Approved: April 10, 2002
Date

MINUTES OF THE HOUSE FEDERAL & STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairperson Doug Mays at 1:35 p.m. on February 19, 2002 in Room 313-S of the Capitol.

All members were present except: Representative Judy Morrison, Excused

Committee staff present: Mary Torrence, Revisor of Statutes
Russell Mills, Legislative Research Department
Shelia Pearman, Committee Secretary

Conferees appearing before the committee:
Sandy Barnett, KS Coalition Against Sexual/Domestic Violence
Rev. Carolyn Brown, First Unitarian Universalist Church of Wichita
Mary Harren, Catholics Free Choice
Daniel Jung, Medical Student
K.C. Keating, Medical Student
Carla Mahaney, Planned Parenthood of Kansas & Mid-Missouri
Mark Pederson, Central Family Medicine
Sylvie Rueff, Kansas N.O.W.
Emily Taylor, member of State Board of Healing Arts
Robert Williams, Kansas Pharmacists Association

Others attending: See attached list

Without objection, bill was introduced by John Peterson requesting "Just Compensation - Hauler Displacement" for solid waste companies. [HB 3002]

Without objection, bill was introduced as requested by Paul Davis representing the Kansas Bar Association making numerous revisions to Kansas Corporation Code. [HB 3022]

Chairman Mays opened the hearing on **HB 2711 - Health care providers' rights of conscience act.**
Mr. Williams stated the Kansas Pharmacists Association adopted a Conscientious Objection resolution at last fall's convention following a survey of members, thus the opposition to the proposed legislation is to encourage the establishment of systems protecting the patient's right to obtain legally prescribed products/services. (Attachment #1) KPhA supports the right of the pharmacist to not participate in providing specific products/services, however advocates a patient's right to obtain legally prescribed services. Of specific interest in accessibility in rural settings because often a retail pharmacist will also serve as the hospital pharmacist.

Ms. Mahany rose in opposition of **HB 2711** because of its vagueness. She referenced testimony submitted by Sean Tipton of the American Society for Reproductive Medicine (Attachment #2) and Dr. Travis Stembridge, Chairman of the Kansas Section American College of Obstetricians & Gynecologists. (Attachment #3) She cited the proposed legislation's inadequacy of addressing of the emergency occurrences. Additionally **HB 2711** elevates 'moral beliefs' to the status of race, sex. religion, disability, etc. under the anti-discrimination laws of Kansas with no legal precedence for protecting everyone's unique moral framework. Following a brief review of the proposed amendment, she stated it remains insufficient as it is more limited than EMTALA. She stated the denial of health care services because of a vague 'moral' belief should never become a civil right. (Attachment #4)

Mr. Jung discussed his concern of the future education of medical students if professors elect not to teach specific information because they personally had a moral objection to specific products/services. Due to the potential for inadequate training, he opposed **HB 2711**. (Attachment #5)

Ms. Keating rose in opposition of **HB 2711** noting adequate access to education as a concern. She also stated it serves to restrict the rights of those who agree with and/or have personal convictions that exclusion of information about, referrals for, and availability of the services outlined in the bill is immoral. She discussed the credibility and licensure problems for Kansas-educated providers will emerge in states other than Kansas with progressive policies about patient rights and education. (Attachment #6)

Ms. Taylor voiced opposition to **HB 2711** stating this legislation defines participation to include counseling, advising, referring and admitting which could deny patients the right to receive any legal procedures they need or desire. She also voiced concerned about advance directives regarding end-of-life care. (Attachment #7)

Ms. Duke stated her opposition to **HB 2711** because it imposes personal beliefs on the practice of medicine by allowing hospitals and individuals to opt out of certain medical procedures they do not approve of in addition to protecting institution and individuals from liability if a patient is harmed by the refusal to provide these services. (Attachment #8)

Ms. Reuff stated her opposition of **HB 2711** would create of medical science, and its supporting public and private organizations and environment where the abilities of the many to support optimal health for the public will be limited by the few whose personal moral beliefs are inconsistent with the ethics and goals generally regarded and legally practiced in the medical community today. (Attachment #9)

Mr. Pederson voiced opposition to **HB 2711** due to employment contracts and malpractice issues (detailed in Attachment #10). He also questioned the ability of an organization to have a conscience recognized by this proposed legislation.

Ms. Brown stated opposition to **HB 2711** as a transparent attempt to manipulate the health care system and the right of conscience for the political agenda of opposing such issues of abortion, birth control, certain kinds of medical research and end-of-life decisions. Good conscience would put the needs of patients first and seek to promote political agenda in a direct way. (Attachment #11)

Ms. Wahto provided family examples of medical treatment potentially negatively affected if **HB 2711** becomes law. She requested the committee refrain from practicing bad medicine and to work on making law that protect the health care access of all Kansans. (Attachment #12)

Ms. Harren stated various legal procedures and products prohibited by the United States Catholic bishops' *Ethical and Religious Directives for Health Care Services* although numerous Catholic couples continue to utilize those options. She urged the committee to consider this "Denial of Care" bill and impose upon the health care providers the obligation of tending to their own conscience. (Attachment #13)

Ms. Barnett stated opposition to **HB 2711** in order to prevent patients perception of the health care system as an unsafe and unsupportive arena for victims due to withholding of information. She provided statistics regarding primary health care, emergency room care and other services that abuse victims rely on in a time of great need. (Attachment #14)

The committee recessed at 3:12 p.m. with testimony for **HB 2711** to continue on February 20, 2002.

HOUSE FEDERAL & STATE AFFAIRS COMMITTEE GUEST LIST

DATE 2/19/2002

NAME	REPRESENTING
Mark Pederson	S. Zarembski, MD Central Family Medicine,
Sylvie J. Rueff	NOW - KANSAS
Darlene Gerr Stearns	League of Women Voters
Barbara Duke	Ks Choice Alliance
Horace Rowe	League of Women Voters
Edward Rowe	" " " "
Rev. Carolyn R. Brown	KS Religious Leaders for Choice
Mary McDonough Sarver	Catholics for Contraception
Diane Wahto	Wichita Choice Alliance
Sandy Barnett	KCSDV
Bill Sneed	UKNA
Mike Farmer	KCC
Bonnie Ann Power	KAHP
Carlos Alberto	Intern w/ Ray Cox
Kathleen C. Keating	
Jim Allen	AKH
BARB Conant	KTRA
David Hanson	Ks Insur Assns
Mary Ellen Conlee	Providence Medical Center
Jason Moon	KU Pharmacy Student (KPLA)
Jackie Feldman	KSNA

Kansas Pharmacists Association
Kansas Society of Health-System Pharmacists
Kansas Employee Pharmacists Council
1020 SW Fairlawn Rd.
Topeka KS 66604
Phone 785-228-2327 ✦ Fax 785-228-9147 ✦ www.kansaspharmacy.org
Robert (Bob) R. Williams, MS, CAE, Executive Director

TESTIMONY

House Federal and State Affairs Committee
Tuesday, February 19, 2002

HB 2711

My name is Bob Williams, Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee on HB 2711.

During the Kansas Pharmacists Association Annual Meeting last September a resolution was passed regarding conscience objection. Attached to my testimony is a copy of that resolution. As the resolution indicates, KPhA recognizes the right of health care providers to object to morally, religiously, or ethically troubling therapies. However, KPhA also recognizes the patient's rights to obtain legally prescribed and medically indicated treatments. For that reason, the attached resolution includes language which "supports the establishment of systems" that protect the patient's right to obtain those services.

While HB 2711 does a fine job of protecting the health care providers right to object, it does little to protect the patient's legal right obtain services. For that reason, KPhA cannot support HB 2711. The adoption of the attached resolution was the result of much debate. However, in the balance between health care provider's rights and patient's rights to obtain legally prescribed services, the patient's rights must outweigh those of the health care providers. All individuals who enter the health care field do so knowing there may come a time when they may be called upon to participate in procedures or services they object to. It is therefore important for those health care providers to be protected from repercussions for their refusal to

House Fed. & State Affairs
Date 2/19/02
Attachment No. 1
Page 1 of 3

participate in services they object to. Equally important is the protection of the patient's r
KPhA believes the attached resolution allows equal protection for the health care provider and patient. We therefore recommend similar language be included in HB 2711.

Due to a shortage of pharmacists, many pharmacies are understaffed in Kansas. In many cases there is only one pharmacist on staff at a time. Additionally, many retail pharmacists also serve as hospital pharmacists in rural Kansas. With no provision in HB 2711 to protect or even accommodate the patient's right to legal services, an undue hardship will be placed on patients in their attempt to obtain legally prescribed services.

Another issue is found in Section 4 (d) of the bill. The first sentence of that subsection purports to preserve the legal requirements for a health care provider to inform a patient of the patient's condition, prognosis and risks of a "health care service subject to this act." Yet, the next sentence states that the health care provider is under no duty to participate in the provision of a "health care service subject to this act." For a pharmacist, these two sentences present a conflict. There is no statutory duty, much less an opportunity, for a pharmacist to consult with a patient regarding risks of a prescription medication, except in connection with the dispensing of the prescription. The dispensing of the prescription medication, within the context of HB 2711 would be the "health care service subject to this act." Therefore, if the pharmacist has no duty under the second sentence of this subsection to participate in the "health care service subject to this act," (has no duty to dispense the medication) the first sentence is moot at best and does little to accommodate the patient.

In conclusion, we would be remiss if we only viewed HB2711 in the context of what is available today. Passage of HB 2711 will not only effect products and services currently available, but all <u>future</u> products and services as well. It is therefore incumbent upon us to make sure HB 2711 is crafted in such a way as to not deny the availability of future products and services. Thank you.

Kansas Pharmacists Association
Professional Policy #01-01

Conscientious Objection

Adopted: 9/22/01

By: Board of Trustees

KPhA recognizes a pharmacist's right to conscientious objection to morally, religiously, or ethically troubling therapies and supports the establishment of systems that protect the patient's right to obtain legally prescribed and medically indicated treatments while accommodating the pharmacist's right of conscientious objection.

