Approved: May 6, 2002
Date

MINUTES OF THE SENATE FEDERAL AND STATE AFFAIRS COMMITTEE.

The meeting was called to order by Chairperson Senator Nancey Harrington at 10:30 a.m. on April 10, 2002 in Room 245-N of the Capitol.

All members were present.

Committee staff present: Russell Mills, Legislative Research Department
Dennis Hodgins, Legislative Research Department
Theresa Kiernan, Office of the Revisor
Nikki Kraus, Committee Secretary

Conferees appearing before the committee:

Carla Mahany, KS Public Affairs Director, Planned Parenthood of Kansas and Mid-Missouri
Mark Pederson, Central Family Medicine
Representative Peggy Long
Mike Farmer, Executive Director, Kansas Catholic Conference
Kathy Ostrowski, Kansans for Life
Denise Burke, Staff Counsel, Americans United for Life (WRITTEN)
Senator Jim Barone
Senator Dwayne Umbarger (WRITTEN)

Others attending: Please see attached

Chairperson Harrington opened the hearing on:

HCR 5051–Commemorative stamp honoring coal miners

Senator Jim Barone presented testimony in favor of the bill. (Attachment 1)

Senator Dwayne Umbarger presented written testimony in favor of the bill. (Attachment 2)

Chairperson Harrington opened the public hearing on:

HB 2819–Establishment of standards for the operation of abortion clinics

Representative Peggy Long presented testimony in favor of the bill. (Attachment 3)

Following discussion, Senator Gilstrap asked Rep. Long if she felt that this bill was for or against abortion, and Representative Long stated that she felt that it met the needs of women in crisis.

The committee discussed the application of these standards for non-abortion clinics.

Carla Mahany, KS Public Affairs Director, Planned Parenthood of Kansas and Mid-Missouri, presented testimony in opposition to the bill. (Attachment 4) She also presented the committee with a copy of an e-mail from The Pro-Life Infonet. (Attachment 5) Ms. Mahany the presented the committee with a "Statement on the Regulation of Health Facilities and Providers" from Planned Parenthood of America in opposition to the bill. (Attachment 6)

The committee discussed past deaths relating to abortions. Ms. Mahany stated that there had been four in the past 20 years, and that it was a very safe procedure. She stated that she did not know any of the specifics of those deaths.

The committee discussed the significance of the drug RU-46 in relation to the bill.

Mike Farmer, Executive Director, Kansas Catholic Conference, presented testimony in favor of the bill. (Attachment7) Mr. Farmer also presented: "2000 Clinical Policy Guidelines," National Abortion Federation (Attachment 8); "Condensed Abortion Protocol," Planned Parenthood of Central and Northern Arizona (Attachment 9); "Manual of Medical Standards and Guidelines," Planned Parenthood Federation of America, Inc.(Attachment 10); "Abortion practitioners licensed by Kansas State Board of Healing Arts," (Attachment 11); "Ambulatory Surgical Centers" (Attachment 12); and "Minimum Standards for Veterinary Premises Sanitary Conditions" (Attachment 13) all in favor of the bill.

Mark Pederson, Central Family Medicine, presented testimony in opposition to the bill. (Attachment 14)

In response to a question from Chairperson Harrrington, Mr. Pederson stated that he was not a medical doctor but an office manager at a clinic.

Mr. Pederson stated that in response to comments about deaths relating to abortion, often they were the result of conditions which the provider had no knowledge of before the procedure. He also stated in response to the veterinarian clinic requirements that vets did not have to have malpractice insurance.

Following further discussion, Senator Lyon asked if it was true that approximately 25% of all births in Kansas were aborted, and Mr. Pederson agreed, stating that this statistic was close to the national average.

Kathy Ostrowski, Kansans for Life, presented testimony in favor of the bill. (Attachment 15) Ms. Ostrowski also presented: "HB 2819-Abortion Clinic Licensing"(Attachment 16); "Board of Medical Examiners: Medical Board Policies" (Attachment 17); "Consent for Elective Abortion" (Attachment 18); Southwestern Bell phone book advertisements for abortions from 2000 (Attachment 19); "Rules of Department of Health:Division 30-Division of Health Resources, Chapter 30-Ambulatory Surgical Centers" (Attachment 20) all in favor of the bill.

Denise Burke, Staff Counsel, Americans United for Life, presented written testimony in favor of the bill. (Attachment 21)

The committee discussed the nurse requirement and what would be needed to fulfill it in the bill.

Senator Teichman made a motion to make a technical amendment to the bill to correct numbering throughout it. Senator Lyon seconded the motion. The motion passed.

Senator O'Connor made a motion to recommend the bill favorable for passage. Senator Lyon seconded the motion.

The committee discussed the possibility of broadening the scope of the application of the bill. Senator Gooch stated that he did not want to discriminate against abortion clinics. He stated that he was concerned about criminal penalties.

Senator O'Connor stated that she felt that broader application would be difficult, and she would not support it.

Senator Barnett stated that he was concerned about politicians getting into medicine too deep.

Senator Gooch stated that he would be willing to vote the bill out, but that he did not want to be caught up in discriminatory practices.

Senator Barnett stated that there are many differences in clinics with different concerns for patient health. He stated that he believed it is good to have safety regulations, but that the bill should not tell doctors how to practice. He stated that he was not sure that he would be able to answer all of his questions today, but that the history bothered him, and that he was concerned about the bill as it is written.

Senator Gooch made a motion to amend the bill to apply to all clinics. There was no second. The motion

failed.

Senator Barnett stated that there may be some problems with the bill as it is.

Senator O'Connor discussed anemia briefly with Senator Barnett, and then stated that she would be happy to work with Senator Barnett on technical changes to the bill, but he may want to do an amendment on the floor. She stated that she would like to move the bill out favorably as it is.

Chairperson Harrington stated that the committee was running out of time this close to the end of session.

Senator Teichman stated that she believed there should be standards on abortion clinics, but that the questions that Senator Barnett had brought up had made questions in her mind, and she felt that there were too many questions to be solved by a floor amendment. She stated that the committee might be rushing through something.

Senator Gooch stated that he would have to vote against the bill at this time. He stated that he hoped that there would be more discussion.

Senator Vratil made a substitute motion that the bill be tabled and the chair request an interim study to be conducted.

Chairperson Harrington stated that she doubted there would be many interim studies because of budget concerns.

Senator Vratil stated that he felt it ought to be further studied before being put on the floor of the Senate.

Senator Barnett stated that he had received some information from Ms. Kiernan, and that he would be in favor of this kind of wording, but he would have to be against both motions at this time.

Ms. Kiernan stated that the committee could amend the definition of who they would want the bill to catch.

Senator Gooch seconded the tabling motion. The motion failed.

Senator O'Connor stated that she would like to pass the bill out favorably and work with Senator Barnett on substitute language.

Senator O'Connor's motion to pass the bill out favorably failed. A division of vote was called. Yeas: Senators O'Connor, Gilstrap, Harrington, and Lyon. Nos: Senators Barnett, Teichman, Brungardt, Gooch, and Vratil.

Senator Teichman made a motion to recommend **HCR 5051** favorable for passage. Senator Gooch seconded the motion, The motion passed.

The meeting adjourned at 12:08 p.m. The next meeting will be held at 10:30 a.m. on April 11, 2002 in Room 245-N.

SENATE FEDERAL AND STATE AFFAIRS COMMITTEE
GUEST LIST

DATE: April 10, 2002

NAME	REPRESENTING
Rachel Johansen	Hiawatha High School
Wyatt Keil	Hiawatha High School
Jared Tarll	Hiawather High School
Brad Robeik	Hiawatha High School
Josh Ivy	Hiawatha High School
Vera Blair-Price	Hiawatha High School
Carla Schuster	Hiawatha High School
Deborah Winter	Hiawatha High School
Jennifer Elsbury	Hiawatha High School
Justin Genix	Hiawatha High School
Robert Childress	" "
Josh Merchant	" "
Joel Marable	Hiawatha High School
Amy DeMuth	Hiawatha High School
Kody Winterscheidt	Hiawatha High School
Ryan Haug	Hiawatha High School
Kaylen Everhart	Hiawatha High School
Carla Nahan	PPKM
Mark Pederson	Central Family Medicine

SENATE FEDERAL AND STATE AFFAIRS COMMITTEE
GUEST LIST

DATE: 4/10/02

NAME	REPRESENTING
Tyrone D. Buel	Topeka Independent Living

State of Kansas
Senate Chamber

JIM BARONE
STATE SENATOR, THIRTEENTH DISTRICT
CRAWFORD, CHEROKEE AND BOURBON COUNTIES

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COMMITTEE ASSIGNMENTS
RANKING MINORITY: COMMERCE
UTILITES
MEMBER: WAYS & MEANS
ECONOMIC DEVELOPMENT
PENSIONS, INVESTMENTS & BENEFITS
STATE BUILDING CONSTRUCTION
MEMBER: NCSL COMMITTEE EDUCATION, LABOR & WORKFORCE DEVELOPEMENT

Democratic Agenda Chairman

ROOM 504-N, STATE CAPITOL
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TESTIMONY OF SENATOR JIM BARONE BEFORE SENATE AND FEDERAL STATE AFFAIRS COMMITTEE WEDNESDAY, APRIL 10, 2002 IN SUPPORT OF HCR 5051 COMMEMORATIVE STAMP HONORING COAL MINERS

Madam Chairman and Members of the Committee:

I believe HCR 5051, urging the United States Postal Service to issue a commemorative stamp honoring America's coal miners, is appropriate and completely meritorious. I must admit my views are somewhat self-serving, since I am the grandson of an emigrated Italian coal miner who came to the United States in 1909 in search of a better life. I will also add that my father had to quit school after the 8th grade and immediately went to work in the deep mines in order to help support the entire family. The resolution says it all and says it very well, and I believe a commemorative stamp is but a small way in which to recognize and honor all of America's coal miners, past, present, and future.

Thank you for the opportunity to submit this testimony.

Senator Jim Barone
District #13

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04/10/02
Attach #1

State of Kansas
Senate Chamber

DWAYNE UMBARGER
SENATE MAJORITY WHIP
SENATOR, FOURTEENTH DISTRICT
LABETTE & NEOSHO COUNTIES
AND PARTS OF CHEROKEE
AND MONTGOMERY COUNTIES
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(DURING SESSION)
(785) 296-8430
(TTY FOR HEARING/SPEECH IMPAIRED)

COMMITTEE ASSIGNMENTS
CHAIRMAN: EDUCATION
CHAIRMAN: JOINT COMMITTEE ON RULES & REGULATIONS
MEMBER: AGRICULTURE
INTERSTATE COOPERATION
JUDICIARY
NATURAL RESOURCES
ORGANIZATION, CALENDAR & RULES

April 4, 2002

To the Senate Committee on Federal and State Affairs;

HCR 5051 The issuance of a stamp commemorating the vital role of coal miners in the history and economic productivity of this great nation.

A stamp of this kind would commemorate a class of American laborers who through their manual labor make it possible for us to have the technological conveniences of modern American life. This stamp would help the public understand the complete implications of the hard work these men and women coal miners have given to the nation as a whole. These men and women that work the coal mines help supply us with over half of our nation's electricity. Coal miners have kept this nation from relying completely on foreign help in gaining sources of energy. The coal mining industry helped make this country a melting-pot by the immigrants it encouraged to come to this country to make us stronger. These new immigrants worked in the coal mines and helped supply the labor resources for other developing industries in this country.

A commemorative stamp for coal miners holds many promises including the illustration of a colorful and historically rich segment of our society that can be used to benefit schoolchildren, stamp collectors, educators, and the public about the vital importance of coal miners and the coal industry to our nation.

Southeast Kansas prospered for a period that helped redefine Kansas, as not just a vast plain that was used to grow food products, but as a complete economic asset to the nation. Southeast Kansas has a relic from the times past called Big Brutus in West Mineral, Kansas. Big Brutus was one of the largest coal shovels in the world at the time of its service.

The people who operated and helped in the production of coal should be honored with a United States Postal Service stamp commemorating the hard work and dedication that these workers have given to the economic backbone of our country. I therefor urge the Committee on Federal and State Affairs to favorably pass HCR 5051.

Sincerely,

Sen Dwayne Umbarger

Senator Dwayne Umbarger

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04/10/02
Attach # 2

STATE OF KANSAS

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REPRESENTATIVE, 76TH DISTRICT
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE-CHAIR: BUSINESS, COMMERCE & LABOR
MEMBER: HEALTH & HUMAN SERVICES
JUDICIARY

TESTIMONY

HOUSE BILL 2819

April 10, 2002

Thank you Madam Chair and Members of the Committee for the opportunity to speak with you today about a compelling need to change Kansas policy in order to ensure greater safety and respect for those who seek answers for a crisis in their lives through an abortion.

I have always heard that abortion was a "safe" procedure. What a shock it has been to find that there is currently no oversight over abortion clinics unless they are licensed as an ambulatory care center. Currently, only one clinic in the state has taken steps to become licensed. You have packets before you that show recommendations for safe procedures that are from the abortion industry itself; yet we have no assurance that these recommendations are being followed. Abortion is indeed a political "hot button," but my intent today is to put politics aside and focus on policy.

In the State of Kansas, there is currently **no** oversight of abortion clinics that are not also designated as ambulatory care centers. We have regulations that require sterile environments for animals in veterinary clinics, yet there is no one who monitors the environment of a clinic for humans where surgical procedures are occurring each and every day. If any person needs protection from this lack of supervision, it is the person who is facing a crisis and unwanted pregnancy.

Please imagine, if you will, the emotional condition of a woman who goes into the clinic. She is frightened, usually ashamed and extremely vulnerable. She is about to place her own welfare into the hands of total strangers in order to resolve her problem. She is in no condition to evaluate the surroundings for their adequacy. She is in crisis.

In January, I was attending a reception and speaking with a group of people about issues that needed to be addressed this session. I spoke to them about this bill. Later, I was approached by a woman I had never met who thanked me for introducing this bill. She counsels women every day who have gone through the abortion trauma. She told me of one beautiful young woman in particular who revealed to her the sexual abuse she had suffered from the abortionist. It was then that I realized just how vulnerable these women can be.

It is appalling to realize that a woman can be examined in unlicensed clinics without a nurse present to provide assurance that there will be no improper behavior on the part of the examining physician. When this type of abuse occurs, who can they turn to? They are depressed, alone and ashamed. How can they tell anyone? This type of violation only adds to their own sense of guilt.

HB 2819 addresses the very problems that I have stated. It is not onerous, it is responsible. We are furnishing you with ample material to learn for yourself that this is an industry that needs more oversight. By passing House Bill 2819, we make the state of Kansas a safer place for women in crisis. We make the abortion industry in Kansas more accountable to follow the recommendations of its own organizations, and we allow the women who have come to these clinics a little more dignity by assuring them there will not be further sexual trauma in that environment.

Thank you for your support of HB2819. I now stand for questions.

Respectfully,

Peggy Long

Peggy Long

76th District Representative

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HAYS CENTER
122 East 12th Street
Hays, KS 67601
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INDEPENDENCE CENTER
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JEFFERSON CITY CENTER
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LAWRENCE CENTER
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MIDTOWN CENTER
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SOUTH KANSAS CITY CENTER
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WARRENSBURG CENTER
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Warrensburg, MO 64093
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WICHITA CENTER
2226 East Central
Wichita, KS 67214
(316) 263-7575

Planned Parenthood®
of Kansas and Mid-Missouri

TESTIMONY
in Opposition to House Bill 2819

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

Senate Committee on Federal and State Affairs

Senator Nancey Harrington, Chair

Wednesday, April 10, 2002

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Attach = 4

Testimony in Opposition to HB 2819 – Carla Mahany, Planned Parenthood of Kansas and Mid-MO
April 10, 2002, Senate Federal and State Affairs Committee

Like minor's abortion restrictions, so-called informed consent laws, attempts to ban certain abortion procedures, later term restrictions, waiting periods, funding prohibitions, conscience laws and so on, legislation like HB 2819 is intended to erode access to abortion services at the risk of women's health and lives. To argue differently stretches credulity.

Contrary to the contention of the proponents, abortion is an extremely safe procedure. It is much safer than childbirth. Since abortion is an alternative to childbirth, the best context for a comparison of mortality statistics is with childbirth. The proponents' evidence is that over the last 20 years there have been four deaths from abortion. However, deaths from childbirth are more than four times that of abortion.

> Calculation: Assume that there have been 200,000 abortions in Kansas over the last 20 years. That means two per 100,000 women die from abortion (or .002 % death rate). In contrast, the AMA estimates that 9.1 per 100,000 women who carried to term between 1979 and 1986 died in childbirth, or more than four times the death rate for abortion. See Induced Termination of Pregnancy Before and After Roe v. Wade, Trends in the Mortality and Morbidity of Women, Council on Scientific Affairs, American Medical Association, JAMA, Vol. 268, p. 3231 (Dec. 9, 1992).

Looking at it in this strictly statistical way, based on the argument of the sponsors, you can see that the lives of at least seven women who would have died in childbirth have been saved through their access to safe and legal abortion services in the past 20 years.

Of course, our major concern at Planned Parenthood is what legislation like HB 2819 could mean to women's health and lives if access is so eroded – through this bill and others -- that illegal and unsafe procedures are the result. If there are family practice physicians or OB/GYNs in the rural corners of Kansas, far from Wichita or Lawrence or Kansas City, who provide confidential, safe abortions for their patients in their private offices, this bill could cause them to stop doing this. We all know that eliminating access to safe abortions doesn't eliminate access to unsafe ones. Abortion has always been, and always will be, available through self inducement, by back alley butchers ... or by demonstrably safe medical procedures that comply with the same standards of practice as orthopedic outpatient procedures or simple in-office plastic surgery.

How is access eroded through HB 2819? Through the increased costs of unnecessary physical and staffing regulations. Are the most onerous of these regulations easy to spot in this bill? No, and that's one of the biggest problems. The South Carolina law was similar to this, with a lot of the specifics left to the administrative process after passage. The administrative regulations were extremely specific, and impossible for most providers to meet without major renovation. Please be careful of what you enable.

Another misrepresentation by the sponsors of HB 2819 concerns the regulations promulgated by Planned Parenthood of Central and Northern Arizona. The testimony by the Kansas Catholic Conference is that the PPCNA protocol reflects the standards of the Planned Parenthood Federation of America, and that all Planned Parenthood affiliates are required to follow these standards if they are going to use the "Planned Parenthood" name.

This statement is completely misleading. The PPCNA standards are NOT those of the Planned Parenthood Federation of America. All of our affiliates in Arizona don't even agree with these standards. PPCNA worked with legislators to codify their facility and practice, even though it does

not reflect other Planned Parenthood affiliates. The sponsors want to pretend that they are the same, since they go into some detail about how this bill conforms specifically to the PPCNA regulations. There are no grounds for doing that. It should be further noted that litigation is not over in Arizona. Another Planned Parenthood affiliate from Arizona is a plaintiff against this law – effectively against PPCNA -- with the support of our national organization.

Yes, the Planned Parenthood Federation of America has standards for our clinics, as the National Abortion Federation has for theirs. However, these proposed regulations are far more onerous than "minimum" health and safety standards, and are more onerous and give less discretion that PPFA or NAF standards. Please note the attached statement from the Planned Parenthood Federation of America regarding the "regulations of health facilities and providers" to see what PPFA thinks about legislation such as HB 2819, including the PPCNA-endorsed law.

Something the sponsors have simply left out is that this bill does – inappropriately and confusingly – apply to both surgical and medical abortions.

Section 1(a)(2) -- This bill applies to "abortion clinics" in which five or more first trimester abortions are performed in any month, or any later abortions are performed. The bill does not define "abortion," but elsewhere in KS law, "abortion" is defined as "the use of any means to intentionally terminate a pregnancy except for the purpose of causing a live birth." KS § 65-6701(a). This would include medical abortion. I think this is the most problematic aspect of the bill, as most of the provisions really make little sense in the context of medical abortion, and would be difficult to apply in that context.

In conclusion, the major misrepresentation by the sponsors of HB 2819 is their mantra that this bill establishes "minimum standards" for abortion providers. Ask a podiatrist who takes care of bone spurs or a plastic surgeon who does simple in-office procedures if they would consider these "minimum standards" for their offices and staffing. I'm sure they would find this bill an offensive intrusion into their practice and ability to exercise their discretion in how best to care for their patients. Should a physician be required to call their patients 24 hours after a confidential procedure? We have a nurse on call 24 hours a day to answer questions and help with any problems experienced by our patients. Should a plastic surgeon be required to have an RN, rather than an LPN or physician's assistant, be present during all exams? Should a physician be told to have full privileges at a hospital, rather than an emergency transfer agreement? Shouldn't the physician have some say over these decisions?

Abortion providers are already regulated by the Kansas Board of Healing Arts and medical malpractice lawsuits. This is adequate.

We call this type of legislation "TRAP," for Targeted Regulation of **A**bortion **P**roviders. TRAP laws attempt to regulate the medical practices or facilities of doctors who provide abortions by imposing burdensome requirements that are different and more stringent than regulations applied to comparable medical practices. These excessive and unnecessary government regulations ultimately harm women's health and inhibit their reproductive choices. The real purpose of TRAP laws is to make it harder for women to exercise their constitutional right to choose abortion.

Please oppose HB 2819. Thank you.

Y[illegible]he pro-abortion American Civil Liberties Union "recognizes the lo[illegible]f a wanted pregnancy, the organization's lobbyist expalined that because the bill creates the unborn child as a victim - separate from its mother.

The ACLU is not opposed to enhancing penalties in cases when the sole crime victim is the mother, said lobbyist Valerie Small Navarro. However, such a stance ignores the unborn child as a victim of a crime.

Raylene Garcia, 28, of Ontario, who lost her baby three days after a 1998 traffic collision caused by a drunken driver, told lawmakers, "We were basically told by the law that our baby never existed."

"We are here today ... so that other families will not have to experience the pain we will have to endure for the rest of our lives," Garcia said." We were here two years ago, and now were are here today, joined by another family that has also had the tragic loss of their baby boy. How many more times will this have to happen before action is taken?"

Mountjoy's proposal is similar to five other bills introduced over the last decade which all stalled early in the legislative process.

AB2623 was granted reconsideration, giving the bill a last chance before the seven-member Public Safety Committee. A new hearing date has not yet been set.

"If a woman chooses to have a child and that [baby] is killed by a drunk driver, that driver should be held responsible," Mountjoy said.

To obtain more information about the bill, contact the California Pro-Life Council at (916) 442-8315.

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You can help women make positive, life-affirming choices when confronting an unexpected pregnancy. Please provide a link on your web site to Pregnancy Centers Online at http://www.pregnancycenters.org

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From: The Pro-Life Infonet <infonet@prolifeinfo.org>
Reply-To: Steven Ertelt <infonet@prolifeinfo.org>
Subject: Kansas State House Approves Four Pro-Life Bills
Source: Associated Press; April 2, 2002

Kansas State House Approves Four Pro-Life Bills

Topeka, KS -- The Kansas state House approved four pro-life bills Wednesday, including measures putting new regulations on abortion facilities and tightening a parental notification law.

One bill, passed 79-44, would require the state secretary of health and environment to establish minimum health and staffing standards for abortion facilities. Similar bills in other states have increased the costs abortion facilities must pay and, in at least one state, an abortion facilirty closed rather than meet the health standards.

Another, approved 77-46, amends a 1992 law requiring abortion practitioners to notify a parent or guardian when a minor seeks an abortion. The bill specifies that the notice be given in person or by certified mail. Pro-life advocates wanted to make sure parents receive proper notification.

Also approved, on a 73-50 vote, was a bill allowing prosecutors to charge criminals who assault pregnant women with two crimes when the assault

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04/10/02
Attach #5

Planned Parenthood Federation of America
212-261-4601
Contact: Paul Audley

STATEMENT ON THE REGULATION OF HEALTH FACILITIES AND PROVIDERS:

Planned Parenthood Federation of America opposes laws and regulations designed to impede access to abortion. Regulatory restrictions that single out women's right to comprehensive reproductive health care cannot be tolerated. Planned Parenthood will remain vigilant in tracking, opposing, and overturning these laws.

Planned Parenthood Federation of America leads the way in establishing medical quality standards for health care (in fact, PPFA's medical standards often exceed those of state regulators). When states pass medical standards legislation or regulations, it is important to insure that the laws or regulations are not disguises for placing limits on women's access to reproductive health care. Appropriate regulations are written to apply neutrally to all types of health facilities and providers. Laws that single out abortion providers with regulatory requirements are simply wrong.

Some states have attempted to restrict access to abortion by passing laws and regulations directed at abortion providers. In Planned Parenthood of Greater Iowa vs. Atchison (1996), the US 8th Circuit Court of Appeals affirmed a federal district court decision to enjoin the State of Iowa from requiring that a Planned Parenthood affiliate obtain a certificate of need (CON) before opening a new clinic. The court found that the state was attempting to use the CON process to prevent the provision of abortions, thereby imposing an obstacle to the exercise of a constitutional right in the absence of a substantial state interest. In addition, in Planned Parenthood of Southeastern Pennsylvania v. Casey (1992) the Supreme Court struck down provisions of a Pennsylvania law that constituted an "undue burden" to the woman's right to choose. Attempts to place undue burdens on access to reproductive health care have taken the form of creating onerous structural, equipment personnel and other requirements targeted at abortion providers. Temporary injunctions and decisions to invalidate these types of laws* have recently been issued in cases in Mississippi and South Carolina. In 1999, bills specifically targeting abortion health facilities and providers were passed in Arizona and Louisiana. They were also introduced in Florida, Indiana, Michigan, North Carolina, Texas and Virginia.

*PPFA's legal department can provide briefings on cases involving anti-choice targeted health facility and provider regulations.

08/19/99.

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04/10/02
Attach #6

Kansas Catholic Conference

6301 ANTIOCH • MERRIAM, KANSAS 66202 • PHONE/FAX 913-722-6633 • WWW.KSCATHCONF.ORG

April 10, 2002

TESTIMONY IN SUPPORT OF HB 2819

Chairman Nancey Harrington
Senate Federal and State Affairs Committee

Madam Chairman and members of the committee I am Mike Farmer, Executive Director of the Kansas Catholic Conference. I appreciate the opportunity to testify today in favor of HB 2819, which would, if enacted, implement minimum health and safety standards for abortion clinics that operate in Kansas. I have prepared a packet of information for each committee member that I will make reference to during my testimony.

I would first like to clarify what this bill is not. As you may recall an abortion clinic licensing bill was introduced last year. It would have required that all abortions in the State of Kansas be performed in an ambulatory surgical center environment. The bill that you have in front of you today, HB 2819, is not the same bill.

HB 2819 is enabling legislation that directs the Secretary of the Department of Health and Environment to adopt rules and regulations for an abortion clinic's facilities. The bill calls out minimum standards that are based on the abortion industry's own standards.

I would like to draw your attention to 3 sets of information in your packet: the "2000 Clinical Policy Guidelines" from the National Abortion Federation (NAF); "Manual of Medical Standards and Guidelines" from Planned Parenthood Federation of America, Inc. (PP); and "Condensed Abortion Protocol" from Planned Parenthood of Central and Northern Arizona (PPCNA).

As to the NAF standards, many of the same areas (i.e. sonograms, anesthesia, monitoring patients given anesthesia, RH testing, obtaining a patient history, sterilizing instruments) that are covered in the NAF clinical policy guidelines are also covered in HB 2819. The NAF provides guidance to its members in these areas and recognizes the importance of obtaining patient histories, using sonograms, etc.

Sn Fed St
04/10/02
Attach #7

The PPCNA protocol reflects the standards from the Planned Parenthood Federation. All Planned Parenthood affiliates are required to follow these standards if they are going to use the "Planned Parenthood" name.

Some examples of how this bill is based on the above-mentioned standards are as follows:

- Page 1 of the PPCNA, Section I, regarding physical facilities, closely mirrors HB 2819, page 1, Section 1(b), lines 28-43.
- Page 2 of the PPCNA, Section IV, regarding medical evaluation and screening, closely mirrors HB 2819, page 3, Section 1(d), lines 11-40.
- Page 3 of the PPCNA, Section VI, regarding recovery room standards, closely mirrors HB 2819, page 4, Section 1(f), lines 18-43, and page 5, lines 1-9.
- Page 3 of the PPCNA, Section VII, regarding follow-up visits, closely mirrors HB 2819, page 5, Section 1(g), lines 13-19.

One of the arguments often cited as a reason not to implement abortion clinic regulations is that "abortion is one of the safest surgical procedures in this country." If you would refer to the four stapled sheets of paper on the right side of your packet, you will find information based on official records from the Kansas State Board of Healing Arts and various court documents. A volunteer researcher found that in the past 20 years there have been 4 known deaths of women following their abortion at the hands of Kansas-licensed practitioners; at least 23 other abortion injuries; and at least 6 abortion injuries or violations of informed consent. As you can see from this report, abortion isn't as safe as is so often claimed.

