occurrence of the risk must be harmful to the patient, for negligence unrelated to injury is nonactionable. And, as in malpractice actions generally, there must be a causal relationship between the physician's failure to adequately divulge the risks and damage to the patient. (*Canterbury v. Spence,* 464 F. 2d 772 [1972].)

A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a

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decision against it. The patient obviously has no complaint if she would have submitted to the spinal anesthetic notwithstanding awareness that the risk of permanent nerve damage was one of its perils. On the other hand, the very purpose of the disclosure rule is to protect the patient against the consequences which, if known, she would have avoided by foregoing the spinal anesthetic. (*Canterbury v. Spence,* supra, and *Natanson v. Kline,* 186 Kan. 393, 350 P. 2d 1093.)

This court said in *Natanson v. Kline,* supra:

"Upon the record here presented Dr. Kline made no disclosures to the appellant whatever. He was silent. This is not to say that the facts compel a verdict for the appellant. Under the rule heretofore stated, where the patient fully appreciates the danger involved, the failure of a physician in his duty to make a reasonable disclosure to the patient would have no causal relation to the injury. In such event the consent of the patient to the proposed treatment is an informed consent. The burden of proof rests throughout the trial of the case upon the patient who seeks to recover in a malpractice action for her injury." (p. 410.)

The factual issue on causal connection has not heretofore been determined by this court, except to say the burden of proof rests on the patient throughout the trial of a malpractice action. Should the issue be determined on an objective or a subjective basis? The point was fully discussed in *Canterbury v. Spence,* supra, where the United States Court of Appeals, District of Columbia Circuit, concluded the objective basis was the better. There the court said:

". . . The more difficult question is whether the factual issue on causality calls for an objective or a subjective determination.

"It has been assumed that the issue is to be resolved according to whether the factfinder believes the patient's testimony that he would not have agreed to the treatment if he had known of the danger which later ripened into injury. [Citing authorities.] We think a technique which ties the factual conclusion on causation simply to the assessment of the patient's credibility is unsatisfactory. To be sure, the objective of risk-disclosure is preservation of the patient's interest in intelligent self-choice on proposed treatment, a matter the patient is free to decide for any reason that appeals to him. [Citing authorities.] When, prior to commencement of therapy, the patient is sufficiently informed on risks and he exercises his choice, it may truly be said that he did exactly what he wanted to do. But when causality is explored at a post-injury trial with a professedly uninformed patient, the question whether he actually would have turned the treatment down if he had known the risks is purely hypothetical: 'Viewed from the point at which he had to decide, would the patient have decided differently had he known something he did not know?' [Citing authorities.] And the answer which the patient supplies hardly represents more than a guess, perhaps tinged by the circumstance that the uncommunicated hazard has in fact materialized. [Citing authorities.]

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"In our view, this method of dealing with the issue on causation comes in second-best. It places the physician in jeopardy of the patient's hindsight and bitterness. It places the factfinder in the position of deciding whether a speculative answer to a hypothetical question is to be credited. It calls for a subjective determination solely on testimony of a patient-witness shadowed by the occurrence of the undisclosed risk. [Citing authorities.]

"Better it is, we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance. [Citing authorities.] If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not. [Citing authorities.] The patient's testimony is relevant on that score of course but it would not threaten to dominate the findings. And since that testimony would probably be appraised congruently with the factfinder's belief in its reasonableness, the case for a wholly objective standard for passing on causation is strengthened. Such a standard would in any event ease the fact-finding process and better assure the truth as its product." (pp. 790, 791.)

We think the foregoing reasoning is persuasive. Whether a patient would have refused treatment or a medical procedure had the physician made adequate disclosure is to be determined objectively. If adequate disclosure could reasonably be expected to have caused the patient to decline the treatment or procedure because of revelation of the kind of risk or danger which resulted in her harm, causation is shown but otherwise not, and the patient's testimony is relevant on such issue, but should not be controlling.

The appellant's third point is that the trial court erred in finding the doctrine or *res ipsa loquitur* was not applicable to this case.

The doctrine of *res ipsa loquitur* and the elements thereof were examined as applied to malpractice cases in *Voss v. Bridwell*, 188 Kan. 643, 364 P. 2d 955, and reviewed in *Tatro v. Lueken*, 212 Kan. 606, 512 P. 2d 529, together with our prior decisions on the subject.

In *Tatro* the court held, consistent with our prior decisions, that the doctrine of *res ipsa loquitur* applies in a medical malpractice action only where a layman is able to say as a matter of common knowledge and observation, or from the evidence can draw an inference, that the consequences of professional treatment were not such as ordinarily would have followed if due care had been exercised.

In *Tatro,* which was a malpractice action based upon the occurrence of a vesicovaginal fistula following an abdominal hysterec-

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tomy, it was held that such operation is so complicated as to lie beyond the realm of common knowledge and experience of laymen as to whether such result would not ordinarily occur in the absence of negligence.

The law on the doctrine of *res ipsa loquitur* need not be further reviewed in connection with malpractice actions in this opinion. The reader is referred to *Tatro v. Lueken*, supra.

In our opinion the administration of spinal anesthesia which results in permanent nerve damage to the patient is a procedure so complicated, considering the delicate anatomy of the human spine and the various possibilities of injury from the needle or anesthetic solution, as to lie beyond the realm of common knowledge and experience of laymen as to whether such result would not ordinarily occur in the absence of negligence.

The judgment of the lower court is reversed with directions to grant a new trial in accordance with the views expressed in this opinion.

TIN, PRINGLE, OLIVER
IPLETT & WALLACE

Case Summary
Leiker v. Gafford, 245 Kan. 325, 778 P.2d 823 (1989)

The plaintiff received permanent injuries that resulted in her death from an overdose of spinal anesthetic when she was delivering her second child. During trial, evidence was presented by way of expert testimony, medical texts and treatises that 15mg of tetracaine, administered as spinal anesthetic in a caesarean section operation, was a massive overdose that cause the plaintiff's injuries and death. Additionally, it was disputed whether the defendants ever made any disclosures about the risk of a spinal anesthetic. Leiker, 245 Kan. at 332. The jury rendered a verdict in favor of the plaintiff. Defendants appealed.

The Kansas Supreme Court upheld the jury verdict and affirmed the trial court. One of the issues on appeal was informed consent.

The trial court gave the jury the following instruction on informed consent:

> In the absence of an emergency a physician or surgeon has a legal obligation to make a disclosure of the risk and dangers incident to a proposed medical or surgical procedure in order that his patient may make an informed consent thereto, but the duty of the physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances.
>
> What is a reasonable disclosure upon which informed consent may rest depends upon the facts and circumstances of each case.
>
> The burden of proof is upon the plaintiff to establish that sufficient information was not disclosed to the patient upon which to rest an informed consent. It is further their burden, before legal liability can be based on such nondisclosure, to establish that the patient, more probably than not, would have refused the procedure had adequate information been disclosed and that, therefore the injury would not have occurred.

Leiker, 245 Kan. at 333.

The defendants acknowledged that they had a duty to disclose but argued that because disclosures were made by the defendants to the decedent and the plaintiff, it was incumbent upon the plaintiff to present expert testimony on the issue of the adequacy of these disclosures. Leiker, 245 Kan. at 333. The defendants continued to argue that the plaintiff presented insufficient expert testimony on this point. Leiker, 245 Kan. at 333.

When responding to this argument, the Court held that the evidence did not conclusively establish that defendants made any

disclosures, and as a result, it was a question for the jury of whether or not any disclosures had been made. Leiker, 245 Kan. at 334, citing, Natanson v. Kline, 187 Kan. 186, 190, 354 P.2d 670 (1960). Further, the Court found that much of plaintiff's evidence on the informed consent issue was directed at Marshall's failure to disclose the incompetence or inexperience of Gafford. Leiker, 245 Kan. at 334.

No. 62,303

SHAWN A. LEIKER, a disabled person, by and through James S. Leiker, her husband and next friend; JAMES S. LEIKER, individually, and as parent and natural guardian of JASON SCOTT LEIKER and JENNIFER ANN LEIKER, minors, and as Special Administrator of the Estate of Shawn A. Leiker, deceased, *Appellees and Cross-Appellants*, v. WENDELL P. GAFFORD; PROFESSIONAL ANESTHESIA, INC., a corporation; GEORGE W. MARSHALL, M.D.; HARRIS, HODGES & MARSHALL, Chartered, a Professional corporation; and ABBOTT LABORATORIES, a corporation, *Appellants and Cross-Appellees.*

(778 P.2d 823)

SYLLABUS BY THE COURT

1. TRIAL—*Jury Instructions—Appellate Review.* Errors regarding jury instructions will not demand reversal unless they result in prejudice to the appealing party. Instructions in any particular action are to be considered together and read as a whole, and where they fairly instruct the jury on the law governing the case, error in an isolated instruction may be disregarded as harmless. If the instructions are substantially correct, and the jury could not reasonably be misled by them, the instructions will be approved on appeal.

2. TORTS—*Personal Injury—Nonpecuniary Damages—Loss of Enjoyment of Life Subcomponent of Pain and Suffering or Disability.* In a personal injury action, loss of enjoyment of life is not a separate category of nonpecuniary damages but is more appropriately considered as an element or subcomponent of pain and suffering and/or disability.

3. SAME—*Personal Injury—Nonpecuniary Damages.* In a personal injury action, an award of damages for the loss of enjoyment of life would ordinarily be duplicative of damages awarded for pain and suffering or disability.

4. EVIDENCE—*Personal Injury—Loss of Enjoyment of Life.* Evidence of loss of enjoyment of life is admissible, if warranted by the facts, and the jury may consider such loss as it relates to disability and pain and suffering. The loss of enjoyment of life is a proper subject for argument by counsel to the jury as it relates to the damages suffered for pain and suffering and disability.

5. TRIAL—*Personal Injury—Jury Instruction—Nonpecuniary Damages—Loss of Enjoyment of Life Not Separate Category.* Loss of enjoyment of life is not a separate category of nonpecuniary damages in a personal injury action and ordinarily it is error to submit an instruction or verdict form on loss of enjoyment of life as a separate category of damages.

6. SAME—*Jury Instruction—Failure to Object at Trial—Appellate Review.* A party may not assign as error the giving or failure to give an instruction unless he objects to the instruction and states the specific grounds for the objection. Absent such an objection, an appellate court may reverse only if the trial court's instruction was clearly erroneous.

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7. DAMAGES—*Personal Injury—Pain and Suffering.* In a personal injury action, damages are recoverable for pain and suffering which is consciously experienced.

8. EVIDENCE—*Personal Injury—Conscious Pain and Suffering—Conflicting Evidence—Question of Fact for Jury.* The determination of whether an injured party sustained conscious pain and suffering is a question of fact for the jury when there is conflicting evidence on the issue.

9. SAME—*Lay Testimony Admissible—Conscious Pain and Suffering.* Whether an injured party has experienced conscious pain and suffering may be established by lay testimony, and expert medical testimony is not essential to support a recovery of damages for pain and suffering.

10. APPEAL AND ERROR—*Excessive Jury Verdict for Damages—Appellate Review.* Where a charge of excessive verdict is based on passion or prejudice of the jury but is supported solely by the size of the verdict, the trial court will not be reversed for not ordering a new trial, and no remittitur will be awarded unless the amount of the verdict in light of the evidence shocks the conscience of the appellate court. Where the alleged passion or prejudice of the jury is not shown by definite proof, but depends for support solely on the size of the verdict, the award will be upheld unless it shocks the conscience of the court. There is no simple, symmetrical pattern or design for determining whether a verdict is sufficient or insufficient, since each case must stand on its own facts.

11. PHYSICIANS AND SURGEONS—*Standard of Care.* The general standard of care required of a doctor is that he possess the reasonable degree of learning and skill ordinarily possessed by members of the profession and of his particular school of medicine in the community where he practices, or in similar communities, and that he will use such learning and skill in treating his patient with ordinary care and diligence.

12. TORTS—*Liability of Person for Acts of Another—Application of Vicarious Liability, Implied Negligence, and Imputed Liability.* Vicarious liability, imputed negligence, and imputed liability are terms generally applied to the legal liability of a person for the acts of another which arises solely because of a relationship and not because of any actual act or negligence of the person held liable for the act of the other person.

13. PHYSICIANS AND SURGEONS—*Anesthetist's Negligence—Liability of Surgeon.* A surgeon usually is liable for the negligence of an anesthetist-resident or a nurse-anesthetist under the "captain of the ship" doctrine. In an appropriate case the surgeon may also be liable based upon K.A.R. 28-34-17(p).

14. COMMON LAW—*Wrongful Death Action Nonexistent under Common Law.* The longstanding rule in Kansas is that there was no right at common law to recover for wrongful death. A cause of action for wrongful death is a creature of statute in Kansas.

15. DAMAGES—*Wrongful Death—Statutory Limitations—Constitutionality.* K.S.A. 1988 Supp. 60-1903 does not violate (1) the constitutional right to

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equal protection of the law under Sections 1 and 2 of the Bill of Rights of the Kansas Constitution or the equal protection clause of the Fourteenth Amendment to the United States Constitution; (2) the constitutional right to trial by jury under Section 5 of the Kansas Bill of Rights; or (3) the constitutional right to remedy by due course of law under Section 18 of the Kansas Bill of Rights and, therefore, the statute is not unconstitutional on any of the grounds asserted by the plaintiffs.

Appeal from Sedgwick district court, NICHOLAS W. KLEIN, judge. Opinion filed August 4, 1989. Affirmed.

Charles D. Green, of Arthur, Green, Arthur, Conderman & Stutzman, of Manhattan, argued the cause and was on the briefs for appellants/cross-appellees George W. Marshall, M.D., and Harris, Hodges & Marshall, Chtd.

Larry Shoaf, of McDonald, Tinker, Skaer, Quinn & Herrington, P.A., of Wichita, argued the cause and *Vincent A. Burnett*, of the same firm, was with him on the briefs for appellant Wendell P. Gafford.

Ronald D. Heck, of Fisher, Heck & Cavanaugh, P.A., of Topeka, appeared for appellant Professional Anesthesia, Inc.

Richard C. Hite, of Kahrs, Nelson, Fanning, Hite & Kellogg, of Wichita, argued the cause and *Charles E. Hill* and *Dennis V. Lacey*, of the same firm, were with him on the briefs for appellee/cross-appellant Abbott Laboratories.

Bradley Post, of Post & Syrios, of Wichita, argued the cause and *Arden J. Bradshaw*, of Wichita, and *Robert E. Keeshan*, of Hamilton, Peterson, Tipton & Keeshan, of Topeka, were with him on the briefs for appellees/cross-appellants Shawn A. Leiker, James S. Leiker, Jason Scott Leiker, and Jennifer Ann Leiker.

Marla J. Luckert, of Goodell, Stratton, Edmonds and Palmer, of Topeka, was on the brief for *amici curiae* Kansas Medical Society and Kansas Hospital Association.

Ronald P. Williams and *Susan G. Saidian*, of Morrison, Hecker, Curtis, Kuder & Parrish, of Wichita, were on the brief for *amicus curiae* Kansas Association of Defense Counsel.

The opinion of the court was delivered by

HOLMES, J.: This is an appeal in a medical malpractice action by the plaintiffs and by the two principal defendants, Wendell P. Gafford and George W. Marshall, M.D., from various portions of the jury verdict and various rulings and orders of the trial court. The plaintiffs have also filed a conditional or contingent appeal from a trial court order granting a directed verdict in favor of Abbott Laboratories, a corporation, and Abbott Laboratories has filed a cross-appeal from certain evidentiary rulings of the court.

Shawn A. Leiker sustained personal injuries on January 28, 1982, as a result of an excessive dose of spinal anesthetic while she was undergoing a cesarean section delivery of her second

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child. She remained semi-comatose until her death on December 14, 1987. This personal injury and wrongful death action was brought by her husband, James S. Leiker, individually, as a representative of her estate, and on behalf of their two children.

The defendants are Wendell P. Gafford, the certified registered nurse anesthetist (CRNA) who administered the spinal anesthesia, and his professional corporation Professional Anesthesia, Inc.; George W. Marshall, M.D., the obstetrician, and his professional corporation Harris, Hodges & Marshall, Chtd.; and Abbott Laboratories (Abbott), a corporation, the manufacturer of the anesthetic drug. At the close of the plaintiffs' evidence, the trial court entered a directed verdict in favor of Abbott. After defendants Gafford and Marshall presented their evidence, the jury determined that Gafford was 90% at fault and Marshall 10% at fault for Shawn Leiker's injuries and resulting death. The jury also found specifically that Marshall was legally responsible for one or more of the acts of Gafford which caused the injury and death.

The jury awarded plaintiffs $1,250,000 for the personal injury claim and $3,003,100 for the wrongful death claim. Of the total award for wrongful death, the trial court reduced the amount of $2,000,000 awarded for nonpecuniary damages to $100,000 pursuant to K.S.A. 1988 Supp. 60-1903(b). Judgment was entered for the plaintiffs for a total of $2,353,100 against Gafford, Marshall, and their respective professional corporations.

The following issues are raised by the parties:

(1) Did the trial court err in instructing the jury on the issue of informed consent?

(2) Did the trial court err in allowing the jury to award damages for loss of enjoyment of life as a separate category of compensable damages?

(3) Did the trial court err in allowing the jury to award damages for pain and suffering under the circumstances of this case?

(4) Did the trial court err in failing to grant a new trial on the ground that the jury verdict was excessive and was rendered under passion and prejudice?

(5) In the alternative, did the trial court err in failing to grant a substantial remittitur of the award of damages?

(6) Did the trial court err in refusing to instruct the jury that

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there is no presumption of negligence by reason of an adverse result and that a medical practitioner is presumed to have carefully and skillfully treated his patient?

(7) Did the trial court err in instructing the jury on the following claims of negligence against Dr. Marshall, on the basis of alleged insufficient expert testimony to support these claims:
- (a) Whether Marshall failed to supervise administration of the anesthetic as directed by K.A.R. 28-34-17(p);
- (b) whether Marshall was liable for failure to confer with Gafford on the anesthetic drug and dosage before the surgery;
- (c) whether Marshall was liable for failing to require adequate fluid preload;
- (d) whether Marshall was liable for not being present in the operating room when Gafford commenced the anesthesia procedure;
- (e) whether Marshall was liable for failing to detect, diagnose, and promptly treat his patient's distress resulting from the anesthetic; and
- (f) whether Marshall was liable for failing to promptly and properly resuscitate his patient?

(8) Are Marshall and his professional corporation vicariously liable for Gafford's negligence and, if so, to what extent?

(9) Did the jury instructions incorrectly set forth the appropriate duty owed by Gafford and allow the jury to set a standard of its own rather than to rely upon expert testimony?

(10) Did the trial court err in applying K.S.A. 1988 Supp. 60-1903 to reduce the award of nonpecuniary damages for wrongful death, on the ground that the statute is unconstitutional?

(11) Did the trial court erroneously grant Abbott's motion for a directed verdict at the close of the plaintiffs' case, for any of the following reasons:
- (a) The trial court's ruling deprived plaintiffs of their right to a jury trial;
- (b) Abbott Laboratories was negligent per se and the negligence caused plaintiffs' injury;
- (c) the court erred in holding as a matter of law that

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Abbott Laboratories had no duty to give an adequate warning regarding its anesthetic drug;

(d) the court erred in overlooking evidence in the record opposing the motion and instead searching the record for evidence to support it;

(e) the court erred in deciding as a matter of law what Gafford knew or should have known about the anesthetic drug;

(f) the court erred in holding as a matter of law that plaintiffs were bound by selected testimony of adverse witnesses;

(g) the court erred in holding that the conduct of Marshall and Gafford could insulate Abbott from liability; and

(h) the court erred in holding as a matter of law that Abbott had no duty to warn Marshall as the treating obstetrician?

(12) Was Abbott Laboratories' 1987 package insert inadmissible pursuant to K.S.A. 1988 Supp. 60-3307?

(13) Did the prejudice to Abbott from admitting the 1987 package insert far outweigh any probative value it may have had against Marshall and Gafford?

This appeal was transferred from the Court of Appeals on this court's own motion, pursuant to K.S.A. 20-3018(c). We have carefully considered all of the many issues and contentions raised by the parties, whether or not discussed at length in this opinion, and find no reversible error. We affirm the trial court. Only a brief summary of the facts is necessary at this point in order to understand the issues raised on appeal.

In January 1982, James and Shawn Leiker were expecting their second child. Their first, Jason, was delivered in 1980 by cesarean section while Shawn was under general anesthesia. The couple was advised that their second child should also be delivered by cesarean, but Shawn wanted to be awake during the delivery. She discussed the options for regional anesthesia with her obstetrician, Dr. George Marshall, who had also delivered Jason. He referred her to Dr. Stoskopf, an anesthesiologist then practicing in Salina where the Leikers resided.

In the early morning of January 28, 1982, Shawn went into labor. Dr. Marshall verified that Shawn was in active labor at

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about 10:00 a.m. at his office, and proceeded to schedule the cesarean section with the hospital. Marshall was informed that Dr. Stoskopf was involved in another surgical procedure that would take the rest of the day. He was informed that Gafford, a CRNA, had just finished a case and was available. Marshall went to the hospital, found Gafford, and asked him to handle the Leiker case. Marshall had worked with Gafford before and had confidence in his ability.

Gafford then met with the Leikers at the hospital and allegedly discussed the available anesthesia options. He reported back to Marshall that the Leikers had elected spinal anesthesia, and Marshall concurred. Marshall then changed his clothes and waited in the doctors' lounge with Dr. Hodges, his associate and assistant surgeon, while Gafford initiated the anesthesia procedure.

At 11:40 a.m., Gafford injected Shawn with a 15 mg. dose of tetracaine, a spinal anesthetic manufactured and distributed by Abbott. At 11:45 a.m., Drs. Marshall and Hodges entered the operating room, checked to be sure the anesthetic had taken effect, and commenced the surgery at 11:47 a.m. A baby girl was successfully delivered at 11:52 a.m., and Dr. Hodges briefly showed the newborn to her parents. Dr. Marshall proceeded to complete the surgery and close the incision.

In the meantime, Shawn made several complaints that she was nauseated and unable to breathe. Shortly before noon, as her husband and baby were leaving the operating room, she passed out. Gafford was unable to obtain a pulse or blood pressure. He initiated resuscitation efforts, including an intravenous administration of Valium and, later, intubation. Sometime after 12:15, when the surgical drapes came down, Marshall could see that Gafford was having problems and that Shawn had been intubated. Because Shawn's lung sounds were abnormal, Marshall requested immediate reintubation. Since there was no improvement, Marshall had Dr. Hodges summoned back to the operating room and initiated Code Blue procedures. Eventually Shawn's blood pressure and pulse returned. By then, however, she had already suffered severe brain damage due to lack of oxygen.

Shawn Leiker never fully regained consciousness. She was hospitalized until July 23, 1982, when she was admitted to the Salina Nursing Home. She remained there until she died on December 14, 1987.

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Evidence presented by expert testimony and accepted medical texts and treatises overwhelmingly indicated that 15 mg. of tetracaine, administered as a spinal anesthetic in a cesarean section operation, was a massive overdose which caused Shawn Leiker's injuries and ultimate death.

James Leiker filed a personal injury lawsuit on Shawn's behalf on August 4, 1983. After she died, an amended petition was filed on December 22, 1987, adding a claim for wrongful death on behalf of James Leiker and the two children. The case went to trial in January 1988. At the close of the plaintiffs' evidence, Abbott successfully moved for a directed verdict. The trial proceeded with evidence presented by Marshall and Gafford. As indicated earlier, the jury rendered a verdict in the total amount of $4,253,100, finding Gafford to be 90% at fault and Marshall 10% at fault. The trial court reduced to $100,000 the $2,000,000 amount awarded for wrongful death nonpecuniary damages. A number of post-trial motions were made, and all were denied.

Marshall and Gafford appeal from the jury verdict finding them liable. In addition to plaintiffs' cross-appeal contending that the trial court should not have reduced the award for nonpecuniary damages for wrongful death, the plaintiffs separately appeal the directed verdict entered in favor of Abbott. Plaintiffs concede that, if the trial court's judgment is affirmed, their separate appeal as to Abbott is moot. Abbott cross-appeals against the plaintiffs, alleging error in the admission of certain evidence against Gafford and Marshall.

Additional facts will be provided as they become relevant to the analysis of the issues. As several of the issues raised by the defendants involve the court's instructions to the jury, we pause to iterate certain basic principles applicable to appeals involving jury instructions.

In reviewing jury instructions, the following guidelines apply:

"Errors regarding jury instructions will not demand reversal unless they result in prejudice to the appealing party. Instructions in any particular action are to be considered together and read as a whole, and where they fairly instruct the jury on the law governing the case, error in an isolated instruction may be disregarded as harmless. If the instructions are substantially correct, and the jury could not reasonably be misled by them, the instructions will be approved on appeal." *Trout v. Koss Constr. Co.*, 240 Kan. 86, 88-89, 727 P.2d 450 (1986).

We now turn to the issues raised by the parties.

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Gafford contended Shawn had been properly advised during her prenatal care and at the hospital. On the other hand, James Leiker testified he could not recall either Marshall or Gafford explaining anything about the complications or risks accompanying the proposed procedure, either when James accompanied Shawn to her prenatal care visits or at the hospital. While both James and Shawn signed a consent form shortly before the anesthetic was administered, he testified no one explained anything about the risks involved. The evidence did not conclusively establish that Marshall and Gafford made any disclosures. It was therefore a question for the jury whether ascertainable disclosures had been made by the defendants in the first place. *Natanson v. Kline*, 187 Kan. 186, 190, 354 P.2d 670 (1960).

As to the contentions regarding expert testimony on the adequacy of the disclosure, the defendants overlook Instruction No. 9, which reads:

> "INSTRUCTION NO. 9
>
> "In determining whether a physician, or other health care professional, used the learning, skill, and conduct required of him, you are not permitted to arbitrarily set a standard of your own or determine this question from your personal knowledge. On questions of medical or scientific nature concerning the standard of care of a physician, or other health care professional, only those qualified as experts are permitted to testify. The standard of care is established by members of the same profession or specialty under like circumstances. It follows, therefore, that the only way you may properly find that standard is through evidence presented by physicians called as expert witnesses."

We do not agree that there was no expert testimony as to the adequacy of the disclosures. Much of the plaintiffs' evidence on the informed consent issue was directed to Marshall's failure to disclose the alleged incompetence and inexperience of Gafford. There was considerable testimony by experts for both sides that, if Gafford was indeed unqualified to administer the anesthetic in this case, the patient should have been informed.

When all of the instructions are read together in light of the evidence before the jury, we find no error in the informed consent instruction given to the jury.