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Formerly The American Fertility Society

February 18, 2002

The Honorable Doug Mays
Chair, House Federal and State Affairs Committee
Room 170-W
State Capitol
Topeka KS 66612

Dear Representative Mays:

On behalf of the American Society for Reproductive Medicine (ASRM) the leading professional association for physicians, scientists and other professionals involved in reproductive medicine – including infertility care, we are writing to express our very serious concerns with HB 2711.

We agree with section 2 of the bill that "people and organizations hold different beliefs about whether certain health care services are morally acceptable." In most cases, we support the right of individual health care providers not to provide services they find objectionable. Physicians do however have an ethical obligation to assist their patients in finding a physician who can provide the service.

The non-discrimination provisions found in section 4c of the bill are particularly troublesome. We are well aware there are some religious groups who oppose any use of medical therapies such as insemination, contraception or in vitro fertilization; just as there are religious groups who oppose therapies such as blood transfusion. Individuals should not be forced to use such services, or perform them.

However, those persons or entities should not be allowed to deny others access to those same medical therapies. A medical facility that provides such services should be able to make participation in those services a condition of employment. There should be no legal right to seek employment at a facility whose actions one has a moral objection to in order to stop that facility from engaging in those actions. Rather than simply protecting the rights of individuals not to participate in activities they may find objectionable, HB 2711 would allow individuals or entities to deny access to care to others.

HB 2711, rather than protecting the rights of individuals to live up his or her own moral code, allows any individual to impose his or own moral code on all of us. This outcome is simply not in keeping with the pluralistic tradition of the United States.

Sincerely,

Sean Tipton
Director of Public Affairs

OFFICE OF GOVERNMENT AND MEDIA RELATIONS • 409 12TH STREET SW, SUITE 203 • WASHINGTON, DC 20024
TEL 202/863-4985 • FAX 202/484-4039 • URL www.asrm.org

House Fed. &
State Affairs
Date 2/19/02
Attachment No. 2
Page 1 of 1

District VII
Kansas Section
Office of the Chairman

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February 19, 2002

The Honorable Doug Mays
Chair, House Federal and State Affairs Committee
Room 170-W
State Capitol
Topeka, KS 66612

Dear Mr. Mays:

I am writing you today as Chairman of the Kansas Section of the American College of Obstetricians and Gynecologists and as a health care provider in Kansas. We wish to voice our strong opposition to the enactment of HB 2711 the "Health Care Providers' Rights of Conscious Act."

We have many concerns about the broad implications of this bill; however, I will highlight a few of the most concerning.

Many of this state's rural health care services are provided by small private offices and small hospitals and pharmacies. They are often staffed on an "as needed" basis with additional help called in as the situation arises. This would mean only one nurse or lab technician would be available under many circumstances. Under this legislation, an employee of the emergency room or labor-delivery unit has the "right" not to participate in the legal health care services subject to this act, such as refusing to give an emergency transfusion to a hemorrhaging pregnant mother. This would place her and her baby at increased risk of death. To avoid this situation, a hospital would be forced to "overstaff" with extra employees (if any are available in this time of national nursing shortage), thus further raising health care costs and placing an additional burden on our rural health system.

Contraception availability and services is another concern of our membership. At a time when there is a nationwide push for including contraception coverage options in health insurance plans, this would allow a sharp move in the opposite, and I feel wrong, direction. Section 6 of this bill states "a health care payer has the right to decline to pay for any health care service subject to the act." Are we really ready to allow insurance companies to decline payment for a medically indicated hysterectomy just because it meets the definition of sterilization?

In conclusion, if enacted this bill would deny Kansans access to many legal health care services and pharmaceuticals and increase health care costs for the citizens of Kansas. I am asking you to please vote no on HB 2711.

Respectfully Yours,

Travis W. Stembridge, M. D.

TWS/daf

House Fed. & State Affairs
Date 2/19/02
Attachment No. 3
Page 1 of 1

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INDEPENDENCE CENTER
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Planned Parenthood®
of Kansas and Mid-Missouri

TESTIMONY
in Opposition to House Bill 2711

by Carla Mahany, Kansas Public Affairs Director
Planned Parenthood of Kansas and Mid-Missouri
913.312.5100, Ext. 227

House Committee on Federal and State Affairs

Representative Doug Mays, Chair

Tuesday, February 19, 2002

Planned Parenthood of Kansas and Mid-Missouri opposes House Bill 2711, as we opposed last year's HB 2491, because of its breadth and vagueness, and because in its eagerness to protect the ability of health care providers to opt out of providing services they find objectionable, it allows for the wholesale denial of care for patients.

Here are some of the things it does, and things it allows. It defines "health care providers" to include all employees of a hospital, adult care home, pharmacy, medical or nursing school, teachers, students, counselors, researchers and any others -- from directors to janitors -- to walk away from any health care service that they construe to relate, however vaguely, to one of the targeted procedures in this act. They don't even have to be right. Even if common sense says the bill doesn't really mean that a custodial worker could decide not to clean a patient's room if the patient has given birth to child who may have been conceived through artificial insemination, what in this bill refutes their ability to do just that?

Nothing in this bill says they have to explain their refusal to participate to their employer, even though there is an extremely weak "notice" to employers specified in Section 7.

In Section 7, it says that an employee should give their employer a written 48 hour notice that they're going to opt out of something. They don't have to say why, and don't have to explain how it fits the criteria of the services specified in the bill. Any reason they invent would have to be accepted, unless they are naïve enough to admit that they don't want to treat a patient because of their race, for example. And it doesn't even say that the notice to the employer really has to be 48 hours.

Written notice to an employer 48 hours from refusing participation is always deemed "reasonable" under this bill. But any other form or timing of notice may be deemed "reasonable" as well. The bill says, "In all other cases (i.e. where a written notice isn't given 48 hours in advance), the reasonableness of notice by a health care provider shall be determined by considering all the circumstances." It doesn't say the circumstances have to make sense, just that they need to be "considered." Would this language allow a phone call to an answering machine two minutes before opting out sufficient notice to an employer?

The emergency exception is likewise flawed. Although it looks like a step in the right direction to invoke EMTALA, the federal "emergency medical treatment and active labor act" also known as the "Anti-Dumping Act," I suppose we must say it's better than nothing, although it does not satisfy the need for a genuine life and health exception to the bill.

For one thing, it applies only to "health care institutions." One result is that "health care payers" do not have to pay for reproductive health services even in an emergency.

The reason EMTALA is inadequate protection for patients is because the definition of an "emergency medical condition" that triggers it is very narrow, and because, even when presented with an "emergency medical condition," the hospital doesn't have to treat the patient, it only needs to stabilize.

Under EMTALA, the health care provider does not have to refer the woman to another provider, nor alert someone else in the institution about the situation. Thus, if a pregnant woman arrives at a hospital and, for some medical reason, say for a life-threatening tubal pregnancy, the pregnancy needs to be terminated, an attending ER physician only has to tell her that she could be seriously hurt if the pregnancy continues, and tell her the risks of abortion, but need not alert another doctor in the hospital to take care of her, nor tell her where else she could go for care.

Elsewhere in this bill, in Section 4(d), "health care providers" only have to comply with the standard of care by informing the patient of their condition, prognosis and the risks of the services they won't provide, presumably in order to convince them not to seek out those services elsewhere. This isn't just the absence of patient referral – it's an "anti-referral."

EMTALA defines an "emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual…in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part."

The "reasonably be expected" language is deficient because it uses an "objective standard" for assessment. Thus, it is not enough that a physician believes an emergency exists; a "reasonable person" would have to agree that an emergency exists. Physicians at religious health care institutions may be hesitant to do an abortion, or other prohibited services, in that situation for fear of being second guessed. Also, the requirement that the serious jeopardy be "expected" suggests that there must be at least a 50% chance that it will happen. This is too high a threshold. Women with dangerous pregnancies should be allowed to terminate if there is any chance of serious harm, but certainly less than a 50% chance.

The "serious jeopardy/impairment/dysfunction" language is too narrow, especially because it could be read as containing a requirement of severe pain before EMTALA is triggered. A woman with severe preeclampsia, for example, might not be in pain, but could be at serious risk unless the pregnancy is terminated.

Supporters of this bill should understand that it doesn't have anything meaningful in it for patients. It needs a true health and life exception. It needs a referral requirement. And it needs to add patient notice and referral.

Those who hope the sponsors will yet add some language providing meaningful protection for patients, please take note of the following suggested amendments for providers, institutions and payers respectively:

> 1. Any health care provider who refuses to participate in health care services pursuant to this act shall communicate the refusal in writing to his or her employer and shall communicate the refusal orally and in writing to the person requesting the health care service that is refused or omitted. The notice of denial of services must be accompanied by a

referral to a health care provider that the person claiming an exemption knows is capable of and willing to provide the health care services.

2. Nothing in this act shall be construed as authorizing a health care provider to refuse to participate in health care services if necessary to preserve the life or health of a patient.

3. Any health care institution that refuses to participate in health care services pursuant to this act shall communicate the refusal orally and in writing to a person requesting the health care service that is refused or omitted. The notice of denial of services must be accompanied by a referral to a health care provider that the institution claiming an exemption knows is capable of and willing to provide the health care services. If a pharmacy employs a person who has exercised an exemption claim, that pharmacy shall have at least one person on duty at all times that is willing to dispense the medication.

4. Any health care institution that refuses to participate in health care services pursuant to this act shall post a prominent sign notifying patients of the excluded health care services in an area of the institution that is open and visible to patients seeking those heath care services. A health care institution that violates this requirement shall be liable to the State for a civil penalty of $10,000. Such a violation shall create in the patient a private right of action for damages, including medical expenses incurred and emotional distress inflicted as a result of the non-disclosure. Nothing in this act shall be construed as authorizing a health care institution to refuse to participate in health care services if necessary to preserve the life or health of a patient. Nothing in this act shall be construed as authorizing a pharmacist to refuse to dispense medication if the patient cannot obtain the medication within the time necessary for utilization.