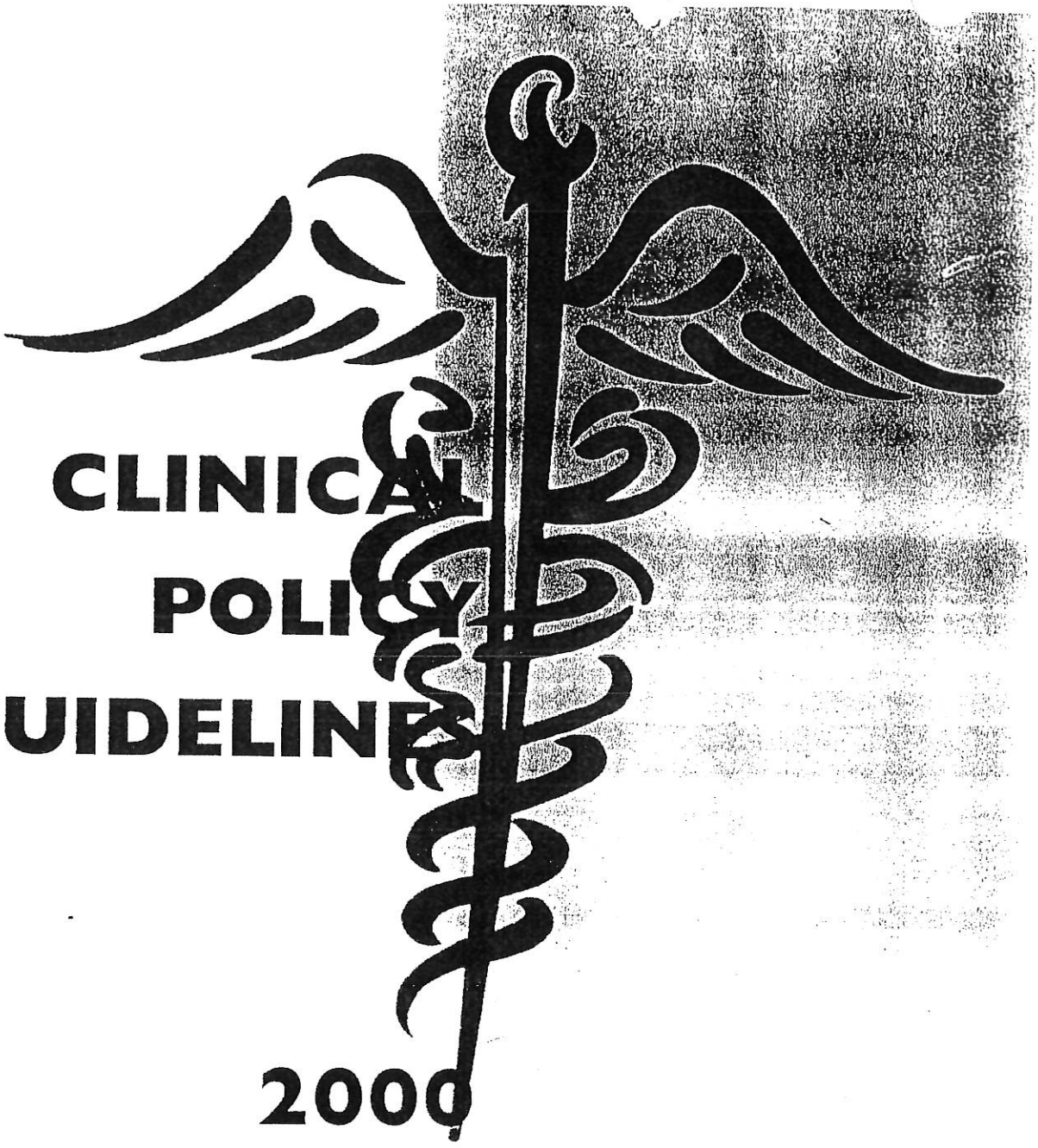
As I mentioned earlier, the clinic licensing bill from last year would have required that all abortions in the State of Kansas be performed in an ambulatory surgical center environment. I have placed a copy of the current Kansas Administrative Regulations that cover ambulatory surgical centers in your packet. You will see that these standards are much stricter and probably would require six of the seven abortion clinics that operate in Kansas to make major changes in the way they do business in order to comply with these regulations. Only one of the seven Kansas abortion clinics is currently licensed as an ambulatory surgery center.

You may be wondering why I have included a copy of the Kansas Administrative Regulations that deal with the minimum standards for Veterinary Premises Sanitary Conditions. If you would make a comparison between the standards being called for in HB 2819 versus the current standards being enforced for veterinary clinics, you will see that even the veterinary clinic standards are much more restrictive than those we are seeking to implement in this bill today. Surely everyone would agree that we value the health and safety of women more than that of our dogs and cats.

Please vote YES on HB 2819. The women of Kansas deserve no less.

2000 Clinical Policy Guidelines

National Abortion Federation



CLINICAL POLICY GUIDELINES 2000

NATIONAL ABORTION FEDERATION

8-2

TABLE OF CONTENTS

Introduction iii

Who Should Perform Abortions 1

Counseling and Informed Consent 3

Rh Testing and Rh Immune Globulin Administration 5

Early Medical Abortion 7

First Trimester Surgical Abortion 11

- Pre-Operative Procedure 11
- Operative Procedure 12
- Post-Operative Procedure 13

Second Trimester Abortion Procedure by D&E 15

- Pre-Operative Procedure 15
- Operative Procedure 15
- Post-Operative Procedure 17

Anesthesia 19

- Definitions 19
- Personnel and Monitoring 19
- Facilities and Equipment 21
- ASA Physical Status Definition 25
- ASA Standards for Basic Anesthetic Monitoring 27

Use of Peri-Operative Antibiotics 29

Pre-Operative Endocarditis Prophylaxis 33

Complications: Bleeding 35

- Pre-Operative Bleeding 35
- Peri-Operative Bleeding 35
- Delayed Bleeding 36

Complications: Perforations 39

Postoperative Care 43

Evaluation of Evacuated Uterine Contents 45

Fetal Tissue Disposal 47

Emergency Procedures 49

National Abortion Federation

2000 CLINICAL POLICIES GUIDELINES

INTRODUCTION

The mission of the National Abortion Federation (NAF) is to promote and enhance the quality of abortion services. An important part of this mission is to assure that women receive high quality abortion care and that they have access to this care in a safe environment. NAF also educates providers in new techniques while setting and maintaining standards for abortion services.

Like its precursors, the 2000 edition of NAF's *Clinical Policy Guidelines* establishes clinical policy guidelines which are developed by consensus, based on rigorous review of the relevant medical literature and known patient outcomes. These guidelines provide a basis for ongoing quality assurance, help reduce unnecessary care and costs, help protect providers in malpractice suits, provide ongoing medical education and encourage research.

NAF's *Clinical Policies Guidelines,* first published in 1996 and revised annually, use the methodology described by David Eddy, MD, in *A Manual for Assessing Health Practices and Designing Practice Policies: The Explicit Approach.* Clinical policy guidelines are defined as a systematically developed series of statements which assist practitioners and patients in making decisions about appropriate health care. They represent an attempt to distill a large body of medical knowledge into a convenient and readily usable format.

When the outcomes of an intervention are known, practitioner choices are limited. But when the outcomes of an intervention are uncertain or variable, and/or when patients' preferences for those outcomes are uncertain or variable, practitioners must be given flexibility to tailor a policy to individual cases. This is addressed by having three types of practice policies according to their intended flexibility: standards, recommendations, and options.

1) **STANDARDS** are intended to be applied rigidly; they must be followed in virtually all cases; exceptions will be rare and difficult to justify.

2) **RECOMMENDATIONS** are steering in nature; they do not have the force of standards, but when not adhered to, there should be documented, rational clinical justification; they allow some latitude in clinical management.

3) **OPTIONS** are neutral with respect to a treatment choice; they merely note that different interventions are available and that different people make different choices; they may contribute to the educational process, and they require no justification.

NAF's *Clinical Policies Guidelines* lists references when appropriate and includes discussions in more controversial areas. These guidelines are meant to be living documents, subject to periodic revision as better information becomes available.

References:

1. Eddy, DM. Clinical decision making: From theory to practice. Designing a practice policy: Standards, guidelines, and options. *JAMA*, 1990, *263*:3077.

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3. Field, M & Lohr, K (Eds). *Guidelines for Clinical Practice: From Development to Use*. Washington, DC: National Academy Press, 1992.

4. Garnick, D, *et al*. Can practice guidelines reduce the number and costs of malpractice claims? *JAMA*, 1991, *266*:2856.

5. Hadorn, D, *et al*. An annotated algorithm approach to clinical guideline development. *JAMA*, 1992, *267*:3311.

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7. James, BC. Implementing Practice Guidelines through Clinical Quality Improvement. *Frontiers of Health Services Management*, 1993, *10*: 1.

8. Leape, LL. Practice guidelines and standards: An overview. *Qual. Rev. Bull.*, 1990, *161*:42.

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8-6

COUNSELING AND INFORMED CONSENT

Policy Statement: Obtaining informed consent and assessing that the decision to have an abortion is made freely by the patient are essential parts of the abortion process.

Standard 1: Accurate information must be provided regarding the risks and benefits of abortion.

Option 1.01: This information may be provided either on an individual basis or in group sessions.

Standard 2: There must be documentation that the patient affirms that she understands the procedure and its alternatives; the potential risks, benefits, and complications; that her decision is uncoerced; and that she is prepared to have an abortion.

Recommendation 0.1: There should be an opportunity for discussion of the patient's feelings about the abortion decision.

Standard 3: A woman must undergo the abortion as expeditiously as possible in accordance with good medical practice.

Standard 4: Information about birth control must be available to patients at the facility.

Standard 5: All reasonable precautions must be taken to ensure the patient's confidentiality.

Discussion: Informed consent and abortion counseling are two different processes.

The goal of informed consent is to assure that the woman's decision is voluntary and informed, and to obtain legal permission for an abortion.

Counseling is a discussion of the feelings and concerns expressed by the woman who finds herself in a crisis situation. There are many different personal styles of counseling, and no one style works best in all situations. Counseling is not therapy and, therefore, is not intended to extend over a long period of time. A referral to community services

should be available if that becomes necessary or the needs of the woman are outside the scope of training of the counselor. Counseling may include an exploration of the woman's feelings, help with decision making and contraceptive choices, values clarification, or referral to other professionals. Abortion counseling is also to prepare the woman for her procedure by reducing her level of anxiety. Counseling must not create a barrier to service and must be voluntary.

Confidentiality might become an issue when third-party payers are involved. It is helpful to obtain information on clinic registration forms on all authorized sources of reimbursement, along with a statement that listing a source of reimbursement constitutes authority from the patient to notify and/or bill that source. If a patient does not provide information about a potential reimbursement source, it may be a breech of confidentiality to notify and/or bill that source unless there is documentation that supplemental consent from the patient has been obtained.

References:

1. Baker, A. *Abortion and Options Counseling: A Comprehensive Reference*. Granite City, Illinois: The Hope Clinic for Women, 1995.

2. Beresford, T. *Short-Term Relationship Counseling*. Baltimore: Planned Parenthood of Maryland, 1988.

Rh TESTING AND Rh IMMUNE GLOBULIN ADMINISTRATION

Policy Statement: Rh alloimmunization is a significant health risk to Rh(-) women undergoing abortion.

Standard 1: Rh status must be documented in all women undergoing abortion.
- a. This documentation may be obtained by on-site testing or outside medical source.
- b. Du testing is not required.

Standard 2: Rh immune globulin administration must be offered to Rh(-) women and documented.

Standard 3: If Rh immune globulin is not administered in the facility, one of the following is required:
- a. informed waiver signed by a patient who refuses Rh immune globulin;
- b. documentation of other arrangements for administration.

References:

I Baskett, TF. Prevention of Rh alloimmunization: A cost-benefit analysis. *Can. Med. Assoc. J.*, 1990, *142*:337.

2. Bowman, J. The prevention of Rh immunization. *Transfusion Med. Rev.*, 1988, *2*:129.

3. Chavez, GFP. Epidemiology of Rh hemolytic disease of the newborn in the United States. *JAMA*, 1991, *263*:3270.

4. Commentary: Immunoprophylaxis for Rhesus disease - Expensive but worth it?. *Brit. J. Obstet. Gynecol.*, 1991, *98*:509.

5. Gibble, JW. Maternal immunity to red cell antigens and fetal transfusion. *Cl. Lab. Med.*, 1992, *12*:553.

6. Roberts, H. The use of anti-D prophylaxis in the management of miscarriage in general practice. *Health Bull.*, 1991, *49*:245.

EARLY MEDICAL ABORTION

Policy Statement: Medical induction is an effective method for early abortion. Adequate counseling and follow-up care will enhance its safety and acceptability.

Standard 1: The patient must be informed about the need for follow-up contact to ensure that she is no longer pregnant.

Standard 2: The patient must be informed about the efficacy, side effects, and risks, especially excessive bleeding and teratogenicity associated with the medications to be used.

Standard 3: Patient instructions must include information about use of medications at home and symptoms of abortion complications.

Recommendation 3.1: Written instructions should be given to all patients.

Standard 4: The patient's willingness to consent to surgical abortion if medical abortion fails must be documented.

Standard 5: The facility must provide an emergency contact service on a 24-hour basis and must offer or assure referral for uterine aspiration if indicated.

Standard 6: Gestational age must be documented.

Recommendation 6.1: Ultrasonography should be used to confirm and document gestational age when physical exam and LMP are substantially discordant.

Option 6.01: Ultrasonography may be used routinely.

Standard 7: Completion of the abortion must be documented.[1]

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[1] See Clinical Policies Guidelines on Evaluation of Evacuated Uterine Contents.

Recommendation 7.1: Ultrasonography should be used to evaluate completion of the abortion when expected bleeding does not occur after medications.

Option 7.01: Ultrasonography may be used routinely.

Standard 8: Rh immune globulin must be offered in accordance with Rh Guidelines.[2]

Standard 9: Ectopic pregnancy must be considered when:

a. ultrasonography shows no intrauterine pregnancy or shows a suspicious adnexal mass; or

b. no preabortion sonography has been performed, and there is no or minimal bleeding in response to medications.

Recommendation 0.1: When methotrexate with misoprostol is used, the patient's gestation should be no greater than 49 days.

Recommendation 0.2: When mifepristone and oral misoprostol is used, the patient's gestation should be no greater than 49 days.

Recommendation 0.3: When mifepristone and vaginal misoprostol is used, the patient's gestation should be no greater than 63 days.

Discussion: Many patients prefer pharmacological methods of terminating early pregnancies rather than suction curettage. Medical abortion has several advantages for patients. It avoids surgery and anesthesia and offers women more active participation and control over the abortion process. By attracting new and more diverse types of providers, medical abortion has the potential to increase women's access to abortion and to help defuse anti-abortion harassment. On the other hand, medical abortion is less effective than surgical abortion (90-98% versus 99% or greater). It also takes longer and may require more office visits.

Extensive research has established the safety and efficacy of methotrexate or mifepristone combined with misoprostol for early pregnancy termination. However, medical methods are still evolving. Investigators continue to explore various pharmacologic agents and dosing regimens, the length of gestation during which they can be used, and the ideal protocols for their use.

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[2]See Clinical Policies Guidelines on Rh Testing and Rh Immune Globulin Administration.

Mifepristone is administered orally. Original trials involved a 600 mg dose, but further research indicates that 200 mg provides comparable overall efficacy. The best studied methotrexate regimen involves 50 mg/m^2 (body surface area) given intramuscularly, the same dose used in treating early unruptured ectopic pregnancy. One study found comparable efficacy using a standard 75 mg dose IM, but the results require confirmation. Recent research also indicates acceptable efficacy when methotrexate is administered orally in doses of 25-50 mg.

Information is also evolving on the types, doses, and routes of administration of the prostaglandin agents used in medical abortion regimens. Highly effective agents used in early European regimens included gemeprost and sulprostone, although the latter was discontinued due to adverse cardiovascular effects. These prostaglandins are not available in the United States. Currently, misoprostol is the favored agent because it is efficacious, cheap, stable without refrigeration, and already FDA-approved for other indications. Data suggest that vaginal misoprostol is more effective and associated with fewer gastrointestinal side effects than oral misoprostol, although efficacy using either route appears comparable at very early gestational ages.

The effectiveness of both mifepristone and methotrexate declines with increasing gestational age. Whereas the major U.S. medical abortion trials used transvaginal sonography routinely for gestational age assessment and follow-up, the extensive French experience relied more on clinical evaluation and hCG monitoring, reserving sonography for cases of uncertain dating or outcome. Sonography avoids underestimation of gestational age, helps confirm complete abortion, and assists in the diagnosis of ectopic pregnancy. However, no randomized trials have been performed to assess the effects of sonography or clinical evaluation on medical abortion outcomes.

These Clinical Policy Guidelines include recommendations for gestational age limits because efficacy rates have been shown to drop significantly beyond those limits.

Pharmacological induction of abortion provides an important alternative to surgical abortion in some circumstances. For example, medical methods may succeed when congenital uterine anomalies or fibroids limit surgical access to the gestational sac. Use of prostaglandin agents such as misoprostol may also avoid surgery in cases of incomplete spontaneous abortion.

References:

1. Paul, M & Creinin, MD (eds). Supplement on Medical Abortion. *Am J Ob Gyn*. In press.

FIRST TRIMESTER SURGICAL ABORTION

Policy Statement: Abortion is one of the safest surgical procedures in the US today. The following guidelines enhance this safety.

PRE-OPERATIVE PROCEDURE

Standard 1: Pertinent medical history must be obtained and documented.

Standard 2: Confirmation of pregnancy must be documented.

Standard 3: Gestational age must be verified and documented.

Option 3.01: Ultrasonography can be of clinical value in verifying intra-uterine pregnancy and gestational age.

Standard 4: The patient must be evaluated for ectopic pregnancy if
a) transvaginal ultrasonography shows no intra-uterine pregnancy and serum quantitative hCG exceeds 2000 mIU/ml[3]; or
- b) abdominal ultrasonography shows no intra-uterine pregnancy and serum quantitative hCG exceeds 3600 mIU/ml.

Standard 5: When a patient with a positive pregnancy test presents with vaginal bleeding and/or pelvic pain, ectopic pregnancy must be considered.

Option 5.01: Evaluation may include
a. sonography;
b. uterine aspiration;
c. serial quantitative hCG.

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[3]All hCG values used in this document are based on the Third International Standard (originally referred to as the First International Reference Preparation).

Recommendation 0.1: Hct or Hgb should be obtained in women with a history of significant anemia.[4]

Recommendation 0.2: Vital signs (e.g. blood pressure, pulse and temperature) and physical exam should be done as indicated by medical history and patient symptoms.

OPERATIVE PROCEDURE

Standard 6: All instruments entering the uterine cavity must be sterile.

Option 0.01: The vagina may be cleansed with a bacteriocidal agent.

Recommendation 0.3: Anesthesia should be used unless there are contraindications.[5]

Recommendation 0.4: The cervix should be dilated gently and gradually.

Option 0.41: Adequate dilation may be achieved by osmotic dilators.

Option 0.42: At very early gestational age, cervical dilation may be facilitated by delaying the procedure.

Option 0.02: Intra-operative ultrasonography can be of value to locate fetal parts and aid in their extraction, to verify an empty uterus, and to verify an intact uterus.

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[4]By establishing a balance sheet of risks, costs and outcomes, it was discovered that a pre-operative HCT was of relatively questionable value statistically in preventing morbidity and mortality in a healthy woman in the first trimester with no history of anemia or major disease process.

[5]See Clinical Policies Guidelines on Anesthesia.

POST-OPERATIVE PROCEDURE

Standard 7: Completion of the procedure must be verified and documented.[6]

Standard 8: Rh immune globulin must be offered per Rh policy guidelines.[7]

Option 8.01: Rh immune globulin may be injected into the cervix for Rh(-) patients.

Standard 9: Clinical Policy Guidelines for Postoperative Care must be followed.

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[6]See Clinical Policies Guidelines on Evaluation of Evacuated Uterine Contents.

[7]See Clinical Policies Guidelines on Rh Testing and Rh Immune Globulin Administration.

SECOND TRIMESTER ABORTION PROCEDURE BY D&E

Policy Statement: Second trimester[8] abortion by dilation and evacuation (D&E) is a safe outpatient surgical procedure when performed by appropriately trained clinicians in medical offices, freestanding clinics, and ambulatory surgery centers. As gestational age increases, complications and risks increase.

PRE-OPERATIVE PROCEDURE

Standard 1: Pertinent medical history must be obtained and documented.

Recommendation 0.1: A patient with prior C-sections should be evaluated for the presence of an anterior low-lying placenta.

Recommendation 0.2: Physical examination should be done as indicated by medical history and patient symptoms.

Standard 2: Verification of gestational age by ultrasonography is required prior to the termination of a pregnancy clinically estimated to be more than 14 weeks LMP.

Recommendation 0.3: A preoperative Hgb or Hct should be done.

OPERATIVE PROCEDURE

Standard 3: Appropriate dilation of the cervix must be obtained.

Recommendation 3.1: Dilation should be achieved gently and gradually.

Recommendation 3.2: Osmotic dilators should be used to facilitate adequate dilation.

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[8]For the purposes of these guidelines, second trimester begins at 15 weeks LMP. (Cunningham, FG, *et al. Williams' Obstetrics: 19th Ed.* East Norwalk, CT: Appleton and Lange, 1993; 249.).

Standard 4: When osmotic dilators are used, a physician must be available for emergency care prior to the scheduled procedure.

Option 0.01: In second trimester abortions intra-amniotic or intra-fetal injection may be given.[9]

Recommendation: These injections, if utilized, should be given at the time of laminaria insertion.

Option 0.02: Fetal cranial decompression may facilitate evacuation of the uterus.

Standard 5: All instruments entering uterine cavity must be sterile.

Standard 6: Uterine forceps appropriate for second trimester abortion must be available.[10]

Recommendation 0.4: Anesthesia should be used unless there are contraindications.[11]

Recommendation 0.5: Oxytocics should be available to aid in control of uterine bleeding.

Recommendation 0.6: Vasopressin should be used in the paracervical block solution (see refs. 2,5,7).

Option 0.03: Intra-operative ultrasonography can be of value to locate fetal parts and aid in their extraction, to verify an empty uterus, and to verify an intact uterus.

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[9]Dig 0.5 - 1 mg. or KCl 0.5 cc of 10% solution to a maximum of 2 cc's (see refs. 1 and 2).

[10]Acceptable forceps include Bierer, Sopher, Hern, Pratt, Peterson, Van Lith.

[11]See Clinical Policies Guidelines on Anesthesia.

Option 0.04: IV access may be established prior to evacuation.

POST-OPERATIVE PROCEDURE

Standard 7: Completion of the procedure must be verified and documented by the operator.[12]

Standard 8: Clinical Policies Guidelines for Postoperative Care must be followed.

Option 0.05: Oral oxytocics may be prescribed.

Discussion: Second trimester procedures comprise approximately 10% of abortions in the United States today. The dilation and evacuation procedure requires special training, techniques, and equipment appropriate for gestational age. Dilation and evacuation is now the predominant second trimester procedure. Other, less frequently used procedures include amnioinfusion with hypertonic solutions (urea, saline) and prostaglandin inductions. Although hysterotomy may occasionally be used, it carries significant risks when compared to other methods and is discouraged (see ref. 6). The presence of fetal anomalies may require individualized procedures to permit thorough examination of an intact fetus for genetic causes.

References:

1. Berkowitz, RL, *et al.* First-trimester transabdominal multifetal pregnancy reduction: A report of two hundred completed cases. *Am. J. Obstet. Gynecol.*, 1993, *169:*17.

2. Dillon, TF. Vasopressin as a hemostatic in gynecology surgery. *Am. J. Obstet. Gynecol.*, 1989, *78:*1285.

3 Fletcher, JC, *et al.* Fetal intracardiac potassium chloride injection to avoid the hopeless resuscitation of an abnormal abortus: II. Ethical issues. *Obstet. Gynecol.*, 1992, *80:*310.

4. Grimes, DA & Schulz, KF. Morbidity and mortality from second-trimester abortions. *J. Reprod. Med.* 1985, *30:*505.

[12]See Clinical Policies Guidelines on Evaluation of Evacuated Uterine Contents.

8-21

5. Julian, TM. Vasopressin use during vaginal surgery. *Contemp. Obstet. Gynecol.*, 1993, *38*:82.

6. Lawson, HW, *et al.* Abortion mortality: United States, 1972 through 1987. *Am. J. Obstet. Gynecol.* 1994, *171*:1365.

7. Phillips, DR, *et al.* The effect of dilute vasopressin solution on the force needed for cervical dilatation: A randomized controlled trial. *Obstet. Gynecol.* 1997, *89*:507.

8. Schultz, KF, *et al.* Vasopressin reduces blood loss from second-trimester dilatation and evacuation abortion. *Lancet*, 1985, 2:353.

9. Townsend, DE, *et al.* Vasopressin and operative hysteroscopy in the management of delayed postabortion and postpartum bleeding. *Am. J. Obstet. Gynecol.* 1991, *165*:616.

ANESTHESIA

Policy Statement: The use of anesthesia and/or analgesia can minimize pain and anxiety in abortion procedures but has certain risks in addition to its benefits.

DEFINITIONS:

1. Local Anesthesia - Elimination or reduction of sensation, especially pain, in one part of the body by topical application or local injection of a drug. In the context of abortion practice, this almost always signifies paracervical block.

2. Conscious Sedation - A minimally depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continuously, to be easily aroused, and to respond appropriately to physical stimuli and verbal commands.

3. Deep Sedation - A controlled state of depressed consciousness from which the patient is not easily aroused. This may be accompanied by a partial or complete loss of protective reflexes, including inability to maintain a patent airway independently and/or to respond purposefully to physical stimulation or verbal command. Deep sedation can result from sedative and analgesic administration intended to produce only conscious sedation.

4. General Anesthesia - A controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently and to respond purposefully to physical stimulation or verbal command.

PERSONNEL AND MONITORING

Standard 1: When conscious sedation, deep sedation, or general anesthesia are used, monitoring of the patient's level of consciousness must be documented.

Standard 2: When conscious sedation or local anesthesia is used, the practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be appropriately trained.

Standard 3: When conscious sedation is used, a person other than the clinician, trained to monitor appropriate physiological parameters, must be present.

Recommendation 3.1: During conscious sedation the patient should be checked frequently for verbal responses.

Standard 4: The personnel administering conscious sedation must recognize that conscious sedation may lead to deep sedation with hypoventilation and be prepared to provide respiratory support.[13]

Standard 5: The supervising practitioner must be immediately available when conscious sedation is administered.

Standard 6: When conscious sedation is used, monitoring must be of a degree which can be expected to detect the respiratory, cardiovascular, or neurological effects of the drugs being used.

Option 6.01: Pulse oximetry may be used to enhance this monitoring.

Recommendation 0.1: During conscious sedation or local anesthesia, IV access should be maintained for patients in ASA III, IV, and V (see Attachment A, *page 21 of this document).*

Standard 7: The practitioner administering general anesthesia or deep sedation must be certified according to applicable state requirements.

Standard 8: The practitioner administering general anesthesia or deep sedation must not be the practitioner performing the abortion.

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[13]See Clinical Policies Guidelines on Emergency Procedures.

Standard 9: For general anesthesia and deep sedation, the patient's oxygenation, ventilation, circulation and temperature must be continually evaluated as prescribed in the ASA Standards for Basic Intra-Operative Monitoring (see Attachment B, *pages 22-23 of this document).*

Recommendation 9.1: When deep sedation and/or general anesthesia are used, IV access should be maintained according to ASA guidelines.

Standard 10: The use of $N_20/0_2$ must follow guidelines for conscious sedation.

Standard 11: Equipment for the delivery of $N_20/0_2$ must:

a) provide a concentration of N_20 of no more than 50% inspired;
b) provide a maximum of 100% and minimum of 21% 0_2 conc.;
c) be outfitted with an 0_2 analyzer;
d) be checked and calibrated regularly.

Recommendation 11.1: N_20 concentrations in the work environment should be kept below the National Institute for Occupational Safety and Health (NIOSH) recommended limit.

Standard 12: When conscious sedation, deep sedation, or general anesthesia is used, there must be documentation that the patient has been warned of possible transient mental impairment.

FACILITIES AND EQUIPMENT: See Emergency Procedures guideline.

Discussion: ON THE USE OF ANESTHESIA IN GENERAL - All medications used in anesthesia have the potential for serious risk. This risk may be reduced to a minimum by adherence to established practice guidelines. Guidelines developed by other organizations concern themselves with anesthesia delivered primarily in hospital settings and to patients varying widely in age and general health. Abortion patients, however, are younger and rarely have significant health problems. Nonetheless, anesthesia complications are an increasing proportion of total abortion morbidity and mortality (see ref. 10).

The promulgation of guidelines for the delivery and monitoring of anesthesia care issued by organizations such as the American Society of Anesthesiologists (ASA), the American Dental Society of Anesthesiologists (ADSA), American Society of Gastrointestinal Endoscopists and others have clarified many of the issues related to anesthesia care. Whether it be local anesthesia, intravenous sedation, or general inhalation analgesia/anesthesia, it is the degree of CNS depression rather than any type of modality *per se* that is the basis for establishment of NAF guidelines. Levels of sedation are not completely distinct, but merge one with the next - each level of deeper sedation requires an increased level of care and monitoring. These levels of sedation are defined elsewhere.

NAF guidelines specifically address the use of conventional anesthesia. It is recognized that patient comfort and reduced anxiety are not dependent only on pharmacologic measures, but are significantly affected by patient counseling and by a supportive staff. It is also recognized that there is a wide range of alternative modalities (such as acupuncture, yoga, hypnosis) that are helpful for many patients. The focus of NAF guidelines, however, is on the monitoring necessary for the safe and effective use of pharmacologic methods generally used in outpatient abortion facilities.