B. Loss of Enjoyment of Life as a Separate Category of Recoverable Damages

Defendants Gafford and Marshall both argue that the trial court erred in instructing the jury that loss of enjoyment of life is compensable under Kansas law as a separate category of nonpe-

I. APPEAL OF DEFENDANTS MARSHALL AND GAFFORD

A. Informed Consent Instruction

The defendants Marshall, Gafford, and their respective professional corporations contend that the trial court erred in instructing the jury on the issue of informed consent. The challenged instruction reads:

"INSTRUCTION NO. 12

"In the absence of an emergency a physician or surgeon has a legal obligation to make a disclosure of the risks and dangers incident to a proposed medical or surgical procedure in order that his patient may make an informed consent thereto, but the duty of the physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances.

"What is a reasonable disclosure upon which an informed consent may rest depends upon the facts and circumstances of each case.

"The burden of proof is upon the plaintiff to establish that sufficient information was not disclosed to the patient upon which to rest an informed consent. It is further their burden, before legal liability can be based on such nondisclosure, to establish that the patient, more probably than not, would have refused the procedure had adequate information been disclosed and that, therefore the injury would not have occurred."

The instruction as given generally follows PIK Civ. 2d 15.16, and goes further by emphasizing the plaintiffs' burden of proof when it is contended that a health care provider failed to adequately advise a patient as to the risks of a proposed procedure.

The defendants do not argue that there was no duty to disclose to the Leikers the risks of the procedure. They do argue, however, that where the evidence shows that the defendants did inform the plaintiffs of the risks associated with a medical procedure, the adequacy of the disclosure may be determined only on the basis of expert testimony as to what reasonable physicians or health care practitioners would deem adequate. *Charley v. Cameron*, 215 Kan. 750, 756-57, 528 P.2d 1205 (1974); *Collins v. Meeker*, 198 Kan. 390, 398, 424 P.2d 488 (1967). In addition, they argue that there was insufficient expert testimony on the issue. Defendant Gafford also argues that the instruction given was erroneous because it failed to inform the jury that the adequacy of the consent given must be determined on the basis of expert testimony.

The evidence as to whether Shawn was properly advised of the risks of the proposed anesthesia was disputed. Marshall and

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cuniary or noneconomic damages for personal injury. *Amici* Kansas Association of Defense Counsel, Kansas Medical Society, and Kansas Hospital Association also contend that loss of enjoyment of life is not separately compensable under Kansas law. The plaintiffs urge this court to adopt what they call the majority rule by recognizing loss of enjoyment of life as a separate category of compensable harm for which damages may be recovered.

The trial court provided the following instruction to the jury on the determination of damages for the personal injury claim:

"INSTRUCTION No. 25

"If it is necessary under the instructions and the directions on the verdict form to fix the loss on the personal injury claims of Shawn A. Leiker, you will then determine the amount of recovery. You should allow such amount of money as will reasonably compensate the Estate of Shawn A. Leiker for her injuries and losses resulting from the occurrence in question, including any of the following shown by the evidence:

"a) Pain, suffering, disabilities, or disfigurement, and any accompanying mental anguish suffered by Shawn A. Leiker up to the time of her death.

"b) *Loss of enjoyment of life and the capacity to enjoy life*, suffered by Shawn A. Leiker up to the time of her death.

"c) Loss of time and income, and earning capacity, by reason of her disabilities up to the time of her death.

"d) The reasonable expenses of necessary medical care, hospitalization, custodial care, and treatment received before her death.

"e) Fair and reasonable compensation for the loss and impairment of Shawn A. Leiker's ability to perform services as a wife to her husband, resulting from her injuries, including loss and impairment of plaintiff's services to her husband in the discharge of her domestic and household duties, and the loss and impairment of Shawn A. Leiker's companionship, aid, assistance, comfort, and society to her husband James S. Leiker." (Emphasis added.)

Defendants Gafford, Marshall, and their respective professional corporations objected to that part of the instruction which allowed the jury to award damages for loss of enjoyment of life as a distinct category of damages.

The personal injury damages portion of the verdict form submitted to the jury was virtually identical to that proposed by the plaintiffs. The jury awarded the following amounts to the estate for Shawn Leiker's personal injuries:

"A. Personal Injury Action

For damages for personal injuries to Shawn A. Leiker occurring on January 28, 1982, and during the period between January 28, 1982, and December 14, 1987, for:

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a. Pain and suffering	150,000
b. Disability	150,000
c. Disfigurement and any accompanying mental anguish	150,000
d. *Loss of the enjoyment of life*	*150,000*
e. Loss of time and income, and earning capacity	100,000
f. Reasonable expenses of necessary medical care, hospitalization, custodial care and treatment	400,000
g. Loss and impairment of services to husband James S. Leiker	150,000."

(Emphasis added.)

Defendants rely heavily on *Hogan v. Santa Fe Trail Transportation Co.*, 148 Kan. 720, 85 P.2d 28 (1938). In *Hogan*, as a result of a motor vehicle collision, plaintiff broke a bone in her left hand, which caused permanent stiffening of her little finger. The plaintiff was an accomplished violinist, although her earnings from her avocation were marginal. As a result of the injury, she was no longer able to play the violin. The trial court submitted to the jury a verdict form, which included fifteen special questions. Question 11(6) specifically requested the jury to itemize the amount allowed for loss of enjoyment from being unable to play the violin. The jury awarded $4,000. On appeal, defendants argued that the damages awarded for loss of enjoyment because of inability to play the violin were too speculative and conjectural. In the alternative, they argued that, even if loss of enjoyment was a proper category of damages, the $4,000 jury verdict was excessive. The Kansas Supreme Court noted that the precise question of whether a plaintiff may recover for "loss of enjoyment" was one of first impression in this court.

After noting the various cases pro and con cited by the parties, the court concluded:

"This court, after careful consideration of the entire subject, has concluded to hold that loss of enjoyment resulting from being unable to play the violin is too speculative and conjectural to form a sound basis for the assessment of damages. It is well to bear in mind the jury allowed [$1,000] separately for pain and suffering resulting from the injury. That item is not in dispute. It will also be well to observe the jury allowed nothing for loss of earnings. . . .

"Plaintiff urges that in question 11(6) she might just as well have asked how much the jury allowed for permanent injury, and the element of loss of enjoyment from being unable to play the violin would have been included therein. . . . Furthermore, question 11(6) leaves this court no room to say the

$4,000 or any part thereof was awarded for permanent injury. That question is clear, and an award for permanent injury cannot be read into it. Then, too, even though the court should be inclined to consider the $4,000 item as having been intended to include permanent damages, the court would have no possible way of determining how much thereof was allowed for permanent injuries. It follows the judgment must be modified by a reduction in the sum of $4,000. Otherwise the judgment will be affirmed." 148 Kan. at 729-30.

Two justices, including the author of the majority opinion, joined in a lengthy dissent. 148 Kan. at 730-37.

The defendants in the instant case argue that the trial court's instructions allowing the jury to make a separate award for loss of enjoyment of life were contrary to the rule in *Hogan*. In response, the plaintiffs contend that *Hogan* did not reject loss of enjoyment as a remedy in all cases, and that its holding should be limited to its specific facts. Plaintiffs also point out that in *Hogan* the court may have been concerned about the certainty of the loss itself, while in the instant case it cannot be questioned that Shawn Leiker suffered a complete loss of enjoyment of life between January 28, 1982, and December 14, 1987, the date she died.

We agree with plaintiffs that *Hogan* is clearly distinguishable from the present case. *Hogan* was limited to the facts then before the court, and nothing in the opinion establishes that loss of enjoyment of life may not be a proper element of damages in an appropriate case. We also note that the argument that such damages are too speculative and conjectural could also be asserted as to any area of nonpecuniary damages, such as pain and suffering.

In other cases, this court has implied in dicta that loss of enjoyment may at least be considered one factor in awarding damages. See *Tos v. Handle*, 209 Kan. 139, 141, 495 P.2d 896 (1972), and *Railroad Co. v. Chance*, 57 Kan. 40, 48, 45 Pac. 60 (1896). We conclude that the issue is an open question before this court and that *Hogan* is not controlling.

Defendants also argue that K.S.A. 1988 Supp. 60-249a, which requires the trier of fact to itemize its verdict in a personal injury action, does not list loss of enjoyment of life. The statute reads in part:

"(a) In any action for damages for personal injury, the verdict shall be itemized by the trier of fact to reflect the amounts, if any, awarded for:

(1) Noneconomic injuries and losses, as follows:

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(A) Pain and suffering,
(B) disability,
(C) disfigurement, and any accompanying mental anguish;
(2) reasonable expenses of necessary medical care, hospitalization and treatment received; and
(3) economic injuries and losses other than those itemized under subsection (a)(2)."

Although defendants' reliance on the statute is somewhat persuasive, the language of the statute does not preclude this court from recognizing loss of enjoyment of life as a separate category of noneconomic damages, and it certainly does not preclude its consideration as an element or factor in assessing damages for one of the other types of noneconomic damages listed in subsection (a)(1). Nothing in K.S.A. 1988 Supp. 60-249a purports to restrict the categories of noneconomic damages to those listed in subsection (a)(1). If the legislature had intended to preclude by statute separate awards for loss of enjoyment of life, it could easily have done so simply by stating that noneconomic damages would be limited to those categories specified in subsection (a)(1). Thus, we conclude the statute does not resolve the issue.

Gafford and his professional corporation correctly assert that PIK Civ. 2d 9.01 does not mention loss of enjoyment of life as a compensable category of damages. However, that fact does not preclude this court from recognizing such damages in an appropriate case. Nor does it automatically render erroneous an instruction which differs from that suggested in PIK. The preface to PIK Civ. 2d reads in part: "[A] pattern instruction may not be exactly right for the evidence introduced in a particular case. The judge must analyze the issues applicable to the evidence in each case and make appropriate selections and modifications." PIK Civ. 2d Preface, p. 8. The failure of PIK to include loss of enjoyment of life in its recommended instruction on damages is not determinative. As directed in PIK, the trial judge modified the pattern instruction to fit the issues and evidence in this case.

Next, defendants argue that it is duplicative to award damages for loss of enjoyment of life in addition to the separate jury award for pain and suffering and/or disability. Defendant Gafford argues that this is especially true where, as here, the jury was not given instructions clearly defining the various subcomponents of damages it was asked to assess. We think the argument has merit.

Much has been written in recent years on the issue of whether

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damages are recoverable for loss of enjoyment of life, sometimes referred to as hedonic damages, as a separate category of damages or as a component of the more traditional categories of pain and suffering and/or disability. See, *e.g.*, Hermes, *Loss of Enjoyment of Life—Duplication of Damages Versus Full Compensation*, 63 No. Dak. L. Rev. 561 (1987); Hilton and Goldstein, *Damages for the Loss of Enjoyment of Life in Personal Injury Cases*, 30 For The Defense, Nov. 1988, at 2; Staller, *Placing a Value on the Enjoyment of Life*, 31 For The Defense, June 1989, at 8; Annot., Loss of Enjoyment of Life as a Distinct Element or Factor in Awarding Damages for Bodily Injury, 34 A.L.R.4th 293.

The cases which have considered the issue generally fall into three categories: (1) those which totally reject loss of enjoyment of life as a consideration in awarding damages; (2) those which hold it is not a separate category of damages but may be considered as an element or component of pain and suffering and/or disability; and (3) those which hold loss of enjoyment of life is a separate category of damages. For an excellent and comprehensive article on the subject, see Hermes, 63 No. Dak. L. Rev. 561.

One of the strongest arguments that has been advanced as a reason for not recognizing loss of enjoyment of life as a separate category of damages is that it duplicates or overlaps other categories of damages, such as permanent disability or pain and suffering. See, *e.g.*, *Huff v. Tracy*, 57 Cal. App. 3d 939, 943, 129 Cal. Rptr. 551 (1976); *Swiler v. Baker's Super Market, Inc.*, 203 Neb. 183, 187, 277 N.W.2d 697 (1979); *Flannery v. United States*, 297 S.E.2d 433, 438 (W. Va. 1982). See generally Hermes, 63 No. Dak. L. Rev. 561. However, loss of enjoyment of life is arguably distinct from pain and suffering. Comment, *Loss of Enjoyment of Life as a Separate Element of Damages*, 12 Pac. L.J. 965, 972-73 (1981). It is also arguably distinct from loss due to disability. In *Thompson v. National R.R. Passenger Corp.*, 621 F.2d 814 (6th Cir. 1980), *cert. denied* 449 U.S. 1035 (1980), the court distinguished some of the different types of damages resulting from physical injury as follows:

> "Permanent impairment compensates the victim for the fact of being permanently injured whether or not it causes any pain or inconvenience, pain and suffering compensates the victim for the physical and mental discomfort caused by the injury, and loss of enjoyment of life compensates the victim for the limitations on the person's life created by the injury." 621 F.2d at 824.

Valid arguments can be made to support all three lines of cases

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which have considered damages for loss of enjoyment of life in personal injury cases. Nothing would be gained by reviewing the various cases, most of which are discussed in the Hermes article and the recent annotation in 34 A.L.R.4th 293. This court must now determine which of the various theories should be recognized in Kansas. We think the more realistic approach as a general rule is that loss of enjoyment of the pleasurable things in life is inextricably included within the more traditional areas of damages for disability and pain and suffering. While it is true that a person may recover from the physical pain of a permanent injury, the resultant inability to carry on one's normal activities would appear to fall within the broad category of disability. In the majority of cases loss of enjoyment of life as a separate category of damages would result in a duplication or overlapping of damages. Our holding on this issue is consistent with what appears to be a slight majority of the cases which have considered the various arguments and it is also consistent with the wording of K.S.A. 1988 Supp. 60-249a. However, we also point out that evidence of loss of enjoyment of life is definitely admissible and proper for the jury's consideration as it relates to disability and pain and suffering, and may certainly be argued by counsel to the jury.

We hold that in Kansas, loss of enjoyment of life is not a separate category of nonpecuniary damages in a personal injury action and that it is error to submit a separate instruction, or provide a separate verdict form entry, on loss of enjoyment of life. However, in a proper case it is a valid subcomponent or element of pain and suffering and/or disability.

Gafford also argues that there should be no recovery for loss of enjoyment of life because Shawn Leiker was not sufficiently conscious or aware of the fact she was being deprived of normal living. He contends that if she did not realize that she was being deprived of enjoyment of life, she cannot recover for it. We think this argument is negated by what is said on the next issue relating to conscious pain and suffering. The question of her awareness or realization of her condition was one for the jury.

We now turn to the question of whether the instruction in the present case constitutes reversible error. We find that it does not. Shawn Leiker remained in a semi-comatose condition for nearly six years and was totally deprived of all aspects of normal living

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the entire time. The jury was carefully instructed by the learned trial judge, and the parties argued Shawn's loss of enjoyment of life as a separate and distinct category of damages. The verdict form listed "Loss of enjoyment of life" as a separate item of damages, for which the jury allowed $150,000. In *Andrews v. Mosley Well Service*, 514 So. 2d 491 (La. App. 1987), an award of $75,000 for "loss of enjoyment of life" was challenged as a duplication of pain and suffering. The appellate court affirmed the judgment and stated as one of its reasons the trial court's instruction on the issue. Under all the facts of this case, we do not think the jury could have possibly been misled or that the itemized verdict included any overlapping or duplication. The jury was instructed to consider loss of enjoyment of life separate and apart from any award for pain and suffering or disability. Considering the horrendous loss suffered by Shawn Leiker, the relatively modest award for six years' loss of any meaningful living belies any duplication in the damages awarded. Under the facts and circumstances of this case, we hold the instruction on the loss of enjoyment of life as a separate category of damages was harmless error which does not require or justify reversal.

C. Conscious Pain and Suffering

Defendants Marshall, Gafford, and their respective professional corporations argue that it was erroneous to instruct the jury that it could award damages to Shawn Leiker's estate for pain and suffering. Marshall also argues that it was erroneous to instruct the jury that damages could be awarded for disfigurement and accompanying mental anguish.

At the outset, it should be noted that the defendants made no objection on the record to the instruction on pain and suffering. In fact, pain and suffering was included in the jury instructions proposed by the defendants. Defendants did, however, make an oral motion for a directed verdict on the issue of pain and suffering, contending that the evidence was insufficient to sustain such an award. They argued that there was no expert medical opinion offered by the plaintiffs that Shawn Leiker experienced conscious pain and suffering, and that the evidence in fact showed otherwise. The trial court denied the motion.

A party may not assign as error the giving or failure to give an instruction unless he objects to the instruction and states the specific grounds for the objection. Absent such an objection, an

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appellate court may reverse only if the trial court's instruction was clearly erroneous. K.S.A. 60-251(b); *Nail v. Doctor's Bldg., Inc.*, 238 Kan. 65, 67, 708 P.2d 186 (1985). K.S.A. 1988 Supp. 60-249a(c) provides that the trial court in a personal injury action shall instruct the jury only on those items of damage upon which there is "some evidence" to base an award. Thus, if there was any evidence to support an award for pain and suffering, it was not clearly erroneous to instruct the jury that it could award such damages in compensation.

In ruling on the defendants' motion for a directed verdict on the pain and suffering issue, the trial court was required to resolve all facts and inferences reasonably to be drawn from the evidence in favor of the plaintiffs, against whom the ruling was sought. If reasonable minds could have reached different conclusions based on the evidence, the trial court was required to deny the motion and submit the matter to the jury. This same rule applies upon appellate review of a trial court decision on a motion for a directed verdict. *Holley v. Allen Drilling Co.*, 241 Kan. 707, 710, 740 P.2d 1077 (1987).

Kansas generally follows the majority rule that damages are recoverable only for pain and suffering which is consciously experienced. *Nichols v. Marshall*, 486 F.2d 791, 793 (10th Cir. 1973) (applying Kansas law); *Fogarty v. Campbell 66 Exp., Inc.*, 640 F. Supp. 953, 963 (D. Kan. 1986); *Folks v. Kansas Power & Light Co.*, 243 Kan. 57, 69, 755 P.2d 1319 (1988); *Fudge v. City of Kansas City*, 239 Kan. 369, 380, 720 P.2d 1093 (1986); *Pape v. Kansas Power & Light Co.*, 231 Kan. 441, 448, 647 P.2d 320 (1982). See generally 22 Am. Jur. 2d, Damages §§ 241, 249. The defendants argue that the plaintiffs offered insufficient competent evidence to support an instruction permitting an award for pain and suffering, because of lack of medical or empirical evidence that Shawn Leiker realized or was aware of any pain and suffering.

Defendants are correct in arguing that the plaintiffs have the burden of establishing damages. *Short v. Wise*, 239 Kan. 171, 177, 718 P.2d 604 (1986). However, this court has never held that medical expert testimony is required in order to establish that the injured plaintiff consciously experienced pain and suffering. In fact, recent cases indicate that sufficient evidence may exist to submit the issue to the jury without any expert medical testi-

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In *Pape v. Kansas Power & Light Co.*, 231 Kan. 441, the decedent suffered severe injuries as a result of accidental electrocution. He died ten days later. The jury award included $2,000 for pain and suffering. On appeal, the defendant contended that plaintiffs' evidence was insufficient to show the decedent experienced conscious pain and suffering before his death. This court concluded:

"We have examined the record and concluded that, although not extensive, there was sufficient evidence to justify a finding that Terry Pape suffered conscious pain and suffering from his injuries until his death. When discovered lying at the bottom of the bins, Terry Pape was breathing, had a bloody cut on his head, and was audibly moaning. In response to a request by Kathleen Pape to squeeze her hand if he understood her, Terry Pape squeezed her hand. Notes in the hospital record indicated that Terry Pape was very responsive to pain stimuli. Under the circumstances, we find that there was sufficient evidence to submit to the jury the element of damages of decedent's conscious pain and suffering and to justify an award in the amount of $2,000." 231 Kan. at 448.

This court obviously did not require expert medical testimony or "empirical data" in order to meet the threshold of sufficiency of evidence to submit the issue to the jury.

In *Fudge v. City of Kansas City*, 239 Kan. 369, the decedent was injured in a motor vehicle collision and died twenty days later of the injuries he sustained in the accident. His wife and children brought a wrongful death and personal injury survival action against the other driver and the City of Kansas City. The jury award included $50,000 for pain, suffering, disabilities, or disfigurement and any accompanying mental anguish. Defendants contended on appeal that the evidence did not support the $50,000 award. They argued that the decedent lost consciousness a few minutes after the collision and never regained consciousness, and that medical records showed he did not respond to stimuli. The defendants presented testimony by a physician that Fudge was in such a deep state of unconsciousness that he could not have felt pain. Ambulance records showed that Fudge had lapsed in and out of consciousness for a ten-minute period after the accident. Fudge's mother-in-law testified that, three days after the accident, he squeezed her fingers twice in response to things she told him about his children, and that he did so two or three more times before he died. This court concluded that the issue was controverted, presenting a fact issue for the

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jury. 239 Kan. at 380. It is apparent that the plaintiffs in *Fudge* satisfied their burden of proof without either medical records *or* expert medical testimony in their favor.

In *Folks v. Kansas Power & Light Co.*, 243 Kan. 57, the decedent was fatally injured when a metal ladder he was using came into contact with defendant's power line. His surviving spouse and minor children brought a wrongful death and survival action. The jury awarded the estate $10,000 for pain and suffering. On appeal, KPL argued there was no competent evidence that Folks was conscious after the accident, and therefore the award for pain and suffering was improper. This court disagreed, citing *Pape* for its holding that, under Kansas law, lay witness testimony is admissible on the issue of consciousness. The court concluded:

"In this case, there is conflicting testimony regarding whether Folks was conscious after the accident had occurred. A police officer testified that when he arrived on the scene Folks was breathing and making incoherent noises, and appeared to be conscious. Folks' employer testified that Folks was never conscious. The jury considered the conflicting testimony, determined that Folks was conscious, and properly awarded damages for pain and suffering." 243 Kan. at 69.

In the case before us, it is undisputed that Shawn Leiker was conscious for nearly twenty minutes after the overdose of anesthetic was administered. Within a few minutes, she complained she was having difficulty breathing, and that she felt nauseated. After the baby was delivered, Shawn complained again about having difficulty breathing. As her husband and newborn baby were leaving the delivery room, Shawn again stated she could not breathe and passed out. It is clear from the evidence that Shawn was conscious and fully aware of her discomfort for at least several minutes after the anesthetic was administered.

It is also clear from the record that Shawn Leiker was permanently impaired due to lack of oxygen and resulting brain damage after she initially lost consciousness. The defendants rely solely on the decedent's physical condition *after* she lost consciousness, contending that she was incapable of experiencing pain and suffering. However, the plaintiffs presented substantial evidence to show that Shawn also experienced pain and suffering between noon on January 28, 1982, when she lost consciousness, and the date of her death on December 14, 1987.

The plaintiffs presented evidence through Dr. Marshall, as an adverse witness, that Shawn flinched the day following the

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surgery when he applied skin clips to her incision. Hospital records stated that Shawn opened her eyes when her name was called and in response to physical stimuli. By early April 1982, hospital records revealed that she exhibited "increased response to painful stimuli," and consistently opened her eyes to verbal and tactile stimuli. In July 1982, hospital records indicated that, when presented with a painful stimulus, she would withdraw an extremity, flinch, or vocalize. She frequently smiled when spoken to and in response to pleasant activity and discussions. She exhibited a startled reaction in response to a sudden noise or unexpected touch.

Plaintiffs also presented testimony of Delanie Meier, a registered nurse at St. John's Hospital who was the primary care nurse in charge of Shawn's case. She reviewed the contents of the hospital records for the jury, including portions about Shawn's response to painful stimuli. She had been trained to observe patients' responses to various stimuli. She noticed Shawn smiling in response to her on many occasions. An occupational therapist noted in the records that on March 19, 1982, while exercising Shawn's upper extremities, Shawn pulled her arm away in what appeared to be a voluntary effort when the therapist ranged the arm to a painful point.

Plaintiffs also presented testimony of Dr. William Cathcart-Rake, an internist who attended Shawn from March 1982 until her death. He testified that, although Shawn had suffered brain damage from lack of oxygen, she did have some brain function, although he could not say how much. On cross-examination, Dr. Cathcart-Rake testified regarding the information he recorded in March 1982, on Shawn's admission to St. John's Hospital. He noted that Shawn had not regained consciousness following resuscitation efforts, and that she was comatose at that time. An EEG was performed on March 29, 1982, showing gross abnormalities consistent with "super coma." On his discharge summary written in July 1982, Dr. Cathcart-Rake again noted that Shawn never regained consciousness following the acute event, and that she would likely remain in a persistent vegetative state. In his neurological examination, he noted "slight responsiveness to painful stimuli." At trial he testified that her response to painful stimuli had included a slight decerebrate movement of the right leg and arm, which he defined for the jury as an

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involuntary reflex type of movement. He testified that Shawn did not seem to be responsive to outside stimuli, and that, although he was not a neurologist, as far as he knew defense counsel was correct in suggesting "she would not feel a thing on a cognitive level." He also testified that he had not read all of the observations noted in the hospital records by Shawn's nurses and physical therapists.

Defendants argue in this appeal that plaintiffs' lay witness testimony regarding Shawn Leiker's responses is not competent evidence to support a finding that Shawn could consciously experience pain and suffering. As plaintiffs point out in response, however, this court has recently held that lay witness testimony is admissible on the issue of the degree of consciousness required to support damages for pain and suffering. *Folks v. Kansas Power & Light Co.*, 243 Kan. at 69. In *Nichols v. Marshall*, 486 F.2d at 793, the court held that lay witnesses are competent to report what they observe without offering medical opinions as to the consciousness of the deceased, and where the evidence is conflicting the issue is properly one for the jury. Lay witness testimony was deemed sufficient by this court in *Fudge* and *Folks* to create a jury question on the consciousness issue. The evidence of whether Shawn suffered any conscious pain and suffering was clearly conflicting and therefore presented a proper issue for the jury.

D. Excessiveness of Jury Verdict

Defendants argue that the jury verdict must be set aside and a new trial granted because the verdict was the result of passion and prejudice on the part of the jury. In the alternative, they contend that the trial court erred in denying defendants' request for a substantial remittitur.

The jury found that Shawn Leiker had sustained a total of $1,250,000 in damages for personal injuries before she died.