5. Any health care payer that declines to pay for health care services pursuant to this act shall notify current and prospective enrollees in the health care payer's health plan of the exclusions and shall communicate the exclusions in writing to any enrollee requesting payment for the health care service that is refused or omitted. Nothing in this act shall be construed as authorizing a health care institution to refuse to participate in health care services if necessary to preserve the life or health of a patient.

Legislation protecting the rights of health care providers to refuse to participate in certain health care services can be drafted in a way that protects the rights of patients.

Patients have a reasonable expectation that they will receive comprehensive and complete information about their health condition and the health care services related to their condition; the health care services prescribed or ordered by their health care provider; and if insured,

payment for the prescribed or ordered health care services from their health care payer as covered under their policy.

Some health care providers may wish to refuse to participate in certain health care services for religious reasons.

However, when the rights of patients to receive prescribed health care services are in conflict with the providers' right to refuse them, who should prevail?

When these rights cannot coexist, the rights of patients to receive care should supercede the rights of providers to refuse that care.

The sponsors of HB 2711 believe patients have no right to receive the health care services they personally object to, and this bill is their treatise on denying them as much access as possible. Services not flat-out denied under the auspices of this bill will be significantly, and perhaps irreversibly chilled due to its breadth and confusion for employers particularly, and I believe that's what the sponsors are counting on.

There are many other problems with this bill. Some will be addressed by other speakers today. I would like to add just one more now:

HB 2711 elevates 'moral beliefs' to the status of race, sex, religion, disability, etc. under the anti-discrimination laws of Kansas. This is a huge problem. There is no legal precedence for protecting everyone's unique moral framework. The denial of health care services because of a vague 'moral' belief should never become a civil right. Since the protection of individuals because of their religious belief is already in current law, the discrimination language in this bill is not necessary.

Thank you for your careful attention to this serious and dangerous legislation. We ask you to oppose HB 2711.

Testimony to oppose House Bill 2711, Kansas state legislators
February 19, 2002

Daniel Jung
4007 N. Bennington apt. 204
Kansas City, MO 64117
816-454-5461 djung@uhs.edu
University of Health Sciences
Medical Student II

My name is Daniel Jung and I am a second year medical student at University of Health Sciences in Kansas City, MO. I am currently taking a forensic pathology elective with Dr. Mitchell here at the Topeka corner's office. I am considering an otolaryngology residency at KU med center and when I learned of House Bill 2711 I became concerned that my medical education would be severely compromised. This is why I am here today.

In August I was privileged to be in Ethiopia on a Global Health Outreach medical mission sponsored by the Christian Medical and Dental Association. One day I was riding on a bus traveling to Nazareth from Addis Abba, passing the time with Frita, a young African American lady who was also on the mission. She was a fourth year medical student at Stony Brook in New York. Frita had a strong Christian faith and told me of her plans to return to the Bronx where she grew up and minister to her patients there. I respected the fact that Frita would return to an underserved area and service a population in dire need of health care professionals. The topic of birth control then came up and Frita informed me that she would not be providing birth control to her patients but was going to advise them on abstinence and sexual intercourse for procreational use only. Frita was a wonderful person but I believe the expectations she plans to put on her patients are unreasonable and unrealistic. Frita will be serving a population without a lot of health care options as it is. Part of family medicine is family planning. Prenatal care begins with contemplating conceiving a child. Under Bill 2711, Frita would be allowed to receive resources and valuable medical dollars while neglecting a large part of her job. Will an underserved rural community in Kansas benefit from Bill 2711in this way as well?

Universities and medical schools exist to train you how to think, not what to think, to evaluate facts, consider information and determine if anything is missing for what you have been presented with. In education all ideas are submitted, sides of an argument are presented, all options and treatments are offered, and then you make an informed decision. Removal of oral contraceptives and endocrine drugs would greatly reduce my pharmacology burden but would leave a hole in my education. Drugs metabolize and do strange things in the body. Drugs interact with one another and display a plethora of side effects. Having a partial picture of pharmacology would be detrimental to the care of a patient. National licensing boards test on these drugs and many patients will choose to take them. After 4 years of medical school a certain level of competence is expected of you as you enter your residency or internship. If educated in Kansas with the removal of "morally offensive" topics would I be equal to a resident from another state? After residency, and I am hired into a group practice or hospital, will I have the standard training expected of me? Will I be able to do all the procedures expected of me? The answer is NO, not if moral items are removed at a professor's discretion.

When I was at University of Missouri, Columbia I had a freshman philosophy class. The class was taught by a 16th round Denver draft pick, African American ordained minister. The second topic covered in class was the debates regarding on religion and the existence of God. Now I am a southern boy, born and raised conservative republican from Cape Girardeau, Missouri. I was raised southern Baptist and took comfort in the fact that a minister would be teaching on these religious debates and arguments from Aquinas and Humes. I felt sure that his personal beliefs would come shining through in what was discussed. But I

was wrong. By the end of the semester I was questioning my faith. In trying to keep an open mind during that course I wavered, and later pulled through with a stronger faith than when I enrolled. Academias, institutes of higher learning, exist for an open exchange of free ideas, regardless of what the educators personal belief system is.

I am a third generation physician. The one common thread I have seen in all the doctors I have come to admire is the way they interact with their patients. They are educators. The word doctor means teacher. They take a patients condition, break it down into a language they understand, discuss ALL the treatment options available, and let the patient decide their course of action. Study after study has shown that when a patient is involved in the decisions of their care they are more compliant, more satisfied, and have better outcomes than when they are not. Bill 2711 is a step backwards. It is taking treatment options and decisions away from patients and giving the decision making power to the physician, hospital, or HMO. As a physician our education does not end the moment we reach for our diploma. Maintaining medical licensure requires forty hours of continuing medical education a year. Family practitioner's are required to retake a board exam every six years. The academy of neurology and psychiatry retests every ten. These steps are taken to ensure that physicians know current treatment options and what is available in patient care. This is what makes us better doctors. This is what makes us better people- educating ourselves in order to provide the best possible care for our patients. Under bill 2711 continuing education would no longer matter with regard to the issues it encompasses because patients would no longer learn of these so-called "morally objectionable" treatments nor would HMOs or hospitals have to provide them- harming our patients, eroding society.

Let's look for a moment at Parkinson's disease. Parkinson's disease starts with tremors, progressing to dementia, coma, and finally death. There is no cure for Parkinson's. Once a patient is refractive (immune) to L-Dopa, which is the one medicine shown to help with the symptoms; there are no further treatments available. While it is easy to stand back and say treatments using fetal stem cells is wrong, what if it was your son, daughter, husband, wife, or grandchild diagnosed? Wouldn't you want the option? Wouldn't you want to know what treatments are available? Wouldn't you want the best care for your loved one? A striatonigral transplant from fetal mesenchymal tissue has shown to be 68% effective in treating the progression and symptoms of Parkinson's disease. I have a right and an obligation to the patients I treat to be educated in all aspects of medicine- and that includes informing them, informing you about this choice.

The last point I'd like to make is a common sense observation. Physicians average twelve years of higher education. If as a physician, you do not believe in abortions, then you are not going to apply for a job at Planned Parenthood. If you are a Jehovah's Witness physician than you are not going to specialize in hematology, and nor would a person of the Jewish faith do autopsies for a living. These are choices that physicians have made for a very long time, rendering this bill unnecessary. For the rest of us physicians out there who want to provide comprehensive care to all of our patients, than this bill shortchanges them, the people, and your constituents. The guise of this bill "Protecting Physician's Rights of Conscience Act" does so at the expense of the patient's rights to services, information, and an educated physician treating them.

BREIF IN OPPOSITION TO HB 2711:
Health Care Providers' Rights of Conscience

House Federal and State Affairs Committee
February 19, 2002

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First Year Student/ Family Practice

If enacted, HB 2711 will reduce access to education about the services outlined in the bill beyond its current flawed level. Medical education in Kansas must be complete and thorough to ensure and improve the quality of care Kansas-educated providers offer to the public. Any impediment to access to education of the services outlined in the bill only serves to spread ignorance about legally available and regularly performed procedures and treatment options.

In the earliest years of our Kansas education, we were told that rights are to be equally distributed among every person. And as we have grown aware of the world that surrounds us, we've witnessed that it is not unusual for the rights of one person to be in direct conflict with the rights of another. HB 2711 attempts to lessen the rights of one person under the guise of securing the rights of another. This deception is easily unearthed upon thoughtful examination of the bill.

Results from HB 2711 will be directly related to the inherent bias of the bill. The underlying premise that one person/entity's rights have precedence over patient's rights, the rights of students, and the rights of willing providers will most likely result in the following:

- Transparency of teaching and training institutions will be reduced.
- A potential population of medical providers will emerge who are unable to perform services outlined in this bill due to denial or impedance to their education.
- Credibility and licensure problems for Kansas-educated providers will emerge in states other than Kansas with progressive policies about patient rights and education.
- Medical providers will be less likely to enter into service agreements relating to underserved areas in Kansas. Moreover, such underserved areas will be further impeded to access the services outlined in the bill.
- The bill allows the right of conscience to be denied or withheld from students and providers holding differing moral convictions from the proponents of HB 2711.

HB 2711 may outwardly state that the bill's function is to protect the rights of those who object to the services outlined in the bill. However, it is obvious that HB 2711 also serves to restrict the rights of those who agree with and/or have personal convictions that exclusion of information about, referrals for, and availability of the services outlined in the bill is immoral.