ON THE USE OF PULSE OXIMETRY - There have been no trials on young women undergoing outpatient abortion who only rarely have respiratory or hemodynamic compromise. Given the low risk of morbidity and mortality associated with this procedure it is unlikely that there will be studies large enough to assess pulse oximetry on the basis of outcomes. The major correlation with prolonged oxygen desaturation is advancing age and cardiovascular function deficits.

ON THE USE OF N_20 - Nitrous oxide has a long history of use for analgesia and sedation, as well as an excellent safety record in the hands of both anesthesiologists and non-anesthesiologists. Attention must be paid to the level of sedation provided and the clinician must be prepared to recognize and care for changes in these levels. Occupational exposure to N_20 has been associated with increased risks of neurologic impairment, spontaneous abortion, subfertility, and hepatic and renal disease. Although there is no OSHA standard for N_20, NIOSH recommends that airborne levels of N_20 be kept below 25 ppm (1995) through well-designed scavenger systems and other engineering controls, equipment maintenance, exposure monitoring, and safe work practices.

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1. ADAS Newsletters, 1988, 20:2, as reported in Rosenberg, MB, & Campbell. RL, Guidelines for intraoperative monitoring of dental patients undergoing conscious sedation, deep sedation, and general Anesthesia. *Oral. Surg. Oral Med. Oral Pathol.*, 1991, *71*:2.

8-26

2. Atrash, HK, *et al.* Legal abortion mortality and general anesthesia. *Am. J. Obstet. Gynecol.*, 1988, *158*:420.

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4. Bell, GD, *et al.* Recommendations for standards of sedation and patient monitoring during gastrointestinal endoscopy. *Gut*, 1991, *32*:823.

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ANESTHESIA

American Society of Anesthesiologists

Physical Status Definition[14]

To avoid confusion as to the basis upon which the Department of Anesthesiology classifies physical status in operative patients, the following represents the official American Society of Anesthesiologists classification.

CLASSIFICATION OF PHYSICAL STATUS

P-1 - A normal health patient.
P-2 - A patient with mild systemic disease.
P-3 - A patient with severe systemic disease.
P-4 - A patient with severe systemic disease that is a constant threat to life.
P-5 - A moribund patient who is not expected to survive without the operation.
P-6 - A declared brain-dead patient whose organs are being removed for donor purposes.

[14]ASA *Manual for Anesthesia Department Organization and Management*. 1997. Reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068.

ANESTHESIA

American Society of Anesthesiologists

Standards for Basic Anesthetic Monitoring[15]

(Approved by House of Delegates October 21, 1986; last amended October 21, 1998, to become effective July 1, 1999)

These standards apply to all anesthesia care although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgement of the responsible anesthesiologist. They are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. They apply to all general anesthetics, regional anesthetics and monitored anesthesia care. This set of standards addresses only the issue of basic intra-operative monitoring, which is one component of anesthesia care. In certain rare or unusual circumstances, 1) some of these methods of monitoring may be clinically impractical, and 2) appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual† monitoring may be unavoidable. *Under extenuating circumstances, the responsible anesthesiologist may waive the requirements marked with an asterisk (*); it is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record.* These standards are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

†Note that "continual" is defined as "repeated regularly and frequently in steady rapid succession" whereas "continuous" means "prolonged without any interruption at any time."

STANDARD I: Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.

OBJECTIVE: Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. In the event there is a direct known hazard, e.g., radiation, to the anesthesia personnel which might require intermittent remote observation of the patient, some provision for monitoring the patient must be made. In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best judgement of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

STANDARD II: During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated.

OXYGENATION

OBJECTIVE: To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.

METHODS:

1) Inspired gas: During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.*

[15]Standards for Basic Anesthetic Monitoring, 1998 is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573.

2) Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed.* Adequate illumination and exposure of the patient is necessary to assess color.*

VENTILATION

OBJECTIVE: To ensure adequate ventilation of the patient during all anesthetics.

METHODS:

1) Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is strongly encouraged.*

2) When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.*

3) When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.

4) During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated, at least, by continual observation of qualitative clinical signs.

CIRCULATION

OBJECTIVE: To ensure the adequacy of the patient's circulatory function during all anesthetics.

METHODS:

1) Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.*

2) Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.*

3) Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.

BODY TEMPERATURE

OBJECTIVE: To aid in the maintenance of appropriate body temperature during all anesthetics.

METHODS: Every patient receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected.

USE OF PERI-OPERATIVE ANTIBIOTICS

Policy Statement: Prevention and treatment of infection will reduce post-abortion morbidity.

Recommendation 0.1: All women should receive antibiotics at the time of surgical abortion.

Recommendation 0.2 Therapeutic doses of antibiotics should be considered for high risk patients.

Recommendation 0.3: For documented infections, CDC guidelines should be followed.[16]

Option 0.01: Antibiotics may be initiated at the time of insertion of osmotic dilators.

Option 0.02: Patients with non-cardiac prostheses may be given peri-operative antibiotics.[17]

Discussion: Our review of the literature supports universal antibiotic treatment of all women undergoing surgical abortion.

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[16]Current treatment guidelines include:

Chlamydia -	Doxycycline	100 mg bid x 7d
	Azithromycin	1 gm stat
	Erythromycin	dosage based on preparation x 7d
	Ofloxacin	300 mg bid x 7d
Bacterial vaginosis -	Metronidazole	500 mg bid x 7d or 2 gm stat

[17]"It is the opinion of the American Academy of Oral Medicine that there is insufficient scientific evidence to support routine antibiotic prophylaxis for patients with prosthetic joints who are receiving dental care." Eskinazi, D & Rathbun, W. Is systematic antimicrobial prophylaxis justified in dental patients with prosthetic joints? *Oral Surg. Oral Med. Oral Pathol.*, 1988, 66:43.

Studies of large series of patients in the past were inconclusive as to whether routine antibiotics were helpful in reducing post abortal infectious morbidity. Because of this controversy, previous NAF Clinical Policy Guidelines recommended that only high risk patients be given perioperative antibiotics. High risk patients are defined as those at increased risk of Chlamydial cervicitis:

a. age under 21;
b. new or multiple sexual partners;
c. mucopurulent discharge;
d. presence of another STD;
e. previous history of pelvic inflammatory disease.

A recently published meta-analysis (see ref. 11) of randomized, controlled, clinical trials published between 1966 and 1994 indicates, however, that regardless of patient risk status, all patients would benefit from receiving antibiotics. Several antibiotic types and doses are effective.

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PRE-OPERATIVE ENDOCARDITIS PROPHYLAXIS

Policy Statement: Endocarditis is a potential risk of surgical procedures.

Option 0.01: Patients with a prosthetic heart valve, previous bacterial endocarditis or surgically constructed pulmonary shunt may be given pre-operative prophylactic antibiotics.

Option 0.02: Patients with mitral valve prolapse *with a murmur* may be given oral antibiotics prior to the procedure.

Discussion: A review of endocarditis prophylaxis literature summarizes the indications for antibiotic prophylaxis as follows: "Prophylaxis against endocarditis, therefore, should be reserved for higher-risk procedures in patients with higher-risk cardiac disorders. Otherwise, prophylaxis should be considered either optional or unnecessary . . .. Prophylaxis is advised when *both* the underlying cardiac condition and the procedure seem to pose substantial risk [emphasis added]" (see ref. 2).

The American Heart Association specifically does not recommend prophylaxis in the absence of infection for the following procedures: urethral catheterization, dilation and curettage, uncomplicated vaginal delivery, abortion, insertion or removal of intrauterine device, sterilization procedures, and laparoscopy. The AHA does not define "absence of infection". Notwithstanding the AHA recommendations, it is reasonable medical practice to follow the advice of consultants and/or referring physicians, about prophylaxis.

"Because no adequate, controlled clinical trials of antibiotic regimens for the prevention of bacterial endocarditis in humans have been done, recommendations are based on *in vitro* studies, clinical experience, data from experimental animal models, and assessment of both the bacteria most likely to produce bacteremia from a given site and those most likely to result in endocarditis. The substantial morbidity and mortality in patients who have endocarditis and the paucity of controlled clinical studies emphasize the need for continuing research into the epidemiology, pathology, prevention, and therapy of endocarditis" (see ref. 1).

References:

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2. Durack, DT. Prevention of infective endocarditis. *New Eng. J. Med.*, 1995, *332*:38.

COMPLICATIONS: BLEEDING

Policy Statement: One of the most serious complications of an abortion procedure is hemorrhage. Early recognition of the source of bleeding can reduce morbidity and mortality.

PRE-OPERATIVE BLEEDING

Recommendation 0.1: An ectopic pregnancy or spontaneous abortion should be considered.

PERI-OPERATIVE BLEEDING

Standard 1: When there is excessive bleeding, the surgeon must institute measures to identify the etiology of the bleeding and control it.

Recommendation 1.1: The surgeon should consider incomplete procedure, atony, fibroids, lacerations, perforations, placenta accreta, cervical or cornual pregnancy, coagulopathy.

Option 1.01: Ultrasonography may be useful to determine whether the uterus is empty and to detect occult bleeding.

Option 1.02: When a cervical bleeding source is suspected, hemostasis may be achieved by compressing the cervix at the lateral fornices with ring forceps or placing a suture.

Option 1.03: When atony is suspected, uterine massage and uterotonics[18] may be useful.

Option 1.04: When coagulopathy is suspected, blood may be drawn for coagulation parameters.

Recommendation 0.2: When excessive bleeding continues, the following measures should be instituted:

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[18] methergine (intracervical or IM); oxytocin (intracervical, IM, or IV); prostaglandins (e.g. Prostin, intracervical or IM)

a) monitor and document blood pressure, pulse, clinical status;
b) uterotonics;
c) establish IV access;
d) initiate appropriate volume replacement;
e) prepare for transfer to a hospital facility if necessary.

Standard 2: The patient must be transferred to a hospital facility when the bleeding does not respond to therapeutic measures or when the patient is hemodynamically unstable.

DELAYED BLEEDING

Standard 3: When a patient reports excessive bleeding[19] after discharge from the abortion facility, she must be evaluated by that facility or an emergency contact service.

Discussion: Excessive bleeding in the peri-operative and in the post-operative period is almost always due to uterine atony, often complicated by incomplete emptying of the uterus. Therefore, the most important initial efforts should be directed at assuring complete evacuation of the uterus and at increasing uterine tone through uterotonics.

Problems arise when bleeding is ignored or its severity underestimated. Clinicians must always remember to do the simple things when confronted with a developing bleeding problem: continue assessment of the blood loss, measure and record blood pressure and pulse frequently, assure intravenous access.

As a preventive measure, many clinicians give uterotonics and vasoconstrictors pre-operatively. Common regimens include:

a) methergine 0.2 mg po 5-30 minutes pre-operatively. Many also use 4-8 units of oxytocin in the paracervical block (e.g. 10 units in 50 cc of lidocaine, using 20 cc of the lidocaine for the block, or 4 units total dose);

b) epinephrine in the paracervical block (20 cc of 1:200,000 in lidocaine, equivalent to 0.1 cc of 1:1,000);

---

[19] saturation of more than one pad per hour for more than 3 hours

c) 2-6 units of vasopressin in the paracervical block for its additional vasoconstrictive effects.

When bleeding continues after assurance of complete uterine emptying and when there are no visible cervical or vaginal lacerations, the clinician must consider other complications such as perforation, coagulopathy, or placenta accreta.

References:

1. Hakim-Elahi, E. & Tovell, H. Complications of first-trimester abortion: A report of 170,000 cases. *Obstet. Gynecol.*, 1990, *76*:129.

COMPLICATIONS: PERFORATION

Policy Statement: Uterine perforation is a complication of abortion that can lead to significant morbidity.

Standard 1: If, in the clinician's judgement, an instrument passes farther than expected, then uterine perforation must be considered.

Standard 2: If a perforation occurs, even if the patient is asymptomatic, close observation and follow-up must be done.

Option 2.01: Antibiotic coverage may be instituted.

Option 2.02: Uterotonics may be administered.

Option 2.03: The patient may be transferred to a hospital.

Option 2.04: If a perforation occurs and *the pregnancy has not been disrupted*, the completion of the procedure may occur immediately, after a delay, or by referral to another provider.

Recommendation 2.1: If a perforation occurs and *the pregnancy has been disrupted*, the abortion should be completed as soon as feasible.

Option 2.05: The uterine evacuation may be completed under direct ultrasonography.

Option 2.06: The abortion may be completed under laparoscopic visualization.

Option 2.07: Re-identification of the uterine cavity may be performed and the abortion completed.

Standard 3: The patient must be hospitalized for definitive care if :

a) intra-abdominal viscera are detected in the uterine cavity, cervix, vagina, suction tubing, or on tissue examination;
b) fetal parts are detected in the abdominal cavity;
c) expanding intra-abdominal hematoma is detected; or
d) hemodynamic instability is present.

Standard 4: When uterine perforation is suspected and the cannula has been inserted into the uterine cavity, suction must be released immediately before the cannula is withdrawn.

Discussion: Perforations may be difficult to identify correctly. When a perforation is suspected, it is safest to proceed as if there has been a perforation until that possibility has been excluded.

Most perforations are midline and/or fundal in location, especially in the first trimester. Perforations are often occult and usually do not present a problem. In second trimester abortions there is an increased risk of serious perforations because the myometrium is more vascular and less resistant to damage by larger instruments. Lateral perforations are more likely to damage uterine vascularity. Perforations are more likely to occur in the following situations:

1) marked uterine anteflexion or retroflexion;
2) cervical internal os stenosis requiring more force to dilate;
3) uterine abnormalities;
4) difficult and prolonged uterine evacuation.

Uterine perforation is likely if:

1) an instrument extends without resistance further into the uterine cavity than expected;
2) the patient experiences more than the expected amount of pain during the procedure;
3) the patient experiences inordinate and persistent pain in the immediate recovery period.

Several factors may help prevent perforations:

1) straightening the axis of the uterus;
2) using laminaria;
3) lubrication of dilators;
4) accurate assessment of gestational age; and
5) accurate assessment of uterine position.

References:

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6. White, MK, *et al.* A case-control study of uterine perforations documented at laparoscopy. *Am.J.Obstet.Gyn.*, 1977, *129*:623.

POSTOPERATIVE CARE

Policy Statement: Most serious abortion complications are detectable in the immediate postoperative period. Appropriate and accessible follow-up care is essential to patients' well-being.

Standard 1: Completion of the abortion must be verified and documented.[20]

Standard 2: Rh immune globulin must be offered in accordance with Rh guidelines.[21]

Standard 3: All patients must be observed during the recovery period by a health care worker trained in postoperative care.

Standard 4: A clinician must remain in the facility until all patients are medically stable.[22]

Standard 5: The following criteria must be documented prior to discharge: the patient must be ambulatory with a stable blood pressure and pulse, and bleeding and pain must be controlled.

Standard 6: The patient must be given instructions outlining the signs and symptoms of postoperative complications.

Recommendation 6.1: Written instructions should be given to all patients.

Standard 7: The facility must provide an emergency contact service on a 24-hour basis and must assure physician referral if indicated.

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[20]See Clinical Policies Guidelines on Evaluation of Evacuated Uterine Contents.

[21]See Clinical Policies Guidelines on Rh Testing and Rh Immune Globulin Administration.

[22]Clinician is defined as a physician, nurse practitioner, physician assistant, or nurse midwife.

Option 0.01: A feedback form may be sent home with the patient to help gather medical, psychological, and social information that may have affected her outcome.

EVALUATION OF EVACUATED UTERINE CONTENTS

Policy Statement: Complete removal and identification of products of conception help prevent complications of abortion.

Standard 1: Evacuated uterine contents must be examined before the woman leaves the facility.

Recommendation 1.1: In first trimester terminations, flotation of tissue with backlighting should be used to identify products of conception, including gestational sac.

Option 1.11: Pathological examination of evacuated uterine contents may be performed.

Standard 2: When insufficient tissue or incomplete products of conception are obtained, the patient must be reevaluated.

Recommendation 2.1: Follow-up pelvic ultrasonographic examination should be considered.

Recommendation 2.2: Resuctioning should be considered.

Standard 3: If insufficient tissue is present after adequate patient evaluation, a protocol to rule out ectopic pregnancy must be followed, and the patient must be informed of symptoms and dangers of ectopic pregnancy.

Recommendation 3.1: If the uterine cavity is determined to be empty, serial quantitative hCG or sensitive urine pregnancy test should be measured.[23]

Standard 4: The patient must not be released from follow-up care until the diagnosis of ectopic pregnancy has been excluded or an appropriate referral has been documented.

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[23] Sensitive urine pregnancy test is positive at 50 MIU of β-hCG.

Recommendation 4.1: A 48-hour post-procedure serum quantitative hCG test should be done. If there is a decrease of 50% or more, no further ectopic follow up is necessary.

Recommendation 4.2: If 48-hour post-procedure serum quantitative hCG testing shows no change, or a subnormal increase in value, ectopic pregnancy evaluation and definitive treatment should be instituted and documented, or a referral made and documented.

Standard 5: In second trimester abortions, placenta and all major fetal parts must be removed from the uterus.

Recommendation 5.1: If the above are not identified, the following should be considered: ultrasonographic evaluation, intravenous pitocin administration, repeat uterine exploration.

Recommendation 5.2: The clinician should continue care of the patient until completion of the abortion has been determined.

Option 0.01: Intraoperative ultrasonographic guidance may be used to facilitate uterine exploration.

FETAL TISSUE DISPOSAL

Policy Statement: The improper disposal of tissue can lead to spread of infectious disease, and can increase the risk of theft or misplacement of tissue. Because of the possible infectious nature of tissue removed during the abortion procedure, guidelines for proper fetal tissue disposal are established.

Standard 1: All surgically removed tissue must be considered biohazardous and be disposed of in accordance with applicable local, state, and federal regulations. A proper protocol for tissue disposal must be in place.

Recommendation 1.1: There should be medically adequate protection of personnel;

Recommendation 1.2: There should be proper handling and storage of tissue using either:
a. biohazard disposal service;
b. licensed pathology laboratory;
c. on-site disposal where permitted by regulations.

EMERGENCY PROCEDURES

Policy Statement: Optimal management of abortion emergencies reduces morbidity.

Standard 1: Functioning equipment and current medications must be available on site to handle medical emergencies and must include: an 0_2 delivery system, oral airways, uterotonics, and epinephrine.

Recommendation 1.1: Facilities should have a specified area for emergency equipment to include oxygen, medications, and supplies.

Recommendation 1.2: Protocols should be in place to ensure ongoing training of staff in the use of emergency equipment, the management of emergencies and the indications for emergency transport.

Recommendation 1.3: Medications should include IV crystalloids, and, in clinics using IV sedation, narcotic antagonists.

Standard 2: When abortion procedures are being performed, a current CPR-certified staff member must be available on-site for emergency care.

Recommendation 2.1: All medical staff should be current CPR-certified.

Option 0.1: The following supplies may be used:

Type of Emergency	Prevention, Treatment
1. Anaphylaxis	Corticosteroids, epinephrine
2. Allergic reactions	Diphenhydramine (Benadryl), epinephrine, albuterol inhalers
3. Respiratory arrest	Oxygen, suction, ambu bag, airways
4. Hemorrhage, shock	IV crystalloid (normal saline or Ringers Lactate), uterotonics
5. Cardiac arrest	CPR

6. Seizure	Diazepam (Valium), midazolam (Versed)
7. Respiratory depression	Pulse oximeter

Condensed Abortion Protocol

Planned Parenthood of Central and Northern Arizona

Sn Fed St
04/10/02
Attach #9

COPY

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of Central and Northern Arizona
5651 North Seventh Street
Phoenix, AZ 85014
(602)277-7526

Planned Parenthood of Central and Northern Arizona
Condensed Abortion Protocol

In response to a request for information from the legislative staff, Planned Parenthood of Central an Northern Arizona is pleased to provide the following condensed protocol related to abortion services provide at our facilities for women who choose to exercise their right to have an abortion performed. These service are offered to ensure access to safe abortions to those patients who have been counseled on every phase o the abortion procedure and who are confident in their decision to terminate their pregnancy.

This condensed protocol covers many of the significant considerations related to the physical facilities supplies, equipment and personnel involved in the procedure. This condensed protocol does not, howeve cover other important considerations related to this procedure; including patient education & informe consent, patient selection - indications and contraindications, pre abortion procedures, post procedur management, quality assurance and management of high risk conditions & complications that are included the complete Planned Parenthood of Central and Northern Arizona protocol.

Questions pertaining to the contents of this document may be directed to Beth Weber, Director of Medic Services of Planned Parenthood of Central and Northern Arizona at (602)263-4296.

SURGICAL SERVICES - ABORTION

I. PHYSICAL FACILITIES

Clinics providing abortion services will have:

1. adequate, private space specifically designated for interviewing, counseling and medic evaluation;
2. dressing rooms for staff and patients, and appropriate lavatory facilities;
3. facilities for pre-procedure hand washing;
4. private procedure rooms;
5. adequate lighting and ventilation for abortion procedures;
6. surgical or gynecologic examination table;
7. post-procedure recovery room, properly supervised, staffed and equipped;
8. emergency exit to accommodate a stretcher or gurney;
9. facilities for sterilization of instruments.

II. SUPPLIES AND EQUIPMENT

Supplies and equipment that must be immediately available for use or in an emergency kit include:

1. electrically safe vacuum aspiration equipment, suction tubing, and a supply of sterile pla cannulas in various sizes;
2. conventional surgical instruments for cervical dilation and uterine curettage, in adequate sup to permit individual sterilized instruments for each patient;
3. equipment necessary for required laboratory testing;
4. a battery-operated light source for emergency back-up;
5. syringes and needles;
6. medications for sedation and analgesia and for local anesthesia;
7. antagonists for any narcotics or sedatives used;
8. parenteral dextrose and electrolyte solutions for emergency use;
9. pulse oximeter in the procedure room when a patient receives IV anesthesia or analgesia available to the recovery room if patients have received IV anesthesia or analgesia;
10. medications for management of emergencies as designated by supervising physician;
11. oxygen, with connectors to nasal prongs or mask and resuscitative equipment;
12. stretcher or gurney;
13. ultrasound.

[redacted] Howard
Exhibit No. [redacted]
Date 10-18-07
Deborah J. Worsley, RPR, CCR

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of Central and Northern Arizona
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All surgical equipment must be safe for the patient and for staff, must meet FDA standards, and will b checked annually to ensure safety and appropriate calibration.

III. PERSONNEL

The Medical Director will be the director of the abortion program. Physicians performing surgery will be licensed board certified/board eligible physicians who have demonstrated competence in the procedures involved and are acceptable to the Medical Director. Family Practice and OB/GYN residents may perform surgery under the direct supervision of the Medical Director or approved provider. A physician with admitting privileges at a local hospital must be available.

An RN, LPN, PA or Nurse Practitioner will be present during every clinic when abortions are performed to provide post-operative monitoring and care.

Surgical assistants and volunteers will receive training in counseling, patient advocacy and the specific responsibilities in the provision of this service.

IV. MEDICAL SCREENING AND EVALUATION

1. A medical history must be completed as required for comprehensive service patients. Special attention must be given to reported allergies to medications, antiseptic solutions, latex or past surgeries.

2. A physical examination including a bimanual exam estimating uterine size and palpation of the adnexa.

3. Laboratory testing shall consist of:
   A. urine or blood test for pregnancy;
   B. hematocrit;
   C. RH typing, unless reliable written documentation of blood type is available;
   D. other tests as indicated (saline suspension, serologic test for syphilis, etc.).

4. All patients will have an ultrasound evaluation. Staff will be trained in ultrasound for the determination of gestational age.

V. ABORTION PROCEDURE

1. Supportive personnel should be available to all patients throughout the abortion procedure.
2. Uterine evacuation must be done in a clean treatment room, using clean drapes, with adequate antisepsis of the vagina and with sterile instruments utilizing no-touch techniques.
3. Local anesthesia, analgesia and sedation may be used by physician order. All necessary equipment and personnel are maintained for safe administration thereof.
4. The manual-surgical-aspiration procedure will be the primary method used.
5. Patients undergoing mid-trimester abortion must have IV access established and maintained until the patient's condition is deemed to be stable in the recovery room.
6. Consciousness must be monitored throughout the procedure. Use of a pulse oximeter is required during all surgical procedures in which higher dose or combined drug narcotic analgesia or intravenous sedation is used. If low dose single drug IV analgesia is used and consciousness is not obtained, a trained person may monitor the patient's respirations, heart rate, and blood pressure. Blood pressure and heart rate must be evaluated and recorded on at least one occasion between the time that the abortion is completed and the patient is transferred to the recovery room.

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VI. RECOVERY ROOM

1. Immediate post-procedure care must consist of observation in a supervised recovery room for as long as the patient's condition warrants. Hospitalization without delay must be arranged if any complication beyond the management capability of affiliate staff occurs or is suspected.

   A licensed health professional who is trained in the management of the recovery area and is capable of providing basic CPR and related emergency care, must remain on the premises until all patients have been discharged.

   A physician must remain on the premises until all patients are stable, or until all patients have left the recovery room, whichever comes first. A physician must sign the discharge order and be readily accessible and available until the last patient has been discharged.

2. Prophylactic Methergine will be used as indicated.

3. RhO (D) immune globulin must be offered to Rh-negative unsensitized women within 72 hours but preferably in the immediate operative period. If the woman refuses, a refusal form must be signed. FDA approved doses must be used as follows:
   - abortion through the end of 12 weeks LMP: 50 micrograms (Microgam) IM;
   - abortion at 13 weeks LMP or later: 300 micrograms (Rhogam) IM.

4. Written instructions with regard to coitus, signs of possible problems, contraceptive use, and general aftercare must be given to each woman. Each patient must have specific instruction regarding access to medical care for complications. When discharged, the woman should be accompanied by a friend or relative. A consumer feedback form shall be given.

5. Contraception must be discussed. Oral contraceptives or DMPA may be initiated on the day the procedure.

6. Time in recovery
   - < 12 weeks = 30 minutes minimum
   - 13 - 16 weeks = 45 minutes minimum
   - 16 - 20 weeks = 60 minutes minimum

7. A call to the patient (when patient consents) will be made within 24 hours after surgery to access patients recovery.

VII. FOLLOW-UP VISIT

1. A post-procedure medical visit will be offered and scheduled for 3 weeks after the abortion. The visit will include a medical examination, including breast exam (when not performed as part of pre-abortion medical screening visit); review of results of all laboratory tests; and offer contraception. A low sensitivity urine pregnancy test will be obtained at the time of the follow visit in order to rule out continuing pregnancy or undiagnosed gestational trophoblastic disease; a continuing pregnancy is suspected, the patient will be evaluated and a physician provid abortion services will be consulted

Planned Parenthood®
of Central and Northern Arizona

FACT SHEET ABOUT EARLY ABORTION

1. WHAT IS IT: A first trimester abortion is an aspiration procedure to end a pregnancy within 14 weeks of the first day of the last normal menstrual period. There are occasions when the physician may require an ultrasound examination prior to performing the procedure. This is done by passing over your abdomen a microphone-like instrument which measures the size of your uterus, or by using a vaginal probe. This helps to more accurately determine the age of the pregnancy and determine whether there are conditions that may cause complications. When done, there may be an extra charge for this service. The final decision as to whether the abortion may be performed in the clinic will depend on your medical history, the physical examination, laboratory tests, and will be made by the doctor.

2. HOW IS IT DONE: The standard method of first trimester abortion is vacuum aspiration (suction curettage):

   - A local anesthetic is usually injected into or around the cervix (the lower part of the uterus). In some cases a tranquilizing medication is administered by injection into a muscle or a vein. Usually, medications are given by mouth to reduce cramping.
   - The opening of the cervix is gradually stretched by a series of narrow rods (dilators), each a little wider than the one before. The largest dilator may be about as thick as your index finger. (Alternatively, the cervix can be stretched open over a period of several hours using osmotic cervical dilators that swell up by soaking up fluid from the cervix).
   - A blunt-tipped tube (cannula) is inserted into the uterus. This tube is attached to a suction machine, which is then turned on. After the uterus has been emptied by gentle suction, a spoon-shaped instrument (curette) may be used to determine that the uterus has been emptied completely.

After this, you will spend as much time as needed in the facility under observation. When your condition is stable and you are ready to leave, you will receive the necessary prescriptions and follow-up instructions, including what you should do in the event of a complication.

You will be referred to one of our centers for an appointment for a check up, usually about 2 weeks after the abortion.

3. COMPARISON OF RISKS: As with any kind of procedure, complications can occur with early abortion. Early abortion by vacuum aspiration is, however, very safe. Fewer than 1 woman in 100 will have a serious complication, including, but not necessarily limited to:

   - Blood Clots in the Uterus - In about one in a hundred cases, blood clots may fill the uterus, leading to severe cramping. Usually the treatment is repeat uterine evacuation.
   - Infection - Infection is caused by germs from the vagina and cervix getting into the uterus. The likelihood of infection is less than 1 in 100 abortions. Such infections usually respond to antibiotics, but, in some cases, a repeat uterine evacuation or hospitalization is necessary. Rarely, surgery may also be required.

(continued on back)

4. Hemorrhage - Bleeding from the uterus, heavy enough to require a transfusion, occurs rarely. Such bleeding may require medications, a repeat uterine evacuation, or, on rare occasions, surgery. The risk of hemorrhage requiring blood transfusion is about 1 per 1,000 abortions.

5. Cervical Tear - The cervix is sometimes torn during the procedure. The frequency of this event is less than 1 in 100 cases. Stitches may be required to repair the injury.