The jury also found that Shawn's heirs sustained damages totalling $3,003,100, itemized as follows:

Nonpecuniary damages	$2,000,000
Pecuniary damages	1,000,000
Funeral expenses	3,100

The trial court subsequently reduced the wrongful death award for nonpecuniary damages from $2,000,000 to $100,000 pursuant to K.S.A. 1988 Supp. 60-1903(a). Hence, although the jury verdict

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The jury awarded $1,250,000 to Shawn Leiker's estate to compensate for the personal injuries and accompanying noneconomic losses she incurred throughout the period of nearly six years before she died, as a result of the defendants' negligence. The jury award to her heirs for wrongful death, as remitted by the court pursuant to statute, totalled $1,103,100, including $1,000,000 for pecuniary loss. The amount for pecuniary loss included compensation to the two small children for their loss of parental care and attention, loss of maternal training and guidance, and loss of financial support the decedent would have provided them had she lived. It also included compensation to James Leiker, Shawn's husband, for loss of attention, care, and services, and for loss of earnings she would have provided. *Wentling v. Medical Anesthesia Services*, 237 Kan. 503, 507-09, 701 P.2d 939 (1985); K.S.A. 1988 Supp. 60-1904. There was testimony by plaintiffs' expert witness that a conservative estimate of the present value of Shawn's anticipated lifetime earning capacity alone exceeded $1,000,000. The expert also testified that the present value of the household and family care services she would have provided between ages 24 and 70 was $556,335. He reduced the totals by $213,303 as the estimated present value of Shawn's lifetime personal consumption, concluding that the total pecuniary loss for earning capacity and household and family care services was $1,633,055. There was sufficient evidence to support the jury verdict of $1,000,000 for pecuniary loss in the wrongful death action. For nonpecuniary loss to the heirs for Shawn's wrongful death, the statutory maximum of $100,000 is not an excessive sum to compensate her husband and two small children for mental anguish, bereavement, loss of society, and loss of companionship resulting from her death.

Gafford also argues that the trial court erred in referring to Shawn Leiker in one of the numerous jury instructions as the one "who was killed," contending this phrase incited passion and prejudice on the part of the jury and led to an excessive award. There is nothing in the record to support the allegations and argument of Gafford. The challenged language was unnecessary and perhaps should not have been used, but when the instructions are read as a whole the language has not been shown to be prejudicial to the defendants under the facts and circumstances presented in this case. *Trout v. Koss Constr. Co.*, 240 Kan. 86, 88-89, 727 P.2d 450 (1986).

totalled $3,003,100, judgment was entered for the heirs in an amount of $1,103,100 on the wrongful death claim.

The jury in this case, after hearing all the evidence, was of the opinion that a fair award for all of plaintiffs' losses was $4,253,100. Due to the legislative enactment of K.S.A. 1988 Supp. 60-1903(a), that total jury verdict was reduced approximately 45% to $2,353,100. When the wrongful death award of $3,003,100 is considered separately, we find nearly a 67% reduction. Defendants have already received, by operation of the statute, what amounts to a substantial reduction in the amount the jury found was just compensation for the clear negligence of these defendants.

The defendants collectively challenge as excessive all components of the jury verdict except Shawn's medical, hospital, and custodial care expenses; loss of services to Shawn's husband; and funeral expenses. Defendant Gafford focuses his challenge on the nonpecuniary damages, essentially arguing they were excessive. Marshall focuses his challenge primarily on the size of the verdict for the wrongful death claims. However, he also argues that there was insufficient evidence to support either the amount awarded for pecuniary damages in the wrongful death claim, or the amount awarded Shawn for her loss of income, time, and earning capacity in the personal injury claim.

In the recent case of *Tetuan v. A. H. Robins Co.*, 241 Kan. 441, 480, 738 P.2d 1210 (1987), this court summarized the rules applicable to a challenge of a verdict as excessive:

"Where a charge of excessive verdict is based on passion or prejudice of the jury but is supported solely by the size of the verdict, the trial court will not be reversed for not ordering a new trial, and no remittitur will be awarded unless the amount of the verdict in light of the evidence shocks the conscience of the appellate court. *Cantrell v. R. D. Werner Co.*, 226 Kan. at 686. Where the alleged passion or prejudice of the jury is not shown by definite proof, but depends for support solely on the size of the verdict, the award will be upheld unless it shocks the conscience of the court. *Henderson v. Hassur*, 225 Kan. 678, 594 P.2d 650 (1979). There is no simple, symmetrical pattern or design for determining whether a verdict is sufficient or insufficient, since each case must stand on its own facts. *McGuire v. Sifers*, 235 Kan. 368, 681 P.2d 1025 (1984)."

See *O'Gilvie v. International Playtex, Inc.*, 821 F.2d 1438, 1448 (10th Cir. [Kan.] 1987), *cert. denied* 486 U.S. 1032 (1988).

Based upon the facts presented in the case before us, the amount of the jury verdict does not shock the court's conscience.

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The plaintiffs in this action suffered a total disruption of their lives for a period of nearly six years. The survivors have continued to suffer the loss of a wife and mother. Shawn remained in a comatose or semi-comatose condition throughout that entire time, and was deprived of every enjoyable element of living. The judgments do not shock the conscience of this court and, as they are amply supported by the evidence, the defendants' requests for a new trial or a substantial remittitur must be denied.

E. Presumption of Careful Treatment

Marshall and Gafford both claim that the trial court committed reversible error by failing to give the following instruction, which they had requested:

"In medical malpractice actions, the physician or surgeon is presumed to have carefully treated or operated on his patient and there is no presumption of negligence from the fact of an injury or adverse result. The physician or surgeon is not a guarantor of good results, and civil liability does not arise merely from bad results, or if bad results are due to some cause other than treatment."

Defendants Marshall and Gafford rely on a long string of Kansas cases in which this court has stated that, in medical malpractice actions, the physician or surgeon is presumed to have carefully and skillfully treated or operated on his patient, and that there is no presumption of negligence from the fact of an injury or adverse result. See, *e.g.*, *Webb v. Lungstrum*, 223 Kan. 487, 489, 575 P.2d 22 (1978); *Tatro v. Lueken*, 212 Kan. 606, 611, 512 P.2d 529 (1973); *Collins v. Meeker*, 198 Kan. 390, 394-95, 424 P.2d 488 (1967); *Voss v. Bridwell*, 188 Kan. 643, 658-59, 364 P.2d 955 (1961); *Rhodes v. DeHaan*, 184 Kan. 473, 476, 337 P.2d 1043 (1959); *Goheen v. Graber*, 181 Kan. 107, 111-12, 309 P.2d 636 (1957); *Waddell v. Woods*, 158 Kan. 469, 474, 148 P.2d 1016 (1944).

The cases cited by the defendants involved the doctrine of *res ipsa loquitur*, and the presumption of careful treatment was discussed in determining the applicability of the doctrine. None of the cases relied upon by the defendants supports their requested instruction. Here, plaintiffs relied upon specific allegations of negligence supported by expert testimony, not upon the doctrine of *res ipsa loquitur*.

Under these circumstances, an instruction that a "physician or surgeon is *presumed* to have carefully treated or operated on his

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patient and there is no presumption of negligence from the fact of an injury or adverse result" could have misled the jury into believing that the plaintiffs' burden of proof was greater than a preponderance of the evidence. The defendants cite no case holding that the failure to so instruct constitutes reversible error, nor has our research disclosed any such case.

The trial court properly instructed the jury in this case that the plaintiffs had the burden of establishing their claims of medical negligence. *Bacon v. Mercy Hosp. of Ft. Scott*, 243 Kan. 303, 307, 756 P.2d 416 (1988). The jury was not left with the impression that Shawn Leiker's injuries alone raised a presumption of negligence. The trial court did not err in refusing the instructions requested by Marshall and Gafford to the effect that there was a presumption that the defendants were not negligent.

F. Duty Undertaken by Gafford as Anesthetist

Defendant Gafford and his professional corporation contend that the trial court gave erroneous instructions to the jury regarding the nature of the duty owed by Gafford, a certified registered nurse anesthetist, to his patient. The challenged instructions read as follows:

"Instruction No. 11

"Instructions herein which refer to the duties of a physician or surgeon apply to others (such as a nurse anesthetist) who undertake to perform the duties of a physician or surgeon."

"Instruction No. 17

"The laws of Kansas provide:

'All anesthetics shall be given by a physician or shall be given under the supervision of a physician.'

"The word 'supervision' in this context is to be given its usual and ordinary meaning. The Random House Dictionary of the English Language - Second Edition - Unabridged - Copyright 1987, gives the following definitions:

'supervision: the act or function of supervising';

'supervising: to oversee (a process, work, workers, etc.) during execution or performance; superintend; have the oversight and direction of.'

"In determining whether the defendants complied with the requirements of this law you may consider all the evidence in the case introduced on that point. The burden on this issue is upon the plaintiff. If you find that either or both Marshall or Gafford failed to comply with the requirement, you must further find that had they complied more probably than not, Shawn A. Leiker would not have sustained injury and death."

Gafford timely objected to both instructions before the trial court. However, most of the numerous arguments advanced by

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Gafford in his brief were not raised below. At trial, Gafford objected to Instruction No. 11 simply as being "too encompassing." Counsel argued that the instruction should have indicated that a nurse anesthetist is to be judged by the same standards as an *anesthesiologist*, not a "physician or surgeon." When Gafford objected to Instruction No. 17, counsel simply adopted the arguments that had previously been raised about that instruction by Marshall. Marshall objected to Instruction No. 17 on the basis that it provided a dictionary definition of the word "supervision" rather than deferring to expert medical testimony for the purpose of determining whether there was a failure to supervise. To the extent that Gafford raises other arguments not presented to the trial court, they may not serve as the basis for assigning error unless the instruction was clearly erroneous. *Tetuan v. A. H. Robins Co.*, 241 Kan. at 467; K.S.A. 60-251.

Instruction No. 11 was not fatally flawed for failing to specify that Gafford would be held to the duties of an anesthesiologist rather than those of a physician or surgeon generally. Since the evidence showed that Gafford undertook only the responsibility of administering and monitoring the anesthesia necessary for Shawn Leiker's cesarean section, it is implicit in the instruction that he will be held to the duties of a member of that particular school of medicine. This is especially true when the challenged Instruction No. 11 is read in conjunction with Instruction No. 10, which refers to specialists in the same field of expertise. Also, Instruction No. 15 clearly delineated the respective specialties of Marshall and Gafford. Considering the limited objections lodged by Gafford, we find no error in Instruction No. 11.

Instruction No. 17 was based upon K.A.R. 28-34-17(p), which is one of several rules applicable to hospitals providing surgical care. While the regulations apply basically to the licensing of hospitals pursuant to K.S.A. 65-425 *et seq.* and the duties imposed upon such hospitals, the regulations may also apply to other health care providers, such as the defendants here, who seek to utilize the facilities of the hospital.

The only objection asserted by Gafford to Instruction No. 17 was to adopt Marshall's previous contention that it failed to limit the jury to expert testimony in determining whether Gafford administered the anesthetic under the "supervision" of Marshall. Gafford argues that the "abstract concept" of supervision of

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one professional by another, within the specialized environment of the hospital operating room, is not within the common knowledge of the public generally. He argues that it was erroneous to provide the jury with a dictionary definition of the term "supervise" instead of directing the jury to consider the question on the basis of pertinent expert testimony, which was plentiful in this case.

Gafford concedes, however, that Instruction No. 9 required the jury to rely only on expert testimony in determining whether a health care professional complied with the appropriate standard of care with respect to questions of a medical or scientific nature. That instruction specifically informed members of the jury they were not permitted to arbitrarily set a standard of their own or determine the question based upon their personal knowledge. When all of the instructions are read together as a whole, and considering the overwhelming evidence of negligence in this case, we cannot say that Instruction No. 17 resulted in any reversible error.

G. Marshall's Duty to Supervise Anesthesia

Marshall and his professional corporation also argue that it was erroneous to give Instruction No. 17 to the jury, absent expert medical testimony defining the conduct required by K.A.R. 28-34-17(p). He argues that the plaintiffs presented no expert testimony defining what a supervising physician should or should not do to comply with the regulation. As did Gafford, Marshall complains that the trial court gave the jury a dictionary definition of the term "supervision."

The general standard of care required of a doctor is that he possess the reasonable degree of learning and skill ordinarily possessed by members of the profession and of his particular school of medicine in the community where he practices, or in similar communities, and that he will use such learning and skill in treating his patient with ordinary care and diligence. *Karrigan v. Nazareth Convent & Academy, Inc.*, 212 Kan. 44, 49, 510 P.2d 190 (1973); *Goheen v. Graber*, 181 Kan. 107, ¶ 1. In the instant case, Instruction No. 17 was given on the assumption that K.A.R. 28-34-17(p) imposes a duty on physicians to supervise the administration of anesthesia by non-physicians working under their control. At oral argument before this court, counsel for Dr. Marshall candidly admitted that the regulation was applicable to Marshall

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Marshall concedes there was expert medical evidence on the question of whether he complied with the alleged obligation to supervise Gafford's administration of the anesthesia. However, he argues that expert testimony was needed to indicate the specific obligations imposed on a surgeon by the supervision requirement of the regulation. We disagree. The specific duties falling under the general umbrella of "supervision" did not need to be detailed to the jury in order to permit an intelligent decision on whether Marshall failed to supervise the administration of anesthesia in this case. There was conflicting testimony from expert witnesses as to whether Marshall appropriately supervised Gafford. In addition, it was undisputed that Marshall was waiting in the doctors' lounge while Gafford injected the anesthetic, and Marshall was not even present until after the procedure had been completed.

It was not necessary for the plaintiffs to put on expert testimony explaining in detail the specific responsibilities of "supervision" in order to present the jury with the issue of whether Marshall failed to comply with the regulation. Marshall's arguments on this issue lack merit.

H. Marshall's Objections to Instruction No. 2

The next five issues raised by Marshall all appear to involve Instruction No. 2 and its recitation of the allegations of negligence asserted by the plaintiffs. Although each issue is addressed separately by Marshall in his briefs, the arguments are similar and we will consider the issues together. We note at the outset that, since Marshall did not object to the instruction at trial, he may not assign as error the giving of the instruction unless it was clearly erroneous. K.S.A. 60-251(b).

Instruction No. 2 was a lengthy general instruction outlining the various claims and allegations of the plaintiffs and the asserted acts of negligence of each defendant. In the instruction, the court explained the general nature of the claims and then listed thirteen specific allegations of negligence against Gafford and his professional corporation. The instruction then addressed plaintiffs' claims against Marshall, including ten specific allegations, which read in pertinent part:

"The claims against George W. Marshall, M.D., and Harris, Hodges & Marshall, Chartered, are based on the failure of George W. Marshall, M.D. to comply

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with standard medical practice which caused or contributed to the injuries and death of Shawn A. Leiker in one or more of the following particulars:

. . . .

"3. Failure to determine the proper amount of tetracaine to be administered for cesarean section and to prevent defendant Gafford from administering an overdose thereof.

"4. Failure to be present when defendant Gafford commenced the anesthesia procedure on Mrs. Leiker.

"5. Failure to monitor fluid intake and require an adequate pre-load.

. . . .

"7. Failure to detect, diagnose, and promptly treat Shawn A. Leiker's distress during and after the cesarean section.

"8. Failure to promptly and properly resuscitate Shawn A. Leiker."

Following the allegations against Marshall, the instruction concluded by stating:

"The plaintiffs have the burden to prove their claims of medical negligence of the defendants and that they caused or contributed to the injury and death of Shawn A. Leiker before damages can be recovered. To sustain this burden, it is not necessary that they establish each claim of medical negligence only that as to each defendant, one or more of those claims be proved.

"The defendants all deny that they committed any acts of medical negligence as alleged by the plaintiffs which caused or contributed to the injury and death of Shawn Leiker."

Marshall's principal argument as to each of the five specified allegations of negligence is that there was insufficient expert testimony for any of the five allegations to be submitted to the jury. We do not agree. This case was replete with expert testimony on the various issues asserted by the parties. Numerous experts testified on behalf of plaintiffs and defendants. All were subjected to intense cross-examination. Without going into detail on each of the five allegations of negligence, our review of the record does disclose expert testimony on each issue sufficient to warrant their submission to a jury. For example, on the issue of the proper dosage of tetracaine (subsection 3 of Instruction No. 2), Dr. Bassell, plaintiffs' expert, testified that an obstetrician-gynecologist has a duty to see that an unsafe dosage of an anesthetic drug is not administered by a nurse anesthetist. Furthermore, Dr. Mathewson testified on cross-examination by plaintiffs' counsel that there should be communication between the obstetrician and nurse anesthetist regarding the anesthetic that will be used and the dosage level to be administered. Comparable evidence was presented on each of the five allegations of negligence that Marshall asserts should not have gone to

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Instruction No. 2, commonly referred to as the issues instruction, essentially informed the jury that plaintiffs claimed Marshall was negligent for failing to comply with standard medical practice, which in turn allegedly caused injury and death to Shawn Leiker. Marshall has not shown that he was prejudiced just because the instruction listed the specific allegations of fault claimed by the plaintiffs. At the end of the instruction, the jury was informed that the plaintiffs were not required to establish each specific claim of medical negligence in order to meet their burden of proof but that they must prove one or more to the satisfaction of the jury. The jury was also provided Instruction No. 9, which required the jury to defer to expert medical testimony in determining whether the standard of care had been met on questions of a medical or scientific nature. When read in context and in conjunction with the other jury instructions, Instruction No. 2 was not clearly erroneous. We conclude the trial court did not commit error in instructing the jury on the alleged acts of negligence attributed to Marshall.

I. Marshall's Liability for Gafford's Negligence

The jury in answer to a special question on the verdict form found Marshall to be legally responsible for one or more acts of Gafford. Marshall goes to great lengths in his briefs to argue that he should not be held "vicariously" liable for any of the negligent acts of Gafford.

At the outset it is clear that one of the plaintiffs' principal allegations against Marshall was that he violated his duty to supervise and control the administration of anesthesia by Gafford. That he had such a separate and independent duty is clear. *McCullough v. Bethany Med. Center*, 235 Kan. 732, 738, 683 P.2d 1258 (1984); K.A.R. 28-34-17(p).

Vicarious liability is a term generally applied to legal liability which arises solely because of a relationship and not because of any actual act of negligence by the person held vicariously liable for the act of another. It is also referred to as imputed negligence or imputed liability. Vicarious liability depends upon the relationship of the parties, such as employer and employee or principal and agent. In such cases, the employer or principal is held liable for the negligent act of the employee or agent solely by reason of the relationship and not because the employer or

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principal actually committed an act of negligence. For discussions of the distinction between vicarious liability and the independent liability of an employer or principal see Prosser and Keeton on Torts, ch. 12, §§ 69-71 (5th ed. 1984); 53 Am. Jur. 2d, Master and Servant § 404 *et seq.*

In the present case, even though the jury answered the question in the affirmative, the thrust of plaintiffs' case is that Marshall breached an affirmative duty to supervise Gafford, failed to take appropriate action when he discovered Shawn Leiker was in trouble, and was guilty of negligence for his own acts as well as one or more of the acts of Gafford.

Marshall's arguments and contentions on the issue of "vicarious liability" are difficult to follow. He first contends that he was not vicariously liable for Gafford's negligence because he merely had the duty to *supervise* Gafford and not the duty to *control* Gafford's work. While he admits his own professional corporation is vicariously liable for Gafford's negligence, he contends he is not personally liable since he was merely a co-employee of the corporation with a duty to supervise Gafford.

Second, Marshall argues that neither he nor his professional corporation may be held vicariously liable for the wrongful death judgment because of K.S.A. 1988 Supp. 40-3403(h), which limits vicarious liability among health care providers qualified for coverage under the Health Care Stabilization Fund for all claims filed after July 1, 1986, the effective date of the statute. Each argument will be addressed briefly.

The jury was provided the following pertinent instruction:

"Instruction No. 16

"On your verdict form you will be required to determine whether or not defendant Gafford was the agent or servant of the defendant Marshall.

"In determining whether a person is the servant of another, sometimes called the master, it is necessary that he not only be subject to the latter's control or right of control with regard to the work to be done and the manner of performing it, but that this work is to be performed on the business of the master or for his benefit. Actual control, of course, is not essential. It is the right to control which is determinative.

"In determining whether or not defendant Gafford was acting as agent for defendant Marshall, you are instructed that an agent is a person who, by agreement with another called the principal, performs or is to perform services for the principal, with or without compensation. The agreement may be written, oral, or implied by the behavior of the parties."

The jury was also instructed as follows:

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"Instruction No. 14

"A physician or surgeon must exercise due care in selecting his assistants including an agent or employee working under him such as a nurse anesthetist and if he fails to do so he may be liable for the negligence or fault of the nurse anesthetist for injuries resulting therefrom."

The parties stipulated, and the jury was so instructed, that Gafford was the agent and employee of his professional corporation and that Marshall was the agent and employee of his professional corporation. At trial, Marshall did not object to any of these instructions.

The following special question was submitted to the jury on the verdict form: "Do you find that Dr. George W. Marshall is legally responsible for one or more of the acts of Wendell P. Gafford which caused the injury and death of Shawn Leiker?" The record does not reflect any request by Marshall that the verdict form require the jury to specify the acts for which the jury found him responsible in the event the submitted question was answered in the affirmative. The jury did answer the question in the affirmative and Marshall cannot now complain about the jury's failure to specify any particular act of negligence. Nor can we speculate on the negligent acts of Gafford for which the jury found Marshall responsible. Suffice it to say the jury did find as a fact that Gafford was negligent, that Gafford was acting as the agent of Marshall, and that Marshall was responsible for one or more of Gafford's acts. Such a conclusion is adequately supported by the evidence, as is the jury's conclusion that Marshall was negligent in his own right for one or more of the acts of negligence attributed to him. The answer to the special question merely determined that Gafford was the agent of Marshall, nothing more.

In *McCullough v. Bethany Med. Center*, 235 Kan. 732, this court discussed the legal relationship between a physician and a nurse anesthetist. This court noted: "[A] surgeon usually is liable for the negligence of an anesthetist-resident or a nurse-anesthetist under the doctrine of 'captain of the ship' which still pertains in most states. 8 Am. Jur. Proof of Facts 2d, Anesthetist Supervision and Control § 1, p. 587." 235 Kan. at 738. This court went on to note that the determination of the right of control is a matter for the trier of fact. In addition, as mentioned

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earlier, Marshall conceded at oral argument that K.A.R. 28-34-17(p) applied to him. We find no merit to this argument of Marshall.

Marshall also argues that K.S.A. 1988 Supp. 40-3403(h) precludes vicarious liability for the wrongful death judgment. The statute reads:

"(h) A health care provider who is qualified for coverage under the [Health Care Stabilization Fund] shall have no vicarious liability or responsibility for any injury or death arising out of the rendering of or the failure to render professional services inside or outside this state by any other health care provider who is also qualified for coverage under the fund. The provisions of this subsection shall apply to all claims filed on or after the effective date of this act [July 1, 1986]."

Nothing in the statute abrogates the duty owed by a health care provider in tending to the needs of a patient. See K.S.A. 17-2715.

Marshall asked the trial court to instruct the jury that, as a matter of law, Marshall and his professional corporation could not be vicariously liable for the misconduct of Gafford, citing the quoted statute. The trial court correctly noted that the personal injury action arose prior to the effective date of the statute, and therefore the statute, if applicable at all, could only apply to the wrongful death claim. The trial court noted that the issue of Marshall's liability for Gafford's negligence was being submitted to the jury on the theory of principal and agent, and that the parties could address the issue after the jury verdict if it made any difference in the outcome. Marshall argued in his motion for new trial that the statute did apply to the wrongful death claim. As noted earlier, Marshall made no request that the verdict form indicate the particular negligent acts of Gafford for which the jury found Marshall responsible. Likewise, there was no request that the jury specify the separate acts of negligence attributed by plaintiffs to Marshall. Absent any such requests, Marshall is in no position to assert reversible error in the verdict returned by the jury. See K.S.A. 60-249(a); *Wozniak v. Lipoff*, 242 Kan. 583, 593, 750 P.2d 971 (1988). Even though the jury found that Marshall was legally responsible for one or more acts of Gafford, it also apparently determined that Marshall was 10% at fault based on one or more independent acts of negligence attributed to Marshall. Certainly the evidence would support such findings. It would appear that the answer to the special question would only become relevant in the event Marshall was found 0% liable for his own actions or if Gafford was unable to respond for the fault

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attributed to him. Then "vicarious" liability could arise based upon the principal and agent relationship discussed in Instruction No. 16 and the jury's finding. Under all of the facts and circumstances of this case, any error which may have occurred on this issue is indeed harmless.

We have carefully considered all of the arguments and issues asserted by the defendants Marshall and Gafford in their appeals, whether discussed at length herein or not, and find no error requiring a reversal of the verdict and judgment.

II. PLAINTIFFS' CROSS-APPEAL AGAINST GAFFORD AND MARSHALL

Is K.S.A. 1988 Supp. 60-1903 Unconstitutional?

The plaintiffs cross-appeal against defendants Gafford and Marshall and their respective professional corporations, contending that the trial court erred in applying K.S.A. 1988 Supp. 60-1903 to reduce the jury award of nonpecuniary damages for wrongful death. The trial court reduced the jury verdict of $2,000,000 for nonpecuniary damages to $100,000, the maximum amount recoverable for nonpecuniary loss under the statute. Plaintiffs argue that the damage cap imposed by K.S.A. 1988 Supp. 60-1903 is unconstitutional.

The challenged statute reads in part as follows:

"**Amount of damages; jury instructions; itemized verdict.** (a) In any wrongful death action, the court or jury may award such damages as are found to be fair and just under all the facts and circumstances, but the damages, other than pecuniary loss sustained by an heir at law, cannot exceed in the aggregate the sum of $100,000 and costs.

"(b) If a wrongful death action is to a jury, the court shall not instruct the jury on the monetary limitation imposed by subsection (a) upon recovery of damages for nonpecuniary loss. If the jury verdict results in an award of damages for nonpecuniary loss which, after deduction of any amounts pursuant to K.S.A. 60-258a and amendments thereto, exceeds the limitation of subsection (a), the court shall enter judgment for damages of $100,000 for nonpecuniary loss."

Plaintiffs argue in their brief that the statute violates (1) the constitutional right to equal protection of the law under Sections 1 and 2 of the Bill of Rights of the Kansas Constitution and the equal protection clause of the Fourteenth Amendment to the United States Constitution; (2) the constitutional right to trial by jury as provided by Section 5 of the Kansas Bill of Rights and the Seventh Amendment to the United States Constitution; and (3) the constitutional right to remedy by due course of law under

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Section 18 of the Kansas Bill of Rights. In their post-trial motion raising the constitutional issue before the trial court, plaintiffs challenged the statute on the basis of §§ 1, 5, and 18 of the Kansas Bill of Rights and the Fourteenth Amendment to the United States Constitution. To the extent that plaintiffs' arguments raise points not presented to the trial court, they are barred from presenting those points for the first time on appeal. *Kansas Dept. of Revenue v. Coca Cola Co.*, 240 Kan. 548, 552, 731 P.2d 273 (1987).

The trial court reasoned that the damage limitation itself is not unconstitutional because there was no cause of action at common law for wrongful death. As the cause of action was created by statute, the court concluded that the $100,000 limitation itself is not unconstitutional. In regard to the statutory bar against informing the jury about the $100,000 limitation, the court reasoned that, if the legislature can take away entirely the right to trial by jury in wrongful death actions or abolish the action altogether, it cannot be unconstitutional to withhold information from the jury about the dollar limitation on nonpecuniary damages.