Elective Pregnancy Termination and Education

A fundamental inclusion of the services outlined in this bill is obviously elective pregnancy termination. Education and training for elective pregnancy termination is already scarce. Ninety-one percent of OB/GYN residents report having no experience with the procedures of elective pregnancy termination. Only 12 percent of OB/GYN residencies require training in first-trimester pregnancy termination. There is evidence that the exclusion of such training is detrimental to the education of medical providers:

> *The AMA encourages education on termination of pregnancy issues so that medical students receive a satisfactory knowledge of medical, ethical, legal and psychological principles associated with termination of pregnancy although observation of, attendance at, or any direct or indirect participation in an abortion should not be required.*
>
> *American Medical Association Resolution 304, 1996*

As the AMA suggests, future physicians need access to all information regarding the services outlined in HB 2711 in order to make their own choices about the services they will provide. The right not to participate in procedures does not directly impinge upon other's rights as the providers are educated enough to pass their knowledge on to their patients or refer patients to knowledgeable or willing providers.

The Issue of Transparency

There is nothing contained in the bill that suggests any responsibility of teaching institutions to inform applicants and students of what they are not being taught. This blinds them from making personal choices that they feel affect the quality of their education.

The Results of Incomplete Training

Currently medical students are under-educated in a procedure that is performed legally on more than one million women every year. The bill includes elective pregnancy termination and many other common services in "health care services subject to this act". Impediment to education about the outlined services allows for the expansion of inadequately informed and trained providers. Medical providers restricted from education about services outlined in the bill cannot adequately inform or treat patients in institutions where full disclosure of treatment modalities and options is a priority. There is already a current crisis of information related to services included in HB 2711: a survey by Medical Students for Choice found that in one medical school as many as one-half of the third-year students did not believe that they were competent enough to advise women seeking elective pregnancy termination. If HB 2711 is enacted, this number is sure to rise as even more medical students are left in the dark. As common as some of the services are, invariably some Kansas-educated providers will have less knowledge of medicine when compared to providers from other states.

Issues of Credibility, Employment Qualifications, and Licensure

HB 2711 would be confined to the state of Kansas, as it would be a state law. The services outlined in this bill are fairly common procedures and are regularly utilized by the public at large. If this bill is enacted, a resident or student enrolled in a Kansas medical school may be seen as having insufficient training by other states or employers. This could have grave effects on the credibility of physicians and other providers educated in Kansas and their ability to secure residencies and employment in other states. The mayor of New York City, Michael Bloomberg, is adamant about changing the requirements of OB/GYN residencies to include pregnancy termination. HB 2711 could cause New York City teaching hospitals and institution to deny admittance at Kansas providers based on inadequate education. The reputation of Kansas's medical schools would be greatly tarnished if HB 2711 becomes law. Enrollment in Kansas's medical schools and other medical training institutions is likely to suffer.

The Effect on Underserved Communities

Kansas has many underserved communities, especially in rural areas. Programs such as the Kansas State Board of Regents medical scholarships and the National Health Service Corps contract with students to provide financial assistance for their schooling in return for commitment to serve in an underserved area. The Kansas State Board of Regents service agreements/scholarships require service be in Kansas. National Health Service Corps places rewardees throughout the country with some limited choice of placement. HB 2711 has the possibility of greatly damaging such necessary programs. It imparts a notion that medicine in Kansas is restrictive: a physician may be silenced or "gagged" from thoroughly explaining and presenting all available options, or that Kansas is an unfriendly place to practice if the provider wishes to offer any of the services outlined in this bill. The environment established by HB 2711 will damage underserved communities that benefit from service programs like the Kansas Osteopathy Medical Service Scholarship and the National Health Service Corps. Fewer people will choose to make service agreements with the state of Kansas or choose service sites in Kansas's underserved areas. Furthermore, isolated communities with few if any health resources would be greatly affected if medical personnel could deny treatment or information about services outlined in the bill.

Direct Violation of the Right of Conscience

Finally, HB 2711 directly affects Kansas's medical students and residents' rights of conscience. The bill focuses on the right of medical providers to *deny* services outlined in HB 2711. The bill fails to recognize or secure the right of medical providers to *include* the services outlined in the bill if they are driven by moral convictions. Persons with moral convictions in direct conflict with HB 2711 can be restricted from their right of conscience. Persons morally driven to ensure in full disclosure of options to patients, or to secure the reproductive rights of women, or to finding cures help people with diseases like Parkinson's could be prevented from fulfilling what they feel is moral, humane medicine. This law assumes that only one side has a conscience or moral convictions. And that those with convictions different than the proponents of this bill can have their right of conscience taken away: their right to access to education crucial to their individual missions and their personal understanding of morality.

House Federal and State Affairs Committee: Testimony in Opposition to H.B. 2711

February 19, 2002

Submitted by: Emily Taylor, Lawrence, Kansas

The Honorable Doug Mays
Chairman, House Federal and State Affairs
Capitol Building, Topeka, KS

Thank you for providing an opportunity for both proponents and oppponents of House Bill 2711 to address this committee.

My name is Emily Taylor. I came to Kansas in 1956 as the Dean of Women at the University of Kansas, a position I held for eighteen years. In 1975 1 went to Washington, D.C.as the Director of the Office of Women in Higher Education. When I retired, I returned to Kansas in 1986.

1 have held several appointments by various governors to state boards and commissions: by three governors to State Commissions on the Status of Women; The Kansas State Commission on Aging, which I chaired for four years; and The State Board of Healing Arts, on which I am currently serving a second four year term. I was president for two terms of the National Association of Commissions on the Status of women

I have also served on many other boards, among them: Douglas County Historical Society, the Lawrence Senior Center, the Jayhawk Area Agency on Aging, the Senior Council of the Lawrence Chamber of Commerce, and the Lawrence Caring Community Council, which I chair. This Council is concerned with improving end of life care.

I have a number of concerns about House Bill 2711.

First, I do not question the right of health care providers, or anyone else, to decline to perform any action which violates their sense of right and wrong. This bill goes far beyond protecting health care providers "rights of conscience" not to participate in performing procedures to which they object. It actually defines participation to include counseling, advising, referring, and admitting. These inclusions certainly could deny patients, particularly in underserved areas, the care of their choice -- their right to receive any legal procedures they need or desire.

In larger Kansas medical centers there would probably be someone to respond to patients' needs for service, although even there it might be difficult to find a substitute on 48 hours notice. But many of our medical facilities are quite small and understaffed. Some areas of Kansas are designated as critically underserved. This bill would make it illegal to discriminate against an applicant for a position who wished to excercise a "right of conscience," even if he/she were the only physician, nurse, or pharmacist available in their work area.

It is one thing for someone to decline to perform an action and quite another to refuse to refer patients to another health care facility where the provider's conscience does not prohibit him or her from assisting patients in legitimate ways.

The health care services subject to this act are a laundry list of medical procedures. If anyone objects to all, or even most, of them, one wonders why they chose a health care profession. I have concerns about a number of these inclusions.

Abortion

In the six years I have served on the Kansas State Board of Healing Arts, there has been not one complaint from anyone -- patient or health care facility -- about a provider refusing to perform or assist with an abortion. Most doctors do not perform elective abortions or expect other health care providers who work for or with them to do so.

Abortion means the removal of a living or dead embryo or fetus. Does this bill protect a health care worker who refuses to assist in removing a dead fetus? Without this medical intervention a woman's life is at stake. And what about a tubal pregnancy? Can a health care provider claim a conscientious objection to removal of such an embryo?

Is it discriminatory according to this bill to expect a health care provider to assist a woman who has been raped, or does the provider's "right of conscience" extend to forcing a woman to bear her rapists child?

Would it be assisting with an abortion to correct the results of a botched abortion? This scenario is less common now that abortion is a legal procedure, but before that time it was not uncommon. I personally know of several such cases where extensive medical assistance was needed to save the lives of women who had attempted to self-abort or had had incompetent providers. I also know one whose life was not saved.

Artificial Birth Control

It seems strange to include birth control and abortion in the same list of services subject to this act. Without adequate birth control, women cannot plan and appropriately space births. Abstinence is fine for children and adults who choose this way of life, but it is not the most desirable marital arrangement. Access to safe and effective contraceptive methods to postpone or avoid having children decreases the mortality rates for both mothers and children. It also greatly decreases the number of unwanted pregnancies and subsequent abortions. We can't have it both ways. For abortion to be rare, women and men must have the information they need to avoid undesired pregnancies.

Sterilization

Although sterilization may seem an extreme form of birth control it is desirable in cases where a pregnancy must be avoided at all costs. It is also the method of choice for some people. Self determination in personal matters is important and no one has the right to deny it to anyone else.

Artificial Insemination

Some women who want very much to have a child to complete their families are unable to conceive naturally. Artificial insemination requires special knowledge, training, and skills. It

is an act of compassion, and anyone who accepts a position in a facility that performs this procedure should not be protected for substituting his or her values for those of the couple seeking help.

Assisted Reproduction

How is this defined and how does it differ from artificial insemination which is certainly assisted reproduction? Services which are included in any legislation should at least be defined if they are not obvious.

Blood Transfusions

The idea that a health care provider could refuse with impunity to assist with a blood transfusion is bizarre. Blood transfusions are not available on demand. They are performed when necessary to save lives or prevent serious health problems. Indeed for some diseases for which no treatment is effective, blood transfusions are the only means available to keep the patient alive.

Infanticide

Infanticide is the murder of a baby. As are all homicides, it is already illegal. What possible reason is there for its inclusion in this act? It cannot be made more illegal and certainly no one could be discriminated against for failure to assist in a murder.

Physician-Assisted Suicide

Physician-assisted suicide is already illegal in Kansas. Including it in yet another bill serves only to intimidate health care providers who fear that their efforts to alleviate pain may result in accusations of overprescribing and thereby killling a patient. Kansans are already undertreated for pain. Many are denied relief because appropriate pain management might hasten the death of a dying patient. Doctors who prescribe medication to relieve pain should not be second guessed as to their intention, and no legislation should discourage physicians from assisting terminally ill Kansans in horrible pain. It is unfair for the state to make even one patient die in agony by an ill-advsed legislative act.

Euthanasia

Euthanasia in this act seems to be connected to physician-assisted suicide. Does it have some special meaning, other than an easy and painless death?