6. Incomplete Abortion - Occasionally, the contents of the uterus may not be completely emptied. The frequency of this event is less than 1 in 100 cases. This problem can lead to infection, hemorrhage, or both. To remove the tissue, it may be necessary to repeat the vacuum aspiration or perform a dilation and curettage at the clinic or in a hospital. In rare instances, surgery may be required.

7. Perforation - Rarely, an instrument may go through the wall of the uterus. The frequency of this event is about 2 per 1,000 cases. Should this happen, hospitalization is usually required for observation and/or completion of the abortion. To inspect the condition of the uterus in this situation, a small telescope (laparoscope) can be inserted through the navel. Rarely, an abdominal operation is required to repair the damage. This can include hysterectomy (removal of the uterus), which makes it impossible to have children. The frequency of hysterectomy in this setting is about 1 in 10,000 cases.

8. Failure to Terminate the Pregnancy - Rarely, the early abortion procedure will not end the pregnancy. The likelihood of this event is about 2 per 1,000 cases. This possibility is one reason that a post-abortion examination is essential. In such cases, another abortion procedure is recommended, since the first attempted abortion can adversely affect normal development of the pregnancy. Alternatively, a tubal (ectopic) pregnancy may exist, which requires an abdominal operation to remove.

9. Anesthesia Reaction - Some women may be allergic to Novocain derivatives and to other medications. If this is known, it is important to tell the doctor. All medicines or drugs, including street drugs, may cause serious and dangerous reactions during anesthesia. It is important that you provide this clinic with information about any drugs you have taken. What you tell us will be kept in confidence.

10. Impact of Abortion on Subsequent Wanted Pregnancies - Studies on abortion have shown that one uncomplicated first trimester abortion by vacuum aspiration does not pose a measurable risk to a woman's future childbearing ability. Whether more than one abortion affects a woman's future childbearing ability is less clear, as less research has been done in this area.

11. Emotional Reactions - Emotional problems after abortion are uncommon, and when they happen they usually go away quickly. Most women report a sense of relief, although some experience depression of guilt. Serious psychiatric disturbances (such as psychosis or serious depression) after abortion appear to be less frequent than after childbirth. Counseling is available to you through our centers.

12. Death - Early abortion is one of the safest operations in all of medicine. The risk of a woman dying from full-term pregnancy and childbirth is many times greater than that from early abortion.

Remember, abortion is a safe procedure. We are available to answer any questions you may have. Please let us know if we can help you.

Manual of Medical Standards and Guidelines

(Section VII-A-1 Abortion; Revised: January 2000)

Planned Parenthood Federation of America, Inc.

SURGICAL ABORTION SERVICES

I. General Information

A. Initiation of Services

1. Abortion may be offered as a comprehensive or limited service.

2. A written request must be submitted to PPFA for review and approval as outlined in Section I-C. There must be:

   a. a separate request submitted to initiate medical and surgical services and for each period of gestation to be covered;

   b. a clear statement of the type(s) of procedures that will be performed and the duration of pregnancy to be covered;

   c. a statement that current PPFA Medical Standards and Guidelines will be followed and a statement that a section detailing the management of abortion complications will be included in the affiliate protocol (see Management of High Risk Conditions, #XII this section, and Guidelines for the Management of Abortion Complications, Section VII-C-1);

B. Duration of Pregnancy - Must be calculated in menstrual weeks

1. Date the onset of the pregnancy from the first day of the last menstrual period (LMP), i.e., first day of LMP = day 1.

2. If day of ovulation is known, but the first day of the LMP is uncertain, add 14 days to the date of ovulation to convert to menstrual dates.

II. Physical Facilities, Supplies and Equipment

A. The physical facility, whether on or off site, must satisfy applicable state and local regulations.

B. Supplies and equipment that must be immediately available include:

1. safe aspiration and surgical equipment that meets FDA standards, in adequate supply to permit individual sterilized instruments for each patient;

2. equipment necessary for required laboratory testing;

2. syringes and needles; medications for sedation, analgesia and for local anesthesia; and appropriate IV antagonists (e.g. naloxone, flumazenil) for any narcotics or other medications used;

3. a pulse oximeter in the procedure room when a patient receives IV anesthesia or analgesia; and available to the recovery room if patients have received IV anesthesia or analgesia;

5. a battery-operated light source and other back-up systems capable of allowing the completion of the procedure in case of a power failure;

6. medications, parenteral dextrose and electrolyte solutions; oxygen, with connectors to nasal prongs or mask; resuscitative and suction equipment; for emergency use.

Staff must be trained in the maintenance of all equipment, which must be checked at appropriate intervals to ensure safety.

III. Personnel – Who must be available include:
III

A. a physician director experienced in the performance of abortion procedures. The Physician Director (or a physician-designee approved by the Medical Director) shall evaluate and approve all clinicians who perform abortions at the affiliate;

A. clinicians performing abortions – who must:

1. be allowed by state law to perform abortions;

2. be appropriately trained and experienced with demonstrated skills in the performance of abortions. Appropriate experience should include staged progression by menstrual age in the performance of procedures under the observation of a physician who is experienced and proficient in the performance of like procedures;

3. satisfy all personnel requirements listed in Section I-A-1 (i.e., education, experience, licensing, credentialing, etc.);

A. licensed health professional(s) – to supervise the recovery area; assist in the procedure room, as needed; or to perform other functions as required;

B. medical assistants - as needed;

C. counselors – who are adequately trained and supervised. The clinician who performs the procedure must ascertain that informed consent has been obtained and that all of the patient's questions have been answered satisfactorily prior to performance of the procedure.

Each counselor must be knowledgeable about:

1. options available to the woman regarding her pregnancy;

2. facts regarding abortion, including relative risks and benefits;

3. sources and referrals for prenatal care, adoption and psychological consultation, which may be requested by the patient or which may be deemed medically advisable;

4. availability of insurance coverage or other reimbursement for abortion, and for prenatal care and delivery;

5. all methods of contraception and availability of contraceptive services.

IV. Patient Selection

A. Indications - Abortion may be performed for a patient who:

1. has freely chosen to terminate her pregnancy and is capable of giving voluntary informed consent;

2. has been medically evaluated and found to have a pregnancy within the gestational age limits of the affiliate program;

3. has a threatened abortion or has retained tissue from a spontaneous abortion;

4. appears to be psychologically prepared to undergo an abortion under local anesthesia and available analgesia;

5. has no contraindications to a procedure performed in an outpatient setting.

B. Contraindications - include:

1. uterine size exceeds the gestational age limitation of the affiliate program;

2. inability to tolerate an abortion procedure under local anesthesia and available analgesia;

3. inability to tolerate the insertion of osmotic cervical dilators when necessary;

4. extreme obesity precluding the use of conventional-length instruments;

5. mucopurulent cervicitis presumptively due to untreated gonorrhea or chlamydia. The patient may be treated per CDC Guidelines shortly before the abortion procedure, with completion of treatment post-procedure;

6. known hydatidiform mole of more than 10 week size or a sac size of greater than 3 cm. (If done, a referral source for follow-up must be given.);

7. intrauterine infection;

8. inaccessible veins;

9. uncontrolled seizure disorder (i.e., more than one seizure a week);

10. significant medical, cardiovascular, gynecological, psychological or hematological abnormalities. The patient must be medically evaluated and deemed an acceptable surgical candidate before performance of the procedure;

11. hematocrit 24% (hemoglobin 8 gm/dl) or less for first trimester procedures; hematocrit 30% (hemoglobin 10 gm/dl) or less for mid-trimester procedures;

12. unexplained fever, with temperature 38°C (100.4°F) or more;

13. known placenta previa if more than 18 weeks LMP (through 17 weeks and 6 days from day 1 of LMP).

C. Referral – must be provided to an alternate provider if a patient is ineligible for an abortion at the affiliate. A list of referral abortion facilities must be prepared and updated annually and must include facilities that provide abortions at any gestational age, using local and general anesthesia.

V. Patient Education and Informed Consent

Special care must be exercised to insure that women considering abortion are not subjected to duress or to coercion, express or implied, of any kind, and that all such decisions are reached on the basis of full information and free discussion.

A. The patient must have the:

1. opportunity to ask questions and to clarify points at any time during the process;

2. option of being accompanied by a person of her own choosing, who also is free to ask questions;

3. option of having the services of another counselor, if so desired;

4. option of deciding not to have the procedure without penalty or denial of other services.

B. Information needed to make an informed decision must be presented in an objective and non-judgmental manner in the language and terminology best understood by the patient. The PPFA Fact Sheet for Early Surgical Abortion (See Section VII-A-2) and other relevant fact sheets must be given and each must have the required information specific to the affiliate. These must be documented on the medical record.

C. Informed consent must be obtained in writing from all women (or from their legal guardians in the case of incompetents) prior to administering a pre-operative sedative or narcotic analgesic. The PPFA Request for the Provision of Surgery or Other Special Services/Procedures must be signed (Section 1-B-2). The name of the surgical procedure, other procedures, (e.g. use of dilators/misoprostol) and medications used (e.g. sedation/anesthesia, RhoGam) must be written in.

D. Consent procedures for minors and others must be consistent with state law.

E. When it is known that fetal tissue will be used for research purposes, the statement "All fetal tissue will be disposed of in a manner consistent with state regulations and community practices for the disposal of surgical pathological specimens" shall be added to the consent forms. An additional consent form may be used by the affiliate to clarify that the fetal tissue will be used for research purposes.

VI. Medical Screening and Evaluation

A. A targeted medical history that includes screening to rule out possible contraindications must be completed. Special attention must be given to reported allergies to medications, antiseptic solutions, and latex.

B. The physical examination must include:

1. temperature;

2. blood pressure;

3. abdominal palpation, including approaching the patient from the side, starting from the xiphoid process and palpating the abdomen downward toward the pubic bone to check for fundal height;

4. visual exam of the vulva, vagina and cervix;

5. bimanual exam, including estimation of uterine size and palpation of the adnexa;

6. additional examination as indicated by history or laboratory findings.

C. Laboratory testing shall consist of:

1. urine or blood test for pregnancy performed at the affiliate within the past 7 days, unless a sonogram has documented a living intrauterine pregnancy;

2. hemoglobin or hematocrit determination;

3. Rh typing, unless reliable written documentation of blood type is available;

4. gonorrhea and chlamydia evaluation (history and examination; testing as indicated);

5. other tests as indicated (e.g., Pap smear, STIs).

D. Ultrasound evaluation

1. Affiliates offering mid-trimester abortion must perform ultrasound routinely for fetal gestational age evaluation. Real time ultrasound capability must be available during D&E abortion procedures.

2. In first trimester abortion programs, ultrasound examination, either on-site or by referral, must be used prior to the procedure in the following circumstances:

a. in very early procedures, when indicated, e.g., pre-procedure to confirm the presence of a gestational sac, or post-procedure if no tissue is found;

b. when uterine size cannot be estimated during bimanual pelvic examination;

c. there is suspicion that the patient may not be pregnant;

d. the uterine size is greater than 14.0 weeks LMP;

e. the pelvic examination reveals an abnormality that might interfere with the safe performance of the abortion (e.g., large adnexal masses, irregular uterine shape, hyperflexion of the uterus, or severe ante - or retroversion).

VII. Pre-Abortion Procedures

A. Cervical Dilation/Ripening

1. Osmotic cervical dilator(s) and/or misoprostol must be used prior to the procedure in women receiving mid-trimester abortions (unless the cervix permits insertion of appropriately sized cannulas with minimal dilation), and is advisable in nulliparas. The use of these is optional as indicated in early abortion.

   - Misoprostol may be given orally or vaginally, from 2-24 hours before the abortion; not to exceed 800 micrograms.

1. The number of dilators used and the amount used and route of administration of misoprostol must be recorded on the patient's chart. The number of dilators must be accounted for at the time of removal.

2. Patients must be given oral and written information and instructions about possible problems and complications. Each woman must be informed that this is the first definitive step in the abortion procedure. (See Facts about Preparing the Cervix for the Abortion Procedure, Section VII-A-3.) Documentation that the fact sheet was given must be included in the medical record.

3. Once a determination of uterine size has been made by the abortion clinician, the clinician may, if (s)he so chooses, subject to applicable state law, permit a specially trained nurse to insert osmotic cervical dilators or misoprostol under the abortion clinician's supervision, i.e., the abortion clinician must be immediately available in case of emergency.

4. Patients must be supervised until discharged and should be accompanied when released from the center. The affiliate must have a twenty-four hour answering service and a medical staff person must be available to respond to patients at all times.

B. Prophylaxis

1. Post-abortal endometritis: A policy regarding the use of prophylactic antibiotics to prevent post-abortal endometritis must be developed. The policy must include a determination as to whether all or selected patients will be offered prophylactic therapy, which antibiotic will be used, and in what regimen. Some providers prefer to treat all patients empirically with a

full course of therapy for lower genital tract chlamydia, although there are no data to prove the necessity or superiority of this regimen. Antibiotic regimens given for 3 or 5 days should be avoided, as they are longer than necessary for prophylaxis and not long enough for effective chlamydia treatment.

If a choice is made to provide a prophylactic antibiotic regimen solely to high-risk patients, those with the following conditions should be included:

a. history of treated cervical GC, chlamydia, or PID in the past year;

b. history of post-abortal endometritis within 1 year;

c. IUD in place at the time of abortion;

d. any chronic or debilitating disease (e.g., HIV) that increases the risk of immunodeficiency:

e. taking a medication that may increase susceptibility to infection (e.g., steroids).

2. Bacterial endocarditis (BE): The American Heart Association (AHA) guidelines for bacterial endocarditis prophylaxis state that women with low risk heart lesions undergoing abortion procedures do not require prophylactic antibiotics. However, in light of the minimal risk related to the use of BE prophylaxis, many providers choose to offer BE prophylaxis for low-risk women. If BE prophylaxis is used, current AHA recommendations must be followed. (See Section IV-A-3).

3. Post-abortal hemorrhage: Uterotonic drugs (such as ergonovine) may be given prophylactically immediately after abortion to avoid post-abortal hemorrhage. Vasopressin (Pitressin), 3-5 units added to the local anesthetic solution used for the cervical block, may decrease the amount of intraoperative and postoperative bleeding, especially with midtrimester abortion procedures. If possible, Hemabate® should be available on premises.

VIII. Abortion Procedure

Duration of pregnancy - in general

A. Very early abortions (VEA) - from the time a pregnancy test becomes positive up to six weeks LMP (through 5 weeks and six days from day 1 of LMP). (The use of a hand-held syringe permits easier identification of the POC due to less disruption and dispersion of the specimen.)

A protocol must be in place with clear guidelines regarding evaluation with ß-hCG or ultrasound and management and referral for evaluation of possible ectopic pregnancies. See sample protocol for very early surgical abortion in Section VII-A-4).

B. First trimester abortions - up to 14 weeks LMP (through 13 weeks and 6 days from day 1 of LMP).

C. Mid-trimester abortions - up to 20 weeks LMP (through 19 weeks and 6 days from day 1 of LMP) or with a fetal biparietal diameter (BPD) up to 50mm, whichever is greater.

IX. Anesthesia, Analgesia and Sedation

A. Local anesthesia must be used: Cervical block may be given by intracervical or paracervical (utero-sacral) infiltration.

B. Analgesia and sedation - analgesia and moderate sedation may be used as an adjunct to local anesthesia.

1. Analgesics are used for the control of pain, but provide little relief from anxiety. Narcotic analgesics induce stupor as well as block the transmission of pain. Women undergoing mid-trimester abortion and those requesting stronger analgesia may receive more potent agents, including short acting intravenous narcotics such as fentanyl. When narcotic medications are used, an antagonist medication, such as naloxone, must be available on site.

2. Sedatives depress the central nervous system and are used to reduce anxiety and relax muscles, although they do not actually reduce pain. Oral or parenteral sedatives may be used to induce mild or moderate sedation for selected patients. When sedatives are administered intravenously, it is necessary to give small doses slowly, while closely monitoring the patient's reaction. If intravenous sedatives such as midazolam or diazepam are used, antagonists such as flumazenil must be available on site.

3. Intravenous sedatives must be used with great caution when given concurrently with a narcotic analgesic, owing to their potentiating effects and the consequent risk of respiratory depression. When intravenous sedatives and narcotic analgesics are given together, the dose of each may need to be reduced.

4. Consciousness must be monitored throughout the procedure. Use of a pulse oximeter is required during all surgical procedures when IV narcotic analgesia or IV sedation is used. The physician/surgeon must be notified immediately if the pulse oximetry saturation (Spo_2) falls below 90. Patients must not be removed from the oximeter or released to the recovery room unless they are spontaneously maintaining adequate oxygenation without being verbally or physically stimulated. Blood pressure and heart rate must be evaluated and recorded on at least one occasion between the time that the abortion is completed and the patient is transferred to the recovery room.

5. When IV narcotic analgesia or IV sedation is used, the physician/surgeon and the recovery room nurse must be currently certified in CPR, be familiar with ACLS guidelines, and must know when and how to perform the following procedures for airway management:

a. evaluate airway competency;

b. apply jaw thrust;

c. insert tongue blade or oral airway;

d. suction airway;

e. administer oxygen by mask;

f. assist ventilation with an Ambu bag;

g. administer appropriate IV antagonists (e.g. naloxone or flumazenil);

h. implement an emergency protocol for outside assistance should such be needed to restore adequate airway function;

i. direct and assist with CPR until outside assistance is obtained.

B. I.V. Access

1. must be established for all patients undergoing mid-trimester abortion and must be maintained (e.g., Hep-lock) until the patient's condition is deemed to be stable in the recovery room.

2. should also be established and maintained in patients receiving IV midazolam HCL until the patient is deemed to be stable in the recovery room.

D. Intravenous barbiturates (e.g., Brevital) or inhalational anesthetics, including nitrous oxide, may not be used, as they induce a state that is considered to exceed moderate sedation. A waiver must be submitted to the National Medical Division if the use of such products is desired.

X. Post-Procedure Management

A. Tissue Evaluation

1. Gross examination of all tissue specimens must be performed by the clinician who performed the procedure, or by clinic personnel with special training and physician supervision in the performance of this task, and blood loss must be estimated. All findings must be recorded on the chart. Tissue evaluation is considered to be complete if all of the following occur:

a. placenta or membranes (preferably both) are positively identified;

b. the volume of aspirated tissue correlates with the estimated gestational age;

c. in pregnancies of 13 weeks LMP or more, all fetal parts are accounted for.

2. If adequate placental or fetal tissue is not readily identifiable, the tissue must be examined by flotation in water or vinegar and inspected, preferably

utilizing back lighting. These procedures should be done while the patient is still in the procedure room, and must be done before the patient leaves the facility to determine if immediate remedial management is called for (e.g., reaspiration).

2. High Alert Management Plan: To respond to situations when placenta or membranes are not positively identified, a High Alert Management Plan designed to exclude the diagnoses of ectopic pregnancy or continuing intrauterine pregnancy must be in place and must include management as found in Section VII-C-1, High Alert Management Plan for Possible Ectopic Pregnancy)

4. All fetal tissue must be disposed of in a manner consistent with state regulations and community practices for disposal of surgical pathological specimens.

B. Recovery Room

1. Immediate post-procedure care must consist of observation in a supervised recovery room for as long as the patient's condition warrants. Hospitalization without delay must be arranged if any complication beyond the management capability of affiliate staff occurs or is suspected.

2. A licensed health professional who is trained in the management of the recovery area and is capable of providing basic CPR and related emergency care, must remain on the premises until all patients have been discharged.

3. If IV anesthesia or analgesia is used, a registered nurse, or a licensed practical/vocational nurse who is certified in CPR and capable of performing other procedures for airway management (as listed above), must supervise the recovery area. This nurse must also be familiar with the operation and interpretation of pulse oximetry and with the immediate IV administration of appropriate antagonists for the anesthesia or analgesic drugs administered.

3. A physician must remain on the premises until all patients are stable, or until all patients have left the recovery room, whichever comes first. A physician must sign the discharge order and be readily accessible and available until the last patient has been discharged.

A discharge summary should be written noting blood pressure, amount of bleeding, and general condition of patient.

C. RhO (D) immune globulin must be offered to Rh-negative unsensitized women within 72 hours, but preferably in the immediate operative period. Informatiiom regarding RhoGam must be given to patient in writing and be documented on the medical record. If the woman refuses, the Release When Test/ Service/

Consultation Will Not Be Obtained As Recommended must be signed (See Section I-B-2). FDA approved doses must be used as follows:

1. abortion through the end of 12 weeks LMP: 50 micrograms IM;

2. abortion at 13 weeks LMP or later: 300 micrograms IM.

B. Post-Procedure Instructions

1. Written instructions with regard to coitus, signs of possible problems, contraceptive use, and general aftercare must be given to each woman. Each patient must have specific instructions regarding access to medical care for complications. A friend or relative should accompany the woman when she is discharged. A consumer feedback form may be given.

2. Contraception must be discussed. Oral contraceptives or DMPA may be initiated, or Norplant inserted, on the day of the procedure (see Section III). An IUD may be placed at the time of the procedure, if desired by the patient and no contraindications exist (See Section IV).

XI. Follow-up Visit

A. A post-procedure medical visit, either at the affiliate or through another medical provider, must be offered and should be scheduled within 2-3 weeks of the abortion.

B. Appropriate referral for other medical, gynecologic or counseling services and treatment should be made wherever indicated.

C. Routine use of a low-sensitivity urine pregnancy test at the time of the follow-up visit is strongly recommended for the purpose of identifying a continuing pregnancy or undiagnosed gestational trophoblastic disease.

D. If a continuing pregnancy is suspected, an evaluation must be initiated. Examples of such conditions are as follows:

1. persistently positive pregnancy test at a time when a negative test would be expected;

2. lack of normal involution of the uterus post-abortion;

3. patient reports that she still feels pregnant;

4. any concern that the abortion procedure did not empty the uterus completely (e.g., less tissue than expected for gestational age).

Documentation of an empty cavity by ultrasound is the safest way to rule out incomplete abortion or continuing pregnancy.

E. Results of this follow-up visit must be recorded in the patient's record. Results of the follow-up examination conducted elsewhere should be obtained and recorded. Monitoring of post-procedure complications is considered essential to quality care.

XII. Management of High Risk Conditions

Each affiliate undertaking an abortion program must include in its manual of medical procedures an affiliate-specific written protocol describing the management of potential

immediate, early and late complications (see Section VII-C-1). The protocol must include, but need not be restricted to, management of:

A. incomplete uterine evacuation;

B. intra-operative and post-operative hemorrhage;

C. acute hematometra (post-abortal syndrome);

D. uterine perforation;

E. cervical laceration;

F. vasovagal reaction, anaphylactic reaction, shock, cardiac arrest;

G. infection;

H. possible ectopic pregnancy;

I. abnormal pregnancy (mole);

J. trapped calvarium or other fetal parts (mid-trimester only);

K. exacerbation of underlying medical or psychological conditions.

XIII. Management of Emergencies

Note: There must be a written agreement with a physician who has full operative privileges at the hospital, specific to the management of possible complications of the services provided (e.g., gynecologic, urological). Explicit documentation must be included regarding backup coverage arrangements when the physician is unavailable. (Affiliate physicians who desire professional liability insurance coverage through the PPFA National Insurance Program for follow-up care provided off-premises must apply to the PPFA Insurance Department for such coverage).

If it is not possible to get a written agreement with a physician (and with a back-up physician) or if the patient will not be in the vicinity where affiliate emergency care could be accessed, written information must be given to the patient regarding emergency room care including the fact that the patient will be responsible for paying for that care.

Abortion practitioners licensed by Kansas State Board of Healing Arts

March 2002

Lawrence, KS

NEUHAUS [Caddell], Ann Kristin [Eisenbise] *(license 4-21596-GenlPract)* Office: **205 W. 8th** Ph. 785-865-3500; closed Wichita offices 5/11/01. See detailed disciplinary Timeline sheet.
Drug Enforcement Agency (DEA) violations 3/19/99: Feds' restrictions trigger KSBHA actions
Disciplinary 10/18/99-9/11/00 KSBHA mandates: (1)Neuhaus may only use one drug-Valium or its generic (2) outside pharmacist must oversee her prescriptions (3) random drug testing for entire staff 4) improve patient record=keeping 5) get resuscitative training with staff 6)monitor patients correctly during surgery; various other demands. Neuhaus' "practices constitute an imminent danger to the public".
Disciplinary Stipulation, Emergency orders, Petition to revoke license, Final order 8/24/01: multiple charges from 5 former patients detailed by KSBHA,ongoing disciplinary investigations for negligence, improper sedation, lack of informed consent, performing an abortion against the patient's wishes, keeping pre-drawn syringes, deviations from standard care pre- and post-op & other charges.

Wichita, KS

TILLER, George R. *(license 4-14025 FamPract)* Offices: **5107 & 5101 E. Kellogg** Ph. 316-636-5255
Disciplinary Stipulation 2/13/84: Record not available to public. See Malpractice sheet.

HARRIS, Norman R. *(license 4-12974 Ob/Gyn)* Office: **5101 E. Kellogg** Ph.316-636-5255; resident of Florida.

CARHART, Leroy *(license 4-24866 Genl Surgery)* Office: **5107 E Kellogg** Ph.316-684-5108, resident of Nebraska, w/office at 1002 W. Mission, Bellevue, Ph.402-292-4164. Is licensed in 7 states. Has been licensed w/o Kansas office address since 12/93. On his KS application , he omits listing his work at the Omaha abortion facility during which time he was charged by various state agencies with abortion medical practice violations. He started w/ Tiller 7/10/00. See Malpractice sheet.
Disciplinary,Nebraska Atty Genl.,Board of Examiners, Dept. Of Health,6/3/93: State settlement wherein Carhart agreed not to: hold personal phone calls while aborting, falsify patient records, interrupt or delay abortions due to fatigue, fail to protect staff from contagious diseases.
Commentary: News stories linked Carhart to fetal tisue sales & research at Univ.of Nebraska. The Supreme Court decision reversing a ban on partial birth abortions bears his name, Stenberg v Carhart.

This record compiled from KSBHA public documents, news articles and court records

Abortion practitioners licensed by Kansas State Board of Healing Arts

March 2002

Kansas City, KS

MILLER, Dennis W. *(license 4-19490-Ob/Gyn)* Office: **21 N. 12th St** Ph.913-621-4001.
Nasty legal history, abortion death, unusually large awards; see Malpractice sheet.
Disciplinary 1/3/89: KSHBA actio , following aborted patient death, was merely that he not abort in his office for 1 year. Miller continued aborting during the 8 months of KSBHA"decision-making" & after.
Disciplinary 6/23/96: KSHBA orders $500 fine & reprimand for keeping pre-signed drug prescription forms for controlled substances, in violation of Kansas & national law.
Commentary: Miller failed the Missouri medical exam 3 times, then continued to retake the Kansas exam until he finally passed it on the 9th try. He also twice failed the exam to become board-certified. During a barrage of malpractice lawsuits, [see KCStar article] he maintained his status as an approved physician for 12 area insurers, as well as the chairmanship of a hospital Ob/Gyn dept.

RAJANNA, Krishna *(license 4-15624-Genl Practice)* Office: **1030 Central**. Ph.913-648-2010
See Malpractice sheet. Shared abortion practice variously w/ Knarr, Neuhaus & Zaremski.
Disciplinary 7/1/2000: Fined for violations of drug handling & distribution.

ZAREMSKI, Sherman C. *(license 4-13172-InternalMed)* Office: **720 Central** Ph.913-321-3343
Disciplinary 12/13/94:Short suspension, fine, probation, censure for numerous actions including 10 years of drug violations connected to partner Wm.Malcolm Knarr [who lost KS license 3/12/94].

Overland Pk. KS

CRIST, Robert D. *(license 4-13176 Ob/Gyn)* Office: **4401 W. 109th** Ph. 913-345-1400;
[Comprehensive Health- Planned Parenthood] No formal KBHA disciplinary file despite 3 abortion deaths (2 in Missouri, 1 in Texas); 1 sterilization patient currently comatose; see Malpractice sheet.

YEOMANS, Ronald *(license 4-14015 Ob/Gyn)* Office: **4401 W. 109th** Ph.913-345-1400;
[Comp Health-PP] Until 6/99, worked also at PP, 1001 E. 47th St. KCMO. See Malpractice sheet

HODES, Herbert C. *(license 4-14447 Ob/Gyn)* Office: **4840 College Blvd.** Ph. 913-491-6878
Extensive lawsuits. See Malpractice sheet.

NAUSER, Traci L.[Hodes] *(license 4-26188 Ob/Gyn)* Office: **4840 College Blvd.**Ph.913-491-6878
In second year of medical practice with dad.

KUMed Ctr.

HARA, Glenn S. *(license 4-15456)* **3901 Rainbow Blvd**. Ph.913-588-6201 See Malpractice sheet.
KRANTZ, Kermit E. *(license 4-12291)* **3901 Rainbow Blvd**. Ph.913-588-6201 See Malpractice sheet.

This record compiled from KSBHA public documents, news articles and court records

Abortion Malpractice in Kansas*

There are 4 known deaths litigated/pending resolution of women following their abortion at the hands of Kansas-licensed practitioners.

There have been, at least, 23 other abortion injuries litigated/pending resolution from Kansas-licensed practitioners.

There are, at least, 6 abortion injuries/violations of informed consent considered findings of fact by the KSBHA.

5/14/80 **Tucker v TILLER: botched abortion**; uterus perforated, failed to get proper care, lack of informed consent. Tiller's speech & behaviors were outrageous, insulting. Plaintiff hospitalized for repairs, assumed settled.