Before addressing the specific arguments of plaintiffs, a brief review of the adoption of the English common law is deemed appropriate. K.S.A. 77-109 provides:

> "The common law as modified by constitutional and statutory law, judicial decisions, and the conditions and wants of the people, shall remain in force in aid of the General Statutes of this state; but the rule of the common law, that statutes in derogation thereof shall be strictly construed, shall not be applicable to any general statute of this state, but all such statutes shall be liberally construed to promote their object."

A comparable statute was adopted by the first territorial legislature of the Kansas Territory effective November 1, 1855, and has been the law of Kansas, in one form or another, ever since. For an excellent history of the common law and its adoption and application in the State of Kansas see *Clark v. Allaman*, 71 Kan. 206, 80 Pac. 571 (1905), where the subject is discussed at length. In *Clark*, the court stated:

> "It will not be denied that in every state particular rules of the common law, as existed in England prior to the fourth year of the reign of James I, are not consciously regarded as binding; many others are consciously rejected, and new rules, the product of American conditions, departing widely from the English common law in fact, and quite indifferent to it in theory, became established and

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must be recognized as of controlling authority. Rules of law have their birth, growth and decay, like generations of men, and in order to meet the expanding needs of the inhabitants of the young commonwealth the legislature enacted the statute of 1868 continuing in force the common law only as modified by constitutional and statutory law, judicial decisions, and the condition and wants of the people." 71 Kan. at 229-30.

In *Gonzales, Administrator v. Atchison, T.& S.F. Rly Co.*, 189 Kan. 689, 695, 371 P.2d 193 (1962), the court said:

"From the beginning of our history as a state (Territorial Laws 1855, ch. 96, Laws 1862, ch. 135, G.S. 1935, 77-109) the common law of England has been the basis of the law of this state, and except as modified by constitutional or statutory provisions, by judicial decisions, or by the wants and needs of the people, it has continued to remain the law of this state."

The plaintiffs go to great lengths in their brief to persuade this court that there never was a common-law rule precluding civil recovery for wrongful death. The apparent purpose of this argument is to avoid Kansas case law which holds that the Bill of Rights of the Kansas Constitution preserves the right to trial by jury (§ 5) and the right to remedy by due course of law (§ 18) only as to civil causes of action that were recognized as justiciable by the common law as it existed at the time our constitution was adopted. See *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan. 333, 342, 757 P.2d 251 (1988); *In re Estate of Suesz*, 228 Kan. 275, 277, 613 P.2d 947 (1980); *First Nat'l Bank of Olathe v. Clark*, 226 Kan. 619, Syl. ¶ 1, 602 P.2d 1299 (1979); *In re Rome*, 218 Kan. 198, 204, 542 P.2d 676 (1975); *Craig v. Hamilton*, 213 Kan. 665, 670, 518 P.2d 539 (1974); *Kimball and others v. Connor, Starks and others.*, 3 Kan. 414, 428 (1866). Plaintiffs ask this court to reverse longstanding Kansas law holding that there was no right at common law to recover for wrongful death, and then to strike down a damages limitation imposed by the very statute that itself abrogated the common-law rule which plaintiffs so vehemently criticize.

Plaintiffs' lengthy arguments are not persuasive. Neither the historical roots of the common-law rule precluding civil recovery for wrongful death, nor its possible lack of merit or logical basis, are relevant to the question before this court. For a comprehensive treatment of the subject, readers are directed to 1 Speiser, Recovery for Wrongful Death 2d, ch.1 (1975). Our cases are clear that, right or wrong, Kansas common law did not recognize a civil claim for wrongful death at the time our Bill of Rights was

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adopted. See *Goodyear, Administratrix, v. Railway Co.*, 114 Kan. 557, 561-62, 220 Pac. 282 (1923); *City of Eureka v. Merrifield*, 53 Kan. 794, 798-99, 37 Pac. 113 (1894); *McCarthy, Adm'r, v. Railroad Co.*, 18 Kan. 46, 48 (1877). The cause of action for wrongful death is purely a creature of statute in Kansas. Since there was no cause of action for wrongful death at common law, neither § 5 nor § 18 of the Bill of Rights can be invoked to challenge the constitutionality of either the $100,000 limitation on nonpecuniary damages resulting from wrongful death, or the prohibition against informing the jury of the statutory limit.

Nor may plaintiffs invoke the right to jury trial as guaranteed by the Seventh Amendment to the United States Constitution. The Seventh Amendment has not been applied to the states through the Fourteenth Amendment. *Colgrove v. Battin*, 413 U.S. 149, 169 n.4, 37 L. Ed. 2d 522, 93 S. Ct. 2448 (1973) (Marshall, J., dissenting), and cases cited therein; *Walker v. Sauvinet*, 92 U.S. 90, 23 L. Ed. 678 (1875); *First Nat'l Bank of Olathe v. Clark*, 226 Kan. 619, 622, 602 P.2d 1299 (1979). It therefore applies only to limit actions of the federal government, and does not apply to state court proceedings.

Other parties have failed in their attempts in other jurisdictions to bypass statutory limitations on wrongful death damages by asking the court to recognize a cause of action at common law for wrongful death. See *Butler v. Chicago Transit Auth.*, 38 Ill. 2d 361, 363, 231 N.E.2d 429 (1967); *Hall v. Gillins*, 13 Ill. 2d 26, 28-29, 147 N.E.2d 352 (1958); *Jirsa v. Ice*, 88 S.D. 209, 217 N.W.2d 465 (1974).

The only remaining basis raised by the plaintiffs for their constitutional attack on K.S.A. 1988 Supp. 60-1903 is the equal protection clause of the Fourteenth Amendment to the United States Constitution and its counterpart in § 1 and § 2 of the Bill of Rights of our Kansas Constitution. Plaintiffs contend that the statute violates the right to equal protection because it improperly distinguishes between wrongful death claimants and other tort claimants, whose damages as a general rule have not been statutorily limited.

Equal protection analysis must begin with a determination of the applicable level of judicial scrutiny to be applied to a statute that distinguishes between classes of individuals. *State ex rel. Schneider v. Liggett*, 223 Kan. 610, 616-17, 576 P.2d 221 (1978).

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Plaintiffs urge this court to apply a "heightened scrutiny" analysis in this case, as was done in the principal opinion of this court in *Farley v. Engelken*, 241 Kan. 663, 670-71, 740 P.2d 1058 (1987), apparently on the reasoning that the limit on nonpecuniary damages impinges on the fundamental right to a jury trial. Defendants and *amici*, however, argue that heightened scrutiny is inappropriate in the instant case. They contend that the traditional rational basis test should be applied. We agree. It may be noted that in *Farley* only two justices, one of whom is no longer on the court, adopted a heightened scrutiny test, while five justices recognized the rational basis test as being appropriate. We have already concluded that the constitutional right to a jury trial is not impinged by K.S.A. 1988 Supp. 60-1903(a) and plaintiffs offer no other reason for applying heightened scrutiny analysis. The statute does not create the kind of "suspect classification" that has triggered strict or heightened scrutiny by the United States Supreme Court. See *Farley v. Engelken*, 241 Kan. at 669-70; *State ex rel. Schneider v. Liggett*, 223 Kan. at 617; *cf. Pollock v. Denver*, 194 Colo. 380, 572 P.2d 828 (1977). The "reasonable basis" or "rational basis" test traditionally has been applied where equal protection challenges have been brought against social and economic legislation. *McGowan v. Maryland*, 366 U.S. 420, 425-26, 6 L. Ed. 2d 393, 81 S. Ct. 1101 (1961); *Farley v. Engelken*, 241 Kan. at 669. A statutory limitation on liability has been held a classic example of economic regulation. *Duke Power Co. v. Carolina Env. Study Group*, 438 U.S. 59, 83, 57 L. Ed. 2d 595, 98 S. Ct. 2620 (1978). A statutory limit imposed on nonpecuniary damages in wrongful death cases has been said to be designed at least in part to preclude a jury from awarding an excessive amount of damages out of sympathy for a decedent's family and would appear to fall under the general heading of social and economic legislation. *Benton v. Union Pac. R. Co.*, 430 F. Supp. 1380, 1385-86 (D. Kan. 1977); 1 Speiser, Recovery for Wrongful Death 2d §§ 7:1, 7:4.

The "reasonable basis" test is violated only if the statutory classification rests on grounds wholly irrelevant to the achievement of the State's legitimate objective. The state legislature is presumed to have acted within its constitutional power, even if the statute results in some inequality. Under the reasonable basis test, a statutory discrimination will not be set aside if any

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state of facts reasonably may be conceived to justify it. *McGowan v. Maryland*, 366 U.S. at 425-26; *Farley v. Engelken*, 241 Kan. at 669; *State ex rel. Schneider v. Liggett*, 223 Kan. at 616.

If the legislature's objective was indeed to prevent juries from awarding excessive damages out of sympathy for a decedent's family, and assuming that goal is a legitimate one, imposing a statutory cap of $100,000 on damages for nonpecuniary harm would appear to be rationally related to that goal. *Amici* suggest that the legislature sought to limit damages for nonpecuniary injuries because such harm suffers from inherent difficulties of quantification and proof. If so, imposing a statutory limit on nonpecuniary damages, while providing unlimited recovery of pecuniary losses, is a legislative strategy that is rationally related to that purpose.

Under the reasonable basis test, it is unnecessary to ascertain the specific purpose the Kansas Legislature espoused, if any, in establishing the challenged classification. Rather, if *any* state of facts reasonably may be conceived to justify the alleged statutory discrimination, the statute will not be set aside as a violation of equal protection. *McGowan v. Maryland*, 366 U.S. at 426.

A statute comes before the court cloaked in a presumption of constitutionality, and it is the duty of the party attacking the statute to sustain the burden of proof. *State ex rel. Schneider v. Liggett*, 223 Kan. at 616, and cases cited therein. The plaintiffs in the instant case have fallen short of this burden, and have not shown that the statutory limit on nonpecuniary damages in a wrongful death action violates either the Kansas or the United States Constitutions for any of the reasons advanced.

Other jurisdictions have upheld statutes imposing limits on damages for wrongful death over various constitutional arguments. See *Pollock v. Denver*, 194 Colo. 380 (equal protection); *Butler v. The Chicago Transit Auth.*, 38 Ill. 2d 361 (equal protection); *Goldstein v. Hertz Corp.*, 16 Ill. App. 3d 89, 305 N.E.2d 617 (1973) (right to remedy for injuries); *Glick v. Ballentine Produce Incorporated*, 396 S.W.2d 609, 615-16 (Mo. 1965) (right to remedy for every injury, due process, and equal protection).

We now turn specifically to the argument that the statute violates the right to trial by jury because it prohibits the court from informing the jury about the cap on nonpecuniary damages.

Both Illinois and New Hampshire have similar provisions in their wrongful death statutes which provide that a jury shall not be informed of the statutory limitation. Ill. Rev. Stat. ch. 70 ¶ 2 (1987); N.H. Rev. Stat. Ann. § 556.13 (1974). New Hampshire has upheld its statute over various constitutional arguments and the contention that the jury must be advised of the limitations. *Gibbs v. Prior*, 107 N.H. 218, 220 A.2d 151 (1966). The New Hampshire court reasoned:

"Knowledge of a statutory limitation upon the amount of recovery is not essential to the proper performance of its task by the jury, nor is authority to impart that knowledge to a jury an essential attribute of the judicial power. Jurors may determine the guilt or innocence of a prisoner without being informed of the penalty for guilt. Like the court-made rule which keeps from the jury knowledge of the existence of insurance in automobile cases, the 1963 statute is designed to exclude from the trial considerations which may reasonably be thought unnecessary to performance of the jury's function, ordinarily irrelevant to the issues before it for decision, and sometimes fraught with the risk of misuse. We think the statute valid . . . ." 107 N.H. at 221.

We conclude K.S.A. 1988 Supp. 60-1903 is not unconstitutional on any of the grounds asserted by the plaintiffs.

III. APPEALS INVOLVING ABBOTT LABORATORIES

A. Plaintiffs' Appeal of Directed Verdict

Plaintiffs have separately filed what they denominate as a "contingent" appeal from the directed verdict rendered in favor of Abbott at the close of the plaintiffs' evidence. The plaintiffs concede that, if the judgment against Gafford and Marshall is affirmed, this appeal is moot. *Tice v. Ebeling*, 238 Kan. 704, 707, 715 P.2d 397 (1986). We agree. In view of our affirmance of the trial court judgment, we need not address plaintiffs' "conditional" appeal.

B. Abbott's Cross-Appeal—Admission of Evidence

On cross-appeal, Abbott argues that the trial court erred in admitting into evidence the 1987 version of the package insert enclosed with the drug tetracaine. In 1987, Abbott changed its package insert to include the information plaintiffs contend should have been included in the 1981 package insert. The package insert was admitted in evidence, over Abbott's objections, during the plaintiffs' case in chief. The evidence was admitted only as to Marshall and Gafford and the court indicated the jury would be instructed not to consider the evidence in the case against Abbott.

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At the close of plaintiffs' case in chief, the trial court sustained Abbott's motion for a directed verdict. Since a directed verdict was entered in favor of Abbott, and as we have determined that the judgment of the trial court must be affirmed, we conclude Abbott has no standing to pursue the cross-appeal. *Gigot v. Cities Service Oil Co.*, 241 Kan. 304, 737 P.2d 18 (1987); *Blank v. Chawla*, 234 Kan. 975, 678 P.2d 162 (1984); *In re Waterman*, 212 Kan. 826, Syl. ¶ 7, 512 P.2d 466 (1973). We therefore decline to consider the issue further.

IV. CONCLUSION

This case was tried before one of the most experienced trial judges in Kansas. The parties were represented by some of the most respected medical malpractice counsel in the state. The trial of the case spanned a period of almost seven weeks. Numerous experts of unquestioned integrity and competence from some of the most prestigious medical facilities in the country were called to testify. The record before this court is contained in seven file boxes and includes nearly 6,000 pages of trial transcript, seven volumes of district court pleadings, numerous medical treatises and articles, trial exhibits, medical records, pretrial transcripts, and numerous depositions. We received comprehensive briefs by counsel for the parties and *amici* briefs from the Kansas Association of Defense Counsel, the Kansas Medical Society, and the Kansas Hospital Association. A careful review of the record and briefs on appeal discloses that, although this may not have been a perfect trial, all parties received a fair trial. They cannot ask for more. *Schneider v. Washington National Ins. Co.*, 204 Kan. 809, 815, 465 P.2d 932 (1970). We conclude that any error which occurred was harmless error. K.S.A. 60-261 and 60-2105.

The judgment is affirmed.

HERD, J., concurring and dissenting: I concur with the majority opinion except for the part which holds K.S.A. 1988 Supp. 60-1903 constitutional. I would hold it unconstitutional under the equal protection guarantees of Sections 1 and 18 of the Kansas Bill of Rights. I find no rational basis for applying limitations on nonpecuniary damages for bereaved spouses and children in a wrongful death action while others are treated differently.

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Madam Chair and Members of the Committee:

I am here today to represent the women of western Kansas. I would like to tell you a story on their behalf. I thought as I approached this hearing how ludicrous it would be if you had passed a law that I had to give you 8 hours notice to exercise my constitutional rights of free speech before I was allowed to speak to you this morning.

For women from western Kansas, your eight hour waiting period amounts to a 24 hour delay. This delay cost me not only extra money that I cannot afford, but my personal integrity. First, I need to talk about the money. It cost me $49 for a motel room, which was a double because it was very, very important to me not to make the drive alone and go through this by myself. My husband would have come with me, but he is at home with our two children. He is missing time from work to do that, and since he works an hourly wage, it will cost almost $100. My friend who came with me could have stayed with the kids, but we felt it best not to leave them. My friend also had to take off work. We had lunch at a fast food place and had a cheap dinner too. The food alone will be another $35 for both of us. This extra night has cost my family nearly $200. That doesn't include the extra day off work I had to take. This might not be so bad if I was from Topeka, Wichita, or Kansas City, but for us living west of Salina, half the state, it is an undue burden.

Imagine how I feel when you tell me that I have to spend an extra day away from my family so I will be able to hear your speech on this procedure. Don't you think that I have thought about this a million times since I made the decision? I am a trustworthy person. I am responsible. With this law, you, the government, are saying to me that I am incapable of understanding something so important. You are telling me you don't really care how much it costs me in dollars or integrity as long as you have your one last chance to change my mind. Now, not only do I have to walk through a barrage of protesters to get to the door, screaming and waiving pamphlets in my face, now you go into the clinic with me. Do you really thing that upon entering those doors, this is the first time I have thought about it?

This right to know does not make any sense to me. Are you going to also legislate that a woman who decides to have a baby should be informed by her OB that childbirth is more dangerous than if she terminated the pregnancy? Will you ask OB's to give the women names and addresses of clinics that could end her pregnancy? Obviously, this has nothing to do with a woman's right to know or this would be included in these bills. Nor would it be reasonable for you to demand that a family listen to the physiology of death before allowing them to end life support systems of a loved one.

If you think this bill is harmless, please, don't be mislead. I am not afraid of being informed, but I am afraid of your version of information. This decision is between me and my doctor. If I have questions, I will ask her. My religion differs than some of you on the committee. Why can't you accept that? Abortion is not immoral for me. I have thought about this issue since I was 13 and had my first period. Another 8 hours is not going to change my mind. I don't need your pamphlets. I don't need your pictures. I don't need your guilt.

ProCho. Action League

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To: Senate Federal and State Affairs Committee
From: Peggy Jarman, Lobbyist, ProChoice Action League
and Women's Health Care Services
Re: H.B. 2269, S.B. 230, S.B. 233, S.B. 234

H.B. 2269 and S.B. 230 Informed Consent

You have been told that women in this state are having abortions without consent, without knowing what they are doing. I want to call your attention to **Attachment A**. It contains the consents that patients sign before an abortion is done. Start with the top page. That is the consent that is sent to patient 8 hours before her procedure. It has been suggested to you that it does not meet legislative intent of the 1992 Kansas Abortion Law and that it is the only consent that a patient ever sees. I challenge both of those assertions.

First, legislative intent. The sponsor of the House bill fails to report to you that the bill that left the House in 1992 had NO informed consent. That amendment was defeated. That amendment was almost identical to these bills. The legislative intent of the House concerning consent was ZERO. When the bill hit the floor of the Senate, an anti-choice Senator, who had expressed great animosity for the bill's sponsor, moved to strike the enacting clause and he was successful. We went back to the drawing board and wrote another bill. WE added informed consent. That is the bill that became law in July, 1992. If there was legislative intent, it was never about creating undue burden for women in this state.

Second, you can see the consents in front of you. I submit to you that NO woman in this state is having an abortion without full knowledge that she is ending a pregnancy. You can also see that she is told the risks of the procedure. ...one by one, in detail. This is quality care, standard care. As remote as these complications are, and they are remote, all patients have this information before surgery. <u>All of the medical requirements in this bill are already being met by physicians providing abortions in this state.</u> They have always been provided. Not because you passed a law, any law, but because it is standard of care in the medical profession.

You are told that physicians who are providing abortions services are the only doctors not regulated. That is entirely and completely incorrect. ALL physicians in this state are licensed and regulated by the Kansas Board of Healing Arts. They have comprehensive standards of care, rules for advertising, penalties for certain actions, and the ability to revoke, suspend, or limit licenses of all physicians in this state. Any physician can be sued for medical malpractice by any patient at any time for any care the patient believes to be substandard. There are no exceptions for physicians providing abortion services. You are also told that physicians providing abortion services are the only ones not required to inform their patients using some type of informed consent. Informed consent is not mandated by statute. It is standard of care, something ALL doctors do, not because you have legislated it, but because it would be considered malpractice if they didn't. This legislation mandates no regulations for doctors concerning quality of care, but dictates to physicians...and only those doing this one type of surgery...who and what and how to set up and deliver services. What the legislation does is interfere with the quality of care physicians now deliver.

It has been suggested to you that physicians who provide abortions services are only interested in money and that quality of care is totally unimportant to them. The implication is also that they are the only physician concerned about money and the only physician who has ever had a patient that has not been 100% satisfied with the care received or the only physicians in the state to have any problems, personal or otherwise. I know you know none of these latter things can possibly be true so I will not belabor this point. I do want to call your attention to **Attachment B**. Those are letters from patients. I am not going to tell you that ever patient has loved our service, found us to be 100% compassionate, loving and caring. But I can tell you that for ever letter we receive from someone who has a complaint, there are 100 like the ones you have in front of you. I ask you to read those letters before deciding physicians providing abortion services are just money-grubbing, uncaring, unqualified doctors who must be singled out by this legislature and told how to deliver medical care. Count the patients who say, "Thank you for saving my life." "Thank you for the quality of care and kindness I received."

Sen. Federal & State Affairs Comm
Date: 3-13-97
Attachment: #16

- This b[illegible] not about information. It is about denying access.
- This bill is not about a woman's right to know. It is about putting up barriers.
- This bill is not about quality of care. It is, in fact, dangerous to women to the point of of risking lives.
- This bill is a deliberate attempt to put doctors in a Catch 22 position where it is impossible to provide services and to return to the good ol' days of pre *Roe v. Wade* where only the rich could get safe abortions.

I call your attention to **Attachment C.** This legislation is simply part of the Kansans for Life "Five Year Plan to Stop Abortions in Kansas." Read the articles I have attached in that section. You will see they are following the outline set forth in Firestorm that tells how to make the issue of the legality of abortion moot by restricting them to the point that no one will have access.

There are many problems with this bill. I have outlined them one by one in **Attachment D.**

I urge you to defeat both H.B. 2269 and S.B. 230.

S.B. 233 Viability

The Kansas Compromise Abortion Bill is unconstitutional. It is unconstitutional because it contains no exception for abortions after viability to protect the health of women, a clear violation of *Roe v. Wade*. This was done to appease anti-choice legislators. They wanted a bill without that exception. They got it. Now they are back wanting more. The definition they now want could make abortions illegal after the first trimester. The state would be saying if a fetus can be attached to a machine, an abortion cannot be done. Nothing about outcome, quality of life, health of the woman....nothing.

I urge you to defeat this terrible bill.

S.B. 234 Banning the Intact D and X (partial birth abortion) Procedure.

Several weeks ago I asked the sponsors of this bill to adopt language that would make an exception to save the life of a woman and to clearly identify this procedure. That is required so that there would be no chance that any woman would needlessly die because people were practicing medicine without a license, i.e. this legislature. And, it was required to make certain that this and only this procedure was banned. You will find the proposed language in **Attachment E** along with supporting documentation from ACOG. It is clear from the response I received that this bill is about politics rather than banning a procedure. I stated as far back as July, 1996 that no physician in this state uses this procedure. This bill is about media and emotionalizing this issue. It is clearly inappropriate for the legislature to take options away from doctors. But given the highly unlikely circumstance that this procedure would ever be used in this state, it seemed wise to me not to oppose this bill if it met logical standards. There are organizations that disagree with me strongly and you have written testimony from them. I hope you will consider all of their testimony carefully. I also hope you will be as disgusted as I am at the total lack of sincerity by the people who are playing games and playing politics with this procedure.

I urge you to defeat this bill.

ı ,hoice 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

Attachment A - 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

Sen. Federal & State Affairs Comm.
Date: 3-13-97
Attachment: #17

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 $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 you or anyone in your immediate family 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 you 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

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 ____________________

17-7

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

17-8

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	**Patient's Signature**
Name ____________	Name ____________
Address ____________	Address ____________
City/State/ZIP ____________	City/State/ZIP ____________
Phone ____________	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

17-11

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...
....

17-12

ırgery 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____

17-13

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

____

____

17-15

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
( ) ( ) Sickle Cell Disease
( ) ( ) Varicose Veins
( ) ( ) Diabetes
( ) ( ) Blood clots in veins
( ) ( ) Breast or Uterine Cancer
( ) ( ) High Blood Pressure
( ) ( ) Breast Tumors
( ) ( ) 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
( ) ( ) Anemia
( ) ( ) Cancer
( ) ( ) Chest pain/Angina
( ) ( ) Dizziness/fainting spells
( ) ( ) Heart Disease
( ) ( ) Inflammation of Veins
( ) ( ) Shortness of breath/ Asthma
( ) ( ) Thyroid disease or Goiter
( ) ( ) Kidney Disease/Infection
( ) ( ) Blood clotting problems
( ) ( ) Vaginal infections
( ) ( ) Liver Disease
( ) ( ) Mononucleosis
( ) ( ) Painful or bloody urination/bladder infection
( ) ( ) Psychiatric treatment
( ) ( ) Nervous disorder
( ) ( ) Depression
( ) ( ) Rheumatic fever
( ) ( ) Migraine Headaches
( ) ( ) Pelvic Inflammatory Disease
( ) ( ) Jaundice/Hepatitis
( ) ( ) Tuberculosis
( ) ( ) Venereal Disease/Herpes
( ) ( ) 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 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

permissio[illegible] my parents (or legal guardian if applicable) or other person (name set forth below) to be notified [illegible]e 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..
....

17-23

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____

12-24

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.crl

Attachment B: Letters from Patients

Sen. Federal & State Affairs Comm
Date: 3-13-97
Attachment: # 18

February 27, 1997

Dear Dr. Tiller,

I just wanted to write you a letter thanking you for what you did for me several years ago. I was one of your patients in 1989. I was sixteen years old and six months pregnant, my boyfriend didn't want anything to do with me and I was to afraid to tell me parents. Finially, my mother figured it out and took me to my Physician. Who referred me to a clinic here in Arizona, I was too far along. That is where we got your clinics name and address. My mother called and the next day we left for Kansas. I was afraid, but you and your staff comforted my fears. I was treated with the upmost respect and dignity, which I desperatly needed during that time in my life. I think you are a great man. You are saving many lives of teenage girls who feel like the only other option is suicide, as I did. I have never regretted my decision to terminate my pregnancy.

I got married in 1991, to a wonderful man. We have two children ages 5 and 2. The time was right and I was ready to be a wife, a mother, a family. I do believe that it is all due to your clinic. You gave me a second chance. Thank you.

I want you to know that you and all of your staff are always in my prayers. I hope that there is always a choice like there was for me, as well as other women. Please, never be discouraged by those who do not understand, you are a good man, you are SAVING lives.

Sincerely,

Leandra

PA

2-81

February 19, 1997

Dr. George Tiller
Medical Director
WOMEN'S HEALTH CARE SERVICES
5107 E. Kellogg
Wichita, KS 67218

Dear Dr. Tiller

We walk through life without looking for or expecting what may lie around the corner or not realizing that what happens to others can happen to us. To know that for women of choice there are organizations such as yours that respect that choice professionally and sympathetically to support those changes that shape our lives and the people that we touch.