Cloning

Cloning of any living thing is in its infancy. Does this act refer to cloning of a person, or does it include sheep and cats? The dialogue on cloning has just begun. Few people understand understand its ramifications. It seems premature to include it in legislation until its usefulness or lack thereof are better understoon.

Embryonic Stem Cell and Fetal Experimentaion

Much the same thing could be said of stem cell and fetal experimentation as of cloning. I doubt very much that anyone is going to be required to assist with these complicated procedures and certainly not to provide them. Doctors have only very recently begun to operate on fetuses and insurance payers should not be discouraged from paying for saving the fetus or correcting an abnormality, even if it is at present considered experimental.

Kansas law provides for advance directives, indicating what services patients do or do not want when they are dying. Many of us are working to improve end of life care and encourage the provision of a peaceful, pain-free death according to the expressed wishes of the patient. We are concerned with any law that seems to encourage health care personnel to ignore the wishes of the patient at the end of life and to substitute their values for those of the dying person.

This bill gives no rights to health care providers that they are not already experiencing. No discrimination against people exercising a "right of conscience" is evident -- no court cases, no disciplinary actions. The bill serves only to prevent or make difficult the provision to some patients of the care to which they are entitled.`

Thank you for listening and again for providing this opportunity to testify.

Emily Taylor

Kansas Choice Alliance

Members:

Aid for Women
American Association of University Women - Baldwin Branch
American Association of University Women - Kansas
American Association of University Women - Shawnee Mission Branch
American Civil Liberties Union of Kansas and Western Missouri
Choice Coalition of Greater Kansas City
Greater Kansas City Chapter of Hadassah
Jewish Community Relations Bureau/American Jewish Committee
Jewish Women International
Kansas Religious Leaders for Choice
KU Pro-Choice Coalition
League of Women Voters of Johnson County
League of Women Voters of Kansas
League of Women Voters of Wichita-Metro
MAINstream Coalition
National Council of Jewish Women, Greater Kansas City Section
National Organization for Women, Johnson/Wyandotte County Chapter
National Organization for Women, Kansas Chapter
National Organization for Women, Kansas City Urban Chapter
National Organization for Women, Lawrence Chapter
National Organization for Women, Manhattan Chapter
National Organization for Women, Wichita Chapter
Planned Parenthood of Kansas & Mid-Missouri
Pro-Family Catholics for Choice
Wichita Choice Alliance
Wichita Family Planning
Women's Health Care Services
YWCA of Wichita

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House Federal and State Affairs Committee: Testimony In Opposition to H.B. 2711

February 19, 2002

Submitted by Barbara Duke on behalf of the Kansas Choice Alliance (785-749-0786)

Chairman Mays and members of the House Federal and State Affairs Committee:

HB 2711 imposes personal beliefs on the practice of medicine by allowing hospitals and individuals to opt out of certain medical procedures they do not approve of. The bill further protects institutions and individuals from liability if a patient is harmed by the refusal to provide these services.

There must be a requirement that providers and institutions make widely known the health services they do not approve of and will not offer. There must a requirement that the referrals be made for the effective and timely provision of the needed service by others. We assert that the patent's right to prescribed health care takes precedence over any right of conscience claimed by providers or institutions

Many of the protected services have to do with reproduction, both family planning and fertility: they are particularly alarming to women whose equality rests on full reproductive rights.

The strictures on birth control are disturbing. Does this mean that condoms might not be available in certain pharmacies and stores? Does it mean that prescriptions for birth control including emergency contraception might not be filled by some pharmacies?

For many residents of Kansas the local pharmacy is the only place to fill prescriptions in a timely way. In some areas the Wal-Mart chain is the only drugstore and pharmacy available. Wal-Mart does not stock emergency contraception (EC) .It has been suggested that there is really no problem if a prescription is turned down at the local pharmacy because it can be filled via the Internet. That is an unrealistic and callous thought. A large number of Kansas are not online. How many who are, know how to access prescription services and/or have a credit card? How many of you would count on mail service office to get a medication to you as quickly as you need to have it?

There must be exceptions in this bill for providing emergency room treatment where time may be of the essence. There may not be time to find another hospital or a different provider who does not object to the needed treatment.

House Fed. & State Affairs
Date 2/19/02
Attachment No. 8
Page 1 of 2

Testimony in Opposition to H.B. 2711 – page 2

In February 2001 a telephone survey of hospital emergency rooms concerning the treatment of rape victims was undertaken by Planned Parenthood and the Kansas Choice Alliance. The survey was completed in April 2001. The following four questions were asked: 1. Do you have rape kits available? 2. Do you offer HIV/AIDS testing? 3.Do you offer testing for other STD's? 4.Do you offer emergency contraception (EC)? When the answer to questions 2,3,or 4 was "no" this follow-up question was asked: "Do you automatically offer referrals?" If the answer was "no" an additional question was asked: "Do you know of any place in town or in your area where she can go?" The survey showed that most emergency rooms do offer standard treatment except for EC.

The brochure I have submitted with my testimony summarizes the results of the survey about the availability of EC in Kansas emergency rooms. It shows that an alarming number of emergency rooms do not offer or provide EC to rape victims

EC does not cause an abortion.. EC prevent pregnancy if taken up to 72 hours after the assault. The sooner it is taken the more effective it is. Rape victims must have timely access to EC. Having the option of avoiding an unwanted pregnancy is an important way to help reduce their trauma. Can you imagine the worry and stress a rape victim must endure if EC is not offered to her? Rape victims in Kansas have a right to standard emergency room treatment across the state

Emergency contraception for rape victims should be standard procedure in Kansas. HB 2711 will impede or make it impossible to accomplish that goal..

I urge you to vote against HB 2711.

Thank you for your attention and thoughtful consideration.

Barbara Duke

House Fed. &
State Affairs
Date 2/19/02
Attachment No. 8
Page 2 of 2

Testimony before the House Federal and State Committee in Opposition to HB 2711
For the Kansas National Organization for Women - Presented by Sylvie Rueff
February 19, 2002

Thank you, Chairman Mays, and Honorable Members of this Committee,

In the United States of America, one of the greatest freedoms we have is the freedom to choose. Whether it is the election of individuals, the products on a grocery store shelf, the size of our families, the conditions of our lives, the religion we practice, or the beliefs that motivate our work; we have choices about what we will offer of ourselves to the world, and, we choose what we will accept into our lives. Governments that do not allow these choices are called tyrannies.

The Kansas National Organization ~~of~~ FOR Women opposes to the passage of House Bill 2711.

We believe this bill is an attempt by a minority of religious organizations and individuals, to use government intervention to co-opt, dominate, stonewall and potentially monopolize the health care service and insurance industries, and to promote their moral objections to abortion, artificial insemination, assisted reproduction, artificial birth control, blood transfusions, cloning, embryonic stem cell and fetal experimentation and sterilization.

We believe this bill would serve to abridge the rights of health care professionals to provide the highest quality, full and complete health care service under the standards held by their fields of practice, their professional oaths and their personal moral and ethical beliefs by subjugating their rights to the stated "rights of organizations". In section 2, the bill provides that we may not discriminate, disqualify, coerce, disable or impose liability on people or organizations because of their refusal to participate in providing one of the health care provisions subject to this act. There is no protection for the action of a person or organization that believes it is morally reprehensible to deny health care to a person in need of the enumerated procedures and assistance.

In other areas of American life, the right of individuals to refuse to provide service for their fellow citizens because of a right of conscience is balance by the obligation to remove themselves from a position where their refusal would impede the normal actions of the organization. Their refusal also precludes them from the rewards otherwise enjoyed by those who agree to serve. Their refusal, if it comes at such a time that it would endanger or impair another, is judged a criminal action and is subject to punishment.

We view this bill as an exercise in discrimination by gender, unequally limiting reproductive health care for women. We are offended by the inclusion in this bill of infanticide, physician-assisted suicide and euthanasia, all of which are illegal in this state at this time.

The focus of health care is the patient. The patient's health is supported or improved through the delivery of procedures and medication. The result of good health care is improved patient health. The professional who accepts responsibility for a patient accepts responsibility for the whole patient, the body, the mind and the patient's ethics, morals, beliefs, and a respect for the patient's need to consider their total lives in considering the treatment the patient is willing and desirous of pursuing. If providers elect to put their moral objections before the patient's needs, the patient needs the ability to elect a provider more compatible with their needs, without the threat of legal action. Likewise a group of people should be able to discriminate and elect to use or not use a health care provider or supporter based on the procedures and support offered and on their own moral beliefs.

We believe individuals, as patients or clients, have the right to access full and complete health care as it is offered by medical science, and, that access to such health care is covered by their constitutional rights to life, liberty and the pursuit of happiness. We believe this law will present undue burdens on, and allow for discrimination against those individuals seeking full and complete health care. Obstruction of these rights through government intervention based on religious dogma is religious tyranny.

We object to the idea that organizations have moral beliefs. And, particularly, that every belief that describes an organization is held by all it's members and with equal passion. We believe that organizations that serve the greater good of the public, especially those that enjoy public support and oversight, must be sensitive to the needs of all citizens.

We recognize the right of a religious organization to provide or not provide services based on morally acceptable beliefs about health care services. We believe however that religious organizations are delineated by four criteria: (1) they have as their purpose the inculcation of religious values, (2) they primarily employ persons who share the religious tenets of the entity, (3) they primarily serve persons who share its religious tenets, and (4) they are tax exempt under Internal Revenue Code section 6033(a)(2)(A)(i). Would that religious organizations wish to provide health services as part of their ministry, they are to be commended. But, to allow those religious organizations to operate with support of public moneys and in unfair competition in the marketplace would be to discriminate against those other religions, and, those religious or non-religious individuals that are not enjoying the same protections and advantages under the law.

We are concerned by the blurring of the lines between church and state. With so much of the health care supported by public funds, religious organizations would have government support to censure thought and practice, and inculcate religious values by dominating public health care systems.