10/22/81 **Boyd v CRIST: death after abortion**; a 19yr old retarded girl, raped in institution, suffered breathing depression and death from drug administered for abortion. No one checked her medical records showing she took anti-psychotic drugs which PDR says are incompatible with abortion sedation drug. Crist was accused of choosing a risky method for 2nd trimester abortion, and not having resuscitative, heart-monitoring or general anesthetic equipment on site.

4/25/81 **Maelzer v HODES: Incomplete abortion**, repeated calls to emegency number without response, permanent injuries. Settlement assumed. 9wks later Hodes fired by Comprehensive Health (Overland Pk,KS)

12/--/82 **Shoemaker(aka Tompkins) v CRIST: botched abortion** followed by sepsis, permanent tubal obstruction, uterine perforation, hospitalization. Settled for plaintiff 9/19/86.

3/--/82 **Schaeffer v CRIST: botched abortion**; hemorhhaging & corrective surgery after abortion. Settled for plaintiff 5/85.

10/--/82 **O'Neill v CRIST: incomplete abortion**; patient released still hemorrhaging, hospitalized to remove remaining fetus. Settled for plaintiff 7/85.

10/13/83 **Raidl v HODES: Incomplete abortion**, 7 weeks of pain, sterilization; remedial surgery performed by KSBHA board member, Ellis, who refuses to testify on behalf of patient. Settlement assumed.

2/21/83 **Price v HARA incomplete abortion on minor**, using method for first trimester on what was a second trimester fetus; retained tissue,permanent & progressive physical & psychological injuries; settled 9/6/84.

11/30/84 **Lemmones v HARA total botched abortion;** an instrument broke inside patient & was not removed properly; uterus perforated; departed from standard of care; wrongly performed in office w/o general anesthesia; failed to give proper patient care & diagnosis, including allowing her to go home. Plaintiff had second abortion & emergency hospitalization 12/4/84 followed by bladder repairs, continuing infections, scarring, infertility & psychological trauma. Court approved settlement12/29/88.

4/--/84 **Johnson v CRIST: botched abortion**; discharged hemorrhaging; charged Crist with negligence, perforating her uterus, sepsis & an emergency hospitalization for sterilization to save life. Settled.

10/2/85 **Wisniakowski v CRIST: incomplete abortion**; expelled mangled, total fetus at home, 2 days after abortion. Corrective treatment at hospital. Summary judgment for defendant 10/9/89

4/--/85 **Pairett v CRIST: abortion complications**; immediate emergency corrective surgery hospital. Settled for plaintiff 10/30/86

--/--/85(unnamed 6/3/90-KCStar) **v MILLER: botched abortion** of non-pregnant woman; 3' of intestine removed, massive bowel damage, hysterectomy sterilization. Plaintiff's personal life devastated; her settlement was $200,000.

--/--/85(unnamed 6/3/90-KCStar) **v MILLER: botched abortion**; punctured cervix, denial of problem by Miller; infection and pain followed by hopitalization to remove fetal tissue. Plaintiff settled for $75,000.00.

3/30/88 **Fisher v MILLER: death during abortion.**18 yr old suffocated on her own vomit as Miller continued to abort. Victim had not been told to fast before procedure. Paramedics noted Miller wasn't doing CPR or anything when they arrived. Miller's deposition: "Since I didn't know what was going on, I don't think it would have made any difference." Victim was DOA at the hospital. Plaintiffs settled 12/14/89 for $475,000.

Note: National Abortion Federation head, and clinic director in Overland Park during this time, praised Miller."He knows how to provide excellent services...we have a lot of confidence in him." By contrast, Miller's actions were labeled grossly negligent by the expert witness in this lawsuit. The KSBHA's only punishment was that Miller could not abort in his office for 1 year-during which time he could (and did) abort in other licensed facilities.

11/4/89 **Cavanaugh v TILLER: wrongly aborted of wanted pregnancy;**woman deceived that pregnancy was tubal; not fully informed of material facts. Has permanent, painful injuries, emotional damage, post abortion trauma.

5/10/91 **Cummings v KNARR: botched second abortion** by Knarr after botch by partner; abortionist could not be reached. Due to massive hemorrhaging, complete hysterectomy. Suit settled 4/19/94 for plaintiff. This case was also a finding of fact in KSBHA petition to revoke Knarr's license

11/2/91 **Veale v CRIST: Death after abortion;** 17yr old had 2nd trimester abortion in Houston; was sent home bleeding profusely and was DOA that evening. Medical examiner ruled death caused when uterus didn't contract to stop the bleeding following abortion. Litigation pending.

Note: Texas State Board of Medical Examiners stated 9/25/92 there was no violation by Crist of the Medical Practice Act. The Kansas State Board of Healing Arts' disciplinary counsel wrote on 12/9/91,"we have no authority beyond our state boundaries ...Even if we went into Texas we would have no ability to get medical records...necessary to prove that Dr. Crist deviated from the necessary standard of care. While this may appear as "insane' to you, it is the law and we must follow it "

--/--/91 (filed 93) **Franek v CRIST: failure to give Rh dose**

--/--/91 (filed 93) **Cutler v CRIST: botched 2nd trimester D&E,** lack of informed consent

--/--/92 (filed 94) **Bobb v CRIST: botched abortion;** 17yr old 2nd trimester abortion; uterus perforated; immediate hysterectomy at hospital. Settled, $75,000.00.

10/29/92 **Phillips v KNARR: Incomplete abortion;** hemorrhaging, incomplete 2nd abortion 1 wk later. Continued bleeding finally resulted in another abortion by 3rd doctor, in hospital, removingforeign object This case was also a finding of fact in KSBHA petition to revoke Knarr's license.

2/16/93 **Barnett v KNARR: inadequate abortion** with lack of follow up and adequate record-keeping. Sent to KSBHA medical/malpractice screening panel.

11/18/93 **Matson v CRIST: failed abortion, baby born alive,** bled to death from buttocks sliced during abortion. Inadequate counseling and hospitalization.

10/6/93 **Mays v KNARR: septic abortion with negligence.**

8/22/96 **Garrett v HODES: abortion protocol failed to verify correct Rh** of mother, led to multiple blood transfusions and troubled subsequent pregnancy; condition prevents future pregnancies. Settled.

4/25/97 **Williams v CRIST: Death after abortion;** 22yr old mother of 3 suffers cardiac arrest & death after abortion. Medical examiner rules amniotic embolism. Suit pending, including issue of delayed ambulance.

*This record does not include the many other cases of botched ob/gyn procedures recorded against these and other Kansas abortionists; e.g. there are at least 15 other medical legal actions against KC abortionist Hodes, beyond these 3 known abortion cases.

ABORTION injuries & law violations considered findings of fact in KSBHA disciplinary actions

1/11/89 "T.R".-**KNARR** perforated uterus; No proper care, hospitalization, record-keeping or consultation. [pg3, Third Amended Petition to revoke, Suspend or otherwise limit licensure W. Malcolm Knarr, D.O. 9/3/93]

12/2/99 "A.B." -**NEUHAUS** did not properly evaluate, examine, monitor, discharge and keep records of abortion procedure. Also, informed consent gestational info not conveyed 24 hrs. prior to procedure. Negligence & unprofessional conduct.

3/8/2000 "S.D." -**NEUHAUS** (same charges as above)

3/8/2000 "H.S." -**NEUHAUS** did not properly evaluate, examine, monitor, discharge and keep records of abortion procedure. Also, informed consent gestational info not conveyed 24 hrs. prior to procedure. Negligence & unprofessional conduct. Written documents not obtained.

5/24/2000 "C.L." -**NEUHAUS** (same charges as above)

6/7/2000 "A.G." -**NEUHAUS** (same charges as above) plus:Patient "A.G."gave limited consent to abortion without sedation.During the procedure,when she withdrew consent and tried to leave, Neuhaus sedated her and aborted her.

[pg2-14, Amended Petition to Revoke, Suspend, or otherwise Limit License, In the Matter of Ann K. Neuhaus, 2/2/2001]

KSBHA INVESTIGATIONS concerning ABORTIONISTS' PRACTICES

Monitored for personal drug/alcohol use:Knarr,Tiller
Inadequate machines & staff training for resuscitation:Knarr,Miller Neuhaus
Unable to perform advanced life-saving: Miller, Neuhaus
Giving drugs unlawfully:Knarr, Zaremski
Inventing false medical records:Zaremski
Violations of DEA drug registration& handling, Knarr, Neuhaus, Rajanna, Zaremski
Long-term mandated drug monitoring by DEA: Knarr, Neuhaus
Over reliance on under trained staff: Knarr, Neuhaus
Record-keeping missing: Knarr, Neuhaus, Zaremski
Board-ordered Drug testing: Knarr, Neuhaus' entire staff (continuous under stipulation)
Outside pharmacist review of prescriptions: Neuhaus
Problems with proper authorization of prescription drugs: Knarr, Neuhaus
Declared public danger: Knarr, Neuhaus
Informed consent violations: Neuhaus
Patients discharged improperly: Knarr, Neuhaus
Pre-drawn syringes("assembly-line"): Knarr,Neuhaus
Failure to document patient's adverse reactions: Neuhaus
Failure to meet standards of care: Knarr, Neuhaus
Public reprimand: Miller,Zaremski

Abortion staff "Whistleblowers" expose procedural failures

Deborah Reay, a clinic administrator, accused **late-term abortionist Leroy Carhart** of violating medical standards during abortions. She said she filed suit, in part, "because patients are unlikely to complain themselves. Who's going to advocate for the woman seeking abortions? Reay asked. "Because it's such a private matter, most women aren't willing to come forward."

The incidents recounted in Reay's lawsuit were taken up by Nebraska's Attorney General, Department of Health, and State Board of Examiners of Medicine & Surgery in 1992-93. Reay and other staffers observed Carhart: **1)fall asleep** while injecting anesthetic

2)conduct personal phone calls while performing abortions

3)alter medical records twice to cover up botched abortions

4)leave a patient on the table for frivolous reasons

5)prohibit staff from wearing masks during contagious patient's surgery.

Omaha World-Herald 7/26/91, 4/13/93, 6/3/93

A clinic staffer with some medical training worked with **impaired abortionist Malcolm Knarr** and then submitted an affidavit to the Kansas State Board of Healing Arts, Oct.92. Within weeks, unbeknownst to her, another patient was injured by Knarr because of the same conditions she tried to expose. [Phillips v Knarr 10/92] The KSBHA investigated her tales and listed 4 women's complaints as part of their eventual removal of Knarr. Some of the wrongdoing Knarr's staffer reported :

1) untrained staff ran IV lines [refer*Neuhaus* KSBHA instructions to get staff trained]

2) patients who arrived with cash were immediately aborted--even if **they had eaten** recently or had **not had time to reflect upon the informed consent** materials [*Fisher v Miller* teen abortion death; count III,*Neuhaus*2/2/01]

3) patient **IDs were never checked** for true identity or for age [refer to *Clinton* (now deceased) who aborted a raped minor 9/93]

4) inadequate amount of RhoGAMgiven [refer *Garrett v Hodes*, *Franek v Crist* here]

5) sonograms were "fudged" for extra fees

6) patients who **changed their minds were ignored** [refer *Neuhaus* 2/2/01, Count V]

7) fetal remains were never checked [reference *Raidl v Hodes*, 1987 *Miller* case,]

8) patients with **negative pathology reports were not contacted** for further diagnosis

9) biological **waste was improperly disposed**

10)80% of **patients didn't return** for checkups

11)torn cervixes & excess bleeding common [*Hodes, Tiller, Miller,Crist* various cases]

12)unprofesssional & **disorganized staff** [*Neuhaus*, 2/2/01]

13)no drug privileges to medicate needy patients [*Neuhaus*]

14)missing drugs

15)dirty setting for drawing blood

16)many OSHA violations; none addressed

17)no resuscitative equipment as mandated by PDR [*Neuhaus*}

18)anesthesia improperly administered [*Neuhaus*, *Fisher v Miller*, teen death]

19)abortionist talks about constant drugged state

20)performed abortions while **impaired**

21) recreational **drug use with staff**

Ambulatory Surgical Centers

Kansas Administrative Regulations 28-34-50 through 28-34-62a

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Attach #12

isting hospital, other than minor alterations, shall be prepared by an architect licensed in Kansas and shall be submitted to the licensing agency prior to beginning construction. "Minor alterations" means those projects which:

(A) Do not affect the structural integrity of the building;

(B) do not change functional operation;

(C) do not affect fire safety; and

(D) do not add beds or facilities over those for which the hospital is licensed.

(2) Plans and specifications shall be submitted at the preliminary plan and outline specification stage and at the contract document stage.

(3) The preliminary plans shall include:

(A) Sketch plans of the basement, each floor and the roof indicating the space assignment, size and outline of fixed equipment;

(B) all elevations and typical sections;

(C) a plot plan showing roads and parking facilities; and

(D) areas and bed capacities by floors.

(4) The outline specifications shall consist of a general description of the construction, air conditioning, heating and ventilation systems.

(5) Contract documents shall consist of working drawings that are complete and adequate for bidding, contract and construction purposes. Specifications shall supplement the drawings to fully describe the types, sizes, capacities, workmanship, finishes and other characteristics of all materials and equipment. The architect shall certify contract documents are in compliance with subsections (a), (b) and (c) of this regulation.

(c) Access. Representatives of the licensing agency shall, at all reasonable times, have access to work in preparation or progress and the contractor shall provide proper facilites for such access and inspection. A complete set of plans and specifications shall be available on the job site for use by licensing agency personnel. (Authorized by and implementing K.S.A. 1991 Supp. 65-431; effective June 28, 1993.)

28-34-33 to 28-34-49. Reserved.

PART 2.—AMBULATORY SURGICAL CENTERS

28-34-50. Definitions. (1) *Ambulatory surgical center*—an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physician services and registered professional nursing services whenever a patient is in the facility; and which does not provide services or other accommodations for patients to stay overnight; and which offers the following services whenever a patient is in the center:

(a) Drug services as needed for operations performed

(b) Provisions for physical and emotional well-being of patients

(c) Provision of emergency services

In addition the center shall provide:

(d) Organized administrative structure

(e) Administrative, statistical, and medical records

(f) Provision for laundry service as needed

(g) Provision for patient isolation and food services as needed

(h) A surgical advisory committee appointed by the local county or regional medical society from its membership; such committee members shall have no proprietary interest in the center

(i) A community advisory board composed of citizens residing in the area to be served by the center; such individuals shall have no proprietary interest in the center

(2) *Chief executive officer*—a person who is delegated the responsibility of carrying out policies and programs established by the governing authority.

(3) *Dentist*—A person who holds a valid license issued by the Kansas dental board to practice dentistry.

(4) *Governing authority*—A board or other governing body in whom the ultimate authority and responsibility for management of the ambulatory surgical center is vested.

(5) *Licensing agency*—The Kansas state board of health.

(6) *Medical staff*—A formal organization of physicians and dentists who are appointed by the governing authority to attend patients within the ambulatory surgical center. Procedures shall be performed only by physicians or dentists who at the time are privileged to perform such procedures in at least one licensed hospital in the community in which the ambulatory surgical center is located, thus providing assurance to the public that patients treated in the center shall receive continuity of care should the services of a hospital be required.

(7) *Patient*—A person admitted to the ambulatory surgical center by and upon the order of a

12-2

physician, or dentist in accordance with the orders of a physician.

(8) *Pharmacist*—A person who holds a valid license issued by the Kansas state board of pharmacy to practice pharmacy.

(9) *Physician*—A person holding a valid license from the Kansas state board of healing arts to practice medicine and surgery.

(10) *Licensed practical nurse (L.P.N.)*—A person who holds a valid license issued by the Kansas state board of nursing to practice nursing as defined in K.S.A. 65-1113 (b) (2).

(11) *Registered nurse (R.N.)*—A person who holds a valid license issued by the Kansas state board of nursing to practice nursing as defined in K.S.A. 65-1113 (b) (1). (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.)

28-34-51. Licensing procedure. (a) No construction shall begin until plans and specifications covering the construction of new buildings, additions, or material alterations to existing buildings are approved by the licensing agency. A written narrative describing the intended use of the proposed construction shall accompany the plans and specifications.

(b) No system of water supply, plumbing, sewerage, and garbage or refuse disposal for these institutions shall be installed nor shall any such existing system be materially altered or extended until complete plans and specifications for the installation, alteration, or extension, together with such information as the licensing agency may require, have been submitted and approved.

(c) Ambulatory surgical centers shall be licensed to provide only those services for which they are qualified.

(d) The application for a license to establish or maintain an ambulatory surgical center shall be submitted to the licensing agency. Such application shall be made in writing on a form provided by the licensing agency for a license for a new facility or for the renewal of a license for an existing facility. Applications for a license for new facility shall be submitted at least 120 days prior to opening.

(e) Upon application for a license from a facility never before licensed, an inspection shall be made by the duly appointed representative of the licensing agency. Every building, institution or establishment for which a license has been issued shall be periodically inspected for compliance with the regulations of the licensing agency.

(f) A license shall be issued for a period of one year beginning January 1 and, unless suspended or revoked, shall expire on the following December 31. The license may be suspended or revoked at any time for noncompliance with the regulations of the licensing agency. The licensing agency shall be notified at the time of any change in ownership, location, or lease of an ambulatory surgical center, and a new application shall be submitted to the licensing agency in the event of such a change.

(g) The current license certificate issued by the licensing agency shall be suitably framed and conspicuously posted on the premises. The license certificate shall remain the property of the licensing agency. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.)

28-34-52. General requirements. (a) All applicable local and state fire, safety, sanitation, and building codes shall be met.

(b) Devices for restraining a patient shall be applied only on the order of a physician to aid in the prevention of injury to the patient or others, or in accordance with policies established by the medical staff.

(c) There shall be provisions for the isolation or immediate transfer of cases of communicable diseases as required by law and the regulations of the state department of health.

(d) Every ambulatory surgical center shall have written policies regarding abortion and sterilization. Ambulatory surgical centers permitting therapeutic abortion or sterilization procedures shall have policies in conformance with Kansas statutes.

(e) Principles for an emergency plan shall be developed in writing for each building to be used as a guide in the event of fire or other emergency where a quick evacuation of the building may be required. Periodic drills shall be held to prepare employees for an emergency. Records of drills shall be kept. A fire alarm shall be transmitted to the fire department headquarters if there is reason to believe that a fire may exist in any part of the building.

(f) A disaster plan shall be developed in writing as a guide in the event a disaster should occur. Periodic drills shall be held to prepare staff and employees for a disaster. Records of drills shall be kept.

(g) Smoking shall be prohibited in areas such as the operating rooms, anesthetizing locations, rooms where oxygen and other volatile gases are

12-3

administered or stored, and other hazardous areas. No smoking signs shall be posted in areas where smoking is prohibited.

(h) Currently acceptable procedures to minimize sources and transmission of infections shall be employed. Adequate surveillance methods shall be used.

(i) Combustible materials and supplies shall be stored and handled in a safe and approved manner, and in conformance with applicable codes and regulations.

(j) Ambulatory surgical centers shall comply with applicable regulations of Kansas administrative regulations regarding child abuse and reporting of infections and diseases.

(k) All dead bodies and reportable stillbirths shall be disposed of as required by the Kansas statutes.

(l) Volatile supplies shall be stored and kept in a safe manner.

(m) All anesthetics shall be properly labeled and inventoried periodically.

(n) Policies governing the use of anesthetics shall be written.

(o) Fire extinguishers shall be of types and makes that are approved by underwriter's laboratories. Extinguishers shall be inspected and tagged annually to make sure that they have not been tampered with or removed from their designated places, to see that they are not empty, and to detect any defects or injuries. Extinguishers capable of producing toxic substances shall be prohibited.

(p) Ambulatory surgical centers shall maintain on file a copy of these regulations, as provided by the licensing agency, and copies of the following publications adopted, wholly or in part, by reference:

(1) "Laws, Rules and Regulations Relating to Communicable and Other Reportable Diseases in Kansas," published by the Kansas State Department of Health, 535 Kansas Avenue, Topeka, Kansas 66603, revised 1959.

(2) "Recommended Dietary Allowances, Revised 1963," Food and Nutrition Board of the National Academy of Science, National Research Council, Washington, D.C.

(3) "Regulations No. 5, Regulatory Taxes on Narcotic Drugs, Opium, Coca Leaves, Isonipecaine or Opiates," part 151 of title 26 (1954) Code of Federal Regulations, United States Treasury Department, Bureau of Narcotics and the Internal Revenue Service, Revised October 1964. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C.

(4) "General Standards of Construction and Equipment for Hospital and Medical Facilities," Public Health Service Publication No. 930-A-7, 1967 Revision. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

(5) "Standards for a Blood Transfusion Service," Fourth Edition Revised 1966, American Association of Blood Banks, 30 North Michigan Avenue, Chicago, Illinois 60602.

(6) "Radiation Protection Regulations," Revised January 1967, Kansas State Department of Health, Environmental Health Services, 535 Kansas Avenue, Topeka, Kansas 66603.

(q) Rules for visitors shall be adopted by the governing authority and posted in a conspicuous place.

(r) Admission of patients, personnel, and visitors to the surgical suite shall be controlled in accordance with written policies.

(s) No procedures which require the presence of special equipment, personnel, and/or facilities due to the risk of the operation involved shall be performed in the center unless such equipment, personnel, and/or facilities are available in the ambulatory surgical center.

(t) The medical staff shall provide adequate supervision and control over the surgery conducted in the center.

(u) No operation shall be performed until an appropriate laboratory examination has been completed, if deemed necessary by the surgeon or required by the ambulatory surgical center, and the preoperative diagnosis has been established and recorded. There shall be no organized emergency department.

(v) An accurate and complete description of findings and technique of operation shall be made within 24 hours after operation by the surgeon who performed the operation.

(w) If deemed necessary by the surgeon or if required by the ambulatory surgical center, tissues removed at surgery shall be examined by a physician whose report shall become a part of the patient's medical record.

(x) Written policies governing operating rooms shall be posted.

(y) Facilities for blood transfusions shall be available at all times.

(z) Resuscitation and suction equipment shall be available at all times.

12-4

(aa) Personnel in the operating rooms shall be properly attired.

(bb) Street clothes and clothing of silk, wool, or synthetic textile materials shall be prohibited in operating rooms.

(cc) All equipment for the administration of anesthetics shall be readily available, kept clean, and maintained in good working condition.

(dd) Conductive flooring and conductive movable equipment of a type approved by the national fire protection association shall be provided in all operating rooms where volatile anesthetics may be used.

(ee) All anesthetics shall be given by a physician or shall be administered under the supervision of a physician personally present in the surgical suite.

(ff) There shall be adequate provisions for post-operative care.

(gg) Post-anesthetic policies and procedures shall be written. Follow-up notes shall include post-operative abnormalities or complications.

(hh) Smoking shall be prohibited in the surgical suite, including corridors within the suite.

(ii) Adequate space, equipment, and personnel shall be provided to assist in the safe and aseptic treatment and protection of all surgical patients, including reasonable protection against cross infections.

(jj) Provisions for setting aside beds or wards for infectious or unclean surgical patients shall be made.

(kk) Safety regulations shall be posted. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.

28-34-53. Governing authority. (a) The governing authority is the ultimate authority in the ambulatory surgical center, responsible for its organization and administration including appointment of the medical staff, employment of a chief executive officer, and maintenance of a physical plant equipped and staffed to adequately meet the needs of the center's program.

(b) The governing authority shall be organized in accordance with its adopted bylaws, rules and regulations, which shall be in conformance with the Kansas statutes governing ambulatory surgical centers. A copy of the ambulatory surgical center's current bylaws shall be available for review by the licensing agency.

(c) The governing authority shall demonstrate evidence of liaison and close working relationship with the medical staff. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.

28-34-54. Medical staff. (a) The ambulatory surgical center shall have an organized medical staff, responsible to the governing authority of the center for the quality of all medical care provided patients in the center and for the ethical and professional practices of its members.

(b) In any ambulatory surgical center, the medical staff, with the approval of and subject to final action by the governing authority, shall formulate and adopt bylaws, rules, regulations, and policies for the proper conduct of its activities and recommend to the governing authority physicians and dentists considered eligible for membership on the medical staff, in accordance with section 1, Definitions, paragraph 6, medical staff, of these regulations.

(c) The medical staff shall hold regular meetings for which records of attendance and minutes shall be kept.

(d) Medical staff committee minutes and information shall not be a part of individual patient records nor subject to review by other than medical staff members.

(e) The medical staff shall review and analyze at regular intervals the clinical experience of its members and the medical records of patients on a sampling or other basis. All techniques and procedures involving diagnosis and treatment of patients shall be reviewed periodically and shall be subject to change by the medical staff.

(f) All persons admitted to the ambulatory surgical center shall be under the care of a physician.

(g) All medical orders shall be given by a physician or dentist and recorded in accordance with the medical staff rules and regulations. All orders shall be signed or countersigned (initialed) by the attending physician. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.

28-34-55. Nursing personnel. (a) There shall be an organized nursing service including a plan of administrative authority with written delineation of responsibilities and duties of each category of nursing personnel.

(b) All registered nurses employed by the ambulatory surgical center to practice professional nursing shall be licensed in Kansas.

(c) All practical nurses employed by the ambulatory surgical center shall be licensed in Kansas.

(d) There shall be a director of nursing service.

125

(e) All licensed practical nurses and other ancillary personnel performing patient care services shall be under the supervision of a registered nurse.

(f) There shall be at least one registered nurse on duty in the ambulatory surgical center at all times that a patient is in the center.

(g) Nursing care policies and procedures shall be in writing and consistent with generally accepted practice and shall be reviewed and revised as necessary.

(h) Private duty nurses shall be licensed in Kansas and shall be subject to the policies, rules, and regulations of the ambulatory surgical center in which they are employed.

(i) Minutes shall be kept of nursing staff meetings which shall be held on a regular basis. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.)

28-34-56. Ambulatory surgical center personnel. (a) All ambulatory surgical center and related personnel shall have a preemployment medical examination which shall consist of appropriate examinations, including chest X-ray or tuberculosis skin test, to protect the welfare of the patients and personnel. Subsequent medical examinations shall be given periodically in accordance with ambulatory surgical center policies. Personnel working in the center having patient contact shall be examined at least annually.

(b) Any personnel having conditions detrimental to patient well-being, or suspected of same, shall be excluded from work until authorized to return to work by a physician. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.)

28-34-57. Medical records. (a) A medical record shall be maintained for every patient cared for in the center.

(b) Medical records are the property of the ambulatory surgical center. Only authorized personnel shall have access to records.

(c) Medical records shall be maintained in retrievable form for the greater of ten years after the date of last discharge of the patient, or one year beyond the date that patients who are minors reach the age of eighteen.

(d) The medical record shall contain sufficient information to justify the diagnosis and warrant the treatment.

(e) The medical record shall contain, when appropriate, identification data, chief complaint, present illness, past history, family history, physical examination, provisional diagnosis, clinical laboratory reports, physician's orders, radiological reports, consultations, medical and surgical treatment, tissue reports, progress notes, care given, pertinent observations, final diagnosis, dismissal summary, and autopsy findings.

(f) Each clinical entry shall be signed or initialed by the attending physician who shall be property identified in the record. Nursing notes and observations shall be signed by a registered nurse.

(g) The ambulatory surgical center shall furnish to the appropriate authority all reasonably available information on deceased patients which is necessary for completion of a proper death certificate.

(h) Completion of the medical record shall be the responsibility of the attending physician.

(i) Statistical data, administrative records, and records of reportable diseases as required by the state department of health shall be maintained and submitted by the ambulatory surgical center to the department as requested.

(j) Adequate space, facilities, and equipment shall be provided for completion and storage of medical records.

(k) Medical records shall be indexed according to diagnosis, operation, and physician.

(l) Nothing in these regulations shall be construed to prohibit the use of properly automated medical records or use of other automated techniques, provided the regulations stated herein are met. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.)

28-34-58. Sterilizing and supply. (a) Policies and procedures shall be established in writing for storage, maintenance, and distribution of supplies and equipment.

(b) Sterile supplies and equipment shall not be mixed with unsterile supplies and shall be stored in dust-proof and moisture-free units. They shall be properly labeled.

(c) Sterilizers and autoclaves shall be provided of appropriate type and necessary capacity to adequately sterilize instruments, utensils, dressings, water, operating and delivery room materials, as well as laboratory equipment and supplies. The sterilizers shall have approved control and safety features. The accuracy of instruments shall be checked periodically by an approved method. Adequate surveillance methods for checking sterilization procedures shall be employed. Contractual

12-6

arrangements for sterile supplies, equipment and instruments may be approved by the Kansas state department of health.

(d) The date of sterilization or date of expiration shall be marked on all sterile supplies and unused items shall be resterilized in accordance with written policies. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.)

28-34-59. Ancillary services. (a) For laboratory services performed in the center, there shall be an approved quality control program in writing and participation in a state approved or operated proficiency testing program. Personnel and equipment shall be appropriate for the services performed.

(b) For radiology services performed in the center, the regulations authorized by K.S.A. 48-1607 shall be met. Radiation protection shall be provided in accordance with the Kansas radiation protection regulations and the recommendations of the national council on radiation protection and measurements. There shall be written policies and procedures, and records shall be kept of at least annual checks and calibrations of all X-ray and gamma beam therapy equipment. Only qualified personnel shall operate radiologic equipment.

(c) If nursing services provided, there shall be proper storage, safeguarding, preparation, and dispensing. Drugs requiring refrigeration shall be stored in a refrigerator which shall be used for drug storage only.

(d) All ancillary services shall be under the direction of a physician. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.)