I truly want to thank you, Dr. Tiller, your wonderful staff, and also those in the background that I did not get to meet, for all your caring and concern in my time of need. The empathy that exists when one goes into a strange place dealing with a very personal concern , not knowing anyone or what the end result will bring emotionally, was totally laid to rest by all that you do and those that you surround yourself with. I was truly impressed with the professionalism, commitment, courtesy, and kindness I received while in the care of your staff. You obviously have taken the time and concern to hand-pick your staff because their character and commitment to you is clearly evident. You have also taken the extra effort to create a safe and secure environment which I'm sure is a unnecessary expense for your cause.

Although having to travel all the way to Wichita, KS seemed extreme, it is obvious that your medical facility is one of a kind, and I could not have received superior care anywhere in this nation. Dr. Tiller, you have truly saved my life, and allowed me the opportunity to fulfill my hopes and dreams, as quoted by you! I must say that because of you and your work, I have a second chance to put my life onto a straighter path and achieve my goals and dreams. I am truly grateful to **Women's Health Services in Pittsburgh** also, for having the knowledge and confidence in your facility so that I could be referred to you. I have been a patient over the years at WHS in Pittsburgh and have received excellent care at their facility as well. I am grateful that I live in a country where a woman still has the right to chose her future. I would like to commit to you that any opportunity I have to ensure that our freedom of choice continues, I will certainly pursue.

Although my decision to discontinue my pregnancy personally was not an emotional one, the actual experience certainly was emotional. And, again I cannot thank you and your highly trained staff enough for the excellent care and emotional support that I received during my stay there. From the very first phone call I made to your facility, to the various calls involving my health insurance, arranging travel and lodging, and to the explanation of the actual procedure, your staff was outstanding in offering support. Upon arrival at your facility, the emotional, medical, and physical support I received from you directly, as well as your excellent nursing staff, was beyond a doubt the most outstanding I have ever received from any medical experience in my 39 years of life. Not only can I speak for myself, but the emotional support you offered to my boyfriend during his struggle of worry and concern for me, was truly remarkable. We as a couple, feel deeply touched and changed by this experience in a very positive way. We have long term plans and goals we wish to attain and with your help we can now see clear to accomplish them. Thank you, Dr. Tiller. I can only hope that you all will think of me as kindly as I do you.

Dr. George Tiller February 19, 1997

In sincere appreciation to you, and your staff, I wish to confirm and pledge my deep commitment to the "Freedom of Choice" for all women in this country. Anyway that I can offer support, by writing my congressmen, offering donations to a fund, or whatever you can be sure that I will. Please feel free to send me any literature or information regarding legislation on this to my home address. All that I would ask is that you please use an envelope **without a return address showing Wichita**. I do live with my parents and would like to keep my privacy.

Thank you again, Dr. Tiller, for saving my life. You are truly a hero in my heart and will always be. I wish you and your staff continued success and prosperity.

Sincerely,

Becky

Becky M.
Pittsburgh, Pennsylvania

cc: Women's Health Services
221-225 Fifth Avenue
Pittsburgh, PA 15222

18-4

1-13-96

Dr Tiller;

I just wanted to let you know how greatfull we are for all you did for us. I came to your office very scared. After meeting you & all your staff, I felt much more comfortable. Being at your facility was a hard experience, but I will alway have good memories from all the time & care you & your staff gave us. By the time we left, I felt that I've known you for a long time. I have a great respect for you, and what you do for people. Also what it takes for you to do your job. Thanks for everything, I'll never forget you & the care you gave me.

Love, Denise
Dal

18-5

January 31, 1997

To all of the caring staff,

My daughter, Erin, and I want to thank you all for the concern and support shown to us by all the wonderful staff at your clinic.

We came to you with problems we felt were very serious and individual to us. Through the explanations and counseling we were assisted emotionally and physically through a very difficult time. We came home feeling much closer to each other and hopeful for the future. The fellowship and closeness we experienced with the other clients and their families was a special plus that made the frightening experience so much less stressful.

We especially appreciated the complete instructions given to us, the support from everyone we came in contact with there and the opportunity to contact you at any time day or night while in Wichita. Such wonderful services you provide make the experience easier to cope with.

Words seem so inadequate to portray our thanks but words are all we can share now.

Thank you all so very much.

Erin - patient
+
Sandy - mother

We were with you 12-9-96 through 12-14-96.

18-6

Dear Dr. Tiller and Dena, 1/97

I feel compelled to write you a note on the anniversary of my trip to Women's Health. I think about you often and will always appreciate your expertise, compassion and dedication to not only me, but to all who encounter you. Although I am nervous at times, Scott and I are anxiously awaiting the arrival of a baby boy in April. I would never been able to

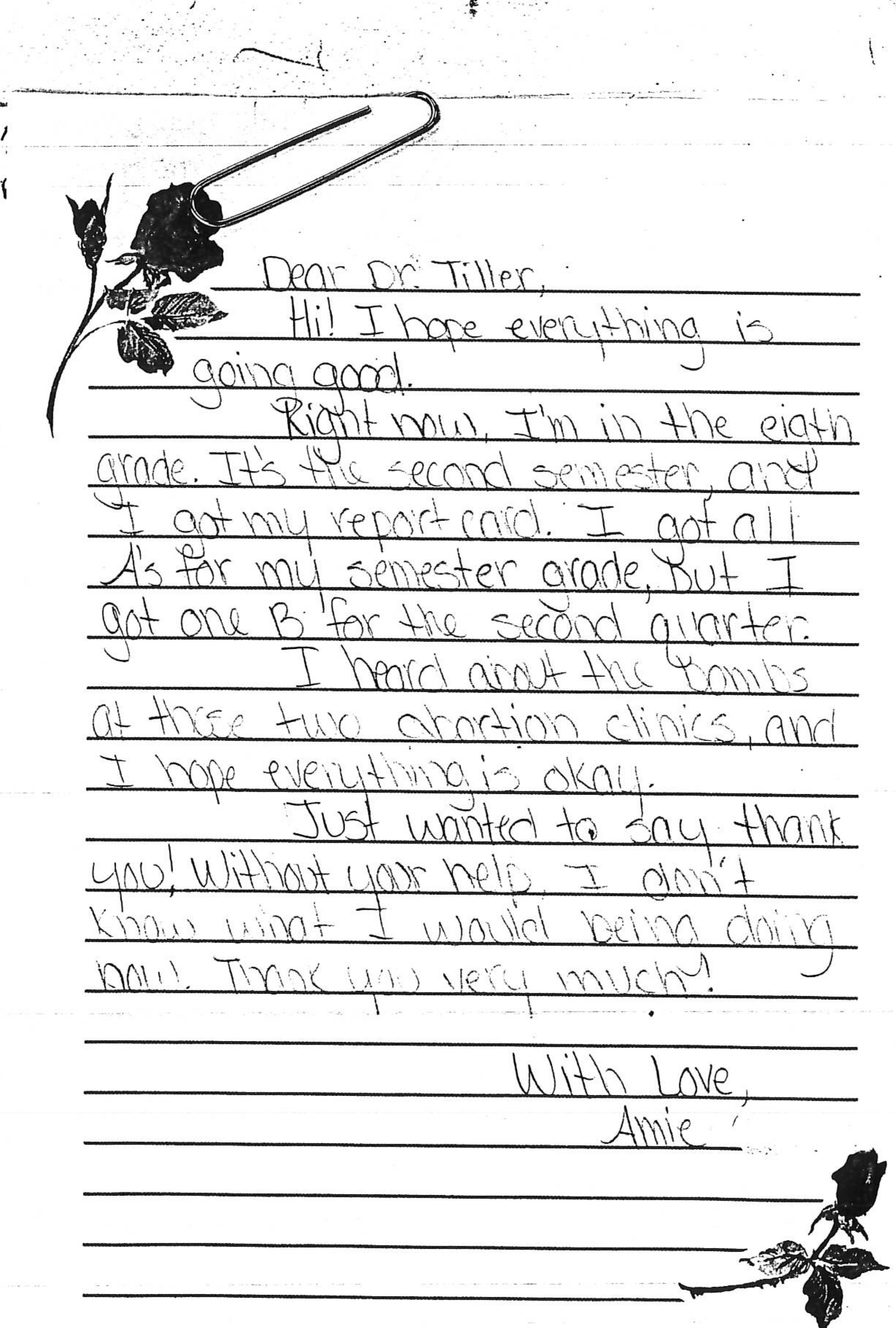
18-7

begin the healing process if it weren't for both of you and everyone else at Women's Health. I wish both of you and your families a healthy and happy new year!

We are forever grateful!

Love,

Ellen and Scott



Dear Dr. Tiller,
Hi! I hope everything is going good.
Right now, I'm in the eigth grade. It's the second semester, and I got my report card. I got all A's for my semester grade, But I got one B for the second quarter.
I heard about the bombs at those two abortion clinics, and I hope everything is okay.
Just wanted to say thank you! Without your help, I don't know what I would being doing now. Thank you very much!

With Love,
Amie

1-7-97

Dear Dr. Tiller,

I cannot find enough words to express my thanks and praise for helping John & I thru such a difficult period in our lives. Although, from this came such beauty and wonderful memories thanks to you & your <u>wonderful staff</u>. The nurses were <u>superb</u>. I know that it will take time to heal, but all the little extra's that you & your office do for us are so wonderful. I could not imagine us walking away from there not ever looking and holding our baby, <u>thanks</u> for ignoring :) our initial request. Holding our beautiful baby was life's greatest gifts. Thank you for being part of it.

Sincerely.

Jeannine & John

Houston, Texas

To Dr. Tiller and staff:

I and my husband and family have been touched and strengthened by the effort you have put forth to create a clinic to support and promote healing of the whole person. Thank you, Dr Tiller, for using your intellect for such a desperately needed service in our society today.

You and your staff helped take my guilt, uncertainty, and shame and turned them into strength, confidence, and the understanding that the birth of our very sick girl was actually a precious and beautiful event to always be cherished.

We have been able to take this little baby and accept her into our loving home unconditionally bringing w/ her anguish, turmoil, and fear, and then finally grief, acceptance, love, and now <u>precious</u> <u>peace</u>.

You and God have worked a miracle in our hearts. May the Lord <u>always</u> continue to work through you and bless you and your families. Love - the,

11-81

The world's
a whole lot better place
Because of people like you
Who give real joy and pleasure
By the nice things that they do,
And with your
recent thoughtfulness
Still very much in mind,
This is meant to bring
a "Thank you"
Of the very warmest kind!

Your family through the Lord our God,

Kara, David, Carlee & Lauren
(and baby Sarah)

I want to thank all of you for being so good to me. Everyone was great at such a difficult time.

Thanks to everyone it made it easier on us.
John & I are very grateful to everyone especially to Dr Teller and all the nurses also to our support group. It helped us alot to know we weren't the only ones going through this I have received letter's from John & Jan and Denise & Neil. It really helps knowing there are such caring people. Thanks again for every thing. And I will let you all know how I am doing. I know this was the right choice and I know my little angel Michael will always be in my heart!

Fran, Kelly, Stacey, Cara Cathy, Sandy and the Rest of the Staff.

It's hard to find people who are quite as nice as all of you, And it's hard to find words to say how many thanks are yours today.

Thanks again

Theresa & John

18-12

Dear Dr. Tiller and Staff,

There aren't enough words to say how thankful we are for the dedication, care and concern you all gave us when we came to you for help in June. My daughter's problems were many and complex and you were able to handle them all. From the first phone call to our departure after my daughter's check out visit, I realized that you and your wonderful staff gave us far more than just medical treatment. You gave us back our dignity and self esteem.

When you called and said you would try to help us, we had reached the point of lost hope. You gave us back some hope of getting control of our lives. The care and understanding given by you and your staff goes far beyond anything we had encountered anywhere else. We really needed those hours of friendship, group counseling, and camaraderie that we shared while we were there. I have already called all the doctors who were not able to help us and the ones who recommended that we come to you to let them know how superbly you and your staff treated us.

We'll never forget you and the cause you are working for to give women more control over their own destinies. Becky has written to and received letters from several people she met there. Each one is important to her just as each one of you will always be important to us. Thanks again for all that you do.

Sincerely,

Glenda

AUGUST 24. 1996

DEAR DR. TILLER AND STAFF:

ALTHOUGH THIS LETTER COMES LATE, ITS NOT WITHOUT MANY THANKS. I WANT YOU GUYS TO KNOW HOW MUCH ALL YOUR CONCERN WAS APPRECIATED. NOT ONLY WERE YOU TAKING CARE OF MY MEDICAL NEEDS, YOU CATERED TO MY EMOTIONAL NEEDS AS WELL. I FELT AS IF I HAD PERSONALLY KNOWN EACH ONE OF YOU FOREVER.

ONCE I FOUND OUT ABOUT MY BABY'S PROBLEMS, I WAS TOLD THAT I HAD NO WAY OUT. IT WASN'T UNTIL I READ THE AMNIOCENTESIS AND ULTRASOUND REPORTS, THAT I KNEW I COULDN'T LET MY BABY LIVE HER LIFE IN PAIN. AFTER MUCH CALLING AND PROTESTING, I WAS REFERRED TO YOUR CLINIC. IT WAS THE BEST REFERRAL I COULD HAVE EVER GOTTEN. YOU MADE A VERY TRAUMATIC SITUATION GO A LOT SMOOTHER, THANKS A BUNCH.

BECAUSE I'M SO YOUNG, ITS VERY HARD TO UNDERSTAND WHY SOMETHING LIKE THIS HAPPENED. I CAN'T QUESTION GOD CAUSE HE HAS A PLAN FOR EVERYONE. I SINCERELY WANT TO THANK YOU, DR. TILLER, DENA, EDNA, MARSHA, DR. HARRIS, TRACEY, AND ANYONE ELSE I MISSED FOR YOUR TIME, PATIENCE, AND SYMPATHY. I WILL NEVER FORGET YOUR KINDNESS. YOU HELPED ME PUT MY LITTLE TIONNA AT PEACE AND MY MIND AT EASE. LOTS OF LOVE TO YOU.

Tamara.

February 13, 1993

Dear Dr. Tiller and Staff,

I'm writing to express heartfelt thanks and love for your kind and gentle treatment for our situation. I'm just sorry it's taken me so long to do this - it's almost a month now and thanks to all of you there's some symbol of normalcy in our home once again.

My daughter, Ta-Aqua, has returned to school and back to life as we had known. She's doing fine and her grades are wonderful, without your kindness and consideration it could've easily been different. I'm grateful that you were there for us and will be there for so many others in the same or similar situations.

You've literally given us new hope and life, and for that I'll always remember you. In some way I feel as if it was fate for me to meet others in the same situation and become lifetime friends with them, gratitude and thanks seem to be less than enough. I hope your staff knows how warm and special they are and their kindness is above board. I also want to say a special hello to Edna, the sunshine of every day we were there, and to all of the staff - they were all beautiful and kind people.

I'll never forget the experience, and I'm also grateful for the opportunities that you have allowed my child to seek out and find. To those I felt close to here's a special hello - Fran, Amy and Cathy - you're all special and kind, stay as sweet as you are. I'll always remember those warm friendly smiles and pleasant hello's - you helped ease the pain more than you know. THANK'S AGAIN!! You were all wonderful.

Sincerely,

Ms. (Ta-Aqua's Mom)

P.S. Keep smiling and wearing your buttons, because truly, ATTITUDE IS EVERYTHING!! Once again, thanks so very much for doing what you do and being who you are.

18-15

February 12, 1993

Dear Dr. Tiller and Staff:

It was a very nice surprise to receive the letter from your clinic a few days ago inquiring about how my daughter is getting along six months after having beeen to see you. Once again, I am so amazed at the care, thoughtfulness and interest you take in each of your patients.

The experience we had in coming to your clinic was one I have had a hard time putting into words. What was a terrible, desperate situation with my daughter became a truly uplifting experience I will never forget. Never have I known people to be more loving, friendly and helpful than we found you and your staff to be. The relationship formed with the other people (patients, parents or friends) there at the same time also was unique. Somehow, we all seemed to come to love each other in a beautiful Christ-like way in just those few days we spent together supporting each other through the ordeal. But it was your lovely clinic which made that possible. The beautiful furnishings in the comfortable waiting room, the video and personal talks with you, Dr. Tiller, and our group sharing session led by dear Fran all made us feel, finally, that everything possible was being done to make everything "OK". We came to realize that there could be a bright future to look forward to. I highly commend the "Step Plan" toward changing one's life for a new direction. That is something that would be good for anyone to consider.

We are very pleased to be able to say that our daughter seems to have finally turned her life around. Just a few days ago, she brought home the first good report card from school since she started in high school three years ago. She has also re-established relations with most of her old friends. And she is pleasant and usually agreeable at home again; helpful and a joy to have around. She will be 17 in May and seems to be on the right path now to a happy, successful life.

You are all thought of often there at the clinic in Wichita. You are all truly some of the finest people anywhere! It is my prayer that God will continue to protect you and make it possible for you to continue with your work. How could some of the so-called Christian people be against what I found to be a "little bit of heaven" on earth?

Sincerely,

Betsy T.

18-16

Dear Dr. Tiller and Staff, 3-22-88

I would like to thank you for your concern and tender loving care while I was a patient at your clinic. All of you made my Dad & I feel at ease and kept us well aware of all the risks concerning my situation. It is good to know that someone cares and believes in you at a time of desperate need and unsurity. I really liked the group sessions. I felt much better about myself and realized I was not the only person caught in a situation such as this. Thank you again for caring and understanding.

Sincerely
Anita

© HMK CDS

September 4, 1992

Dr. Tiller and Staff:

Where do I begin? You did so very much for my 11-year-old niece, Tara, through the entire week we were at the clinic. I could never possibly find the words to express how thankful I am to you all. I know you have probably heard this before, but you will never know how greatly you have touched my life. When I walked out of the doors of the clinic for the last time, August 1, 1992, I knew my life would never be the same.

We came to you during a time of great anguish and loss. Anguish over a very devastating situation surrounded with a lot of sorrow over the loss of innocence. Innocence that was stolen from a child whom I hold very near and dear to my heart. And with that there was a tremendous amount of self-blame and guilt over my inability to see what was happening. I love that child more than life itself and would do anything to have spared her the sorrow she has had to endure a great majority of her still very young life. But, what's done is done and I can no longer continue to lay the blame. I can only go on from here and help her to heal and become the very best person she can be. She may have been victimized at a young age, but she will not grow up to be a victim of her circumstance! She is still very much a child, (THANK GOD FOR THAT), and just as a child she will heal faster, stronger, and better than most. With much counseling, support, and love, we will all be okay!!

As for me, you and your staff have had a lot to do with my personal healing process. I did not realize how strongly I had been affected by this until I came home and spent many a day away from her. As I sat and pondered upon my days at the clinic, I came to realize the need for not only the freedom to choose, but the need for a safe haven to go to after the choice has been made. You provided that in the most effective manner.

You all went above and beyond the call of duty for all who came to you. People like you all are hard to come by in a society such as ours. I truly thank God for you all! Please know you have my highest praise and deepest thanks!!

Thank you for taking one of the worst situations of my life and making it one of the best experiences I have ever had. I honestly think I learned more in those five days than in many years of schooling.

Good Luck and Best Wishes to you all!! Continue on with your fight and as you stand for your beliefs know that you do not stand alone! As a very wise man once said, "You could have missed the pain, but you'd a had to miss THE DANCE!"

Sincerely, Jana

P.S. Edna, I owe you an extra special THANK YOU. Tara would not have made it as easily without you! I love you for that!! (KEEP SPEAKING YOUR MIND TO THE OPRAH SHOW!!) May God be in all you endeavor!!

18-18

August 10, 1994

Dear Dr. Tiller and Staff,

I would like to thank you for all of the love and care that you gave to my husband and me. Although it was the most difficult time for us, your professional and personal help guided us when we needed it most. I know that this must be difficult time for you all with the recent murder of the doctor in Florida, and I wanted to write and tell you that we recognize your bravery and respect your strength to do what you believe is right.

When I came back to Rochester and visited my doctor who referred you, I told him that I would be more than willing to speak with anyone else that he refers to you. I know the fear we felt before coming to Wichita, and I believe that we could help them by explaining not only what exactly will take place, but also, we could help to alleviate some of their fear by describing the care, love and strength you provide.

We will always be able to remember our daughter without guilt. I cannot adequately express what a gift that is to us. You gave us a choice to do what we felt was best for everyone, and now we can continue to live with our love and memories of our daughter, Madeleine.

Sincerely,

Leslie A.

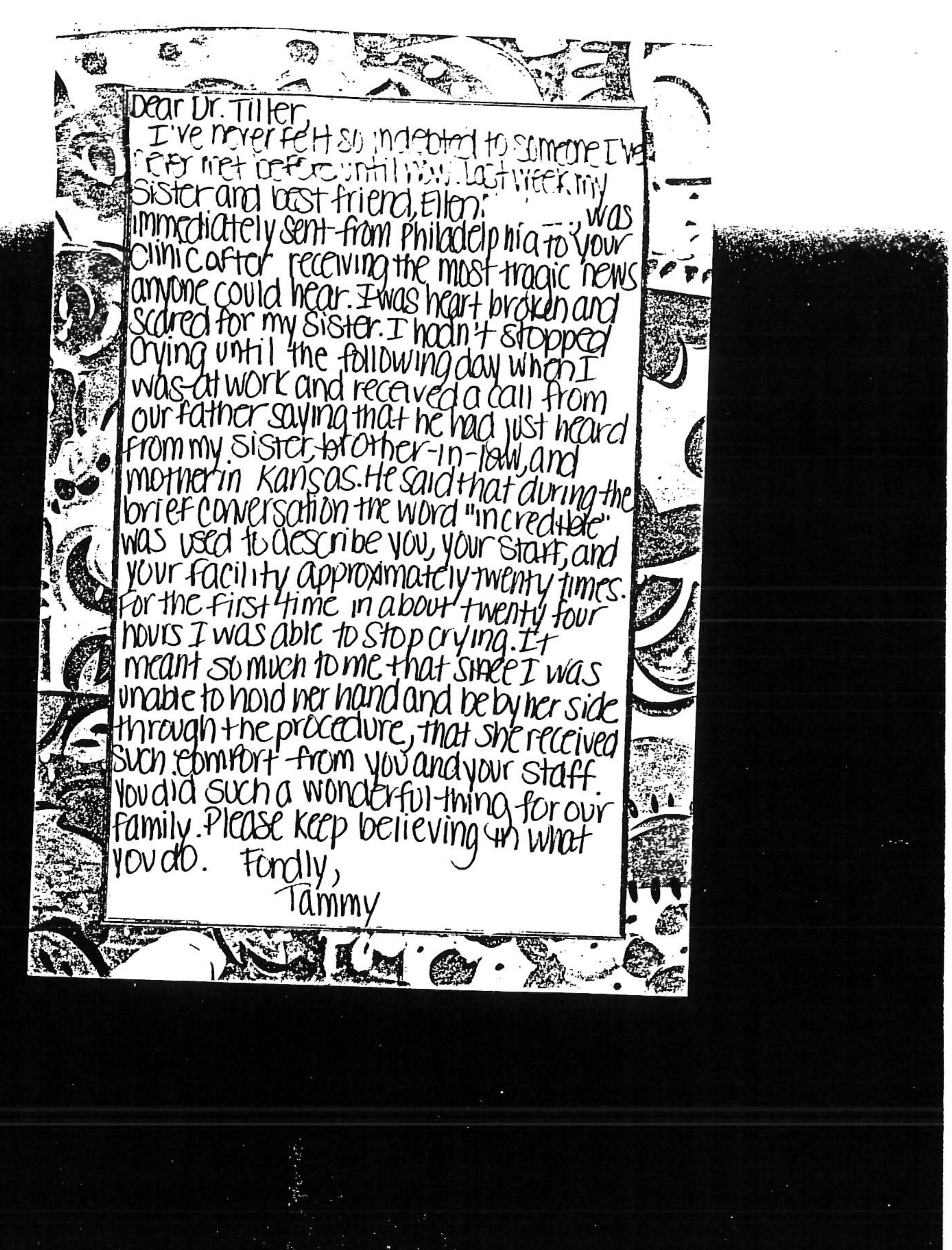
18-19

Dear Dr. Tiller & Staff,

We wanted to let you know how much we greatly appreciated your kindness and understanding during our time of need. We received all the love and support that any couple would hope for. I hope your clinic is able to be available far into the future for all the other people who have similar circumstances as we did. You were all truly there for us when we needed you most.

Thanks so much

Sincerely,
John & Joyce


Dear Dr. Tiller,
I've never felt so indebted to someone I've never met before until now. Last week my sister and best friend, Ellen [redacted], was immediately sent from Philadelphia to your clinic after receiving the most tragic news anyone could hear. I was heart broken and scared for my sister. I hadn't stopped crying until the following day when I was at work and received a call from our father saying that he had just heard from my sister, brother-in-law, and mother in Kansas. He said that during the brief conversation the word "incredible" was used to describe you, your staff, and your facility approximately twenty times. For the first time in about twenty four hours I was able to stop crying. It meant so much to me that since I was unable to hold her hand and be by her side through the procedure, that she received such comfort from you and your staff. You did such a wonderful thing for our family. Please keep believing in what you do. Fondly,
Tammy

Dear Dr. Tiller & Staff,

I just wanted to write & tell all of you how wonderful I think you are & thank you for taking such good care of me. When I came to you, I was very scared & very unhappy. However, after seeing & hearing what you are and discovering how my life would change for the better, I realized I was in very good hands. You & your staff made me feel comfortable & I knew everything was going to be alright. You all showed me that somebody cared & that I wasn't going to have to go through this alone.