Medical health care organizations operate as services to the public. We do not have the right to provide or not provide services as a public entity based on the client's/customer's/patient's race, religion, or country of origin without the threat of a suit for discrimination? A business, however, may make the choices as to what services it may offer and thereby submit its policies to the judgments and discriminations of the marketplace.

In our society, free from religious controls, we allow individuals the personal exercise of their religious faith. But, that practice is separated from the interventions of government in the marketplace. An ice cream store cannot offer only vanilla ice cream with a religious treatise wrapped around it and then charge religious discrimination when the marketplace chooses to support the place down the block that has a full rainbow of flavors and wraps it's cones in a utilitarian napkin. Nor should the employer of the rainbow flavor shop be required to hire and maintain the employee who will answer the request for any order with a vanilla cone wrapped in a treatise instead of a napkin.

This bill unequally singles out the health care professions and their supporting bureaucracy for special treatment. It would seem we could see similar bills for professionals working in the fields of education, the judiciary, the courts, police, prisons, attorneys, farming, or any businesses that operate for the public.

This bill would create of medical science, and its supporting public and private organizations an environment where the abilities of the many to support optimal health for the public will be limited by the few whose personal moral beliefs are inconsistent with the ethics and goals generally regarded and legally practiced in the medical community today.

…tes for House Federal and State Affairs, 2-19-02, 1:30pm, HB 2711 Denial of Care.

1. This conscience clause condones intolerance.
2. Organizations cannot have conscience anymore than they can vote. They should be held responsible for it's omissions or denial of care.
3. Our government cannot force particular religious beliefs upon us. A governmental grant of any kind carries certain freedoms and resposibilities upon the grantee, those grants include state health care, privileges of incorporation or doing business in the state. Grants of health care make the grantee a public service, which serve the needs of many different religions and morals. By allowing a public service to dictate morality, by denial of service, is to admit a particular religion into government.
4. A pre-employment contract based upon performance of a deniable service would be voidable by this bill under Sections 7(a) and 3(a). An employee of an OB/GYN clinic hired by contract specifically for working around 'artificial' birth control, could refuse to perform the job function after hire because it involves a deniable service, get fired for non-performance, and then sue the employer for ~~religious~~ moral discrimination. Under K.A.R. 21-30-17 Pre-employment inquiries, I cannot ask questions that might reveal the employee's religious affiliations, and therefore reveal their impending conscientious objection.
5. Some of these health care terms are poorly defined and overly-broad when liberally construed.
6. "Blood transfusion" can also mean any plasma, rhogam needed for pregnant Rh-negative women, or platelet therapy for hemophiliacs.
7. "Assisted reproduction" can also mean any male or female sexual dysfunction, any treatment for miscarriages, pre-mature labor, labor induction, Cesarian-section, and infertility.
8. "Infanticide" is not a legal medical service anywhere (see K.S.A. 21-3401, 3402, murder).
9. "Physician-assisted Suicide" is not a legal medical service in Kansas. (see K.S.A. 60-4404 and 21-3406).
10. "Artificial birth control," as contrasted to Natural Family Planning, can also mean condoms, hormone pills, injections and subdermal implants, intra-uterine devices, sterilization, and male contraception pills (e.g. nifedipine same as ProCardia) are all probably artificial, and excludable under this act. Women with endometriosis taking birth control pills as treatment could be denied their hormone pills by all pharmacists. Should pre-menopausal women with other reproductive health problems, for example bleeding fibroids, be denied a hysterectomy? Should married couples be denied information about condoms?
11. Responsibility clause in Section 4(d) wherein "Nothing in this act shall relieve a health care provider from any duty, which may exist under law concerning current standards of normal professional practices and procedures, to inform a patient of the patient's condition, prognosis and risks of a health care service subject to this act." The only law I could find that requires a provider to inform a patient of their diagnosis or prognosis is breast cancer under K.S.A. 65-2836. There are medical oaths, malpractice case law and peer-review boards which define a standards, but 4(d) refers to statutory law, not case law. Therefore the PROVIDERS ARE UNDER NO OBLIGATION AND GIVEN MALPRACTICE IMMUNITY UNDER 5(b) WHEN NOT INFORMING A PATIENT OF THEIR DIAGNOSIS OR PROGNOSIS, BECAUSE THE PROVIDER DISAGREES WITH THE POSSIBLE HEALTH CARE OPTION UNDER THIS ACT. We saw how HMO's abused their power by not telling patients about their alternative but more expensive medical options. Same problem, different priority.
12. In summary, HB2711 is a reaction to continued medical breakthroughs that push the envelope of our morality and ethics. I think continuing use of pre-employment contracts, insurance declarations of covered services, getting fired for non-performance, and paying malpractice claims for denying service, as they already exist should continue or be improved.

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The Honorable Doug Mays
Chair, and to all other Members of House Federal and State Affairs Committee
State Capitol, Room 170-W
Topeka, KS 66612

February 17, 2002

Regarding: Objections to HB 2711, from Mark Pederson, Medical Office Manager.

1. My first objection is to Section 2 "...that people and organizations hold different beliefs about ***whether certain health care services are morally acceptable***" that I interpret as intolerance. These services are provided, not received, by the providers. Those whom object to receiving certain immoral services do not need to receive them. Health care is a public service position through governmental grants, serving the needs of the public of many different religions and morals. By allowing a public service position to dictate, by denial of service, acceptable morality is to admit a particular religion into government. Religion and morality are tolerated because of their beautiful diversity. One reason why we left England is because of religious intolerance. Since there are many variations of religion and morality, and laws are supposed to be invariant and easily enforceable, the law should not be involved in enforcing any particular religion or morality. What happens later when a legislature of a different religious bent makes changes to this now-opened door? Shall we deny medical services to women who are unaccompanied by a family-male per Taliban rules. Or deny services to unwed mothers, an anathema to some Christians. Or deny organ transplants because of soul embodiment.

Morality is strictly human. I believe that organizations do not have the "right of conscience" anymore than an organization has a "right to vote it's conscience". If an organization could vote it's conscience, the result would be that many organizations would be formed just to overpower the human votes, thwarting democracy. The right of conscience is similar and belongs to humans.

2. My second objection is Section 2 "The provisions of this act ***shall be construed liberally*** ..." This is dangerous when combined with vague words later on. This would impair the obligation of contract (see U.S. Constitution, Article II, Section 10): a pre-employment contract based upon performance of a deniable service would be voidable by this bill.

> Section 7(a) ***"Any health care provider aggrieved by an alleged employment practice...based on the refusal to participate in the provision of a health care service subject to this act may file a complaint and receive relief..."***,

and then under Section 3(a) defining employment discrimination

> ***"...'Discriminate' means*** any conduct or practice...or in any other manner engage in ***coercion against any*** person, ***health care provider...because of their refusal to participate in the provision of...health care services subject to this act."***

This absurd example hilights that AN EMPLOYEE CANNOT BE FIRED. An employee of an OB/GYN clinic hired by contract specifically for working around pap smears, dispensing birth control pills and information about them could refuse to perform her hired job because it involves artificial reproduction, get fired for non-performance, and then sue the employer for religious discrimination. K.A.R. 21-30-17 Pre-employment inquiries and practices, will not allow me to ask whether they are a member of an no-birth-

control organization, which would have otherwise tipped me off that they won't perform and reproductive health services. **Those deniable services will most probably be made less available, the true purpose of this act. Assume that all health care providers will choose this option especially when driven by insurance economics and hospital take-overs.**

My solution is to continue to allow pre-employment contracts to itemize what services will and will not be provided, the invisible hand of laissez faire.

3. My third objection is to Section 3, the definition of services subject to this act. They are any services surrounding abortion, artificial insemination, assisted reproduction, artificial birth control, blood transfusions, cloning, embryonic stem cell and fetal experimentation, infanticide, physician-assisted suicide and euthanasia and sterilization. Some of these terms are poorly defined and overly-broad when liberally construed.

"Blood transfusion" can also mean any plasma, rhogam injections (plasma by-product) needed for Rh-negative women (approximately 15% of population) who are pregnant to stop possible spontaneous miscarriages, or platelet therapy (clotting-factor)(plasma by-product) for hemophiliacs.

"Assisted reproduction" could be interpreted to include any sexual dysfunction, female AND male, impotence, any treatment to stop miscarriages, stop pre-mature labor, inducing labor, Cesarian-section delivery, and to correct infertility.

"Infanticide" as far as I know is not a legally allowed medical service anywhere (see K.S.A. 21-3401, 3402, murder), so unless there is a definition other than the killing of an already-born child, why is this even here?

The same applies to **"Physician-assisted Suicide"**. Should prescribing morphine or oxycontin (narcotics) for a possibly-terminal patient in pain, but a patient who might stockpile meds and misuse them for suicide, be considered irresponsible (physician-assisted suicide) or sadistic if denied? This is hard issue to decide, and is not a legal medical service in Kansas. (see K.S.A. 60-4404 and 21-3406).

"Artificial birth control" is a contentious phrase as contrasted against the presumed and supposed 'natural family planning'. There is nothing natural or normal about abstinence from our God-given sexual urges, otherwise our species would not have survived. Under this vague definition condoms, estrogen/progesterone pills, injections and subdermal implants, intra-uterine devices, sterilization, and male contraception pills (when they become available) are all probably artificial, and would therefore wither under this act. Also consider women with endometriosis, a monthly bleeding and scarring outside the uterus, who take birth control pills, even though they are not having sex, to minimize the scarring damage and pain until they can have children, who could be denied their hormone pills by all pharmacists because the pharmacists thinks she is using it for artificial contraception. Should married heterosexual couples who are vague about contraception be denied information about condoms by their religious Internist? Should sexually-active unmarried people be denied information about condoms preventing sexually-transmitted diseases, since condoms are also a contraceptive? Or deny a hysterectomy, since that is sterilization/artificial birth control, to a woman who is pre-menopausal but having excessive bleeding from persistent uterine fibroids?

4. My fourth objection is to emphasize how deceptive this act is. Section 3(b) defines the deniable service as

> "...any phase of patient medical care, ...including but not limited to...counseling, diagnosis or prognosis,...rendered by health care providers or health care institutions."