28-34-60. Supportive services. (a) Provision shall be made in writing for the proper laundering of linen and washable goods. Soiled and clean linen shall be handled and stored separately. Written sanitation controls shall be maintained to prevent contamination.

(b) Food services as required shall be provided. Written policies shall be posted.

(c) Dressing and lounge areas for personnel and patients shall be provided in such a manner as to not jeopardize the safe treatment of surgical patients.

(d) An adequate waiting area shall be provided.

(e) Appropriate business office facilities shall be provided. Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.

28-34-61. Sanitation and housekeeping. (a) Ambulatory surgical centers shall comply with applicable codes.

(b) Suitable equipment shall be provided for the regular cleaning of all interior surfaces. Operating rooms shall be thoroughly cleaned after each operation. Recovery rooms shall be thoroughly cleaned after discharge. No wax shall be applied to conductive floors which render them nonconductive. Adequate and conveniently located spaces shall be provided for the storage of janitorial supplies and equipment.

(c) The premises shall be kept neat, clean, and free of rubbish.

(d) Housekeeping procedures shall be written.

(e) All garbage and waste shall be collected, stored, and disposed of in a manner that will not encourage the transmission of contagious disease. Containers shall be washed and sanitized before being returned to work areas or shall be disposable.

(f) All openings to the outer air shall be effectively protected against the entrance of insects and other animals by self-closing doors, closed windows, screening, controlled air currents, or other effective means. Screening material shall not be less than 16 mesh to the inch or equivalent.

(g) A sufficient supply of cloth or disposable towels shall be available so that a fresh towel can be used after each handwashing. Common towels are prohibited.

(h) There shall be adequate handwashing facilities conveniently located.

(i) Common drinking cups shall be prohibited.

(j) Dry sweeping and dusting shall be prohibited.

(k) Adequate and conveniently located toilet facilities shall be provided.

(l) Periodic checks shall be made throughout the buildings and premises to enforce sanitation procedures. The times and results of such checks shall be recorded. (Authorized by K.S.A. 1973 Supp. 65-431; effective Jan. 1, 1974.)

28-34-62. (Authorized by and implementing K.S.A. 65-431; effective Jan. 1, 1974; amended June 12, 1979; revoked May 1, 1986.)

28-34-62a. Construction standards. (a) General provisions. All ambulatory surgical center construction subsequent to the adoption of this regulation, including new buildings and additions or alterations to existing buildings, shall be in accordance with those standards set forth under sections 1., 2., 3., 4., 5., 6., and subsections 9.1, 9.2,

12-7

9.5, and 9.9 in the American institute of architects publication entitled 1992-93 "guidelines for construction and equipment of hospital and medical facilities."

(b) Codes and publications. The codes and publications that are referenced in subsections 1.5.E and 1.5.F of "guidelines for construction and equipment of hospital and medical facilities" shall be followed.

(c) Provisions for handicapped. All construction shall be in compliance with those standards set forth in the "Americans with disabilities act" as published in the federal register at 28 CFR Part 36, Subpart D on July 26, 1991, which are hereby adopted by reference.

(d) Construction plans and specifications.

(1) Plans and specifications for each new ambulatory surgical center and each alteration and addition to any existing ambulatory surgical center, other than minor alterations, shall be prepared by an architect licensed in Kansas and shall be submitted to the licensing agency prior to beginning construction. "Minor alterations" means those projects which do not affect the structural integrity of the building, which do not change functional operation, and which do not affect fire safety.

(2) Plans and specifications shall be submitted at the preliminary plan and outline specification stage and at the contract document stage.

(3) The preliminary plans shall include:

(A) sketch plans of the basement, each floor, and the roof indicating the space assignment, size, and outline of fixed equipment;

(B) all elevations and typical sections;

(C) a plot plan showing roads and parking facilities; and

(D) areas and bed capacities by floors.

(4) The outline specifications shall consist of a general description of the construction, air conditioning, heating, and ventilation systems.

(5) Contract documents shall consist of working drawings that are complete and adequate for bidding, contract, and construction purposes. Specifications shall supplement the drawings to fully describe the types, sizes, capacities, workmanship, finishes, and other characteristics of all materials and equipment. The architect shall certify that contract documents are in compliance with subsections (a), (b), and (c) of this regulation.

(e) Access. Representatives of the licensing agency shall, at all reasonable times, have access to work in preparation or progress, and the contractor shall provide proper facilities for such access and inspection. A complete set of plans and specifications shall be available on the job site for use by licensing agency personnel. (Authorized by and implementing K.S.A. 65-431; effective May 1, 1986; amended, T-87-51, Dec. 19, 1986; amended May 1, 1987; amended Dec. 29, 1995.)

28-34-63 to 28-34-74. Reserved.

PART 3.—RECUPERATION CENTERS

28-34-75. Definitions. (1) *Chief executive officer*—a person who is delegated the responsibility of carrying out policies and programs established by the governing authority.

(2) *Cook manager*—A person who is qualified to assume the responsibility for food preparation, food service, and daily operation of a food service department.

(3) *Dentist*—A person who holds a valid license issued by the Kansas dental board to practice dentistry.

(4) *Dietitian*—A person who meets the educational and training requirements in the sciences of nutrition or food service management established by the American dietetic association and who is proficient in the application of the principles of these sciences to feeding individuals and groups.

(5) *Food service supervisor*—A person who meets the requirements for membership in the hospital institutional educational food service supervisors society.

(6) *Governing authority*—A board or other governing body in whom the ultimate authority and responsibility for management of the recuperation center is vested.

(7) *Recuperation center*—An establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than twenty-four (24) hours of every day to provide treatment for four or more nonrelated patients who require inpatient care but are not in an acute phase of illness, who currently require primary convalescent or restorative services, and who have a variety of medical conditions; and which offers the following services:

(a) Continuous physician coverage by the medical staff, either on duty or on call

(b) Organized administrative structure

Minimum Standards for Veterinary Premises Sanitary Conditions

Kansas Administrative Regulations 70-6-1

Sn Fed St
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Attach # 13

and implementing K.S.A. 47-821 and 47-829; effective April 4, 1997.)

70-4-10. Examination applications. Each applicant for examination shall be enrolled in or be a graduate of a college of veterinary medicine identified in K.A.R. 70-4-8(c) or shall be enrolled in or have graduated from the American veterinary medical association's educational commission for foreign veterinary graduate program. (Authorized by and implementing K.S.A. 47-824, 47-825, and 47-826; effective April 4, 1997.)

Article 5.—FEES

70-5-1. Amount of fees. The following fees shall be charged.

a)	Veterinary medicine license; application	$125.00
b)	Veterinary medicine license; annual renewal	$ 75.00
c)	Veterinary medicine license; late renewal penalty	$ 50.00
d)	National board examination; administration fee	$ 65.00
e)	Clinical competency test; administration fee	$ 65.00
f)	Veterinary premise registration; application	$ 50.00
g)	Veterinary premise registration; renewal	$ 15.00
h)	Veterinary premise registration; late renewal penalty	$ 50.00
i)	Veterinary premise; initial inspection	$ 50.00
j)	Veterinary premise; non-compliance inspections	$100.00
k)	Veterinary technician registration; application	$ 20.00
l)	Veterinary technician registration; renewal	$ 10.00
m)	Veterinary technician registration; late renewal penalty	$ 50.00

(Authorized by K.S.A. 47-821, 47-822, 47-824 and 47-829; implementing K.S.A. 47-822, 47-824, 47-826, 47-827, and 47-829; effective May 1, 1985; amended, T-70-6-13-88, June 13, 1988; amended July 3, 1989; amended May 23, 1994; amended Feb. 21, 1997.)

Article 6.—MINIMUM STANDARDS FOR VETERINARY PREMISES SANITARY CONDITIONS AND PHYSICAL PLANT

70-6-1. Premises sanitary conditions and physical plant. (a) Each veterinary premises, except for a mobile veterinary clinic, shall meet all of the following minimum standards for sanitary conditions and a physical plant.

(1) General facilities and grounds.

(A) Sanitation. All areas of a veterinary premises, and all instruments, apparatus and apparel used in connection with the practice of veterinary medicine, shall be maintained in a clean and sanitary, inoffensive, and orderly condition at all times. Cleaning agents capable of killing viruses and bacteria shall be used to disinfect the premises.

(B) Safety. All public areas of a veterinary premises shall be maintained in a safe condition for the client and patient.

(2) Exterior and grounds.

(A) Exterior structure. The exterior structure shall exhibit evidence of regular maintenance.

(B) Signs. Signs shall be kept in good repair.

(C) Landscaping. The grounds shall exhibit evidence of regular maintenance.

(D) Parking lot and sidewalks. Parking lots shall be large enough for both staff and clientele. Parking lots and sidewalks shall be kept in good repair and free of debris.

(E) Loading and unloading structures of a facility. The loading and unloading structures of a facility shall be of adequate strength, and in good repair.

(F) Outside housing. If the temperature is below 50 degrees Fahrenheit or above 85 degrees Fahrenheit, small animals housed outside shall have adequate shelter.

(G) Holding facilities. Holding facilities shall be of adequate size and design to insure the animals' safety and well being. The area shall contain provisions for food and water when necessary.

(H) Windows. All windows shall be kept clean. If windows are opened for ventilation purposes, effective screening shall be required.

(3) Interior.

(A) Space. Adequate space to safeguard each patient shall be available.

(B) Environment. Adequate heating, cooling, and ventilation necessary to maintain comfort of the patient, client and staff shall be provided.

(C) Water. Hot and cold running water shall be available.

(D) Storage. Adequate sanitary storage for the building size shall be available.

(E) Library. A library shall be provided with basic veterinary textbooks and current veterinary periodicals.

(F) Restraint devices. Restraint devices shall be of adequate design, clean and in good working order to insure the safety of the animals and personnel.

(G) Lighting. Indoor lighting for halls, wards, reception areas, examining and surgical rooms shall be adequate for the intended purpose.

13-2

(H) Odor and waste control. Ventilation and cleaning shall be provided to keep odors from lingering in the rooms.

(4) Reception room.

(A) Seating. Adequate seating shall be provided for the clientele.

(B) Lavatory. A clean lavatory shall be available to the clients.

(C) Permit. A current facility permit shall be conspicuously displayed.

(5) Examination room or rooms. An examination room or rooms shall be available for the complete physical examination of patients by a veterinarian.

(A) Size. This room shall be of sufficient size to accommodate the doctor, assistant, patient and client comfortably.

(B) Sanitation. The exam table surface shall be sanitized between patients.

(C) Equipment. Proper diagnostic equipment needed for the physical examination shall be readily available.

(6) Wards. Those premises where animals are retained overnight shall meet all of the following requirements.

(A) Exercise. Exercise shall be provided for animals having to stay in an overnight facility. Walking the animal shall meet this requirement.

(B) Walls and floors. Floors shall be smooth, waterproof, nonabsorbent, capable of being scrubbed with detergents and effective sanitizing products and in good repair. Walls shall be smooth and free of cracks or gaps large enough to interfere with effective cleaning.

(C) Temperature. The temperature shall be maintained in a range that is comfortable and safe for all patients.

(D) Separate compartments. A separate compartment shall be available for each animal.

(E) Compartment size. Caging or housing shall be designed with the animal's physical comfort as the primary consideration.

(i) Physical comfort assuring that the animal is dry and clean shall be provided.

(ii) Sufficient space shall be provided to assure freedom of movement and normal postural adjustments with convenient access to food and water.

(F) Good repair. Cages, runs, stalls, pens, and other animal compartments shall be kept in good repair to prevent injury to the animal and to promote physical comfort.

(i) Sharp corners and edges, broken wires and any dangerous surfaces shall not be present.

(ii) Cages made of metal other than stainless steel shall be kept in good repair by regular painting or other maintenance as required.

(G) Cleaning procedures. Compartments shall be sanitized between patients. Floors and walls shall be regularly disinfected. Waste cans shall be metal or plastic, shall be leakproof and have tight-fitting lids.

(H) Drains in runways. Drains shall be constructed so that they facilitate sanitization between runways. To maintain proper sanitation runways shall be cleaned between uses.

(I) Food Storage. Bulk food shall be stored in a vermin-proof container. Opened canned food shall be refrigerated until used.

(J) Sanitizing feeding dishes. Water and feed dishes, if not disposable, shall be sanitized.

(K) Feeding. Adequate daily feedings, with a wholesome, nutritional, palatable food, except where medically contra-indicated, shall be provided.

(L) Water. Adequate daily fresh water within easy reach of all patients, except where medically contra-indicated, shall be provided.

(M) Identification. An animal identification system shall be used.

(N) Isolation. Premises shall allow for the effective separation of contagious and noncontagious cases.

(7) Operating room. If other than minor surgical procedures are to be performed, room for major surgical procedures shall be provided, and shall meet the following requirements.

(A) Floors. The floors shall be made of impervious materials, including but not limited to terrazzo, sealed cement, and linoleum.

(B) Intravenous fluid setup. An intravenous setup for fluid administration shall be available.

(C) Emergency drugs. Emergency drugs shall be readily available.

(D) Surgery table. The surgery table shall be constructed of impervious material that is easily sanitized.

(E) Instruments. Instruments and equipment commensurate with the type of surgical services shall be provided.

(8) Sterilization. Articles to be used in surgery shall be sterilized either by gas sterilization or steam sterilization. Chemical sterilization shall be acceptable under field situations and in emergency situations. Surgical packs shall be dated as to the last time sterilized. Monitors shall be included within surgical packs regularly to detect

proper sterilization. Caps, masks, gowns, drapes, towels, and sterile gloves shall be available.

(9) Oxygen. A mechanism of oxygen administration shall be available.

(10) Pharmacy. The veterinarian shall insure the storage, safekeeping and preparation of drugs.

(11) Radiology.

(A) Service availability. If radiology services are not available in the facility, arrangements shall be made to promote this service outside the facility within a reasonable distance.

(B) Film badge monitoring. Film badge monitoring of exposure levels shall be provided for all personnel working with or near an X-ray generator.

(C) Film identification. Permanent identification of the radiograph shall occur at the time of exposure or just prior to development.

(D) Protective apparel. "Leaded" aprons and gloves or mitts shall be available for anyone helping to restrain or position patients during radiography.

(12) Laboratory. The clinical pathology services shall be available either in the hospital or in a medical facility, and the results shall be made available within a reasonable time frame.

(13) Waste disposal.

(A) Dead animals and animal tissues. Prompt and sanitary disposal of dead animals and animal tissues shall be required. All animal tissues and dead animals shall be contained in plastic bags and kept in an area away from the public before being picked up for disposal. Dead animals held until a delayed pick up shall be placed in a refrigerator or freezer.

(B) Needles and syringes. Needles and syringes shall be destroyed or adequately disposed of in a proper manner.

(b) A mobile veterinary clinic shall meet the minimum standards for sanitary conditions and physical plant established in subsection (a) of this regulation except for paragraphs (a)(2)(E), Loading and unloading structures of a facility, (a)(2)(F), Outside housing, (a)(3)(B), Lavatory, (a)(6), Wards, and (a)(9), Oxygen. (Authorized by and implementing K.S.A. 47-840(b); effective Dec. 27, 1994.)

Article 7.—STANDARDS OF VETERINARY PRACTICE

70-7-1. The practice of veterinary medicine. Each veterinarian shall meet the following minimum standards in the practice of veterinary medicine.

(a) Storage compartments. Each veterinarian shall maintain clean, orderly, and protective storage compartments for drugs, supplies, and equipment. Refrigeration shall be available for drugs which require it.

(b) Field sterilization. Each veterinarian shall provide a means of sterilizing instruments when practicing veterinary medicine away from a veterinary premises.

(c) Posting of emergency numbers. Each veterinarian shall post emergency phone numbers for police, fire, and rescue at the main telephone in the building.

(d) Conflict of interest. When representing conflicting interests, including representation of both the buyer and seller of an animal to be inspected for soundness, the veterinarian shall make full disclosure of the dual relationship and shall obtain express consent from all parties to the transaction.

(e) Health certificates. A veterinarian shall not issue a certificate of health unless the veterinarian has personal knowledge, obtained through actual inspection and appropriate tests of the animal, that the animal meets the requirements of the certificate.

(f) Patient acceptance. Each veterinarian shall decide which medical cases will be accepted in the veterinarian's professional capacity and what course of treatment will be followed once a patient has been accepted. The veterinarian shall be responsible for advising the client as to the treatment to be provided.

(g) Control of services. A veterinarian shall not allow professional services to be controlled or exploited by any lay agency, personal or corporate, which intervenes between the client and the veterinarian. A veterinarian shall not allow a non-licensed person or entity to interfere with or intervene in the veterinarian's practice of veterinary medicine. Each veterinarian shall be responsible for the veterinarian's own actions and shall be directly responsible to the client for the care and treatment of the patient.

(h) Anesthesia and anesthetic equipment. Each veterinarian shall provide anesthesia services as needed. An anesthetic agent shall be administered only by a veterinarian or a person trained in its administration under the direct supervision of a licensed veterinarian. Each veterinarian shall use disinfectants capable of eliminating harmful viruses and bacteria for cleaning anesthetic equipment.

13-4

Opposed to HB 2819, from a National Abortion Federation abortion provider

by Mark Pederson, Office Manager of Aid For Women/Central Family Medicine, 720 Central Avenue, Kansas City, KS 66101

General Objections:

Proponents claim this bill "only" follows acceptable national abortion guidelines: Not True.

If these are such good guidelines, why are they not implementing this for ALL outpatient surgury?

Of the abortion-related deaths in Kansas or the U.S., I doubt these regulations would have prevented them. The few abortion deaths are from adverse reactions that are unstoppable once detected. Patients lying to clinic staff about their medical history including last food intake are more frequent serious factors.

Abortions are safe. From the KDHE website, years 1990-1998, 2 abortion-related deaths in 98,000 abortions, 23 childbirth-related deaths in 338,000 childbirths. Childbirth is many times more dangerous than abortion, yet childbirth at home is legally allowed. The U.S. statistics are the same, about 10 times safer than childbirth. Early abortions are always safer than later abortions.

These regs are micro-management of medicine. Administrators unfamiliar with abortion will be deciding how to do abortions, thereby worsening abortion care, not improving it, and increasing the cost of abortion, making abortion less available to women, forcing dangerous full-term pregnancy on them.

We also do General Practice in the poor part of Wyandotte county, accepting Medicaid and Medicare from local elderly patients, and also hispanics since we are bilingual. Since we cannot survive on Medicaid/Medicare fees alone, if we have to quit doing abortions, our community will lose us also.

It will cost money to have hearings, make, and enforce these regulations, even if copied from another state.

Itemized Objections:

Non-surgical abortions are less invasive yet restricted the same, inferring that this bill isn't about healthcare.

The procedure room (b)(5) does not need a regulated 'adequate' size anymore than an OB/GYN does. Why are 'adequate' rooms required to talk (interview and counsel)(b)(1) with a patient. Internists aren't.

'Adequate' lighting and ventilation is vague (b)(6). To my knowledge there has not been a case of abortion infection caused by airborne causes (the prosecution in *Greenville Women's Clinic v. Bryant,* No. 6:96-1898-21, D.S.C. Feb. 5, 1999, admitted that airborne disease is not an infection vector in vaginal procedures). If it was a vector, then OB/GYN's need to be regulated also. Room lighting regulation is micro-management, but if not, why not all doctors? Besides we use head-lamps during the procedure.

We have never needed 'emergency exits for gurneys' (b)(9). Complications like DIC would not be helped <u>even</u> if it occurred in a hospital setting much less in a clinic requiring paramedic transport, and will usually happen after the patient has left the clinic. Hemorrhage can be controlled when detected early, and therefore transport would be useful, but if not detected early, transport is not useful. Complications from anesthesia are too quick to be helped by admitting into a hospital.

How will competence in abortion (c)(2) be demonstrated to oneself? The Medical Director is usually the abortion provider. Most abortions are not done in hospital-sized management schemes.

Admitting privileges to a hospital (c)(3) are not needed if admission arrangements are made, but unnecessary anyway. Privileges and admission-arrangements allow expediting the intake process. There are few abortion emergencies, and those who do high-risk abortions will have such privileges or admission arrangements in place. Privileges would not have helped the abortion-related deaths in Kansas.

OB/GYN's are not required to have licensed nurses (RN, RPN, LPN) for bimanual pelvic exams, why should we (c)(4)? A female chaperone is all that should be needed. We use female CMA's, not Rn's.

Requiring an Registered Nurse instead of a less expensive Certified Medical Assistant for post-Op monitoring (c)(5) costs more with no medical benefit.

Requiring undefined counseling training of all surgical and volunteer staff (c)(6, 7) costs more and doesn't reduce risks. Counseling and advocacy is already provided by a counselor.

Sn Fed St
04/10/02
Attach #14

Kansans for Life

2501 E. Central Ave.
Wichita, Kansas 67214-4511

1-800-928-LIFE (5433)
(316) 687-LIFE (5433)
FAX (316) 687-0303
E-Mail: kfl@kfl.org
Web site: www.kfl.org

April 10,2002

In SUPPORT of HB 2819

Good morning.
My name is Kathy Ostrowski and I am the mother of five children, age 12-23. My husband John is a Topeka attorney, from whom I get sound, free, legal advice, not to mention use of the office copier. I am the volunteer whom Mike Farmer contacted to prepare records and I am testifying on behalf of Kansans For Life. In the name of countless abortion-damaged women, I ask this body to enact regulations for an industry which has enjoyed kid-glove treatment for far too long.

I accidentally began a 10 year study of abortion practice in Kansas when I went to Topeka's first clinic in March 1992. I was horrified to see the abortionist drive up on the first day of operations, get out of his dirty car with a few dishevelled people, take a boxy suction machine out of his dusty trunk and stumble across the driveway up to his new "offices." The man was obviously impaired and I was in disbelief. A short while later, the abortionist packed the suction machine back into his trunk and he and his "staff" drove jovially away. This was his mode of operations between his 3 clinics. Have machine, will travel.

My disbelief grew when the Kansas Board of Healing Arts wouldn't answer citizens' requests that they send their staff to see this travesty of "health care." After a damning affidavit from a "whistleblower" clinic staffer, and a slew of lawsuits within a short time period, the Board checked up and found that he had lied on his applications, that he was a convicted felon and drug-addicted. *[refer to "whistleblowers", page 4 of info on abortionists, Catholic Conference packet]*

This abortionist, Knarr, was finally suspended. His clinics were now staffed by his pals, who, like him, had no training or certification in obstetrics & gynecology. One of them was his business partner and co-abortionist who had supplied him with drugs for 10 years. The Board merely slapped the wrist of this partner named Zaremski. He is still aborting today--a 71 yr. old lung doctor--in KCK. Yes, this clinic trembles at the thought of HB 2819.

Knarr recruited a foreign doctor out of retirement, one who had defrauded several entities, including his ex-wife, and had his own failed clinic in Nebraska. This Rajanna , also known as "affordable abortion" in the yellow pages, had a wrongful death suit within the year. This 64 yr. old KCK practitioner trembles at HB 2819.

The third Knarr replacement was his old pal Kris Neuhaus, who is currently under an extended investigation and series of restrictions from the Board of Healing Arts. She is truly a poster girl for this legislation. Drug limited by the feds (DEA) and determined to be a danger to the public by the Board of Healing Arts, Neuhaus is a prime example of the kid-glove treatment given abortionists. *[refer to the the second column of pg.3 in the abortionist info of Catholic Conference packet]* Neuhaus has escaped loss of her license, while complaining to the media about her dire

Sn Fed St
04/10/02
Attach # 15

financial straits. The Board sent Neuhaus to life-saving training with her staff, mandated record-keeping overseen by an outside pharmacist, and still requires random drug-testing of her entire staff. You better believe HB 2819 scares her.

But we have plenty of poster boys, also. Miller in KCK, had a Kansas teen die while he was still aborting her. He didn't know how to resuscitate her; neither did the staffer who ran for smelling salts. He was quoted as not even knowing what was going on. The KCStar ran a front page story about his numerous, and expensive, lawsuits, paid for with Kansas insurance funds. His Board punishment for the death was to stay out of his office for 1 year.

Then there's Hodes and Crist--operating practically across the street from each other. One could honestly say a woman has a "choice" there in Overland Park: you could try Hodes, with at least 18 lawsuits, or take on Crist with only 14 known suits, although Crist's does include 3 deaths plus a still-comatose mother of three. Which to try ???

This isn't exhaustive; Tiller has added Carhart, of Nebraska partial-birth & fetal tissue fame, who was disciplined for substandard medical care, including falsifying records. I have found at least 22 other lawsuits for botched ob/gyn surgery for Kansas abortionists. The list of 33 lawsuits & Board reported findings of fact for abortion damages and violations of Women's Right to Know is in the Catholic Conference packet.

I have submitted the Missouri statutes & regs regarding abortion clinics. Missouri officials went inside a Springfield clinic in 1992 thru 1994 and found rust on the operating table, bugs in the recovery room, and many personnel violations, especially of Knarr's staff (this was one clinic in his circuit). Crist also worked at this clinic in 1991-92. A girl who was nearly bleeding to death from a botched abortion there, was told by clinic staff that she could only be repaired in Little Rock, Arkansas, instead of the nearby hospital. This incident was the final straw leading to its closing.

Missouri has been regulating their clinics and, guess what? 5,136 of the 6,003 out of state women aborted in Kansas come from Missouri! It would appear that lack of regulation on our side of the state line has a clear consequence. Colorado enacted standards for office-based surgery & anesthesia last November. *[I have included them]* Guess we can expect increased Colorado women aborted here next year--unless we enact HB 2819.

Women in crisis pregnancies are victimized by abortion profiteers. The consent pages taken from the website of Hodes & Nauser (a father/ daughter duo) have claims that would be patently indefensible in court, yet are worded to frighten women away from attempting to get compensated for injuries. For example: "If I seek alternative treatment.without prior instruction...I may not hold either doctor responsible; ...shall absolve the doctors of all medical, legal and/or financial reponsibility."

The abortion clinics that tremble at this bill have good reason to do so. They have gotten a pass too often. Abortion may yet be legal but the facade of being safe is cracking. HB 2819's minimum standards are long overdue here in Kansas. The common sense formula for oversight is patient screening; pre-op evaluation; hospital "back up" privileges; proper record-keeping; instrument-monitoring; attended recovery; anesthesia protocols, training and machinery. Please do the right thing: pass these minimum standards out of committee and let abortion predators tremble.

Thank-you, I stand for questions.

HB 2819- ABORTION CLINIC LICENSING

--establishes minimum standards for abortion clinics over which **KDHE currently has no oversight**
--**follows the abortion industry standards** of Planned Parenthood & Nat'l Abortion Federation
--**follows anesthesia standards** of ACOG(AmCollege Ob/Gyn) & ASA (Am Society Anesthesiologists) as to records; patient screening, testing & monitoring; qualified staff; emergency care plans
--**matches regulations in other states which have passed Constitutional challenges** including: undue burden on women's right to choose abortion, patient privacy, vagueness, improper delegation of state licensing authority, and the Establishment Clause. [1]

WHY OVERSIGHT is NECESSARY:

--CDC: since 1983, anesthesia complications have become most frequent cause of abortion deaths ; [2] abortion deaths from anesthesia **complications rose from 7.7 %** in 1972 to **29.3 %** in 1985 [3]
Example: **death of Kansas teen** Erna Fisher/abortionist Dennis Miller (see packet)
--Anesthesia complications in abortion deaths are nearly 4 times the rate of live birth anesthesia deaths [4]
--Medical procedures costs have risen 500% over last 30 yrs-- except abortions! A first trimester abortion that cost $350 in 1972 should cost $2150 today. To keep prices down, standards of care have been sacrificed. Low paid, poorly trained staff do everything but surgery. [5] (see packet,Whistleblower)

LEGAL ENVIRONMENT: Patients are **winning lawsuit settlements from Kansas abortionists** for wrongful death, failure to give Rh medicine, delayed ambulance during abortion death, negligence in abortion training, failed recovery room procedures, lack of resuscitation skills & equipment, inability to contact abortionist during emergency, not checking medical history. **All these are topics of HB 2819.**

POSITION of KANSAS STATE BOARD of HEALING ARTS: medical "practices that are below the standard of care do create a danger to the public that, **while not necessarily likely to occur with great frequency**, [are] of such gravity that when an incident does occur, **patient harm is all but inevitable**," KSBHA/In the Matter of Ann K.Neuhaus MD, 8/24/99. This extended investigation began after her DEA federal restrictions. Question: could Neuhaus administer anesthesia drugs "without creating an immediate threat to the public, health, safety or welfare"? Answer: No! KSBHA orders her supervised by an outside pharmacist, with random drug testing of entire staff and other standard of care upgrades.

HOW HB 2819 matches KSBHA ORDERS to ABORTIONIST NEUHAUS:

--don't use unmarked, pre-drawn syringes- 1(b) 1
--follow informed consent for gestational age- 1(d) 5
--printed sonogram put in patient file 1(d) 3 (D) 4,5
--allow adequate recuperative stay- 1(b) 8; 1(c) 5; 1(e) 5
--get life-support training- 1(f)3
--equipment breakdown protocol- 1(b)1
--record-keeping inspection- 1(b) 1
--complete consultation before patient enters procedure room- 1(a) (b) 1
--train staff to understand clinic emergency protocol- 1(c) 6
--dedicate one staffer to stay with patient for monitoring & attention to emergency conditions- 1(c) 4,5
--follow ASA guidelines for Sedation & Analgesia by Non-Anesthetists- 1(d) 1; 1(e) 3,4,5; 1(f) 1,2,3

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[1]AUL testimony 2/21/02 House Fed/State committee [2]Strahan, Assoc Interdisc ResBull, Vol.12 No.1 [3]Legal Abortion Mortality & General Anesthesia" H. Atrash, Am Obstet and Gynecol 158:420-424 (1988) [4]"Pregnancy related Mortality Surveillance, U.S. 1987-90" LMKoonin et al, MMWR 46(ss-4); 17-36 (8/8/97) [5]Gina Kolata, "As Abortion Rate Decreases, Clinics Compete for Patients" New York Times, 12/30/00, p1.