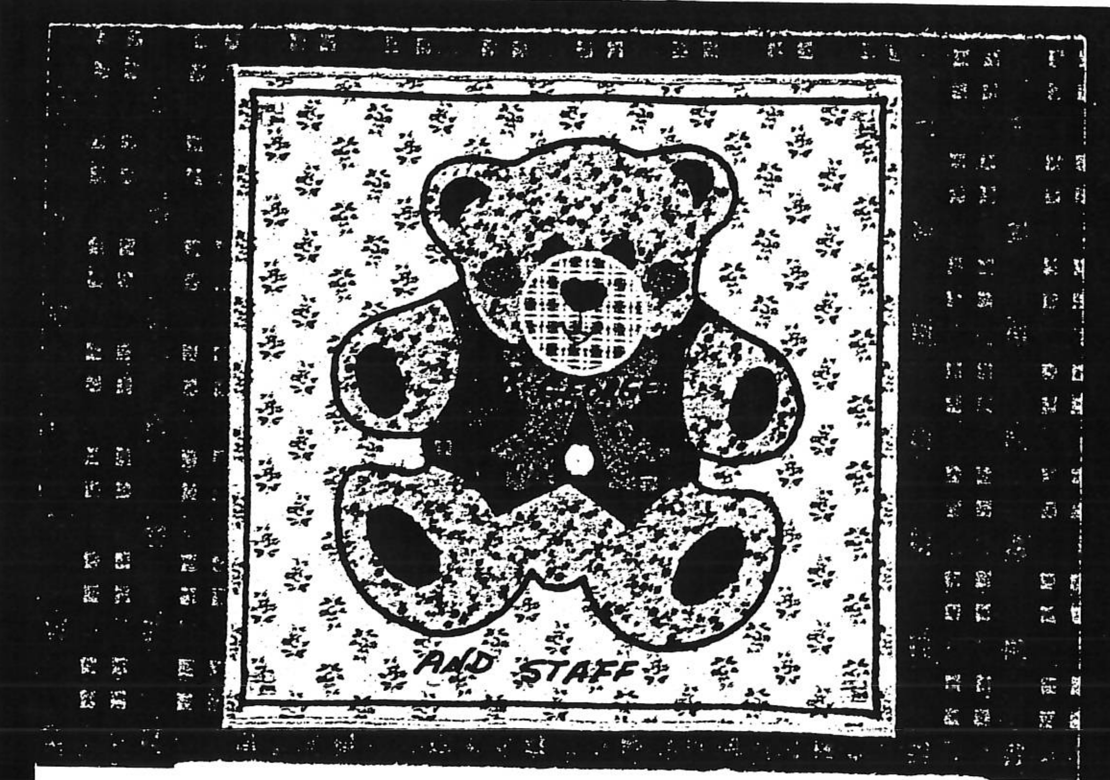
Well, everything is ~~begg~~ oops! beginning to look brighter & I feel like I can do whatever I set my mind to. I've had my down moments but I just remember all that you said & it gives me the strength I need to succeed. I'm going to make my dream of being a great nurse come true, but I couldn't have done it without all of you. I didn't think I'd be anybody but now I know I am somebody. I want to thank you all again for the caring, the words of encouragement, & the gift of a bright future. I will miss you all but you'll be in my thoughts because I now have something to look forward to & it would have never happened if you hadn't been there.

Thanks again!

Love,

Michelle

18-22



NO WONDER THERE'S SUCH
WARMTH BEHIND
THE THANKS THIS BRINGS YOUR WAY,
YOUR SPECIAL KINDNESS
BROUGHT SUCH HOPE -
IT REALLY EASED MY DAY...

AND WHEN ANY GROUP OF PEOPLE
DOES THE THOUGHTFUL THINGS
YOU DO,
IT'S HARD TO FIND
WORDS WARM ENOUGH
TO THANK EACH ONE OF YOU!

DEBORAH

March 7, 1992

To Everyone,

I wish to express my sincere thanks to all of you for making the hardest decision in my life a little easier.

It is hard to believe that in todays times with all these new technologies that the abortion issue seems to be going backwards. I had to deal with the fact that the child I had carried for seven months was very sick and probably wouldn't have lived till its first birthday. Making the decision to terminate my pregnancy was hard enough then I found out that the only place this could be done was two thousand miles away from home. I think that is absolutely absurd.

Everyone of you made my mother, mother-in-law and myself feel very welcome. We got to know people from all over the United States that were having the same problems. Each of you should be commended for the work you do, right down to the clinic volunteers and guards that stand outside.

Thank you all for believing that the decision to do with my body is mine alone. If you need my help or my families help for any reason you know how to contact me. I consider you all part of my family.

Sincerely,
Suellen

In Loving Memory:
Daniel Joseph

1/11/93

Dear. Dr. Tiller and Staff,

I would like to take this opportunity to thank you and your staff. For giving me a chance to acheive my goals in life. You were all very caring and considerate, your explanation of the whole procedure was very comforting. I feel that every individual should be given a new chance on life, and to continue with there dreams.

Thank you again,

C.V.

New York

May 8, 1988

Ruth .

Kentwood, MI. 49508

Women's Health Care Services
5107 E Kellogg
Wichita, KA. 67218

Dear Dr. Tiller and Staff:

We made the 890 mile drive home safely and everything is looking much better in every way -thanks to you all. Surely you have boxes of thank-you notes beyond those displayed in the office. You do a great service to rebuild lives. Our daughter was 14 when she was the victim of several statutory rapes by a 30 year old man. She was 15 when we finally found out and she felt that her life was over. Thanks so much for a new start.

My husband made out the card before I remembered that the Clinic that refered us had lost their brochure. We are sending one to them with letter (copy inclosed.) We will also take one brochure to the Planned Parenthood office when we take Jenny for her checkup. We shall keep one for anyone who may find need of it after the word of our predicament gets around.

Again please accept our heart felt thanks. What would we have done without you all?

Ruth

Ruth & Jenny

18-26

May 8, 1988

Ruth

Kentwood, MI. 49508

Heritage Clinic
425 Cherry SE
Grand Rapids, MI. 49503

Dear Sirs:

Last Tuesday, you advised us of a clinic in Wichita, KA. that would admit patients who were beyond 22 weeks. We went there and can vouch for Dr. Tiller and his whole staff. They are not only very kind and sensitive but most professional. Please do not hesitate to refer other late patients to that facility. We are inclosing a brochure from "Women's Health Care Services" of above named city and feel free to give my name and phone number to anyone who wants some first hand information. We cannot praise the doctor and staff too highly.

Thank you again for your refural. We are,

Ruth

James & Ruth

538-8524

18-27

February 16, 1993

Dear Dr. Tiller, Edna, Cathy, Fran, Tracy, and all of you who helped us but whose names I've forgotten:

We've thought of you often since we were at your clinic the week of Christmas.

I can't put in words how difficult it was for us to decide to ask for the help that you eventually provided. We loved our unborn child so much.

Only after much consultation and agonizing did we decide that we loved our child too much to allow her to be born to a life of suffering. It was the most kind, loving decision we could make, for a child who was as wanted an any child could be.

Many tears have been shed, and continue to be shed, for our daughter. Our comfort is our belief that she's in a place where she's whole and happy.

We've often said how grateful we are that you were there to help us through our difficult situation. Our families are also grateful you provided us with an option, and were so kind to us. Among other things, it must take courage to continue your work.

We are especially thankful for your kind, sensitive, supportive, and professional care. The options you provided for our precious daughter - baptism, naming her, holding her, cremation, pictures - have facilitated our healing process. We remain in contact with the "other couple from Minnesota" (Jerry and Cindy) who were at the clinic the same time we were.

Gradually, we are healing. Our two-year-old continues to brighten our days. We are optimistic of having a healthy sibling for Eric in the future. I'm taking high dose folic acid in hopes of decreasing future pregnancy risk.

Friends from Minnesota,

Amy and Todd J.

18-28

Dear Dr. Tiller,

This letter we are writing to you is long overdue. However we feel that this is the best time to thank you for everything you have done for us.

My husband and I came to you a year ago March 12 at thirty five weeks gestation to terminate a Dandy Walker Syndrome (and other multiple disorders) Fetus. This was the hardest and saddest thing we ever had to do but knowing we had made the right choice and that is what we thank you for — THE CHOICE! If it wasn't for you we would not be writing of our very happy announcement!

Only eight weeks after we left Kansas I conceived once again. However this time we delivered a very healthy baby boy named Craig Michael weighing 6 lbs 14 oz on Feb. 2, 1993.

Thank you so much Dr. Tiller, because our [illegible] would have never happened if it wasn't for you. You are truly a Blessing!

We also want to thank the staff for all their help and compassion and special thanks to Cathy your nurse and Marilyn your office manager!

Yours truly,

Robert & K

Heidi

Oakdale New York

18-29

3/14/90.

Dr. Tiller and Staff,

I just wanted to write and tell you all "thank you". The warm, gentle service I received at the clinic made a pretty traumatic time in my life more comfortable. Looking back, it's as if this minor setback in my career and life goals never even happened. I can't begin to imagine how my life would be at this very moment if I hadn't been able to come to your facility.

For all the other girls that may be reading this letter and find it encouraging, it should be. All the letters you see should prove to you that you're in the right place and you're making the right decision.

I hope that the clinic can continue to function in a safe environment without interference from the govt. or other outsiders. The service you provide is greatly needed and appreciated. My family and I are grateful for your help. Thank you so much.

Tiffany.

16/90 - 2...

18-30

Dear Dr. Tiller & Staff,

Just a short note to thank-you again for all of your help & support during our recent tragedy. I was told by my new doctor (one that believes in womens rights) that I can start trying to get pregnant again in January. Hopefully soon I'll be able to send you a picture of our happy HEALTHY baby.

Thank you so very much for everyth.

Kathi & Bill R.

Modena, Italy 09-12-92

Dearest Dr. Tiller,

Words will never be able to express my gratitude

that I will always feel for you.

You gave me back my smile.

Endless thanks, and a strong hug.

18-32

July 94

Dear Dr Tiller And Staff

The help you gave
meant such a lot,
and, hopefully, you'll know
This comes with
lots more gratitude
than words
could ever show.

And a great big hug
from me to thank
you all for helping
me!

Love always
[illegible]

December 6, 19[illegible]

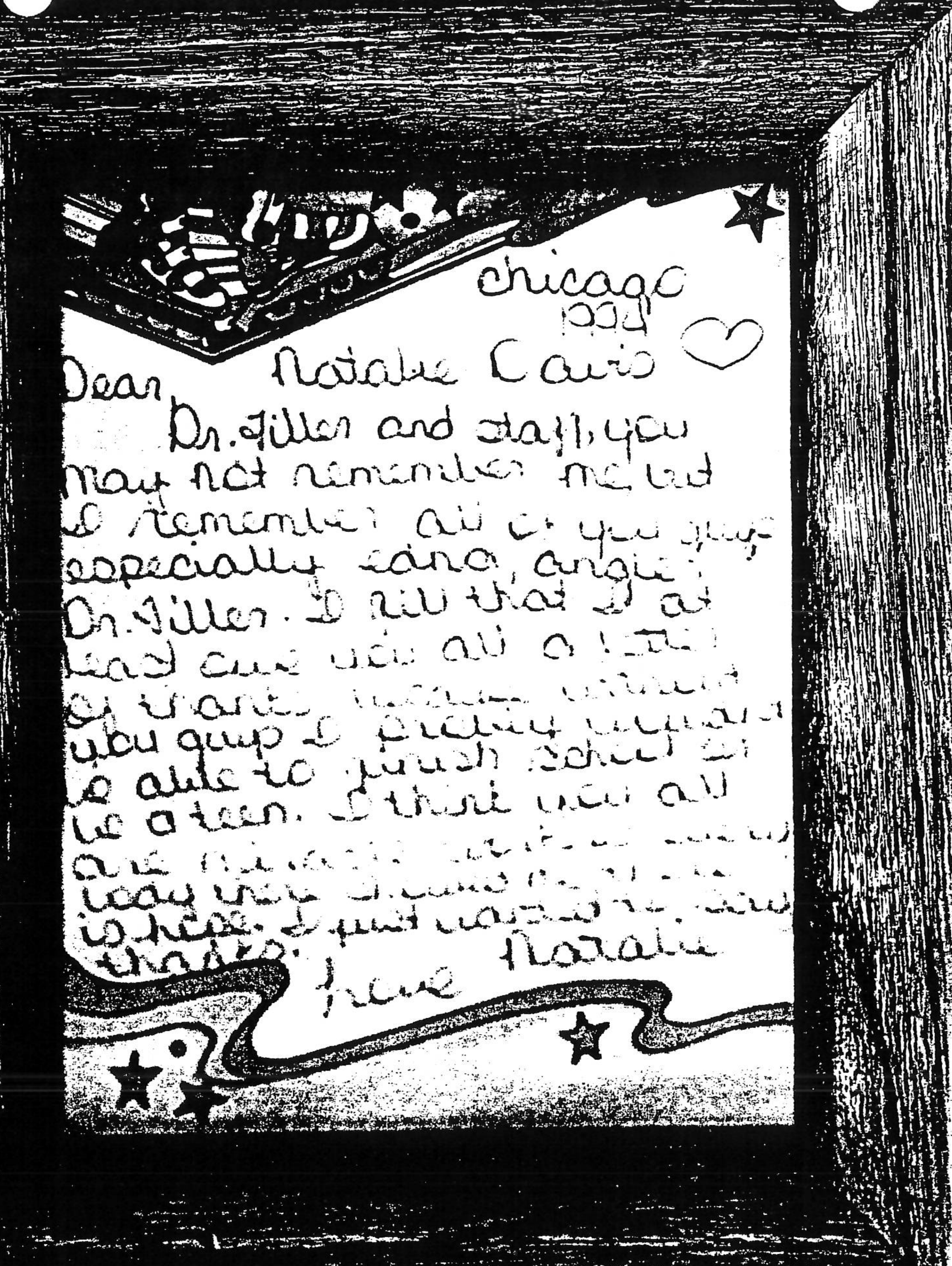
Dr George Tiller,

Thanks to you and your staff for coming to the aid of my Granddaughter (Marianne) Even though I was not there in Kansas with them I received daily progress reports & I was more than impressed with your Women's Health Care Services' facility.

Our family will remain thankful and grateful to you. I'd like to be able to get placed in touch with you who might be in a similar situation.

Sincerely,

[illegible]



Chicago
1994

Dear Natalie Cavis

Dr. Filler and staff, you may not remember me but I remember all of you guys especially Lana, Angie & Dr. Filler. I felt that I at least owe you all a little of thanks because without you guys I probably wouldn't be able to finish school [illegible] be a teen. I think you all are [illegible] way [illegible] is here. I just want to say thanks.

Love Natalie

Dear Dr. Tiller and staff,

Hi! I would just like to tell you thank's for everything! Thank's to you I help my life seems to be back in focus! I am a lot happier now, and everything seems to be going on! If it wasn't for you my life would be a total mess! I was very scared when I went down there. But thanks to you and your staff, I felt so comfortable. After I meet all of you I knew you would take good care of me. I am so grateful for you, Dr. Tiller because if it wasn't for your practice alot of girls that didn't want to have their babies would have to, but thanks to you we have a 2nd chance to pursue are goals in life!! Your counseling meetings really helped me out alot because I thought I was going thru alone, but then I realized that I am not the only girl who had this problem. And everyone their made me feel so much better about myself. I would just like to tell all the girls that come into that office not to worry because they are in the very best hands. Thank-you for helping me out! I thought that all my goals that I had just disappeared because of what happen but you made me realize that just because I made one mistake doesn't mean my life is over, it's just starting. Thank-you.

Love,
Brooke.

Went to see my Doctor Last Friday and he said that every thing was [illegible].

I KNOW THAT I HAVE MADE THE RIGHT DECISION
I KNOW THAT IT'S OK
I JUST HAVE TO KEEP MY GOALS IN MIND
AND TRY TO ACCOMPLISH THEM EVERYDAY.

I HAVE TO KEEP MY HEAD UP HIGH
AND LOOK ON DOWN THE ROAD
FOR I AM NOT THE ONLY ONE
I HAVE NOT TRAVELED ALONE.

I PLAN TO MAKE SOME CHANGES IN MY LIFE
TO HAVE MADE THIS ALL WORTHWHILE
I'LL DO WHAT HAS TO BE DONE
AND I'LL CARRY ON MY FACE A SMILE.

NOTHING IN LIFE IS EASY
AND THIS MAY HAVE BEEN ONE OF THE TOUGHEST
BUT IF YOU BELIEVE AND PERSEVERE
YOU CAN OVERCOME THE ROUGHEST.

IN WHATEVER YOU DO
NEVER LOOK BACK
KEEP GOING FORWARD
ALL OF YOUR GOALS YOU MUST ATTACK.

TIFFANY A.
1992

To Dr. Hiller & Staff

Well I'm sure you can all remember me
Jeanne (March 2 to 5). I just thought that
I would write to you but first I'd like
to thank you all because if you hadn't of
been there I would of had to have a
baby at the age of (15) and that would
have ruined my life. But you guys were
great and made my future alot better. Well
its been almost 2 weeks I'm feeling great
and almost ready to get my life started
again. But I will sure think before I
do anything because of [illegible] [illegible]
I had to go through. I also learned that
I can tell my family anything and they'll
help me. I know I had alot of problems
you guys had to deal with such as: I dilated(?)
twice, I had bad cramps. And the worst of all
I had an allergic reaction to the [illegible] and
that caused alot of suffering for me. But I
just want to say thanks to Dr. Hiller for
believing I could go through with it. Cathy
for being patient and understanding. Rhonda
for being kind, caring and helpful and
taking care of "my teddybear". And the
rest of the staff for being so helpful. I
hope you hang this in a frame it would
make me feel good even though I live
in [illegible], Canada. Well I'll try to keep
in touch and I love you all.

Love you always
Jeanne.

PS. Please show this to Rhonda, Cathy, Dr. Hiller it would mean alot to me please.

P.S.S. tell Rhonda that I love the teddybear(?)

18-38

Date
7/29/90

Dr. Harris and staff,

Thank you for giving my life back. I am so glad that you guys helped me out. I am so glad that you guys did this for me it made me so happy. I am so glad I got this done. You guys really helped me out. I am so glad we came to you guys for this. If we have any ~~promblems~~ problems we will call you or come back. I am doing really good on my pills. I take them every day. I feel much much better after I got this done I really do. Thank you guys for getting me out of trouble. Well I got to say good by. I will right you back as soon as I can.

Sorry so short.

Yours,
Truly

[signature]

Love
Always

Dear Dr. Hellen and Staff ~

Thank you for all your support during my recent abortion. I think when you do so many procedures as your clinic does, and when it's done so quickly and efficiently it would be easy for the clinic to lose its caring attitude and regard for the patient. But, what I found at your clinic was a caring, supportive atmosphere that was very nonjudgmental. I want to thank you with all my heart for that. You helped me through one of the most difficult decisions and times in my life by warmness and caring.

Thank you again!

Very Sincerely Yours,

Rebecca

Dear Dr. Tiller;

Hello, how are you? I am fine, thanks to you and your staff. My mother sent me this book to send you. She is very thank-full to you to. We (my mother + I) do not know what we would have done without you. We have no words that can express our gratitude to you. Thank-you very much, God-bless you doctor and your staff too.

Yours Sincerly
Portia [illegible]

You know somethin'?
You make the world nicer
just by being in it.

18-41

January 18, 1986

To Whom It May Concern:

Three times within the past few days I have driven by your facility. Each time I have seen some half-dozen adults on duty with pro-life signs brandished at me.

It occurred to me today that many of us support your work and your facility, yet we do not stand out there demonstrating our support to passersby.

So I turned around and entered your waiting room to inquire how I might make my support known. Edna, an old friend (I didn't know she worked there), said I should write my support.

Therefore, this letter to you.

I may not carry a sign. I may not stand on your corner. But I do support your efforts to maintain a woman's right to choose regarding her own body and life.

Sincerely,

William Hubert

William Hubert

18-42

To: Dr. Tiller and
His Staff

9-30-8_

I guess the best way to start this letter is to say what's been on my mind since the operation. Thank you so very much for giving me a new life! I still don't know wether any complications will arise, but whatever happens I am so grateful to you for giving me a second chance at life. I was scared to go on the pill because of the side effects. Now I feel the risks are nothing compared to the risks involved in getting pregnant. I've learnt my lesson the hard way. Thank you so much for all you've done. I do plan to go through with the medical check-ups, and I pray that everything will be okay not only for myself, but for all the girls that went through this with me. I hope that you can continue to save the lives of women, Dr. Tiller. I have enclosed the letter you requested. Once again, thanks.

Lata P.

18-43

To all the Staff at this wonderful clinic: Smile :) Turn over ->

December 3, 1995

!! Hello !!, Sorry it took years
so long to write but I
didn't forget you all.
I thank the Staff for doing
so much and a wonderful
gift. I know I made a
mistake and I have paid
for, but needed this time to
understand. Last year I
went in the School year with
my own attitude, on
track. I went to State
for the 1600 Run, without
this clinic I wouldn't have
been able to do that, but
I am grateful. There are
still some mixed feelings
but they will pass. Thank-
you once again. Sheila

Construction & General Laborers' Union
LOCAL NO. 1329
(A. F. L.)
IRON MOUNTAIN, MICHIGAN 49801

R. ALESSANDRINI, Business Manager
North U.S. 2, P.O. Box 863
Phone 774-6070
Iron Mountain, MI 49801

Dennis Schaefer
~~C. ALESSANDRINI, Jr.~~, Sec. - Treasurer
North U.S. 2, P.O. Box 863
Phone 774-6070
Iron Mountain, MI 49801

Dear Dr. Tiller + Staff,

I wish to express my heartfelt thanks to you and your staff for your comittment and excellent care for my daughter Anita. I do not know what we would have done without you. It is people like yourselves that make me see that there is hope in this world.

Your staff's excellent care and attitude helped us through a difficult time.

Please keep up your important work. I also know what it is to stand for a belief in human rights. The Union is also knocked about, but what would conditions + wages in the workplace be with out us. - Hang in there, don't let the S.O.B's get you down!

President
Dean Romagnoli
Dean F. Romagnoli

18-45

Dr. George R. Tiller
5101 E. Kellogg
Wichita, KS. 67218

July 15, 1991

Dr. Tiller:
This will be a formidable week for you. I had some tough weeks a few years ago, struggling with the decision of what to do about an unwanted pregnancy. Thankfully, I had a choice and someone like you to help me when my decision was made.

You are a caring, brave and talented man. Please, please HANG IN THERE. I shudder to think of what will happen if the few, like you ,who are willing to take a stand in favor of choice are defeated. There are so many of us out here who appreciate you and what you are doing. Know that we are here and know that we care.

With much admiration and support,

Lynda C.

18-46

Dr. George Tiller 6-20-91

5107 E. Kellogg
Wichita, KS

Dear Dr. Tiller (and Staff),

Amidst the siege of media and protest, I thought you might like to hear from a Kansas woman who supports your right to do the work you do at your clinic. I applaud the stand you've taken on legal abortion in our state. Women all over Kansas may not know it, but they have a champion in you.

Incidentally, as a very young child, I was a patient of your father. He treated our entire family and my mother considered him a trusted friend. I have no doubt that he would be proud of your firm convictions.

Sincerely-

Michelle L. G.

4-20-88

I want to thank you once again for every thing you and your staff done for me. I feel really fine as nothing had happen. No pain what so ever. I feel this was the best for myself, my children and David. I love all 3 of them very much. But I know way back in my mine and heart I wish it could have been. Just wrong timeing & my age. I have two beautiful children, and my David that loves me very much.

I'am sending my love to all of you. Thanks very much.
Donna

March 21, 1988

Dear Staff,

"Hi," hope everyone is doing fine! Myself - I couldn't be better! I owe all of you - so many thanks! You've helped me to put my life an future back on the Right track! And all of you were a part Of that. Thanks again!

Here is my Doctor's Report for my week & three week Check-ups! I'm fit as a fiddle - and Ready for Deisti Weather!

Love to you all
"Happy Easter"
Cindy C

To Bos Waverly.

DR. TILLER + "ALL" -

words can not express my gratitude to you for virtually saving my life. You all, through your support, love, and care, gave me the strength to begin a new life.

Hope you're happy today.

I know I am,

just because of you.

I am doing very well; quite anxious to begin my vigorous training routine to get back into shape for basketball!

From the bottom of my heart... ☺

THANK YOU... Kathy

Dr. [illegible] 06-24

I just wanted to write a little letter to thank you and your staff. My mother and I were very impressed with your facility! Everyone was nice, polite, and patient. You were able to make a very bad experience good. I've had alot of support from my family, boyfriend, and my friend. They've been there and are still there for me. I just went for my three weeks check-up and everything is fine. I will return to work tomorrow. Emotionally, I'm doing well too. My boyfriend has been great! He's made me smile and lifted my spirits when I really needed it. Again thanks for everything! The smiles, hugs

and hand squeezes were really appreciated! THANKS!

Love-
Denise

18-53

Dear Dr. Tiller and Staff,

Everyone makes mistakes in there life and wish there was a way they could change it or make it better.

Thank you Dr. Tiller for being there when we neided a way to fix the mistake in judgement that was made.

I can never repay you enough for help. I only pray now that as we age in we remember that you and your staff was there to see us through.

Best wishes and lot of luck to you and your Staff.

Thank you
very much.

[illegible]

18-54

Jessica
Prospect, Kentucky 40059

Dr. Tiller + Staff,

I wanted to thank you so much for everything you all have done for me. It was a very hard thing for me to go through but the comfort and understanding you all gave me helped so much. The support group helped me a great deal also. I think that is a very good idea. I was glad you had that. It was neat talking to all the other girls and knowing [illegible] were going through the same things I was going through.

I'm back to work now and back with my school work.

My mom and I are alot closer and I feel like I can tell her things now whether its big or small. So I'm real happy about that. This summer we are going to Fort Worth, Texas and we might stop by in Wichita so if we do I will stop by and say hi, hopefully it will be on different terms Right?! Thanks for everything!

Love,
Jessica!

P.S. Think about me when you watch the Derby on T.V.

18-55

Dear Dr. Tiller & Staff,

I shall always remember your kindness & compassion in my unfortunate situation. I don't know what I would have done if I were forced to have a baby with the severe abnormalities my baby had. I thank God every day that there are people like you to help people like me. Dr. Tiller I want to thank you once again for the kindness & respect you gave to me & my husband. This world needs more people like you. The care I was given was unique & I told my doctor I don't feel I would have been treated better anywhere else. I know I will vote to keep you in practice to help others as you have helped me. I still cannot believe my baby is gone - that she was so sick - I only hope & pray to God to give me & Dennis another chance at having another "healthy" baby.

The help you gave
meant such a lot,
and, hopefully, you'll know
This comes with
lots more gratitude
than words
could ever show.

May God Bless all of you & keep you & your families health. I will never forget you. Thank you for everything.

Sincerely,
Donna

(P.S.) Dr. Tiller & Tracey
Thanks so much for the letters re: my insur.
I know they will help.

r[illegible] there are also no words to
press my gratitude for all you
fered me, my daughter Ellen
d son-in-law Scott. You offered
fety and saneness at a time of
eat heartache. Your compassion,
isdom and dedication will always
e remembered. I feel that a little
iece of each of you will be with
e always.

With Heartfelt Affection,

Sussie

Ambler, Pennsylvania

January, 1996

18.56

Dear Dr. Tiller and Staff,

On Tuesday morning I was ready to leave for work and the only problem on my mind was what kind of pasta should I make for dinner. There was no way I could know that that night I would be sleeping in Wichita, over 2,000 miles from home.

That morning I was expecting my 1st grandchild and that evening I was sharing grief.

That morning I was thinking of how busy my schedule looked and that evening the calendar came to a halt.

Many folks have written you fabulous poems and poignant prose. They think of the power of words but my mind is thinking of the inadequacy of words. Political words ring hollow and are so rigid not allowing for exceptionalities. Families in great crisis don't always fit the molds some politicians have created.