Tie that in with the supposed-responsibility clause in Section 4(d) wherein

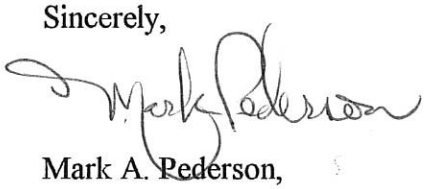
> *"Nothing in this act shall relieve a health care provider from any duty, which may exist under law* concerning current standards of normal professional practices and procedures, to inform a patient of the patient's condition, prognosis and risks of a health care service subject to this act."

House Fed. & State Affairs
Date 2/19/02
Attachment No. 10
Page 3 of 4

...nat laws exist in Kansas with regards to informing patients of their medical treatment options? N... except breast cancer under K.S.A. 65-2836.[1] But there are medical oaths, malpractice case law, and malpractice peer-review boards which define that standard. But 4(d) refers to statutory law, not case law. Therefore the PROVIDERS ARE UNDER NO OBLIGATION AND GIVEN MALPRACTICE IMMUNITY (Section 5(b)) WHEN NOT INFORMING A PATIENT OF THEIR DIAGNOSIS OR PROGNOSIS, BECAUSE THE PROVIDER DISAGREES WITH THE POSSIBLE HEALTH CARE OPTION UNDER THIS ACT. Have we not been griping about health care reform because HMO's, for example, abused their power by not telling patients about their alternative, but more expensive, medical options? Same problem, different priority.

In summary, this is a knee-jerk reaction to continued medical breakthroughs that push the envelope of our morality and ethics. I think continuing use of pre-employment contracts, insurance declarations of non-coverable services, getting fired for non-performance, or taking malpractice hits for denying service, as they already exist should continue or be improved.

Sincerely,



Mark A. Pederson,
Medical Office Manager
720 Central Avenue
Kansas City, KS 66101-3546

hb2711b.wpd

[1] If Personal Injury or Death results, maybe. For breast cancer, yes. K.S.A. 65-2836 "A licensee's license may be revoked, ...upon finding of the existence of any of the following grounds: ...(m) The licensee, ...has failed to inform in writing a patient suffering from any form of abnormality of the breast tissue for which surgery is a recommended form of treatment, of alternative methods of treatment recognized by licensees of the same profession in the same or similar communities as being acceptable under like conditions and circumstances."

TESTIMONY TO THE KANSAS LEGISLATURE

Tuesday, February 19, 2002

FROM

The Reverend Willard T. Reece
Minister, Christian Church (Disciples of Christ)
And
Co-chair Kansas Religious Leaders for Choice
Co-chair, Kansas Religious Leaders for Choice
5702 Chadowes
Wichita KS 67208
316-683-6256

I want to thank you for the opportunity to present testimony concerning Health Care Providers' Rights of Conscience Act. I am deeply concerned about all people in need of health care. As Co-chair of Kansas Religious Leaders for Choice, I am especially concerned about the needs of women who would be in particular danger if this bill is passed.

The health care professions and institutions of our state are held in high regard for their selfless dedication to providing the best possible health care to everyone in need. This tradition, exemplified by rural doctors in past generations, making house calls in all kinds of weather, night or day, as well as by modern doctors and nurses and other health care workers working long hours caring for patients in their offices, hospitals and emergency rooms, has been a model we have all admired. The needs of the patient have always been the priority.

This bill turns this tradition upside down, making the health care provider the higher priority rather than the patient. While recognizing the important of conscience, the long tradition of health care has held the patient to be the highest priority.

Conscience, by itself, is not a reliable standard for providing health care. Conscience is a subjective standard influenced by feelings and beliefs of the individual. It is a changing standard subject to new information and experiences. In the past conscience justified slavery, child labor, second class status for women and racial discrimination. Individual conscience by itself is an insufficient standard for a public need.

Through the years dedicated medical professionals have developed commonly accepted standards. They are not perfect standards but the wisdom of the profession as a whole revises those standards as new truth emerges. The standards are established with the well being of the patient in mind.

This is not to say that individual conscience should not be considered. The rights of individual health care providers to refuse to participate in health care services that go

against their consciences should be recognized, but only when no harm would result to the patient Refusal would be acceptable only as long as the patient receives the care in a timely and effective manner from another provider. This bill does not provide for the priority of the patient.

One of the needs of the health care system is for the patient to be able to access care with reasonable ease. Should a desperately ill person be refused care because of the conscience of the health care provider? Should the patient who may be in an emotional or life threatening state be forced to search for another provider? Should a person in need of medical care be required to travel to another community to find care because of the refusal of a doctor based on conscience? Should a poor person who has no transportation to another hospital or doctor be refused care because of the conscience of a health care provider?

This bill is a transparent attempt to manipulate the health care system and the right of conscience for the political agenda of opposing such issues of abortion, birth control, certain kinds of medical research and end-of-life decisions Good conscience would put the needs of patients first and seek to promote political agenda in a direct way.

I trust you will see the potential harm of this bill and vote against it.

Presented by Rev. Carolyn Brown, Minister of the First Unitarian Universalist Church in Wichita, Kansas.

House Fed. &
State Affairs
Date 2/19/02
Attachment No. 11
Page 2 of 2

Diane Wahto
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Members of the House Federal and State Affairs Committee:

Thank you for allowing me the chance to speak to you on the matter of HB 2711. I am speaking in opposition to the bill for a couple of personal, but important reasons. Those reasons are my son and daughter-in-law, two fine people who, a few years ago, were desperate to conceive a child, but found out that they would have to fertility treatments in order for that to happen.

My son and daughter-in-law were fortunate enough to be able to obtain fertility treatments that included *in vitro* fertilization. Eventually, for a variety of reasons having nothing to do with the treatments themselves, they decided to adopt and I now have two lovely granddaughters to add to my wonderful brood of grandchildren. However, the point is that, while this bill will erode access to the birth control pills, condoms, tubal ligations and other forms of contraception for people who *don't* want to get pregnant, it will also jeopardize access for people like my son and daughter-in-law who *do* want children.

Think about the nightmare scenario for such a couple if, in the middle of their treatment, a key staff member at a fertility clinic or hospital decided it was against his or her conscience to participate in fertility treatments. The employer would have no recourse against this employee because that employer could be charged with discrimination. Imagine the sadness of such a couple if their doctor were unable to carry out fertility treatments in the hospital in which he or she practices medicine.

I have other personal reasons for opposing this bill. My father suffered from depression as he got older and he found that anti-depressants were quite effective in treating this condition. He would have found his last years of life difficult if someone in his health care provider pipeline decided that it is unbiblical for him to ease his mental suffering with medication. When he was diagnosed with ALS, he made a living will that directed the family not to resuscitate him. Given his condition, all my family members would have been quite sad if a health care provider had denied my father's wishes.

Now that my mother is suffering from Alzheimer's disease, I would be quite unhappy if we were forced to extend her life by artificial means only because a health care provider's conscience conflicts with our conscience.

We are already on the defensive for economic reasons when it comes to health care provision; this bill is bad law that would further erode health care access for many of us.

I respectfully ask the committee members to refrain from practicing bad medicine and to work on making laws that protect the health care access of all Kansans.

Thank you,

Diane Wahto

Diane Wahto

House Fed. &
State Affairs
Date 2/19/02
Attachment No. 12
Page 1 of 1

Health Care Providers' Rights of Conscience Act

Thank you - I appreciate the opportunity to speak today - it is a privilege to appear here before our Kansas Legislators.

I speak as a Catholic woman -a member of Religious Leaders for Choice - active in my Church as a woman who supports women's reproductive rights as well as all safe contraceptive measures of birth control - the one effective anti-abortion measure the Vatican will not allow. I speak as a mother and grandmother of many children - as one who is dedicated to social justice, religious freedom and, most importantly, to the welfare of all women and children everywhere.

The Rights of Conscience Act speaks to the conscience of the providers - the health care workers - the right to withhold any procedure which *they* may deem as violating their conscience. Thus the rights of women to access to their conscience is set aside - and the grave possability of denying her the health services she has sought.

I'm not sure that many of you are aware that the United States Catholic bishops' *Ethical and Religious Directives for Health Care Services* prohibits - among other things--tubal ligations, vasectomies, in vitro fertilization, and prescribing and dispensing birth control devises and drugs - plus denying thearpy for AIDS victims which would involve condoms. Beyond that the *Directives* even restricts the use of the emergency contraceptive pill for rape victims at Catholic health care facilities. To be more explicit - if a raped woman, of child-bearing age, is brought to an emergency room in a Catholic hospital, she will be denied the e.c. pill and in many cases will not be advised that there is procedure which will prevent a pregnancy as a result of the rape. In essence, her access to her conscience in this life-threatening situation has been commandeered by the Catholic bishops.

What happens when Catholic health care becomes the only option for a woman seeking reproductive health services? In some cities, especially in smaller communities - e.g. in western Kansas - a woman who wishes to get an immediate post-partum tubal ligation will be forced to go elsewhere, undergoing unnecessary additional surgical risks and considerable stress and expense in addition to her delivery. This is a procedure which many Catholic women as well as women who are not Catholic are requesting. It is folly to believe that Catholic women are not using contraceptive birth control or resorting the tubal litagtions to control the size of their families. It matters not who conducts survey or polls - the results are always the same - Catholic couples use contraceptive birth control - as well as vasectomy and tubal litigation - at the same rate as non-Catholic couples. It is quite simply not a matter of confession any longer. Responsible family planning includes the basic right of couples to decide freely the number of

children, and spacing of their children. They feel they have earned the right as moral agents and therefore birth control/family planning is a matter to be decided by individual conscience.

In light of the recent exposure of the fralities exhibited by priests and hierarchy in the matter of sexual abuse against our children and youth - is it any wonder our women and men choose not to listen to the voice of their celebate hierarchy.