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04/10/02
Attach #10

Medical Board Policies

Policy Number: 40-12
Title: Office-Based Surgery and Anesthesia Date
Issued: 11/08/01
Purpose: See attached policy statement introduction.
Policy: On November 8, 2001, the Colorado Board of Medical Examiners adopted the attached policy statement concerning office-based surgery and anesthesia.

Introduction

This policy provides guidance regarding the provision of surgical and anesthesia services in office settings. We identify the roles and responsibilities of physicians providing, or overseeing by proper delegation, surgical and/or anesthesia services in office settings. This policy does not extend or limit the scope of any license. Further, this policy is to be used in concert with state and federal requirements governing the provision of office based surgery and anesthesia.

This policy does not apply to minor surgical procedures performed under topical or local infiltration blocks. This policy applies to any procedure involving general and/or regional anesthesia and/or the use of conscious sedation.

For purposes of this policy "office based surgery" is defined as surgery that is performed in a facility outside a hospital or ambulatory surgical center licensed by the Colorado Department of Public Health and the Environment.

Guidelines for Office Based Surgery and Anesthesia

1. Selection of Procedures and Patients

In general, it is the responsibility of the surgeon to determine that the office is an appropriate forum for the particular procedure(s) to be performed on the particular patient. Furthermore, it is the responsibility of the surgeon and, when involved, the qualified anesthesia provider to determine that the patient is an appropriate candidate for the anesthesia to be provided in the office setting. However, it is the opinion of the Colorado Board of Medical Examiners that under generally accepted standards of practice in Colorado, the following procedures should not be performed in the office:

2. Preoperative Evaluation

An appropriate preoperative evaluation, including history and physical, must be conducted prior to the performance of any surgery, regardless of setting. The surgeon must evaluate and discuss the risks and benefits of the surgical procedure with the patient and obtain informed consent from the patient. Additionally, the surgeon and qualified anesthesia provider must assess the patient before surgery to evaluate the risk of anesthesia.

3. Privileges

The surgeon should have staff privileges at a licensed hospital to perform the same procedure in that hospital as is being performed in the office setting. Alternatively, it is suggested that the surgeon be able to document satisfactory completion of training such as Board certification by a Board approved by the American Board of Medical Specialties or the American Osteopathic Association, or certify comparable background, training and experience.

A written transfer agreement with a licensed hospital within reasonable proximity should be obtained for emergency purposes. For the purposes of these guidelines, "reasonable proximity" is defined as less than thirty minutes transport time from office to hospital.

4. Records

The surgeon must maintain complete records of each surgical procedure; this would include anesthesia records when applicable. The records must contain documentation of informed consent from the patient. The record should document that the patient is medically stable before discharge. A discharge order should be written.

5. Anesthesia

a) Definitions:

1) For purposes of these guidelines, a "qualified anesthesia provider" is an appropriately trained and qualified physician, a certified registered nurse anesthetist ("CRNA"), or a physician assistant ("PA") appropriately trained and qualified in anesthesia working under the on-site supervision of a physician.

2) For the purposes of these guidelines, "monitoring a patient" includes ongoing evaluation of the patient's oxygenation, ventilation, circulation and temperature.

b) Administration of any general or regional anesthetic should be done by a qualified anesthesia provider. Administration of conscious sedation, when not done by a qualified anesthesia provider, should be directly supervised by a qualified physician.

c) A qualified anesthesia provider must be continuously present to monitor the patient when general or regional anesthesia is being used.

d) During any surgery where general or regional anesthesia or conscious sedation is given, qualified personnel in addition to the operating surgeon should be continuously present to monitor the patient.

e) All facilities should have a reliable source of electricity, oxygen, suction, resuscitative equipment and emergency drugs.

f) If services are being provided to infants or children, appropriately sized equipment, medication and resuscitative capabilities must be available.

g) When inhalation anesthesia is used, an anesthesia machine that is monitored and maintained in accordance with the standards of the American Society of Anesthesiologists should be used.

h) Explosive anesthetics should not be used.

i) Personnel with training in appropriate resuscitative techniques (ACLS or PALS) should be immediately available until all patients who have received anesthesia are discharged.

j) The patient should not be discharged home until the patient is medically stable.

k) At least 36 ampules of dantrolene must be immediately available for any procedures when general anesthesia and/or succinylcholine are administered.

6. Duration of Surgery

The planned duration of the surgical procedure(s) for each patient should be reasonable with respect to both the capabilities and training of the personnel available to monitor the patient and the nature of the facility.

It is not recommended that a patient stay overnight in an office setting following a surgical procedure unless that facility is appropriately accredited. "Accredited ambulatory surgical centers" are accredited as a Class B or Class C facility by one of the following organizations: Joint Commission on Accreditation of Healthcare Organizations (JCAHO); American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF); Accreditation Association for Ambulatory Health Care, Inc. (AAHC); or the Colorado Department of Public Health and the Environment.

7. Complications and Emergencies

a) If a patient does not meet discharge criteria and is not in a Class B or Class C facility, the patient should be transferred to an appropriately accredited ambulatory care center or a licensed hospital within reasonable proximity.

b) The facility should have written protocols for cardiopulmonary emergencies.

c) The surgeon and at least one assistant should be currently certified in Basic Life Support. Additionally, if a qualified anesthesia provider is not managing the anesthesia, the surgeon and at least one assistant should be currently certified in Advanced Cardiac Life Support.

d) All facility personnel should be appropriately trained in and regularly review the facility's written emergency protocols.

e) The facility should have written protocols for external events that may affect office-based surgical procedures, such as fire, flood or tornadoes.

f) Back-up power sufficient to ensure patient protection in the event of an emergency should be available.

CONSENT for ELECTIVE ABORTION

PLEASE INITIAL

_____1. **I am :** _____, **AGE:** _____. **I** hereby consent to the performance upon me of an **abortion** by suction "D & C" using local anesthetic ("Paracervical Block") by Herbert C. Hodes, M.D., or Traci L. Nauser, M.D. The procedure is being done at **MY** request; and with **MY** consent, which **I** give freely.

_____2. **I** further consent to the performance of **any** additional emergency procedures, which may be indicated because of unforeseen conditions arising during the abortion.

_____3. **I** have disclosed to the doctor my **COMPLETE** medical history: including **ALLERGIES**, adverse reactions to other medications or anesthetics; **ANY** previous surgery, abortions, or procedures on my cervix; as well as telling the doctor **ANY** medications or drugs that I have taken since my last menstrual period.

_____4. **I believe** I am less than **22** weeks pregnant. My **LAST MENSTRUAL PERIOD** began on: ____/____/____. My period: was / was NOT normal. (circle one)

_____5. **I** understand there are very few complications from abortions, and certainly less than from a full-term delivery. **Any** surgical procedure involves risks of possible complications that could occur **without** fault of Dr. Hodes or Dr. Nauser.

_____6. **SOME of the possible** complications of abortions are the following:

a.	Retained blood clots or tissue requiring repeat suction, or a "D & C"	<1: 100
b.	Hemorrhage (Excessive bleeding), or Infection	<1: 500
c.	Missing an Ectopic ("tubal") pregnancy (pregnancy outside of the uterus)	<1: 500
d.	"Missing" an early pregnancy (and still being pregnant)	<1: 1000
e.	Failure of the blood-clotting mechanism with need for extensive blood transfusion replacement (disseminated intravascular coagulopathy, "D.I.C.")	<1: 1000
f.	Uterine Perforation, with damage to other organs (bladder, intestines); Hospitalization; Major Surgery; Hysterectomy; or Sterility (inability to get pregnant)	<1: 10,000
g.	Death	<1: 250,000

_____7. **I** realize that such complication(s) can be caused by my own medical condition, my behavior after the procedure, by the treatment of follow-up physicians; OR may occur spontaneously without the fault of ANY person.

_____8. **IF I have any problems** after the abortion, **I** will immediately notify one of the above doctors as explained in the *Aftercare Instructions*. **I understand** that my failure to promptly notify the doctor may lead to delay of proper treatment and could cause further complications. **I** understand that if **I** seek alternate treatment without the prior instruction of one of the doctors to do so, I may **not** hold either doctor responsible for subsequent medical expenses, **or** any other loss experienced as a result thereof.

_____9. **I agree** to have a Post-Abortion Exam in **1 (one) to 3 (three) weeks**; and that failure to do so shall absolve the doctors of **all** medical, legal, and/or financial responsibility for **any** abortion-related problems that might arise at a later date.

____10. **I** acknowledge that it is MY responsibility to ask the doctor **any questions** that I have pertaining to the abortion; OR to this consent form **before** I sign it below.

I hereby certify that I have read this entire form, initialed it, and fully understand its contents.

Signed: _____ *Date*: ____/____/____

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Mo. Clinic Law

Rules of
Department of Health
Division 30—Division of Health Resources
Chapter 30—Ambulatory Surgical Centers

Title		Page
19 CSR 30-30.010	Definitions and Procedures for Licensing Ambulatory Surgical Centers	3
19 CSR 30-30.020	Administration Standards for Ambulatory Surgical Centers	4
19 CSR 30-30.030	General Design and Construction Standards for Ambulatory Surgical Centers	6
19 CSR 30-30.040	Preparation of Plans and Specifications for Ambulatory Surgical Centers	10
19 CSR 30-30.050	Definitions Relating to Abortion Facilities	11
19 CSR 30-30.060	Organization and Management for Abortion Facilities	11
19 CSR 30-30.070	Physical Standards for Abortion Facilities	13

SnFedSt
04/10/02
Attach #20

3. Each set of the plans and each set of specifications shall bear the date of its completion or its latest revision.

4. The plans shall be on sheets of the same size, securely bound into complete sets, with the sheets in the proper order. The specifications shall be securely bound into complete sets.

(B) The working drawings and specifications shall include the following: the material set out in paragraphs (1)(A)1.—12. of this rule; courses and distances of property lines; dimensions and locations of any building, structures, easements, rights-of-way or encroachments on the site; details of party walls, and walls and foundation adjacent to lot line; detailed information by the city engineer or other official report as to established curbs, buildings lines, streets, alleys, sidewalks; all utilities including size, characteristics and location of these services, piping, mains, sewers, poles, wires, hydrants and manholes upon, over or under the site and location of high pressure gas lines within one thousand two hundred feet (1200') of the building; complete information as to the disposal of sanitary, storm water and subsoil drainage; official datum upon which elevations are based and benchmark established on or adjacent to the site; contours on elevations at two foot (2') intervals over site and elevations at the bottom of excavation; and thickness, consistency, character and estimated safe bearing value of various strata encountered.

Auth: section 197.225, RSMo (1986). This rule was previously filed 13 CSR 50-30.040. Original rule filed Dec. 2, 1975, effective Feb. 1, 1976.

19 CSR 30-30.050 Definitions Relating to Abortion Facilities

PURPOSE: This rule defines terminology used in 19 CSR 30-30.060 and 19 CSR 30-30.070, and presents procedures to follow in making application for a license.

(1) The following definitions shall be used in the interpretation and enforcement of 19 CSR 30-30.060 and 19 CSR 30-30.070:

(A) Abortion—The intentional destruction of an embryo or fetus in a woman's uterus or the intentional termination of a pregnancy of a woman with intent other than to increase the probability of a live birth or to remove a dead or dying embryo or fetus;

(B) Abortion facility—A facility in which the number of patients having abortions represents fifty-one percent (51%) or more of the patients treated or seen for any health condition or where fifty-one percent (51%) or more of the revenues of the facility are from abortions or procedures related to abortions;

(C) Administrator—A person who is designated to provide daily supervision over an abortion facility;

(D) Complication—Includes, but is not limited to, hemorrhage, infection, uterine perforation, cervical lacerations and retained products;

(E) Department—The Missouri Department of Health;

(F) Discharge summary—A statement completed by a physician or registered nurse on the condition of the patient at the time of discharge;

(G) First trimester—The first thirteen (13) weeks of gestation, based upon gestational age;

(H) Gestational age—The length of pregnancy measured from the onset of the last menstrual period;

(I) Health assessment—A determination of a patient's physical and mental status;

(J) Licensed practical nurse—A person licensed to practice practical nursing under the Nursing Practice Act, sections 335.011—335.096, RSMo (1986);

(K) Person—Any individual, firm, partnership, corporation or association;

(L) Physician—Any person licensed to practice medicine pursuant to Chapter 334, RSMo (1986);

(M) Registered nurse—An individual who is a graduate of an approved school of nursing and who is licensed to practice professional nursing under the Missouri Nursing Practice Act, sections 335.011—335.096, RSMo (1986); and

(N) Surgical technologist—An individual who is certified by the Association of Surgical Technologists, Inc.

(2) Procedures for Licensing Abortion Facilities.

(A) In any facility other than licensed ambulatory surgical facilities and hospitals where abortions may be performed, a license to establish and operate an abortion facility shall be required in the absence of evidence to support that the facility is not operating in accordance with the definition established in subsection (1)(B). The evidence required must include, but need not be limited to, statistical records of individuals treated and financial reports including revenue from abortions and procedures related to abortions and total revenues.

(B) Application for the licensing of an abortion facility shall be made in writing to the Department of Health on forms provided by the Department of Health. Each application for a license shall be accompanied by an annual license fee of two hundred dollars ($200).

(C) The application shall be made by the person(s) or corporation operating the facility.

(D) The licensee shall notify the Department of Health in writing of any change in the name of the facility or change in the name of the administrator.

(E) Separate licenses are required for facilities maintained on separate sites even though operated by the same owner.

(F) The license shall be conspicuously posted in a public area in the facility.

(G) A license shall not be issued by the Department of Health until a facility is in compliance with all requirements of 19 CSR 30-30.060 and 19 CSR 30-30.070.

Auth: sections 197.200—197.240, RSMo (1986). Original rule filed July 15, 1987, effective Oct. 25, 1987.

19 CSR 30-30.060 Organization and Management for Abortion Facilities

PURPOSE: Section 197.205, RSMo (1986) authorizes the Department of Health to establish standards for the operation of abortion facilities in order to provide acceptable care in a safe environment. Abortion facilities are considered ambulatory surgical centers as defined by section 197.200(1), RSMo (1986) and are subject to licensure as required by section 197.205, RSMo (1986).

(1) Governing Body, Administration and Medical Staff.

(A) The facility shall have a governing body which may be an individual owner(s), partnership, corporate body, association or public agency.

1. The governing body shall have full legal responsibility for determining, implementing and monitoring policies governing a facility's total operation and for ensuring that these policies are administered in a manner to provide acceptable care in a safe environment.

2. The governing body shall select and employ an administrator who is a physician licensed in Missouri, a registered nurse licensed in Missouri or an individual who has at least one (1) year of administrative experience in health care.

3. Bylaws of the governing body shall require that an individual who complies with paragraph (1)(A)2. of this rule shall be in charge in the absence of the administrator.

4. The department shall be notified in writing of any change in the designation of the administrator of the facility.

5. Governing body bylaws shall acknowledge that duly appointed ambulatory surgical center surveyors of the department shall be allowed to inspect the facility at any time the facility is in operation consistent with due regard for the medical condition and privacy of the on-site patients.

6. Bylaws of the governing body shall require that the medical staff, facility personnel and all auxiliary organizations shall be directly or indirectly responsible to the governing body through the administrator.

7. The governing body, through the administrator, shall establish criteria for the content of patients' records and shall provide for timely completion of those records and disciplinary action for noncompliance.

8. The governing body shall ensure that the abortion facility abides by all applicable state and federal laws.

(B) An administrator shall organize the administrative functions of the facility and establish a system of authorization, record procedures and internal controls.

1. The administrator shall be responsible for establishing effective security measures to protect patients, employees and visitors.

2. The reporting of suspected incidences of child abuse shall be made to the Division of Family Services as established under section 210.115.1., RSMo (1986).

3. The administrator shall be responsible for a written plan for evacuation of patients and personnel in the event of fire, explosion or other internal disaster. The plan shall be kept current and all personnel shall be knowledgeable of the plan.

4. All fires, explosions or other physical actions taken against the facility shall be reported to the department.

5. The administrator shall be responsible for the development and enforcement of written policies which prohibit smoking throughout the abortion facility except specific designated areas where smoking may be permitted. Each such designated area shall have one hundred percent (100%) of the air supplied to the room exhausted.

6. Written smoking control policies shall be posted throughout the abortion facility.

7. Smoking shall be prohibited in any room or compartment where flammable liquids, combustible gases or oxygen are used or stored and in any other hazardous location. These areas shall be posted with NO SMOKING signs.

8. The facility shall establish a program for identifying and preventing infections and for maintaining a safe environment. Infectious and pathological wastes shall be segregated from other wastes at the point of generation and shall be placed in distinctive, clearly marked, leak-proof containers or plastic bags appropriate for the characteristics of the infectious wastes. Containers for infectious waste shall be identified with the universal biological hazard symbol. All packaging shall maintain its integrity during storage and transport.

9. All reportable infectious or communicable diseases identified shall be reported to the Department of Health.

10. The facility shall have policies and procedures for the handling, processing, storing and transporting of clean and dirty laundry. The facility may provide laundry services at the facility or utilize contract services.

11. The administrator shall develop written personnel policies which contain at least the following:

A. Provisions for orientation of all personnel to the policies and objectives of the facility and participation by all personnel in appropriate employee training;

B. Provision for periodic evaluation of employees' performance;

C. Provisions for written job descriptions, including job qualifications; and

D. Provisions for licensed personnel to have current Cardiopulmonary (CPR) training so that at least one (1) licensed and trained personnel is on-site at all times patients are present during and following surgery.

12. The administrator shall be responsible for ensuring that the provisions of Chapter 188, Regulation of Abortions, RSMo (1986) are adhered to.

13. A personnel record shall be maintained on each employee and shall include documentation of each employee's orientation, health status, education and training, as well as verification of current licenses for physicians, registered nurses (RNs) and licensed practical nurses (LPNs).

(C) The medical staff shall develop and, with the approval of the governing body, shall adopt policies governing physician activities in the abortion facility.

1. Medical staff membership shall be limited to physicians.

2. Each physician requesting staff membership shall submit a written application to the administrator of the facility on a form approved by the governing body. Each application shall be accompanied by evidence of education, training, professional qualification, license and standards of performance.

3. The governing body, acting upon recommendations of the medical staff, shall approve or disapprove appointments. Written criteria shall be developed for privileges extended to each member of the staff. A formal mechanism shall be established for recommending to the governing body delineation of privileges, curtailment, suspension or revocation of privileges and appointments and reappointments to the medical staff.

4. Physicians performing abortions at the facility shall have staff privileges at a hospital within fifteen (15) minutes' travel time from the facility or the facility shall show proof there is a working arrangement between the facility and a hospital within fifteen (15) minutes' travel time from the facility granting the admittance of patients for emergency treatment whenever necessary.

5. Each facility shall arrange for at least one (1) physician who is board-certified or board-eligible by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology to be available either as a staff member or as a consultant for the purpose of providing consultation as needed and to advise staff members with respect to maintenance of a satisfactory quality of treatment.

(2) Records.

(A) The facility shall maintain a daily patient roster of all patients receiving abortion services. This daily patient roster shall be retained for a period of two (2) years.

(B) The facility shall maintain a medical record according to professional standards for each patient. Information required for the individual abortion report required by section 188.052, RSMo (1986) shall be readily retrievable from the medical record.

(C) The medical record shall contain—a unique identifying record number, patient identifying information, name of physician, diagnosis, medical history and physical examination record, laboratory reports, tissue reports, anesthesia, allergies/drug reactions, physician's orders, clinical notes, counseling notes, patient consent form, medication administration records and discharge summary. All pharmaceutical agents administered shall be timed, dated and signed by the person making the entry.

(D) Medical records for adults shall be retained for seven (7) years from the time of discharge and medical records for minors shall be retained for seven (7) years from the time of discharge or two (2) years past the age the patient reaches majority, whichever is longer. All medical records shall be safeguarded against loss and unofficial use.

(E) Medical records are the property of the abortion facility and shall not be removed from the facility except by court order, subpoena, for the purposes of microfilming or for off-site storage approved by the governing body. Information provided with tissue sent to a laboratory, information provided for statistical purposes and information provided for any other purpose shall contain the unique identifying number, not the patient's name.

20-3

(3) Patient care services shall be under the direction of an RN. An RN shall be present in the clinical area whenever there is a patient in the procedure room or recovery room. An LPN or a surgical technician shall be present in the procedure room whenever there is a patient in the procedure room. The surgical technician shall be a certified surgical technologist or shall provide documentation of training in assisting abortion procedures.

(A) An RN or An LPN shall be present in the recovery room when a patient is in the recovery room.

(B) An abortion shall be performed only by a physician.

(C) A medical history shall be obtained and a health assessment including a pelvic examination shall be performed. There must be confirmation of pregnancy by clinical evidence and laboratory tests. The findings shall be used in determining the duration of gestation, identifying preexisting medical or other complications, and detecting any factors which could influence the choice of the procedure, anesthesia or preoperative and postoperative management. If the physician determines gestation is beyond the first trimester, an ultrasound examination shall be performed and results shall be recorded in the patient's chart.

(D) A physician shall be on the premises and immediately available for any assistance to a patient in the recovery room.

(E) A patient shall be fully reactive and her vital signs shall be stable before discharge from the facility.

(F) Written instructions shall be issued to all patients in accordance with the practice of the physician in charge of the abortion facility and shall include the following:

1. Symptoms of noticeable complications;
2. Activities to be avoided; and
3. Abortion facility emergency telephone numbers, available on a twenty-four (24)-hour basis, to be used by the patient should any complication occur or question arise.

(G) Professional and nonprofessional personnel providing patient care in the facility should be given the training and orientation period appropriate to the needs and level of preparation as required by the individual job description.

(H) A person who is trained to provide information on abortion procedures, alternatives, informed consent and family planning services shall be available to each patient to—

1. Assure written informed consent establishing that the patient understands the particular risk associated with the abortion technique to be used;
2. Prepare the patient for surgery in a manner that facilitates her safety and comfort; and
3. Assist the patient in reaching a decision about the method of birth control she will use, if any, after the procedure, respecting her choices.

(I) An emergency tray equipped to treat seizures, bleedings, anaphylactic shock, respiratory arrest and cardiac arrest shall be immediately available to the procedure room and recovery room.

(J) Each abortion facility shall develop a quality assurance program that includes all health and safety aspects of patient care and shall include a review of appropriateness of care. Results of the quality assurance program shall be reviewed at least quarterly by the administrator, director of patient care, a representative of the medical staff and the governing body. The quality assurance program shall include a review of at least the following:

1. Completeness of clinical records;
2. Incidence of morbidity and mortality;
3. Intraoperative and postoperative complications;
4. All cases transferred to a hospital;
5. All cases that resulted in a length of stay of more than twelve (12) hours;
6. Errors in diagnosis;
7. Problems in compliance with state and local laws and regulations; and
8. All cases in which the gestational age was determined to be beyond eighteen (18) weeks.

(K) The quality assurance program must show evidence of action taken as a result of the identification of the problems.

(L) Emergency drugs, oxygen and intravenous fluids shall be available in the procedure room to stabilize the patient's condition when necessary. A manual breathing bag, suction machine and endotracheal equipment shall be located in the clinical area for immediate access.

(4) Laboratory Services.

(A) All fetal tissue shall be grossly examined at the time of the procedure by the attending physician. The results of the tissue examination shall be recorded in the patient's chart.

(B) In the absence of visible fetal parts or placenta, the tissue may be examined under a low-power microscope for the detection of villi. If this examination is inconclusive, the tissue shall be sent to a pathology laboratory for microscopic evaluation.

(C) All tissue obtained from abortions, except tissue submitted to a pathologist for analysis, shall be submerged in a preservative solution and shall be transported in a leakproof container to a facility with a waste sterilizer or an incinerator approved by the Department of Natural Resources. If kept for more than twelve (12) hours, all tissue shall be refrigerated.

(D) The following laboratory procedures shall be performed on every abortion patient: hematocrit; urinalysis, including pregnancy test; and Rh typing.

(E) Anti-Rh immune globulin therapy shall be given to all Rh negative patients upon completion of the abortion procedure. If for any reason a patient refuses this therapy, this refusal shall be noted by the physician in the clinical record, and, if possible, documented by the patient's signature on appropriate release forms in order to protect the physician and the facility.

(5) Complaints. Any persons having a complaint pertaining to the care of a patient rendered by an abortion facility shall direct the complaint in writing to the Missouri Department of Health, Bureau of Hospital Licensing and Certification, P.O. Box 570, Jefferson City, MO 65102. The person making the complaint shall be contacted by the Department of Health within five (5) working days of receipt of the complaint and the complaint shall be investigated by the Department of Health within twenty (20) working days of receipt of the complaint.

Auth: sections 197.200—197.240, RSMo (1986). Original rule filed July 15, 1987, effective Oct. 25, 1987. Amended: Filed June 14, 1988, effective Oct. 13, 1988.

19 CSR 30-30.070 Physical Standards for Abortion Facilities

PURPOSE: Section 197.200, RSMo (1986) authorizes the Department of Health to establish physical standards for abortion facilities in order to provide acceptable care in a safe environment. Abortion facilities are considered ambulatory surgical centers as defined by section 197.200(1), RSMo and are subject to licensure as required by section 197.205, RSMo (1986).

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Requests for deviations from requirements on physical facilities shall be in writing to the Department of Health. Approvals for devia-

tions shall be in writing and both requests and approvals shall be made a part of the permanent Department of Health records for the abortion facility.

(2) Any abortion facility constructed or renovated after October 25, 1987 shall have plans prepared by an architect or engineer registered in Missouri. These plans shall be submitted to the department for review and approval prior to construction. New abortion facilities shall have the following:

(A) At least two (2) remote exits shall be provided for each floor directly to the outside or through an enclosed stairway or passageway to the outside;

(B) Corridors serving patients shall be at least six feet (6′) wide;

(C) All doors through which patients pass shall be at least forty-four inches (44″) wide and of solid-core construction;

(D) One (1)-story buildings shall be at least of Type II (111) protected noncombustible construction as described in *Standard on Types of Building Construction 1979* published by the National Fire Protection Association;

(E) Multistory buildings shall be constructed of at least Type II (222) fire-resistive construction as described in *Standard on Types of Building Construction* published by the NFPA, or shall be protected throughout by an approved automatic sprinkler system;

(F) Multistory buildings shall have at least one (1) elevator. The elevator cab shall be at least five feet by seven feet (5′ × 7′) clear inside. The car door shall have a clear opening of not less than forty-four inches (44″);

(G) Trickle-charge battery pack units shall be located to provide emergency lighting in the procedure room, recovery room, exit corridors and exit stairs to grade;

(H) A manual fire alarm break station shall be located near each exit and connected to a local audible alarm which can be heard throughout the facility;

(I) At least two (2) ABC-type fire extinguishers are to be located in the facility, one (1) in the clinical area;

(J) Illuminated exit signs shall be located above each exit and illuminated directional exit signs shall be located where needed to direct patients and personnel to exits in event of an emergency;

(K) Ceiling, wall and floor finishes in the clinical area including the procedure rooms, recovery room, personnel change rooms, central sterile and supply, janitor's closet and laboratory shall be smooth and easily cleanable;

(L) Scrub-up facilities shall be knee- or foot-operated and provided at the rate of one (1) per procedure room. Scrub-up facilities shall be located outside but immediately available to the procedure room;

(M) Procedure rooms shall have the following:

1. A minimum length and width of twelve feet (12′);
2. A minimum ceiling height of nine feet (9′);
3. A door with a minimum width of forty-four inches (44″); and
4. There shall be no windows in the room except there may be a fixed-view window in the wall between the procedure room and the adjacent corridor;

(N) The recovery room shall be separated from the procedure room and be of sufficient size to accommodate at least four (4) recovery beds or recliners for each procedure room. There shall be three feet (3′) of clear space on both sides and at the foot of each recovery bed or recliner;

(O) The procedure room and recovery room shall be provided with a minimum of six (6) air changes per hour. Air supplied to all areas shall be filtered through a filter with at least a twenty-five percent (25%) efficiency rating;

(P) Personnel change rooms shall be provided for each sex and located convenient to the procedure room. Each change room shall be equipped with a toilet and lavatory;

(Q) The laboratory shall be equipped with a counter, sink and refrigerator;

(R) The procedure room shall be equipped with a ceiling-mounted surgical light, operating table or a conventional gynecological examining table with accessories, closed cabinets for equipment and sufficient tables to hold an emergency tray and other necessary equipment;

(S) There shall be one (1) electrical outlet in the procedure room for the emergency light and at least one (1) duplex outlet on each wall;

(T) There shall be one (1) electrical outlet in the recovery room for the emergency light and at least one (1) duplex outlet for each two (2) recovery beds or recliners;

(U) Piped-in or portable oxygen and suction equipment shall be located in the recovery room;

(V) The sterilizing room shall be equipped with a steam sterilizer, counter and sink, and storage space for clean supplies. Air pressure in this room shall be positive in relation to adjacent areas;

(W) The soiled/decontamination room shall be equipped with a counter and sink. This room shall be equipped with a constant running exhaust;

(X) A patient toilet with lavatory shall be located convenient to the recovery room. This room shall be equipped with a constant running exhaust;

(Y) At least two (2) patient change rooms with secure storage for personal effects shall be provided; and

(Z) Office space, waiting room, record storage space and counseling rooms shall be provided. Counseling rooms shall be separate and not smaller than ten feet by ten feet (10′ × 10′).