18-57

July [illegible]

Dr. Tiller & Staff-

I just wanted to let you all know how much I appreciate everything you all did for me while I was in your care. It was amazing to me to find a place where everyone seemed genuinely concerned about me & my feelings. I especially would like to thank Missy & Stacy for their unlimited patience & understanding for my low tolerance to pain, Edna for always being able to make me smile when I would have not thought it possible, & Dr. Tiller for treating me like a person with feelings, not just a patient. Before my visit, I would have never imagined that it would have been so hard to say good bye. I can not think of any thing else anyone could have done to make my stay any easier. I left the information you gave me about the clinic with the office where I had my check up (by the way, I'm doing just fine) & told them all about your clinic so they can let others know how wonderful you are. I really can't thank you enough. Take care of yourselves -

Love -
Karen

August 2

Dear Dr Ziller and Staff,

I am finding it very hard to express my true feelings and the Thanks I'm feeling on paper. I felt like I had come to the end of my rope. You all took turns holding my hand and helping me back up. I've stoped crying and hating myself for putting myself in that posetion. I'm now in the process of getting back in my clothes and putting my life back in the proper prospective. Next year is my Senior year. Thanks to you, Now I can continue with and graduate.

After graduation I will attend College. I really beleave this would not have been possible with out your help. Again, I would like to say Thank You. Although I feel these simple words do not say enough. All of you are wonderful, Special people. Never again will I find people to equal your attitudes and kindness.

Thank You,
and Best of
Love,
Laura C
Leesville, La.

Dr. [illegible] and Staff

I just wanted to thank everyone for their thoughtfulness and care that I received during my stay at the hospital. I was scared to death when I arrived and the day I [illegible] when I left was unbelievable. I couldn't believe I could make so many friends in three short days. You are definitely to be commended for your professionalism and [illegible] everything in general. I will never forget how well I was treated and I will never forget your wonderful, delightful people. Thank you again and may the new year bring happiness for each and everyone of you.

Love,
[illegible]

The world could use
more nice people
like you!

Thanks Again

[illegible]
(the [illegible])
[illegible]

12-27-94

F-60

Dear Dr. Tiller,

I am writing you and you're staff with sincere thanks. Everything that you have done for me was greatly appreciated. I cannot express how warm, & caring you and your staff was to me. You accomadated me to the fullest. You would always be remembred, and I hope to visit Wichita some time next year. Please I hope others find what I found in you & thats confidence.

Love & thanks April

Dearest Dr. Tiller & staff

You're the kind of person
who does nice things
for others,
and you do them
without even giving them
a second thought.
The kindness that you've
shared with me
shows just how much
you care for me.
That's why I want to tell you
"You're terrific.
Thanks a lot."

April & Devon

December 2[illegible]th, 1989

It's nice knowing people
with such thoughtful ways
Who bring so much pleasure
to so many days
And think of such pleasant
and kind things to do--
It's nice knowing people
as special as you!

Thanks So Much
To Each and
Every One of You

Mr. Diller & Staff -

Thank you very much for the opportunity to have this second chance. I know I was quite a pain during the procedures, but you and your staff overlooked that and helped me a great deal. Like I said that last day, "I'm never going through this again." But I'm glad you were there for me. [illegible]

18-62

December 18, 199[illegible]

Dear Dr. Tiller and the staff,

How have you been? It has already been one week since we left your clinic. I don't know how to thank you. We very much appreciated your warmhearted, sympathetic, and quick treatment. I now feel as if it was not myself who was worrying about so many things. Thank you very much.

Looking back on the pregnancy, it was very tough. In October, I was told that I had twins but that there was almost no chance to have both babies in a healthy condition. It kept me awake at night again and again. I was examined once or twice a week at hospitals, but nothing good ever came of it. Although I hoped something better might happen at least to one of the twins, some fatal failure was finally detected. It was the 24th week and too late in Michigan to get the medical treatment that you kindly did for me. As soon as we were informed of your clinic from our doctors here and decided to see you, I prayed that I could come to your clinic safely. Since I was told that babies may have to be delivered even in the 24th week and, if so, the abnormality may last for their entire lives, I could not be relieved until I safely arrived at Wichita airport and came to see you. When I visited your office, all of you treated me warmly and with great consideration. The security staff also helped me to feel relieved. The slogan, "Attitude is Everything" shown on your badges, was an encouragement, too. I did not expect you to offer me such a nice gentleman, Dr. Chang, for translation service. What a wonderful consideration for us, foreigners! His translations really relieved me very much.

"You did well and your decision was right. You should have a delightful future." These words Dr. Tiller gave us and smiles and sympathy your nurses and staff offered us encouraged me and my husband to try to make our future bright and be full of delight. Thank you very much.

We thought that there was no hope for us to have a joyful Christmas anymore. However, thanks to your help, we can enjoy and celebrate Christmas with our two-year-old daughter.

May happiness be with you and your families. Please take care of yourself, too. Thank you very much. I wish you a Merry Christmas and a Happy New Year!

We support your practice!

Sincerely yours,

18-63

1/31/96

Dear Dr. George Tiller:

Right now it been 2 weeks after the procedure, sometimes I think it was a bad dream, but then I realize that everything was true. I will always remember you as the person that helped me when everybody had turn their backs at me. I know that what we did it was the best thing for all of us, and for my precious Gabriela Mary. I will never forget her. She was one of the things that I wanted the most but I knew that somehow I had to let go but I didn't know how, and I'm steel holding one but God its helping me let go day by day.

Thank you and your staff for the attention that you all gave me. I will always keep you all in my heart because the way you all were with me and treated me, and specially you Dr. Tiller that made me feel like I was your family. My mother-in-law that was with me over there, she can just stop ~~at~~ talking about how wonderful you. God bless you for your job and personality, you are a really nice person. Thank You Once Again! Nitza

This message, though brief, Has an especially warm touch... For it comes from the heart— "Thank you all very much!"

Gabriela Mary
1/18/96
Hydrocephalicis

79-81

...It is more blessed
to give than to receive.
ACTS 20:35

Warren & Pam

It's through people like you
that God's blessings
are known,
And I'm grateful to you
for the kindness
you've shown.

P.S. Thanks to you all
for your moral support
as well as your spiritual
support. Special Thanks to
you Dr. Tiller for your guidance
and to you Tracy for kindness &
to you Edna for your devotional
period & to Dana for Concern.
Thanks again everyone

Nov 27, 1992

Dear Dr. Tiller,

This is just a little note to say thank you. It's a little word that expresses the appreciation for your care, attention, thoughtfullness, and of course, the good care of your staff. I'm doing fine and feel great, thanks to you!

Sincerely Doris

If "thank-you's" could be flowers, I would send a bright bouquet

To show that I'm more thankful than mere words could ever say!

99-81

Dr. Juler, Dr. Harris, and their wonderful nurses –

I just wanted to take this minute to tell you all thanks for all you did for me. I really appreciate your sincere, kind, caring, and loving attitude that you had towards me. It made everything so much more comfortable and alot easier on my part. Thanks for being there when I needed you most. I really appreciate everything.

Enjoy your goodies!

With love, Lindsay

It's just a little message,
But in it you will find
A great big "thanks" for being
So thoughtful and so kind!

Thanks again
With lots of love,
Lindsay M.

Attachmen C

News from the Lobbyist

The Kansas legislature legalized abortion in Kansas in 1968. Though restrictive, the law was considered liberal at a time when abortion was still illegal in many states. From 1973, Kansas operated under the *Roe v. Wade* decision that legalized abortion for all women in America. Beginning in 1973 and continuing each year, all out efforts have been made by the anti-choice faction to regulate and restrict abortion services in Kansas. Every year for over two decades, the Kansas legislature rejected anti-choice efforts to restrict abortion services...all 103 bills. Kansas has, and continues to reflect, a great respect and trust for the women of this state.

This was never more true than in 1992 when legislation that would continue to ensure access to abortion services for the women of Kansas was passed. Anti-choice legislators and lobbyists continued to push for abortion restritions. Many legislators did not understand women, reproductive freedom, or their own misogynist feelings. One anti-choice legislator even went so far as to sug gest that women were having abortions on healthy nine month old fetuses because they were having a bad hair day!

"A look at Kansans for Life 'Five Year Plan to Stop Abortions in Kansas' will put it all into perspective."

Last year a new approach was implemented. Rather than their bills being known as restrictions, they were touted as protections— "protections of minors," "protections of women."

Really? Is protection the issue?

A look at *Firestorm* will clarify what actu ally took place. A look at Kansans for Life "Five Year Plan to Stop Abortions in Kansas" will put it all into perspective.

Firestorm is a "book" by Mark Crutcher, founder of Life Dynamics, Inc. *Firestorm* is also the code name for his "guerrilla war" on reproductive freedom, in general, and on doctors who provide

(Continued on page 4)

(over)

Sen. Federal & State Affairs Comm.
Date: 3-13-97
Attachment: #19

News from the Lobbyist

from page 3

(Continued from page 2)

provide abortion services, in particular. He writes in *Firestorm*, first on Page 34 and 35: "Obviously, every single one of the problems we face today are directly related to the process of making abortion illegal. **But let's remember that the pro-life moment's goal is not to outlaw abortion, but to stop it.** Outlawing is simply the vehicle we've always chosen to do that. The time has come to explore the possibility that there are other vehicles as well....**That brings us to unavailable. And that's where the real opportunities are.**" And again on page 36 on the Guerrilla Campaign: "Webster's Ninth New Collegiate Dictionary defines a guerrilla as: '....one who engages in irregular warfare especially as a

(continued at top of next column)

member of an independent unit carrying out harassment and sabotage.'

"It's often been observed that wars are not necessarily won by the side with the most powerful army, but by the side that makes the fewest mistakes. And in my opinion, not having an organized, aggressive, strategic-minded guerrilla campaign working legally within the political process, is easily the single biggest mistake ever made by the pro-life movement.

"The good news is that it is not too late to start one. As I mentioned a moment ago, we have opportunities before us today that, if properly exploited, could make abortion unavailable even if it remained legal...."

"We have opportunities before us today that, if properly exploited, could make abortion unavailable even if it remained legal"

Enter Kansans for Life and their Five Year Plan to Stop Abortions in Kansas— take over the House (done), take over the Senate (?), take out the Governor in 1998. That's what you call an "aggressive, strategic-minded guerrilla campaign working within the political system." They recently bragged in a *Wichita Eagle* article that they were "right on schedule."

More from Mark Crutcher this time on restricting abortion: "All G-3 (restrictive) legislation should be sold as 'pro-woman and/or 'consumer protection' legislation. The standard statement that politicians who propose these bills should defend them with is:

"Look, whether women have a right to abortion is not at issue here. This piece of legislation would not legally deny one single woman in this state the right to have an abortion. It is simply meant to insure that abortions are as safe as they can be for the women who have them. Period."

Sound familiar? If you were here to listen to any of the debate last year with the so called "Woman's Right to Know" bill, it does. That is almost a direct quote from the persons carrying the bill— in both chambers.

You can be certain that all abortion bills you see this session will be about restricting abortion—simple bills that will be sold to you with the words you have just read from Mr. Crutcher. You can be equally sure that they are about making abortion so unavailable that whether they are legal or not simply does not matter.

Peggy Jarman

19-2

Attachment 1

Faction plans push in Kansas

Abortion foes outline agenda to win Senate and governor's office.

By JUDY THOMAS
Staff Writer

7-27-95
KC Star

Saying they are riding a wave of success after last fall's elections, leaders of Kansas' largest anti-abortion group are declaring war against the state Senate and Gov. Bill Graves.

Kansans for Life, under its five-year plan, intends to use churches and grassroots politics to put abortion opponents in control of the state Senate next year and in the governor's office in three years.

The ultimate goal: to outlaw abortion in the state by the year 2000.

"We're playing hardball," Kansans for Life President Harry Biltz said this week. "We want to take the state Senate, just like we have a majority in the House. And then we want the governor's office. We are going to stay after this until we put our own people in office and we will

See FOES, A-8, Col. 1

Foes of abortion outline ambitious plan

Continued from A-1

be (in control of) the state.

"And we will do everything possible to get rid of the notion that the state of Kansas has the authority to sanction the killing of innocent human beings as a matter of social policy."

Abortion rights advocates take the aggressive plan seriously.

And the plan is almost certain to create an even greater split in the already divided Kansas GOP. That split is between moderates and conservatives, who talk about "family values" and tend to oppose abortion and gun control.

Abortion foes took control of the Kansas House in the 1994 elections, toppling a longstanding abortion-rights majority. But their attempts to pass further restrictions on abortion were thwarted by the more moderate Senate. That has made moderate senators a target for next year's elections.

Graves is a moderate Republican who supports the state's current abortion law, which places some restrictions on abortion but keeps it legal in most cases. His stance is unpopular with conservatives, among them state party chairman David Miller of Eudora, a former state organizer for the Christian Coalition and political action director of Kansans for Life.

In addition to victories in the Kansas House, abortion opponents — led by Kansans for Life — orchestrated conservative Republican Todd Tiahrt's upset of longtime incumbent Dan Glickman, a Democrat, in the 4th Congressional District race last fall.

Nancy Brown, co-founder of the Johnson County-based MainStream Coalition, said she found the plan "very disturbing."

"They're identifying, from their point of view, who is and who isn't a Christian," said Brown, a moderate Republican and former state legislator who supports abortion rights. "That's what bothers me the most. Their litmus test has shifted, in a way, from whether or not you oppose abortion to whether you're their kind of Christian. And that's appalling to me."

Senators likely to be targets because of votes supporting abortion rights include moderate Republicans from Johnson County: Mark Parkinson from Olathe, Audrey Langworthy from Prairie Village, and Bob Vancrum and Dick Bond, both of Overland Park.

Plan starts with churches

Under the first phase of its plan, Kansans for Life — which has 75 active chapters across the state and thousands on its mailing list — will put together educational materials on abortion, including films and inserts for church bulletins, said Dave Gittrich, the group's executive director.

Next, the group will present the material to churches across the state.

"We're going to put every church we can find into our computer and send them letters and follow up with a phone call," he said. "After we talk to them about what's going on, then we try to get them involved in the political process."

That includes getting every Christian registered to vote and encouraging candidates who oppose abortion to run for office, he said.

He said the group wouldn't exclude any religious affiliation, but added: "We're targeting anybody who is pro-life, and we find that most of them happen to be Christians."

Another part of the plan involves working with Christian radio stations throughout the state to produce daily news programs informing listeners about issues "that they don't hear about in the mainstream media."

Also included in the plan is an effort to "realign" the media.

"We think the media as a whole has as their agenda to keep abortion legal," Gittrich said. "We think the media ought to tell the truth and be held accountable when they lie."

That will involve calling reporters and news organizations when their stories are deemed biased or inaccurate, Gittrich said, and "exposing" the inaccuracies to the public through press releases or Christian radio programs.

Then it starts over

At the end of two years, the group will re-evaluate its program, Gittrich said, then start over, "doing for the general public what we did for churches."

"We're not done until everybody knows what's going on. And when we're done, abortion will be illegal," he said.

Gittrich said skeptics may argue that U.S. Supreme Court rulings will prevent Kansans for Life from achieving its goal. Those rulings prohibit outright bans on abortion, but allow states to pass some restrictions.

"My answer is that if nobody had ever disagreed with the Dred Scott decision, we'd still have slaves now," he said.

Peggy Jarman, head of the Pro-Choice Action League, said the plan shows that Kansans for Life, which in the past has been considered the more moderate of the state's anti-abortion groups, is not moderate at all.

"They have now shown their true colors," Jarman said. "Any group that wants to outlaw all abortions in the state cannot be viewed as anything but extremist."

Biltz, a former leader of the Wichita Rescue Movement, denied that his group was doing anything extreme.

"Don't panic, everybody," he said. "We just want to put our people in office. We're just gonna say you can't kill anybody. What's so extreme about that?"

Graves' press secretary, Mike Matson, said the governor was aware of the plan, but not overly concerned.

"The governor has always believed in the big umbrella concept," Matson said.

ABT2N. (JTHOMAS) A:APZ-08/19/96;11:05 E: -08/19/96;11:05 D: 22.70?

{BC-ABORTION-TARGET-TWOTAKES-KAN}<
{ABORTION FOES' PLAN IS ON TARGET IN KANSAS}<
{(For use by New York Times News Service clients)}<
{By JUDY L. THOMAS}=
{c. 1996 Kansas City Star}=

KANSAS CITY, Mo. -- Primary election results earlier this month in Kansas read like a page ripped from the playbook of the state's largest anti-abortion group.<

With the help of churches and organizations opposed to abortion, Kansans for Life succeeded in nominating and electing abortion opponents to every office from district court judge to the state Board of Education.<

Several legislators who support abortion rights were toppled by staunch abortion foes _ two of those victors were arrested in Operation Rescue's 1991 ''Summer of Mercy'' protests in Wichita.<

All four candidates who won their primaries for the state Board of Education were backed by abortion opponents.<

And many candidates openly backed by Gov. Bill Graves, a moderate Republican, were defeated.<

Kansans for Life officials say their five-year plan to stop abortion in the state _ which they began last summer _ is right on target. And they predict that after the November general election, they will control both houses of the Legislature.<

''We're very pleased at the primary results,'' said Tim Golba, Kansans for Life's political director. ''This was part of our political agenda. So far, things are working out well.<

''We have a great chance of getting a pro-life majority in the Senate next session. And I think we'll even make a few gains in the House.''<

Abortion opponents took control of the 125-member Kansas House in the 1994 elections, toppling a longstanding abortion-rights majority. But they have been several votes short in the 40-member Senate. And that made moderate senators a target in the primary.<

Abortion-rights activists are taking notice.<

''I am very concerned,'' said Peggy Jarman, lobbyist for the ProChoice Action League and spokeswoman for Wichita abortion doctor George Tiller. ''In the Senate, there are 31 races up for grabs, and about 24 have anti-choice people running in them.<

''People forget that states still have the power to restrict abortion. And that's what Kansans for Life knows, and that's why they believe they can be successful with their five-year plan to stop abortion.''<

According to the plan, Kansans for Life would use churches and grass-roots politics to put abortion opponents in control of the state Senate next session and in the governor's office in 1998.<

The ultimate goal: to outlaw abortion in the state by the year 2000.<

The first phase of the plan was to put together educational materials on abortion, including films and inserts for church bulletins.<

Next, the group was to present the material to churches across the state to try to get them involved in the political process. That included getting every Christian registered to vote and encouraging candidates who oppose abortion to run for office.<

Another part of the plan was to use Christian radio throughout the state to inform listeners about issues ''that they don't hear about in the mainstream media.''<

The plan worked. The most visible victories were at the congressional level, where Sam Brownback defeated Sheila Frahm in the GOP primary for the seat vacated by Bob Dole, and Vince Snowbarger defeated Overland Park Mayor Ed Eilert in the race for the 3rd District House seat.<

Both Frahm and Eilert are considered moderates. Brownback and Snowbarger are abortion opponents.<

At the state level, Bob Small, who was arrested in Operation Rescue's Wichita protests, defeated Rep. Belva Ott, a moderate Wichita Republican.<

Sen. Marian Reynolds, a Dodge City Republican, was trounced by Tim Huelskamp, who also was arrested in the Wichita protests. And Sen. Lillian Papay, a Great Bend Republican, lost by fewer than 250 votes to abortion foe Laurie Bleeker.<

Reynolds and Papay were considered moderates.<

Golba said he wasn't concerned about the arrests of some candidates.<

''If you go back and look at the House members who got elected in the past, some of them were arrested, too,'' he said. ''But it didn't seem to be an issue with the people.''<

In Sedgwick County, voters also elected a staunch abortion foe as a district court judge, another action that has upset abortion-rights advocates. Former state Sen. Eric Yost is likely to be assigned what are known as judicial bypass cases. A judicial bypass is a process in which a pregnant teen who feels she cannot notify a parent that she intends to get an abortion can ask for a court order to circumvent the state's notification law.<

Some of the moderate candidates defeated in the primary say they were victims of Kansans for Life's five-year plan.<

MORE...MORE<

{BC-ABORTION-TARGET-2ndTAKE-KAN}<
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{(For use by New York Times News Service clients)}<
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(Kansas City, Mo.: they were victims of Kansans for Life's five-year plan.)<
''I'm just sick,'' Papay said. ''I went from being about 25 points ahead to losing. They had it well planned, and they kept it very quiet.''<
Papay said fliers were passed out at several area churches shortly before the election.<
''Nothing they said about me was true,'' she said. ''One of the fliers said that I had voted for same-sex marriages. I definitely did not.<
''Then they made phone calls the Friday before the election in Barton County and told people that George Tiller was supporting me and that he had given me money. I wouldn't know George Tiller if he walked in the door.''<
Papay said she spent nearly $1,000 on radio ads in her district ''trying to tell people the truth.''<
''They will go to any length. They tell lies about people, they do anything they want to do, and they do it in the name of God,'' she said. ''I just can't believe it's gone this far.''<
Golba defended the use of ''voters' guides'' in the campaigns.<
''They're not endorsements, but issue pieces,'' he said. ''We believe they're accurate, and the concept has been upheld in recent court cases.''<
Leaders of other groups that oppose abortion agreed that the successes in the primary were significant.<
''I would describe it as awesome progress,'' said Jim McDavitt, executive director of the Kansas Education Watch Network.<
Not only could religious conservatives control the Legislature next year, McDavitt said, but they also have an excellent chance of taking over the state Board of Education.<
''But that doesn't mean they're going to roll heads the minute they get in the door,'' he said. ''What the public needs to understand is that conservatives aren't out to destroy public education; they're out to restore what historically has been a wonderful system that is currently wrecked on the rock of liberalism.''<
Talk like that scares Jarman and others.<
''What they really want is prayer in school and vouchers and abstinence-based sex education,'' she said. ''And there's no doubt in my mind that these people would allow parents to go in and demand that creationism be taught.''<
Jarman said the anti-abortion strategy puts moderates at a great disadvantage.<
''Because the anti-choice people organize through their churches, that gave them an enormous base from which to communicate who to vote for,'' she said. ''But the moderate churches just refuse to have their church services infiltrated by politics.''<
Furthermore, Jarman said, moderates lack ''fire and dedication.''<
''Ralph Reed spoke at a Christian Coalition convention a number of years ago and said, 'We do not have to have a majority to win. We need 15 percent,' '' she said. ''You have half of the people right off the bat who aren't registered to vote, so you're left with 50 percent of the people. If half of them don't vote, you have 25 percent, so with 15 percent you have won.<
''That was his point and that's exactly what happened.''<
Some ''pro-choice'' candidates are so worried about their political futures that they are trying to distance themselves from the issue.<
''There are candidates who call themselves pro-choice who have refused to accept contributions from Dr. Tiller,'' Jarman said.<
If abortion foes are as successful in the November election as they

predict, problems could also lie ahead for Graves.<
''The governor has thrown down the gauntlet by doing things to the Legislature that displeased a lot of people,'' McDavitt said, referring in part to Graves' veto last session of a bill that restricted abortions. ''I would say that, yes, there are going to be some seeds growing up this legislative session that he may have to face the fruit of.<
''And if he doesn't recognize the writing on the wall, the wall may fall on him.''<
The governor's press secretary put a different spin on the situation.<
''Yes, some of the people the governor supported got beat,'' said Mike Matson. ''But many won. Keep in mind the governor made appearances and campaigns for Sam Brownback ... and a lot of other folks who would be considered pro-life.''<

Right-to-life group splits with GOP on health care

By BOB SIPCHEN
Los Angeles Times

NASHVILLE, Tenn. — Conservative members of Congress who killed the Clinton health-care plan, terming it dangerous "rationing," may soon get a taste of their own medicine.

And the dose comes from a striking source — the nation's leading anti-abortion group, which in recent years has become one of the Republican Party's most reliable sources of support.

Warning that certain Republican proposals for reforming Medicare could lead to "involuntary euthanasia" of the poor, the old and the mentally disabled, leaders of the National Right to Life Committee urged their members at the organization's convention here this weekend to "sound the Klaxon of alarm" over proposed "managed care" health reforms.

Last year, the National Right to Life Committee used its formidable lobbying and grass-roots organizing apparatus to help GOP leaders defeat the Clinton administration's health reform plan. Now, Right to Life executive director David N. O'Steen has urged activists to unleash the same tactics on Republican legislators who have embraced managed health care as a key way to reduce projected spending on Medicare and Medicaid by an estimated $[illegible] billion between now and 2002.

That call could presage a massive, and until now largely unheralded, collision between the central goal of the new Republican majority in Congress — balancing the budget — and the core beliefs of anti-abortion activists. Reducing the rapid growth of Medicare and Medicaid spending is a crucial element of all proposed plans to balance the budget, and nearly all proposals to reduce those costs rely, to one extent or another, on some form of managed care.

Many of the nation's elderly are at risk of being labeled economically unviable as society turns to various forms of "rationing," she and her colleagues contend.

The potential conflict between right-to-life activists and the Republican leadership may come as a surprise to outsiders, accustomed to labeling abortion opponents as reliably "conservative" political players. But the two groups already have clashed over welfare reform, with anti-abortion activists arguing that proposed limits on payments to mothers could lead poor women to have abortions rather than additional children. Activists interviewed here say that on health care, too, the bottom line for them isn't about a budget.

Many Right to Life Committee members, explains Gerster, "are social conservatives but not fiscal conservatives. We think anyone who needs health care should be able to get it."

Right to Life Committee leaders admit that because of the intricacy of health issues, this new front is a dangerous one for their organization. Rank-and-file members who are passionate about abortion may not easily grasp the effort to fight on the other end of what the group's leaders call the "life spectrum."

O'Steen says the group is standing for principle. The Right to Life Committee's goals can't be defined as liberal or conservative, but only as "life or death," he says — an assertion that defies conventional wisdom and leads quickly into complicated ethical, philosophical and political turf.

The battle, as Right to Life Committee members see it, is on behalf of the helpless — people who would otherwise be crushed as mere obstacles by a society stampeding along in reckless self-indulgence. Their language echoes both social conservatives' rhetoric about the nation's moral decline and the left's traditional defense of "the marginalized."

Balch and other Right to Life leaders believe society is increasingly giving health-care providers and doctors the power to make decisions that should belong to the individual or the individual's family.

Plan's goal: Stop abortion by 2000

ABORTION

ProCh(\ction 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 + S.B. 230

H.B. 2269 will prevent many women from accessing abortion services. It gives 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) require duplicate reporting,
(G) negate anonymity of reporting protocols by adding additional requirements, initiating a stealth attempt at preventing medical abortions,
(H) 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 a 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 additional hardship on teenagers, effectively eliminating their access to the judicial by-pass.

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 effectively mandates and the constitutional requirement of judicial by-pass will be a joke.

A look at ecifics of the bill makes clear its problems. Some are implied, suggestive innuendo. Some problems are ab ess to abortion services. This list is not complete but provides a place to start.

Sec. 1 - definitions

(a) Abortion - Definition has changed. See Attachment #4. This definition could lead to waiting periods for taking birth control pills, getting IUDs. **Page 1, Line 17**

(d) 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 1, Line 30**

(p) Assign personhood to a fetus from moment of fertilization. Sets uneasy precedent. Needs lawyers interpretation.