This is America. We are a democracy. This is not the Holy Roman Empire. Therefore, I ask that you carefully consider the ramifications of this "Denial of Care" bill and impose upon the health care providers the obligation of tending to their own consciences.

Mary McDonough Harren
Catholics for Contraception-Religious Leaders for Choice
Wichita, KS.

KANSAS COALITION AGAINST SEXUAL AND DOMESTIC VIOLENCE
UNITED AGAINST VIOLENCE
220 SW 33rd Street, Suite 100 Topeka, Kansas 66611
785-232-9784 • FAX 785-266-1874 • coalition@kcsdv.org

House Federal and State Affairs Committee
February 19, 2002

HB: 2711 Oppose

Contact: Sandy Barnett

Dear Chairman Mays and Members of the Committee:

The Kansas Coalition Against Sexual and Domestic Violence represents the 28 programs in Kansas providing services and advocacy to victims of domestic violence and sexual assault. These programs provide service to more than 50,000 people each year (see KCSDV brochure). KCSDV also gives voice to a primarily voiceless and faceless group of Kansans – victims of these heinous crimes. These crimes are not bound by race, ethnicity, age, religion, or economics.

Being victimized at the hands of someone who you trust, as in the case of domestic violence and often true for those who suffer a sexual assault or rape, impacts every domain of the victims' life. Victims often turn to the criminal and civil justice system, the health care system, employment and social service systems, child protection systems, and their faith leaders for help.

But, as often as we think of the criminal justice system in response to domestic violence and sexual assault, only a small percentage of victims ever interact with law enforcement and the courts. Far larger portions of victims rely on their health care provider, public health clinics, and emergency rooms to help (see attached fact sheet). Accessible health care that addresses the needs of victims is critical. SB 2711 limits access to a full range of health care services a victim may need in an emergency situation. A rape victim may be refused emergency contraception and then get no information about options should a pregnancy result. A victim of domestic violence who is coerced and forced to have sex may be denied information about birth control. When one does not control the timing of sexual activity, as is the case in rape, incest, and violent relationships, rhythm methods are useless. When pregnancy does result the violence in abusive relationships often escalates. Pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other cause. A victim of rape could also be denied services to treat potential Sexually Transmitted Diseases, which left untreated could cause very serious health complications.

Being allowed to make informed choices about health care is essential for victims of domestic violence and sexual assault to maintain their safety. If victims perceive that health care providers are withholding information and not aiding them in making informed choices, the health care system will no longer be viewed as a safe and supportive arena for victims. This further increases victims' isolation and denies a potential life-saving resource (the health care system).

The lack of resources that many victims have access to is also seen in insurance coverage. A victim of domestic or sexual violence may have very limited insurance options. insurance coverage to receive. Many victims could potentially be cut off from services that would continue to increase safety and well-being.

KCSDV respectfully requests that the Committee carefully consider these unintended consequences to victims and not pass HB 2711 out of committee.

FACT SHEET
Domestic Violence: #1 Health Risk to Women

Primary Health Care

- A 1999 study published in *The Journal of the American Medical Association* found that an estimated 10% of primary care physicians routinely screen for intimate partner abuse during new patient visits and 9% routinely screen during periodic checkups. (Rodriguez, Bauer, McLoughlin and Grumbach, 1999).
- Women with persistent headaches, chest pain, back pain, pelvic or abdominal pain may be victims of domestic violence (Stark et al., 1979; Warshaw, 1989).
- Physicians are more likely to prescribe analgesic and psychoactive medications to battered women than to women not in abusive relationships, even when they do not address the abuse directly (Stark et al., 1979; Warshaw, 1989).
- A study in a university-based Gastro-intestinal clinic found that 36% of their women patients had histories of physical and/or sexual abuse as adults. Women with functional GI complaints were more likely to have been subjected to forced intercourse and frequent physical abuse (Drossman et al., 1990).
- Eight percent of teenage girls age 14 to 17 report knowing someone their age who has been hit or beaten by a boyfriend (Children Now/Kaiser Permanente poll, December 1995).

Emergency Room

- Every year, domestic violence causes approximately 100,000 days of hospitalization; 28,700 emergency room visits; and 39,900 visits to a physician. This violence costs the nation between $5 and $10 billion per year (American Medical Association, Violence: A Compendium from JAMA. American Medical News and the Specialty Journals of the American Medical Association, released 1992).
- Battering is the single most frequent reason why women seek attention at hospital emergency departments and is the single major cause of injury to women, accounting for 25% of female suicide attempts, and 4,000 homicides per year (Holtz and Furniss, "The Health Care Providers Role in Domestic Violence," 1993).
- The level of injury resulting from domestic violence is severe: of 218 women presenting at a metropolitan emergency department with injuries due to domestic violence, 28% required hospital admission, and 13% required major medical treatment. 40% had previously required medical care for abuse (Berios and Grady, 1991).
- The U.S. Department of Justice reported that 37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend or girlfriend. (U.S. Department of Justice, August 1997).
- The Joint Commission for the Accreditation of Hospitals and Healthcare Organizations (JCAHO) requires that accredited emergency departments have policies and procedures, and a plan for educating staff on the treatment of battered adults. (Joint Commission on Accreditation of Healthcare Organizations 1997 Hospital Standards-Possible Victims of Domestic Abuse and Neglect).

Pediatrics

- Over 3 million children are at risk of exposure to parental violence each year (Carleson, 1984).
- In a national study of over 6,000 American families, 50% of the men who frequently assaulted their wives also frequently abused their children (Straus & Gelles, 1990).
- Children who witness domestic violence at home display emotional and behavioral disturbances as diverse as withdrawal, low self-esteem, nightmares, self-blame and aggression against peers, family members and property (Peled, Jaffe & Edleson, 1995).
- The negative effects of the perpetrator's abuse in interrupting childhood development can be seen immediately in cognitive, psychological, and physical symptoms (Jaffe, et. al., 1990).
- Male children in particular are affected and have a high likelihood of battering intimates in their adult relationships (Hotaling & Sugarman, D.B., 1986).
- Children (from violent homes) are more likely to be involved in violent criminal activity in the future than their non-abused peers (Widson, The Cycle of Violence, 1992; The Cycle of Violence Revisited, NIJ Research Preview, 1996).
- When the mother is assaulted by the father, daughters are exposed to the risk of sexual abuse 6.5 times greater than girls in non-abusive families (Hart, 1992).

Obstetrics / Gynecology

- Recent clinical studies have proven the effectiveness of a 2-minute screening for early detection of abuse to pregnant women (Soeken, McFarlane & Parker, 1998). Additional longitudinal studies have tested a 10-minute intervention that was proven highly effective in increasing the safety of pregnant abused women (McFarlane, Parker & Soeken, Silva & Reel, 1998).
- Each year, at least 6% of all pregnant women, about 240,000 pregnant women, in this country are battered by the men in their lives. (Centers for Disease Control and Prevention, 1994).
- Abused women are twice as likely as non-abused women to delay the start of prenatal care until the third trimester (Macfarlane, Parker, Soeken & Bullock, 1992).
- There is some evidence that battered women are more likely to give birth to low birth weight infants (Bullock & Macfarlane, 1989).
- Obstetrical manifestations of abuse include miscarriages and spontaneous multiple abortions (Stark et al., 1979).
- Complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding are significantly higher for abused women as are maternal rates of depression, suicide attempts, tobacco, alcohol, and illicit drug use (Parker, McFarlane, Soeken, 1994; McFarlane, Parker & Soeken, 1996).
- Battered lesbians report high levels of sexual violence against them by their female partners (Renzetti, 1992).
- In one random population study, 45% of women with sexual problems and 47% of those with other gynecological complaints were battered women. (Schei & Bakkteig, 1989; Campbell & Alford, 1989).
- Between 67% and 83% of HIV positive women in one clinic were or had been in abusive relationships with men who refused to use barrier protection (Cohen, Warshaw, Deamant, Boxer, Damont & Gradinski, 1995).

Mental Health

- Half of the women referred to one mental health center by their primary care physicians turned out to be unrecognized battered women (Hilberman & Munson, 1977-78) and 64% of women on an inpatient psychiatric unit had experienced physical abuse as adults (Jacobsen & Richardson, 1987).
- Studies of battered women indicate that 37% have symptoms of depression (Gelles & Straus, 1988; Housekamp & Foy, 1991), 46% have symptoms of anxiety disorders (Gelles & Harrop, 1989) and 45% experience post-traumatic stress disorder (Housekamp & Foy, 1991).
- In one study, 25% of all women seen in the Emergency Department with psychiatric symptoms were battered women, as were 10% of the women who presented with acute psychotic episodes (Stark, Flitcraft & Frazier, 1979).
- In one study, 50% of African American women and 29% of all women seen for suicide attempts were battered, often in close proximity to the attempt (Stark et al., 1979; Stark & Flitcraft, 1995).
- In a study of battered women who sought medical or psychiatric treatment, Rounsaville and Weissman found that 19% had suffered severe head injuries as a result of being battered, 5% had suffered lacerations requiring sutures, while 62% had received contusions and soft tissue injuries. Eighty-four percent of these women had been injured severely enough to require medical treatment on at least one occasion (Ewing, Battered Women Who Kill: Psychological Self-Defense as Legal Justification, 1987).
- Up to 50% of alcoholism in women may be precipitated by abuse (Hotaling & Sugarman, 1986).

National Resources

Family Violence Prevention Fund
Provides model training materials, departmental guidelines, protocols and other tools for health care providers.

888-RX ABUSE
www.fvpf.org

Kansas Resources

Kansas Coalition Against Sexual and Domestic Violence
Provides training, materials, and referrals to local agencies.

785-232-9784
coalition@kcsdv.org

Your local domestic violence and/or sexual assault program information:

House Fed. & State Affairs
Date 2/19/02
Attachment No. 14
Page 4 of 4

This project was supported by Grant No. 96-WR-NX-0019, awarded by the Violence Against Women Grants Office, Office of Justice Programs, U.S. Department of Justice.
Points of view in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.