Page 2, Line 17

(q) Viability - See notes on S.B. 233 **Page 2, Line 19**

Sec. 2 (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 2, Line 26

These consents are already being done. Plus a lot more. In fact, to only consent patients as outlined in this section of the bill would be doing a grave misservice, likely medical malpractice.(See Attachment #3).

(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 3, Line 11**

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 3, Line 30**

Most of what Sections 2 does 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.

Sec.4 State prepared information for distribution and a toll free, 24 hour a day telephone number. At what cost, for what purpose? **Page 4, Line 4**

Sec 7 (a) Sets new precedent in medical malpractice. **Page 5, Line 39**

In conclusion, this legislation is unnecessary, inappropriate, and biased against physicians, women, and teenagers. I urge you to defeat S.B. 230.

A look at [illegible]ecifics of the bill makes clear its problems. Some are implied, suggestive innuendo. Some problems are ab[illegible] [illegible]ess to abortion [illegible]vices. This list is not complete but provides a place to start.

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 ~~#2~~ A **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 this 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 option 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 A).

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**

Availability 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.

Attachment F.

Senate Bill No. 234

Section 1 - no changes in (a), (1), (2)

Change (b) to read as follows:

(1) No person shall perform or induce an Intact Dilatation and Extraction (partial birth) abortion unless the abortion is necessary to preserve the life of the pregnant woman.

(2) As used in this subsection, Intact Dilatation and Extraction (partial birth) abortion means an abortion containing all of the following four elements: (a) deliberate dilatation of the cervix; (b) instrumental conversion of the fetus to a footling breech; (c) breech extraction of the body except the head; and (d) partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

(3) no change except renumbering

Sec. 2 and 3 - no change

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; **and**
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

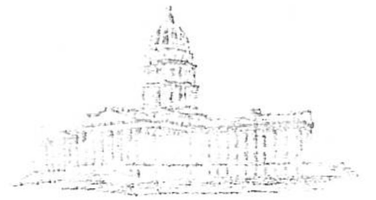
continued. . .

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920 • Washington, DC 20090-6920 Telephone 202 638 5577

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the **only** option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. **The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.**

Approved by the Executive Board
January 12, 1997

State of Kansas
House of Representatives



Susan Wagle
Speaker Pro Tem

Testimony--Woman's Right to Know Act
Senate Federal & State Affairs Committee
March 13, 1997
H.B. 2269

Thank you Chairperson Oleen and members of the Senate Federal and State Affairs 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 in the House 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

Sen. Federal & State Affairs Comm
Date: 3-13-97
Attachment: #22

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. I am sure you have heard and will be hearing from more women who wish the provisions of this act had been in place when they were having to make their decisions whether or not to abort their babies. Most of these women feel their decision to abort was made because they thought 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. We have an opportunity to make sure women in the future have been given the facts they need to help them make an informed choice about abortion. I hope you will support HB 2269.

Thank You!

(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.

22-3

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.

22-4

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.

COMPREHENSIVE
health for women

Testimony in Opposition to SB 230

Senate Federal and State Committee

March 12, 1997

Comprehensive Health for Women, a provider of abortion services in Overland Park, is opposed to SB 230 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 unless 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.

Betty Armstrong
Dir, Community Relations

4401 WEST 109 STREET
OVERLAND PARK, KANSAS 66211
TEL (913) 345-1400
1 800 227-1918

Sen. Federal & State Affairs Comm
Date: 3-13-97
Attachment: #23

Law Office of

WARNER, BIXLER & ASSOCIATES, L.L.C.

3252 SW Plass Ave. Topeka, Kansas 66611
Tele: (913) 266-8820 Fax: (913) 266-0690

To: Kansas Senate Federal and State Affairs Committee

From: Amy C. Bixler, Attorney at Law

Re: Opposition to Senate Bill 230

Date: March 13, 1997

Dear Committee Members

I stand in opposition to Senate Bill 230 which is an alleged "informed consent" bill addressing the issue of abortion.

While my opposition covers many areas in this bill, I chose to address only a few areas for purposes of this written testimony.

Section 1 (a) "Abortion."

This definition includes any drug which has the intent to terminate the pregnancy of a female person (in conjunction with the terms "contraception" and "pregnant" and "unborn child" defined in the bill as well). As birth control pills often serve to prevent implantation of the embryo, this bill would make birth control pills (oral contraceptives) illegal. I must oppose such a measure.

Section 2 (c)

This section defines in the manner and location in which the physician must disclose the "informed consent" information. Unfortunately, it requires that it be done "to the woman individually and in a private room" for privacy and confidentiality. First, this isolates the woman from any of her support group (who by this bill cannot be allowed into the room). The abortion law as it stands adequately provides for this support group. Second, should a discrepancy arise between the physician and the woman as to the information provided, this places the woman's word against the physician as no other witnesses would be present.

Section 2 (g)

This section permits the woman not to pay any amount for the abortion procedure until the 8-hour waiting period has expired. In effect, this provision requires physicians to provide services without compensation. Under the law [as the physician becomes a *de facto* agent of the state, see Section 4 (a)(1) addressed below], this serves as a "taking"; the physician by law would be required to work for free. This is illegal.

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Section 4 (a)(1)

This section requires that the physician act as an agent of the State of Kansas. This section requires that the physician to quote a state-authorized script to the woman undergoing the abortion. It is likely that this provision violates the physician's constitutional rights of free speech as the physician is in reality a private citizen.

Section 4 (a)(5)

This section requires that the physician present to the woman illustrations of the fetus at two-week gestational periods. For a woman who has made the abortion decision, mandating her to view such materials is cruel and unconscionable. This provision is intended only to frighten, coerce, and cause great anxiety to the woman. I must oppose such treatment of her.

Section 6 (b)

This section states that no physician shall be guilty of violating this act if the physician demonstrates (by a preponderance of the evidence) that s/he reasonably believed that the information would have caused severe mental or physical distress to the woman.

The U.S. Constitution, specifically the 4th and 5th amendments, requires that the government bear the burden of proof, never the accused. Demanding that an accused prove his or her innocence is blatantly unconstitutional.

Section 7 (a)

This section permits "when requested" that the court close to the public any proceedings regarding violations of the act in order to preserve the woman's privacy. Again, under our U.S. Constitution, trials must be made public. A court does not have the authority to override the Constitution in such a manner.

For the above reasons, I stand in opposition to Senate Bill 230.

Respectfully submitted,

Amy C. Bixler,
Attorney at Law

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Testimony in Opposition to SB 230

Senate Federal and State Committee

March 12, 1997

My name is Sheila Kostas. I am the Director of Counseling at Comprehensive Health for Women in Overland Park, Kansas. Comprehensive Health for Women is a state-licensed facility and one of the largest providers of abortion services in Kansas.

I am writing to express my opposition to Senate Bill 230. This bill is nothing more than another attempt by anti-choice groups to restrict access to abortion services in Kansas. It is certainly not about a woman's right to know!

Comprehensive Health for Women has always provided very thorough counseling services to those women choosing to have abortions. This counseling involves an explanation of the abortion procedure, complete aftercare instructions, birth control information, informed consent including risks and complications and an assessment of the woman's decision to terminate her pregnancy. Women expressing ambivalence concerning this decision are given appropriate referral information and sent home.

Comprehensive Health for Women is committed to the provision of quality healthcare services for women. The basis of this commitment is education. Education is essential. Women do need and deserve to be educated about reproductive healthcare issues. Especially in regard to abortion care! However, you must understand that it is already happening. Women <u>are</u> receiving the information they need and they <u>are</u> capable of making this very personal decision.

The current Kansas Abortion Law ensures that women receive adequate information and counseling prior to having an abortion. Therefore, the real purpose of Senate Bill 230 must be to place additional and completely unnecessary restrictions on the provision of abortion services in our state. Women will gain nothing by the passage of this bill. They will, however, lose a lot! Please consider the true impact this bill will have on women. Senate Bill 230 would only create more barriers and cause an undue burden for women seeking abortion services in Kansas!

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Senate Federal and State Affairs Committee
Written Testimony re: SB 230 & HB 2269
March 12, 1997

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Honorable Chair and Distinguished Members of this Committee:

As physicians, we are concerned about the impact bills such as SB 203 and/or HB 2269 will have on the practice of medicine as well as the accessibility of services to women. The result of these bills will be to place burdens on physicians as well as patients. We encourage you to consider the following points during debate of these bills.

In accordance with the law, physicians currently provide detailed appropriate information to patients. There is no need to dictate the format of that information or how and when it is delivered. Requirements such as these are proposed in these bills and will directly affect policies and procedures of day-to-day operations in doctors' offices where abortions are performed. No other specialty area of medicine is forced to tolerate this type of government intrusion on office management.

At no other place in Kansas law do statutes spell out exactly what is required for informed consent for specific surgical procedures. This bill interferes with doctors' judgment regarding what is necessary for informed consent.

These bills hold doctors responsible for information that is outside their area of training, experience, and expertise. The information which will be required regarding social service agencies, monetary compensation, etc. are all better offered during decision counseling, not during the informed consent process. Physicians are medical experts, not social workers.

We will appreciate your consideration of these points while debating these bills. Thank you.

Iris A. Brossard, M.D.

Burtram J. Odenheimer, M.D.

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Date: 3-13-97
Attachment: #26

Supplemental Testimony

Submitted By: Jana L. E. Gryder
Kansas National Organization for Women
Date: March 13, 1997

As I was listening to yesterday's proponents, I became aware of some testimony that I wanted to provide clarification on.

Some proponents have testified about "abortionists" trying to make a sale. These qualified physicians could have chosen any field to practice in. They have chosen to serve woman in the most terrorized, legislated, and dangerous field of medicine. There practice is constantly being threatened with restrictive statutes and new forms of civil liability. They are picketed, harassed, and shot. The doctors and their families live their lives in constant harassment and danger. Why would someone choose this kind of life? Because of their dedication to women's reproductive freedom. Some people would have you believe it is all for the pursuit of money. There are many other forms of medicine that these physicians could have chosen that would have brought them more money and a much safer and peaceful existence.

The proponents also testified to the fact that doctors are "pulling women off the streets for abortions." These physicians are accused of not fully informing these women about the procedure. So the legislature is going to mandate this information - beyond what is truly needed by the woman. 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 possibility of a medical malpractice suit already is a deterrent to doctors from intentional or negligent acts

To use the terms of the proponents - there are millions of women who are pulled off the street and given breast implants. This is a high dollar business that has nothing to do with the health or well-being of the woman. Children have been harmed and thousands of women have been killed, maimed and deformed by this procedure. We have seen these consequences in real, multi-million dollar lawsuits. Why do they not have informed consent and restrictive laws placed upon these truly, harmful consequences?

I sympathize with the proponents that testified as to their abortion experiences, but these were performed long ago. Do we have anyone that is saying this is true today - here in Kansas?

If you want to provide truly good information to women seeking abortions, then let the people who really care about reproductive rights of women decide what should be

"informed consent". The people who are in support of these bills are trying to outlaw abortions all together. Their intent is to stop abortions, not to inform and protect women. Pro-choice people have no hidden agenda. We are not trying to sell abortion. In fact, we would like to have better education and access to contraception to prevent the need for abortions. Pro-Choice is about protecting each woman's right to choose her own options in reference to her life.

These bills are religion based. There is a vast range of religious beliefs among Kansans and no way to consolidate them all. Reproductive choices are not to be decided by law courts, legislator's or one particular religious group. These decisions do not effect you. They effect each individual person, and they can, through their own religious faith, make decisions concerning their lives.

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KANSAS SENATE FEDERAL AND STATE AFFAIRS COMMITTEE
SENATOR LANA OLEEN, CHAIR

March 12-13, 1997

Madam Chair and Members of the Committee:

Two years ago, the Kansan's for Life organizaiton very publicly stated that their intended goal was to outlaw all abortions in the state by the year 2000. All of the bills you will hear over these next two days are steps toward that goal. Attached, please find testimony from our organization about these bills which is based on our experience as a reproductive health care provider for 62 years.

HB 2269 and SB 230 are remarkably similar to the bill that Governor Graves vetoed last year. It is the height of audacity to submit the same bill again with only minor changes. This is obviously a political game as the sponsors know that the governor is running for re-election next year. They are daring him to veto it again.

These bills are not about information, they are about access to abortion. The attached testimony regarding these bills illustrates this point. The current law works. We don't need more laws on the books to tie up the time and energy of women and doctors. The efforts of the bills' sponsors would be better spent in making affordable birth control and comprehensive sexuality education more readily available so that unintended pregnancies and the abortion rate would be reduced.

SB 233 and SB 234 constitute unprecedented interference into the best judgment of physicians by those who have no medical training. It is a terrifying thought that any doctor that I might come into contact with might be restricted by the government from giving me the most accurat information and best medical care to maintain my health and well-being. This is true whether it is my HMO or the state which gags or restrains my doctor regarding the details of medical practice.

Please vote against all of these bills before you today. The women of Kansas need and deserve access to good medical care, not the moral judgment of those who do not know them or their situations.

Respectfully,

Ellen W. Brown

Ellen W. Brown
Public Affairs Coordinator

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Senate Federal & State Affairs Committee
March 12-13, 1997

Testimony in opposition to
SB 234

Last year, Congress attempted to ban a particular abortion procedure medically known as Intact Dilation & Extraction (ID&X). The sponsors of this bill created a term designed to be as inflammatory as possible: partial birth abortion. Since this fictitious term has come into the national consciousness, there has been tremendous debate marked by a great deal of confusion and emotionalism. Now, you have before you a bill very similar to the one introduced in Congress last year and again this year.

One of the misperceptions people have regarding SB 234 is that it would only outlaw post-viability abortions. This is untrue. The bill has a section regarding abortions done at this point in pregnancy, but it does not limit the ban to post-viable fetuses. This bill would outlaw some abortions done in the second trimester before the point of viability. Abortions done during this time are constitutionally protected and the state does not have the authority to legally ban them.

Abortions involving viable fetuses are already illegal in the state of Kansas unless performed in cases involving a fetus with severe deformities or abnormalities or a woman whose life is at risk, and are done in the most tragic of circumstances. This bill does not contain an exception for the health of the woman--an omission which is unconstitutional under the *Roe* and *Casey* decisions of the Supreme Court. The perception that women are getting third-trimester abortions because they feel fat or just don't want to be pregnant is not only wrong, but extremely offensive--both to the women who need these abortions under devastating circumstances and the doctors who perform them.

Another misunderstanding about SB 234 is that it outlaws a very specific procedure. This is also untrue. This bill defines the procedure to be banned as "an abortion in which the physician performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery." This definition could encompass a variety of different abortion methods. If, during the abortion, any part of the fetus comes into the birth-canal, a doctor would be guilty of performing a "partial-birth" abortion. This dramatically limits the options available to a doctor and the woman involved in this operation during the second trimester.

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It is terrifying that those with no medical training or knowledge think find it acceptable to limit the ability of doctors to choose any procedure that would save my life or maintain my health. We trust doctors to make the best medical decisions for our individual situations and that they will be able to give us the most accurate information available. We trust women to make the best decisions for themselves and for their families. There has been a lot of media attention recently on the practice of HMO's who restrict the ability of doctors to tell their patients what medical treatment is available to them or to provide that treatment. <u>If it is wrong for HMO's to restrict doctors in their employ in this way, how is it right for the state to do the same thing</u>?

Please vote against attempts to ban any medical procedure. Government restriction of the medical judgment of doctors and intrusion into the lives of women is unacceptable.

Respectfully submitted,
Patricia C. Brous

Patricia C. Brous
President

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Senate Federal & State Affairs Committee
March 12-13, 1997

Testimony in opposition to
HB 2269 & SB 230

Last year Governor Graves vetoed a bill that would require women seeking abortions to make two trips to a clinic and receive a state approved lecture by the doctor before she would be able to have the surgery. Kansans for Life has also made no secret of the fact that they are working hard to outlaw all abortions by the year 2000. So, it should be no surprise that those who oppose abortion in the state legislature have resurrected the bill that Governor Graves vetoed last year-- in the form of **HB 2269 and SB 230**, disguising their efforts by claiming that they want "women to have information before they have abortions".

What's wrong with this picture? These new bills have nothing to do with women receiving appropriate information, but everything to do with making it harder for women to obtain early, safe, and legal abortions. The same groups who support these bills support legislation designed to reduce access not only to abortion services, but also sexuality education and affordable contraceptives--things that would reduce the need for abortion and have wide support among the state's citizens.

This bill requires a woman to be physically present in the clinic eight hours prior to the abortion, where the doctor who is to perform the abortion gives her information about the abortion, its risks, and alternatives **and** information on social service agencies and benefits she may be eligible for if she chooses not to terminate her pregnancy. This not only forces women from the far reaches of Western Kansas to unnecessarily schedule and pay for two days off from work, child care, hotel, transportation, etc. But it also forces doctors to become social workers--something for which they are not trained and keeps physicians from the highly-skilled work for which they are trained. This provision would cause havoc in the day to day operations of the clinic and dramatically drive up the costs of an abortion for the woman involved.

The bill additionally requires that the state set up a 24-hour-a-day toll-free hotline to refer women for services (not abortions). Between this hotline and the vast amount of materials that must be printed, the state will be expending money that could be better spent on actual services to help

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women and their children. Additionally, promising services to women in this time of massive welfare cutbacks would be a cruel hoax with lifelong consequences for women and their children.

The state of Kansas currently has a law that requires that women who seek abortions be given, in writing, much of the information that is required by this bill-- and most clinics give them much more depending on their circumstances or desires. Already, a woman must wait eight hours after receiving the information to have an abortion. She can receive the information through the mail or from her referring doctor (if she has one). There have been **no** reports that this current regulation has been violated. There is no reason why women must be required to make unnecessary trips to the clinic--particularly when they live far away. And there is no reason to divert doctors from their true purpose of treating patients and performing surgery by turning them into social workers and dictating the information they must provide to their patients.

I urge you to vote no for HB 2269 and SB 230. Similar state laws have been enjoined by federal courts. This level of government intrusion into the lives of women and into the medical judgment of doctors is bad public policy which is opposed by the majority of Kansans and violates the US Constitution.

Respectfully submitted,

Patricia C. Brous

Patricia C. Brous
President

Testimony
of
The Rev. Lynn NewHeart
Planned Parenthood of Mid-Missouri and Eastern Kansas
March 12, 1997
for the
Senate Federal & State Affairs Committee
of the Kansas Legislature
in opposition to
House Bill No. 2269 and SB 230

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 new section 2. 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 "complete and accurate 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 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 public assistance and food stamps 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, as these two bills do, 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 and SB 230 have within them 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 or SB 230.

Contact: Carla Mahany ACLU

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 and SB 230 - March 13, 1997
Senate Federal and State Affairs Committee, Senator Lana Oleen, Chair

Members of the Committee: The bills before you are 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 and SB 230 represent 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, scarcely different from an outright 18-hour or 24-hour requirement). Other provisions is the bills are equally onerous.

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 or SB 230 were passed into law:

> 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 <u>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</u>. That effect means that for a large fraction of women seeking abortions, the law is likely to operate as a <u>substantial obstacle</u> 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 <u>necessarily</u> unconstitutional, this provision <u>can be found by a court to be unconstitutional</u> 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 or SB 230 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. These bills are another attempt by extremists to prevent as much access to abortion services as possible. Please oppose this blatant attempt to restrict women's constitutionally protected right to full reproductive choice.

Sen. Federal & State Affairs Comm
Date: 3-13-97
Attachment: # 32

NEWS RELEASE

ACLU OF KANSAS AND WESTERN MISSOURI

1010 W. 39th Street, Suite 103, Kansas City, Missouri 64111

For Immediate Release
March 12, 1997

Contact:
Carla Mahany, Associate Director
(816) 756-3113 (Kansas City)

KANSAS ABORTION BILLS INTENDED TO DENY ACCESS

Topeka, Kansas -- The Kansas Senate Committee on Federal and State Affairs began hearings today on four bills **intended to very seriously restrict women's access to abortion services** in this state. The hearings continue through March 13. One of the bills, SB 233, was tabled today.

"The much-touted plan by 'Kansans for Life' to outlaw all abortions in this state by the year 2000 would be greatly furthered if these bills were to pass into law," stated Susan Perry, chair of the ACLU's Kansas City Metro Chapter legislative committee. "These bills are not about information, they're not about protecting women, and they're not about protecting healthy fetuses aborted in the eighth month of pregnancy. They're about denying as much access to abortion services as possible, about intimidating the doctors who perform abortions, and about distorting the facts about the procedures and the women who seek them."

THE BILLS:

SB 230 and HB 2269 are nearly identical to the so-called "Women's Right to Know Act" which was passed by the legislature last year and vetoed by Governor Graves.

They are not about giving women information -- they are about denying as much access to abortion services as possible.

Changing the waiting period from 24 hours to 8 hours does NOT make these bills better.

"Informed consent" is already part of the current Kansas abortion law. By requiring the doctors who perform abortions to personally give state-mandated information to women eight hours before their procedure, the women will have to visit clinics twice. In rural states the size of Kansas, with very few abortion providers, this two-visit requirement is very likely to meet the "undue burden" test for **unconstitutional abortion regulations**. Such barriers are unthinkable for other medical procedures.

SB 234 and HB 2336 broadly define and ban "Intact Dilation and Extraction" (the so-called "partial birth) procedures. There are no exceptions for circumstances in which the **health** of the woman would be seriously affected if the procedure is not performed. Much more broad than Congressional models, they are written so that common second-trimester procedures, as well as late-term, would be outlawed. This is the intention of the sponsors -- to ban as many abortion procedures as possible. The Supreme Court has held that states may impose limits on late term procedures only if exceptions both for women's lives and women's health are included. Similar bills in other states are being challenged successfully on this basis.

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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 2336 and SB 234 - March 13, 1997
Senate Federal and State Affairs Committee, Senator Lana Oleen, Chair

These bills called "partial-birth abortion" bans (a vague term unrecognized by the medical profession) are unconstitutional. The government may not enact an abortion regulation that compromises a woman's health by forcing her from a safer procedure to a riskier one. Even if these bills were precisely crafted to reach only their apparent target, the intact dilation and extraction procedure, it would do just that – they could deprive a woman seeking an abortion of the safest and most appropriate abortion method which provides the best chance for preserving her health and life in her particular circumstances.

Physicians consider many factors in selecting an abortion method that, in their medical judgment, is safest for a particular woman. These factors may include the woman's medical condition; fetal size, location, and medical status; the length of gestation; and the physician's skills and experience with different abortion methods. The Supreme Court has emphasized that physicians must have discretion to determine the best course of treatment for a woman seeking an abortion:

> 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 . . . "[T]he abortion decision in all its aspects is inherently, and primarily, a medical decision." (Colautti, 439 U.S. at 387 (emphasis added)

An Ohio federal court that recently considered a constitutional challenge to a state ban on D&X procedures -- and issued an injunction against the ban's enforcement -- found that D&X "appears to have the potential of being a safer procedure than all other available abortion procedures" after the 19th week of pregnancy. That court compared the D&X procedure to induction, hysterotomy (a cesarean section performed before term), and hysterectomy.

The Ohio court also found that use of D&X in the late second trimester "appears to pose less of a risk to maternal health" than D&E "because it is less invasive -- that is, it does not require sharp instruments to be inserted into the uterus with the same frequency or extent -- and does not pose the same degree of risk of uterine and cervical lacerations."

Not only would HB 2336 and SB 234 channel some women to riskier procedures, it would also limit a physician's discretion to adapt the abortion procedure to preserve a woman's health once the operation has begun. The Ohio court commented that physicians who use the D&X procedure "may not know which procedure they will perform until they encounter particular surgical variables and circumstances after they begin the procedure to terminate the pregnancy." For example, a physician may resort to the D&X procedure if the fetus is in a breech position but may otherwise use a standard D&E.

Government regulation that relegates a woman to riskier abortion procedures contravenes the United States Supreme Court's decision in Planned Parenthood v. Danforth. That case considered a ban on the saline amniocentesis abortion method after the first 12

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weeks of pregnancy. The Court struck down the ban because it "forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." Further, under the United States Supreme Court decision in Thornburgh v. American College of Obstetricians & Gynecologists, state abortion laws may not 'require the mother to bear an increased medical risk' to serve a state interest in fetal welfare."

These bills would not permit use of the banned procedures for abortion of a non-viable fetus for any purpose except to save the woman's life. In so narrowly restricting the circumstances in which the banned procedures remain permissible, they fall far short of constitutional principles. It is no answer that other procedures may remain available. A woman and her doctor must remain free to choose the method safest for her.

When a fetus is viable, the government may regulate and even ban abortion -- except when the procedure is necessary to preserve the life or the health of the woman. Here again, the bills unconstitutionally restrict the purpose for which a woman may choose to terminate her pregnancy. Because it omits a health exception, the bill could force a woman whose health is seriously threatened by her pregnancy either to undergo a more dangerous operation when she is already ill or to wait until she is dying to have recourse to the otherwise banned procedures. The government may not reduce her to such dangerous options.

Please oppose the passage of HB 2336 and SB 234.

Contact: Carla Mahany
(816) 756-3113, ext. 305

Mary Beth Blake
570 LAKESHORE WEST • KANSAS CITY, KANSAS 66106

March 13, 1997

Lana Oleen
Chair
Senate Federal and State Affairs Committee
Kansas State Capitol

Dear Senator Oleen,

I have been asked to give my personal view with respect to HB 2269's proposed "informed consent" requirement for abortions. The following is my personal observation on this piece of legislation based on nineteen years of law practice in Kansas which has focused on many aspects of health care law.

In my opinion, this bill is unnecessary, will inevitably be dated and inaccurate (if it is not already) and invades the confidential relationship of physician and patient. The bill is unnecessary because physicians are already required by common law to obtain informed consent from all patients before performing an invasive procedure. As a matter of fact the informed consent that is required by law must describe both the risks and of the procedure. The proposed "Miranda Warnings for Abortion" do not address the benefits of the procedure. The legislature must keep in mind that the practice of medicine is dynamic and it does not serve the public to have medical inaccuracies reduced to statutory requirements with draconian penalties. Physicians will be caught between practicing appropriate medicine with complete and accurate informed consent procedures and giving inaccurate and incomplete warnings as prerequisite to performing an abortion procedure.

The physician-patient relationship is essentially confidential. This statute proposes a "required statement" from a physician to his/her patient. The physician is a professional with an obligation to each patient to evaluate the individual case, identify the realistic options for each patient and discuss the risks and benefits of those options in language that the patient will understand. It is an invasion of this relationship for the state to require a verbatim statement from the physician prior to all abortions. The statement does not meet any standard of professionalism because it is not tailored to individual circumstances.

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Moreover, the law requires the patient to breach her confidential relationship with her physician by signing a document stating that the notice as required by the statute has been delivered. This requirement flies in the face of well established common and statutory law that protects the confidentiality of physician-patient communication.

Sincerely yours,

Mary Beth Blake

Mary Beth Blake

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