(3) Any abortion facility in operation at the time these rules are adopted shall comply with the following:

(A) Smoke detectors shall be located in all rooms and in corridors at thirty-feet (30′) intervals unless the building is rated Type II (222) fire-resistive or if it is a one (1)-story building rated Type II (111) protected-noncombustible as described in *Standard on Types of Building Construction 1979* published by the NFPA. If the building is multistoried and rated combustible, it shall be protected throughout by an approved automatic sprinkler system;

(B) There shall be a system of corridors, passageways and elevators adequate in size and arrangement to allow a patient on a stretcher to be moved from any point in the abortion facility to a street-level exit;

(C) Space shall be provided for waiting, registration, counseling, medical evaluation, examination and referral. This space shall be equipped with suitable furnishings and accommodations;

(D) Dressing rooms shall be provided for the privacy, physical comfort and convenience of patients and personnel;

(E) At least one (1) procedure room shall be adequately equipped, supplied and staffed to safely perform abortions. The procedure room shall be equipped with an operating table or a conventional gynecologic examining table with accessories, a closed cabinet for equipment and tables to hold an emergency tray and other necessary equipment. The procedure room shall be well lighted and maintained at a comfortable temperature;

(F) Personnel change rooms and scrub-up facilities shall be located convenient to the procedure room;

(G) A utility room with facilities for steam sterilization and space for storage of clean and sterilized supplies shall be provided. There shall be sufficient surgical instruments sterilized and available for each patient who presents herself for an abortion. The room shall be arranged to prevent cross traffic of clean and dirty material;

(H) The recovery room shall be separate from the procedure room and be of sufficient size to accommodate at least four (4) recovery beds or recliners for each procedure room. The recovery room shall be well-lighted and maintained at a comfortable temperature.

20-5

Recovery beds or recliners shall be spaced to permit easy staff access to each patient;

(I) Piped-in or portable oxygen and suction equipment shall be located in the recovery room;

(J) Trickle charge battery pack units shall be located to provide emergency lighting in the procedure room, recovery room, exit corridors and exit stairs to grade;

(K) A manual fire alarm break station shall be located near each exit and connected to a local audible alarm which can be heard throughout the facility;

(L) At least two (2) ABC-type fire extinguishers shall be located in the facility, one (1) in the clinical area;

(M) Illuminated exit signs shall be located above each exit door and illuminated directional exit signs shall be located where needed to direct patients and personnel to exits in event of an emergency;

(N) Wall and floor finishes in the procedure room, recovery room and the sterilization area shall be smooth and easily cleanable;

(O) The laboratory shall be equipped with a counter, sink and refrigerator; and

(P) At least two (2) remote exits shall be provided for each floor. Each exit shall discharge directly to the outside or through an enclosed stairway or passageway to the outside.

Auth: sections 197.200—197.240, RSMo (1986). Original rule filed July 15, 1987, effective Oct. 25, 1987.

Revised Statutes of Missouri 1986

Title XII
PUBLIC HEALTH AND WELFARE

Chapters

188 Regulation of Abortions
189 Aid to Local Governmental Health Facilities
190 Emergency Services
191 Health and Welfare
192 Department of Health
193 Vital Statistics
194 Death—Disposition of Dead Bodies
195 Drug Regulations
196 Food and Drugs
197 Medical Treatment Facility Licenses
198 Convalescent, Nursing and Boarding Homes
199 Missouri Rehabilitation Center (Formerly Chest Hospital)
200 State Cancer Center
201 Crippled Children
203 Air Conservation (Transferred to Chapter 643)
204 Common Sewer Districts in Certain Areas
205 County Health and Welfare Programs
206 Hospital District Law
207 Division of Family Services
208 Old Age Assistance, Aid to Dependent Children and General Relief
209 Aid to Blind Persons
210 Child Protection and Reformation
211 Juvenile Courts
213 Human Rights
214 Cemeteries
215 State Housing

Chapter 188

REGULATION OF ABORTIONS

Sec.

188.010. Intent of general assembly.
188.015. Definitions.
188.020. Physician, required to perform.
188.025. Hospital required, when.
188.027. Consent, written and informed, required.
188.028. Minors, abortion requirements and procedure.
188.029. Physician, determination of viability, duties.
188.030. Abortion of viable unborn child permitted, when, procedure —second attendant physician also required, duties.
188.035. Death of child aborted alive deemed murder in second degree, when.
188.037. Experimentation with fetus, or child aborted alive, prohibited, exception.
188.039. Consent, form, content—coercion prohibited—woman to be informed of certain facts, when.
188.047. Tissue sample authorized—pathologist to file report, copies furnished.
188.052. Physician's report on abortion and post-abortion care, when —department of health to publish statistics.
188.055. Forms to be supplied to health facilities and physicians.
188.060. Records to be retained for seven years.
188.065. Revocation of license, when.
188.070. Breach of confidentiality prohibited.

20-7

188.075. Violation of sections 188.010 to 188.085 a class A misdemeanor.
188.080. Abortion performed by other than a licensed physician with surgical privileges at a hospital, a felony.
188.085. Sections 188.010 to 188.085 not to be deemed exclusive of other regulations or remedies.
188.100. Definitions.
188.105. Discrimination by employer prohibited because of failure of employee to participate in abortion—exceptions.
188.110. Discrimination by colleges, universities and hospitals prohibited—no requirement to pay fees, when.
188.115. Severability clause.
188.120. Cause of action for violation of discrimination laws, treble damages, attorneys fees.
188.130. No cause of action for wrongful life.
188.200. Definitions.
188.205. Use of public funds prohibited, when.
188.210. Public employees, activities prohibited, when.
188.215. Use of public facilities prohibited, when.
188.220. Taxpayer standing to bring suit, when, where.

188.010. Intent of general assembly.—It is the intention of the general assembly of the state of Missouri to grant the right to life to all humans, born and unborn, and to regulate abortion to the full extent permitted by the Constitution of the United States, decisions of the United States Supreme Court, and federal statutes.

(L. 1974 H.B. 1211 § 1, A.L. 1986 H.B. 1596)

188.015. Definitions.—Unless the language or context clearly indicates a different meaning is intended, the following words or phrases for the purposes of sections 188.010 to 188.130 shall be given the meaning ascribed to them:

(1) **"Abortion"**, the intentional destruction of the life of an embryo or fetus in his or her mother's womb or the intentional termination of the pregnancy of a mother with an intention other than to increase the probability of a live birth or to remove a dead or dying unborn child;

(2) **"Abortion facility"**, a clinic, physician's office, or any other place or facility in which abortions are performed other than a hospital;

(3) **"Conception"**, the fertilization of the ovum of a female by a sperm of a male;

(4) **"Gestational age"**, length of pregnancy as measured from the first day of the woman's last menstrual period;

(5) **"Physician"**, any person licensed to practice medicine in this state by the state board of registration of the healing arts;

(6) **"Unborn child"**, the offspring of human beings from the moment of conception until birth and at every stage of its biological development, including the human conceptus, zygote, morula, blastocyst, embryo, and fetus;

(7) **"Viability"**, that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems.

(L. 1974 H.B. 1211 § 2, A.L. 1979 H.B. 523, 626 & 902, A.L. 1986 H.B. 1596)

188.020. Physician, required to perform.—No person shall perform or induce an abortion except a physician.

(L. 1974 H.B. 1211 § 3, A.L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

188.025. Hospital required, when.—Every abortion performed at sixteen weeks gestational age or later shall be performed in a hospital.

(L. 1974 H.B. 1211 § 4, A.L. 1979 H.B. 523, 626 & 902, A.L. 1986 H.B. 1596)

(1981) A requirement that second trimester dilation and evacuation abortions be performed in a hospital is unconstitutional because the court found that an out patient procedure was no more dangerous to maternal health than a hospital procedure while being far less expensive. Planned Parenthood v. Ashcroft (8th Cir.), 664 F.2d 687.

(1983) The second-trimester hospitalization requirement of this statute is unconstitutional because it unreasonably infringes upon a woman's constitutional right to obtain an abortion. Planned Parenthood of Kansas City, Mo. v. Ashcroft, 103 S.Ct. 2517.

188.027. Consent, written and informed, required.—No abortion shall be performed except with the prior, informed and written consent freely given of the pregnant woman.

(L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

188.028. Minors, abortion requirements and procedure.—1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:

(1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or

(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

(1) The minor or next friend shall make an application to the juvenile court which shall as-

20-8

sist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

(2) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. If any party is unable to afford counsel, the court shall appoint counsel at least twenty-four hours before the time of the hearing. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor;

(3) In the decree, the court shall for good cause:

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied;

(4) If the petition is allowed, the informed consent of the minor, pursuant to a court grant of majority rights, or the judicial consent, shall bar an action by the parents or guardian of the minor on the grounds of battery of the minor by those performing the abortion. The immunity granted shall only extend to the performance of the abortion in accordance herewith and any necessary accompanying services which are performed in a competent manner. The costs of the action shall be borne by the parties;

(5) An appeal from an order issued under the provisions of this section may be taken to the court of appeals of this state by the minor or by a parent or guardian of the minor. The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.

3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor against her will, except that an abortion may be performed against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to preserve the life of the minor.

(L. 1979 H.B. 523, 626 & 902, A.L. 1986 H.B. 1596)

(1981) Provisions of statute requiring notice to parents of all minors seeking abortions is unconstitutional because it requires notice to the parents of minors who are mature or minors for whom it is not in their best interest to give notice. Planned Parenthood v. Ashcroft (8th Cir.) 655 F.2d 848.

(1983) Statute requiring minors to obtain parental or judicial consent to obtain an abortion is constitutional as interpreted in Planned Parenthood v. Ashcroft, 655 F.2d 848 (8th Cir. 1981). Planned Parenthood of Kansas City, Mo. v. Ashcroft, 103 S.Ct. 2517.

(1985) Requirement that unemancipated minor secure parental consent or court ordered right to self-consent in order to obtain abortion is constitutional. C.L.G. v. Webster, 616 F.Supp. 1182 (D.C.Mo.).

188.029. Physician, determination of viability, duties.—Before a physician performs an abortion on a woman he has reason to believe is carrying an unborn child of twenty or more weeks gestational age, the physician shall first determine if the unborn child is viable by using and exercising that degree of care, skill, and proficiency commonly exercised by the ordinarily skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. In making this determination of viability, the physician shall perform or cause to be performed such medical exminations and tests as are necessary to make a finding of the gestational age, weight, and lung maturity of the unborn child and shall enter such findings and determination of viability in the medical record of the mother.

(L. 1986 H.B. 1596)

188.030. Abortion of viable unborn child permitted, when, procedure—second attendant physician also required, duties.—1. No abor-

tion of a viable unborn child shall be performed unless necessary to preserve the life or health of the woman. Before a physician may perform an abortion upon a pregnant woman after such time as her unborn child has become viable, such physician shall first certify in writing that the abortion is necessary to preserve the life or health of the woman and shall further certify in writing the medical indications for such abortion and the probable health consequences.

2. Any physician who performs an abortion upon a woman carrying a viable unborn child shall utilize the available method or technique of abortion most likely to preserve the life and health of the unborn child. In cases where the method or technique of abortion which would most likely preserve the life and health of the unborn child would present a greater risk to the life and health of the woman than another available method or technique, the physician may utilize such other method or technique. In all cases where the physician performs an abortion upon a viable unborn child, the physician shall certify in writing the available method or techniques considered and the reasons for choosing the method or technique employed.

3. An abortion of a viable unborn child shall be performed or induced only when there is in attendance a physician other than the physician performing or inducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion. During the performance of the abortion, the physician performing it, and subsequent to the abortion, the physician required by this section to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman.

(L. 1974 H.B. 1211 § 5, A.L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

(1983) Requirement of a second doctor during a second-trimester abortion is constitutional. Planned Parenthood of Kansas City, Mo. v. Ashcroft, 103 S.Ct. 2517.

188.035. Death of child aborted alive deemed murder in second degree, when.—Whoever, with intent to do so, shall take the life of a child aborted alive, shall be guilty of murder of the second degree.

(L. 1974 H.B. 1211 § 6, A.L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

188.037. Experimentation with fetus, or child aborted alive, prohibited, exception.—No person shall use any fetus or child aborted alive for any type of scientific, research, laboratory or other kind of experimentation either prior to or subsequent to any abortion procedure except as necessary to protect or preserve the life and health of such fetus or child aborted alive.

(L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

188.039. Consent, form, content—coercion prohibited—woman to be informed of certain facts, when.—1. No physician shall perform an abortion unless, prior to such abortion, the physician certifies in writing that the woman gave her informed consent, freely and without coercion, after the attending physician had informed her of the information contained in subsection 2 of this section and shall further certify in writing the pregnant woman's age, based upon proof of age offered by her.

2. In order to insure that the consent for an abortion is truly informed consent, no abortion shall be performed or induced upon a pregnant woman unless she has signed a consent form that shall be supplied by the state department of health, acknowledging that she has been informed by the attending physician of the following facts:

(1) That according to the best medical judgment of her attending physician whether she is or is not pregnant;

(2) The particular risks associated with the abortion technique to be used;

(3) Alternatives to abortion shall be given by the attending physician.

3. The physician may inform the women of any other material facts or opinions, or provide any explanation of the above information which, in the exercise of his best medical judgment, is reasonably necessary to allow the woman to give her informed consent to the proposed abortion, with full knowledge of its nature and consequences.

(L. 1979 H.B. 523, 626 & 902, A.L. 1986 H.B. 1596)

(1981) The 48-hour waiting period required by subsection 1 of this section is unconstitutional. Planned Parenthood v. Ashcroft, (8th Cir.) 655 F.2d 848.

(1981) The informed consent provision requiring notice to parents and the provisions for informed consent under subsection 2 are unconstitutional. Planned Parenthood v. Ashcroft, (8th Cir.) 655 F.2d 848.

188.047. Tissue sample authorized—pathologist to file report, copies furnished.—A representative sample of tissue removed at the time of abortion shall be submitted to a * board eligible or certified pathologist, who shall file a copy of the tissue report with the state department of health, and who shall provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced and the pathologist's report shall be made a part of the patient's permanent record.

(L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

* Word "a" does not appear in original rolls.

(1983) Statute requiring pathology reports following all abortions is constitutional because it is reasonably related to important health-related state concerns. Planned Parenthood of Kansas City, Mo. v. Ashcroft, 103 S.Ct. 2517.

188.052. Physician's report on abortion and post-abortion care, when—department of health to publish statistics.—1. An individual abortion report for each abortion performed or induced upon a woman shall be completed by her attending physician.

2. An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. This report shall include:

(1) The date of the abortion;

(2) The name and address of the abortion facility or hospital where the abortion was performed;

(3) The nature of the abortion complication diagnosed or treated.

3. All abortion reports shall be signed by the attending physician, and submitted to the state department of health within forty-five days from the date of the abortion. All complication reports shall be signed by the physician providing the post-abortion care and submitted to the department of health within forty-five days from the date of the post-abortion care.

4. A copy of the abortion report shall be made a part of the medical record of the patient of the facility or hospital in which the abortion was performed.

5. The state department of health shall be responsible for collecting all abortion reports and complication reports and collating and evaluating all data gathered therefrom and shall annually publish a statistical report based on such data from abortions performed in the previous calendar year.

(L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

188.055. Forms to be supplied to health facilities and physicians.—1. Every abortion facility, hospital, and physician shall be supplied with forms by the department of health for use in regards to the consents and reports required by sections 188.010 to 188.085. A purpose and function of such consents and reports shall be the preservation of maternal health and life by adding to the sum of medical knowledge through the compilation of relevant maternal health and life data and to monitor all abortions performed to assure that they are done only under and in accordance with the provisions of the law.

2. All information obtained by physician, hospital, or abortion facility from a patient for the purpose of preparing reports to the department of health under sections 188.010 to 188.085 or reports received by the department of health shall be confidential and shall be used only for statistical purposes. Such records, however, may be inspected and health data acquired by local, state, or national public health officers.
(L. 1974 H.B. 1211 § 10, A.L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

188.060. Records to be retained for seven years.—All medical records, reports, and other documents required to be kept under sections 188.010 to 188.085 shall be maintained in the permanent files of the abortion facility or hospital in which the abortion was performed for a period of seven years.
(L. 1974 H.B. 1211 § 11, A.L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

188.065. Revocation of license, when.—Any practitioner of medicine, surgery, or nursing, or other health personnel who shall willfully and knowingly do or assist any action made unlawful by sections 188.010 to 188.085 shall be subject to having his license, application for license, or authority to practice his profession as a physician, surgeon, or nurse in the state of Missouri rejected or revoked by the appropriate state licensing board.
(L. 1974 H.B. 1211 § 12)
Effective 6-14-74

188.070. Breach of confidentiality prohibited.—Any physician or other person who fails to maintain the confidentiality of any records or reports required under sections 188.010 to 188.085 is guilty of a misdemeanor and, upon conviction, shall be punished as provided by law.
(L. 1974 H.B. 1211 § 13)
Effective 6-14-74

188.075. Violation of sections 188.010 to 188.085 a class A misdemeanor.—Any person who contrary to the provisions of sections 188.010 to 188.085 knowingly performs or aids in the performance of any abortion or knowingly fails to perform any action required by sections 188.010 to 188.085 shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law.
(L. 1974 H.B. 1211 § 14, A.L. 1979 H.B. 523, 626 & 902)
Effective 6-29-79

188.080. Abortion performed by other than a licensed physician with surgical privileges at a hospital, a felony.—Notwithstanding any other penalty provision in this chapter, any person who is not a licensed physician as defined in sec-

20-11

tion 188.015 who performs or attempts to perform an abortion on another as defined in subdivision (1) of section 188.015, is guilty of a class B felony, and, upon conviction, shall be punished as provided by law. Any physician performing an abortion who does not have surgical privileges at a hospital which offers obstetrical or gynecological care shall be guilty of a class B felony, and, upon conviction shall be punished as provided by law.
(L. 1974 H.B. 1211 § 15, A.L. 1986 H.B. 1596)

188.085. Sections 188.010 to 188.085 not to be deemed exclusive of other regulations or remedies.—Nothing in sections 188.010 to 188.085 shall be construed to exempt any person, firm, or corporation from civil liability for medical malpractice for negligent acts or certification under sections 188.010 to 188.085.
(L. 1974 H.B. 1211 § 16)
Effective 6-14-74

188.100. Definitions.—Unless the language or context clearly indicates a different meaning is intended, the following words or phrases for the purposes of sections 188.100 to 188.120 shall mean:

(1) **"Employer"**, the state, or any political or civil subdivision thereof, or any person employing two or more persons within the state, and any person acting as an agent of the employer;

(2) **"Participate in abortion"**, to perform, assist in, refer for, promote, procure, or counsel a woman to have an abortion not necessary to save the life of the mother; or to undergo an abortion;

(3) **"Person"** includes one or more individuals, partnerships, associations, organizations, corporations, legal representatives, trustees, trustees in bankruptcy, receivers, or other organized groups of persons.
(L. 1986 H.B. 1596)

188.105. Discrimination by employer prohibited because of failure of employee to participate in abortion—exceptions.—1. It shall be unlawful:

(1) For an employer:

(a) To fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his or her compensation, terms, conditions, or privileges of employment, because of such individual's refusal to participate in abortion;

(b) To limit, segregate, or classify his, her, or its employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his or her status as an employee, because of such individual's refusal to participate in abortion;

(c) To discharge, expel, or otherwise discriminate against any person because he or she has opposed any practices forbidden under sections 188.100 to 188.120 or because he or she has filed a complaint, testified, or assisted in any legal proceeding under sections 188.100 to 188.120;

(2) For any person, whether an employer or employee, or not, to aid, abet, incite, compel, or coerce the doing of any of the acts forbidden under sections 188.100 to 188.120, or to attempt to do so.

2. Notwithstanding any other provisions of sections 188.100 to 188.120, the acts proscribed in subsection 1 of this section shall not be unlawful if there can be demonstrated an inability to reasonably accommodate an individual's refusal to participate in abortion without undue hardship on the conduct of that particular business or enterprise, or in those certain instances where participation in abortion is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.

3. Nothing contained in sections 188.100 to 188.120 shall be interpreted to require any employer to grant preferential treatment to any individual because of such individual's refusal to participate in abortion.
(L. 1986 H.B. 1596)

188.110. Discrimination by colleges, universities and hospitals prohibited—no requirement to pay fees, when.—1. No public or private college, university or hospital shall discriminate against any person for refusal to participate in abortion.

2. No applicant, student, teacher, or employee of any school shall be required to pay any fees that would in whole or in part fund an abortion for any other applicant, student, teacher, or employee of that school, if the individual required to pay the fee gives written notice to the proper school authorities that it would be in violation of his or her conscience or beliefs to pay for or fund abortions. The school may require the individual to pay that part of the fees not funding abortions, if the school makes reasonable precautions and gives reasonable assurance that the fees that are paid are segregated from any fund for the payment of abortions.
(L. 1986 H.B. 1596)

188.115. Severability clause.—If any provision of sections 188.100 to 188.120 is found by a court of competent jurisdiction to be invalid or

unconstitutional as applied to a specific person or class of persons, the provisions of sections 188.100 to 188.120 shall remain in full force and effect as to every other person or class of persons who is otherwise covered under these sections.
(L. 1986 H.B. 1596)

188.120. Cause of action for violation of discrimination laws, treble damages, attorneys fees.—Any individual injured by any person, association, corporation, or entity by reason of any action prohibited by sections 188.100 to 188.120, as now or hereafter amended, may commence a civil cause of action against the person, association, corporation, or entity who caused the injury, and shall recover treble damages, including pain and suffering, sustained by such individual, the costs of the suit and reasonable attorney's fees.
(L. 1986 H.B. 1596)

188.130. No cause of action for wrongful life.—1. No person shall maintain a cause of action or receive an award of damages on behalf of himself or herself based on the claim that but for the negligent conduct of another, he or she would have been aborted.

2. No person shall maintain a cause of action or receive an award of damages based on the claim that but for the negligent conduct of another, a child would have been aborted.
(L. 1986 H.B. 1596)

188.200. Definitions.—As used in sections 188.200 to 188.220, the following terms mean:

(1) **"Public employee"**, any person employed by this state or any agency or political subdivision thereof;

(2) **"Public facility"**, any public institution, public facility, public equipment, or any physical asset owned, leased, or controlled by this state or any agency or political subdivisions thereof;

(3) **"Public funds"**, any funds received or controlled by this state or any agency or political subdivision thereof, including, but not limited to, funds derived from federal, state or local taxes, gifts or grants from any source, public or private, federal grants or payments, or intergovernmental transfers.
(L. 1986 H.B. 1596 § 1)

188.205. Use of public funds prohibited, when.—It shall be unlawful for any public funds to be expended for the purpose of performing or assisting an abortion, not necessary to save the life of the mother, or for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life.
(L. 1986 H.B. 1596 § 2)

188.210. Public employees, activities prohibited, when.—It shall be unlawful for any public employee within the scope of his employment to perform or assist an abortion, not necessary to save the life of the mother. It shall be unlawful for a doctor, nurse or other health care personnel, a social worker, a counselor or persons of similar occupation who is a public employee within the scope of his public employment to encourage or counsel a woman to have an abortion not necessary to save her life.
(L. 1986 H.B. 1596 § 3)

188.215. Use of public facilities prohibited, when.—It shall be unlawful for any public facility to be used for the purpose of performing or assisting an abortion not necessary to save the life of the mother or for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life.
(L. 1986 H.B. 1596 § 4)

188.220. Taxpayer standing to bring suit, when, where.—Any taxpayer of this state or its political subdivisions shall have standing to bring suit in a circuit court of proper venue to enforce the provisions of sections 188.200 to 188.215.
(L. 1986 H.B. 1596 § 5)

Revised Statutes of Missouri 1992 Supp. (2 pages)

Small type is commentary (court cases); ordinary type is text of statute.

Title XII

PUBLIC HEALTH AND WELFARE

Chapter 188

REGULATION OF ABORTIONS

Sec.

188.036. Prohibited abortions, those done with intent to use fetal organs or tissue for transplant, experiments or for consideration, exceptions.

CROSS REFERENCE

188.015.

Life begins at conception, RSMo 1.205

188.025.

(1987) United States District Court for the Western District of Missouri Central Division, on March 17, 1987, held that section 188.025 was unconstitutional and the state was permanently enjoined from enforcing this provision. Reproductive Health Services v. William L. Webster, 655 F. Supp. 1300 (W.D. Mo. 1987).

(1988) United States Court of Appeals for the Eighth Circuit affirmed the district court's judgment that this section is unconstitutional. Reproductive Health Services v. William L. Webster (Nos. 87-1641 and 87-2157, July 13, 1988).

188.028.

(1986) This section held constitutionally valid. T.L.J. v. Webster, 792 F.2d 734 (8th Cir. 1986).

188.029.

(1987) United States District Court for the Western District of Missouri Central Division, on March 17, 1987, held that the second and final sentence of section 188.029 was unconstitutional and the state was permanently enjoined from enforcing this provision. Reproductive Health Services v. William L. Webster, 655 F. Supp. 1300 (W.D. Mo. 1987).

(1988) United States Court of Appeals for the Eighth Circuit affirmed the district court's judgment that the requirement that doctors determine gestational age and fetal weight and lung maturity is unconstitutional. Reproductive Health Services v. William L. Webster (Nos. 87-1641 and 87-2157, July 13, 1988).

(1989) Where tests required by statute would increase expense of abortion and statute regulates discretion of physicians in determining viability of fetuses, statute permissibly furthers state's interest in protecting potential human life and is not unconstitutional. Webster v. Reproductive Health Services, 109 S.Ct. 3040.

188.036. Prohibited abortions, those done with intent to use fetal organs or tissue for transplant, experiments or for consideration, exceptions.—1. No physician shall perform an abortion on a woman if the physician knows that the woman conceived the unborn child for the purpose of providing fetal organs or tissue for medical transplantation to herself or another, and the physician knows that the woman intends to procure the abortion to utilize those organs or tissue for such use for herself or another.

2. No person shall utilize the fetal organs or tissue resulting from an abortion for medical transplantation, if the person knows that the abortion was procured for the purpose of utilizing those organs or tissue for such use.

3. No person shall offer any inducement, monetary or otherwise, to a woman or a prospective father of an unborn child for the purpose of conceiving an unborn child for the medical, scientific, experimental or therapeutic use of the fetal organs or tissue.

4. No person shall offer any inducement, monetary or otherwise, to the mother or father of an unborn child for the purpose of procuring an abortion for the medical, scientific, experimental or therapeutic use of the fetal organs or tissue.

5. No person shall knowingly offer or receive any valuable consideration for the fetal organs or tissue resulting from an abortion, provided that nothing in this subsection shall

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(L. 1988 H.B. 1479)

188.039.

(1987) United States Distric
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that section 188.039 was unco
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ductive Health Services v. V
Supp. 1300 (W.D. Mo. 1987)
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188.130.

(1989) Harm was not suffere
statute applied where child wa
date of statute but born after s
action for negligence against
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when mother alleged emotiona
covering such defect after birt
Anthony's Medical Center, 78

188.205.

(1987) United States District
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permanently enjoined from enf
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Supp. 1300 (W.D. Mo. 1987).

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189.030. State Board of Health to
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189.095. Hospitals which qualify fo
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20-14

prohibit payment for burial or other final disposition of the fetal remains, or payment for a pathological examination, autopsy or postmortem examination of the fetal remains.

6. If any provision in this section or the application thereof to any person, circumstance or period of gestation is held invalid, such invalidity shall not affect the provisions or applications which can be given effect without the invalid provision or application, and to this end the provisions of this section are declared severable.

(L. 1988 H.B. 1479)

188.039.

(1987) United States District Court for the Wetern District of Missouri Central Division, on March 17, 1987, held that section 188.039 was unconstitutional and the state was permanently enjoined from enforcing this provision. Reproductive Health Services v. William L. Webster, 655 F. Supp. 1300 (W.D. Mo. 1987). The portion of the order enjoining the enforcement of this section was not appealed.

188.130.

(1989) Harm was not suffered until child was born and statute applied where child was conceived prior to effective date of statute but born after such date. Statute did not bar action for negligence against physician alleging failure to inform mother prior to birth that her fetus was deformed when mother alleged emotional distress from shock of discovering such defect after birth. (Mo. banc) Shelton v. St. Anthony's Medical Center, 781 S.W.2d 48.

188.205.

(1987) United States District Court for the Western District of Missouri Central Division, on March 17, 1987, held that section 188.205 was unconstitutional and the state was permanently enjoined from enforcing this provision. Reproductive Health Services v. William L. Webster, 655 F. Supp. 1300 (W.D. Mo. 1987).

(1988) United States Court of Appeals for the Eighth Circuit held that Missouri's ban on expenditure of public funds for purpose of performing or assisting abortions is constitutional but the portion of the section which prohibits the use of public funds for encouraging or counseling a woman to have an abortion is void for vagueness. Reproductive Health Services v. William L. Webster (Nos. 87-1641 and 87-2157, July 13, 1988).

(1989) Where state interpretation of statute was that it was not directed at primary conduct of physicians or health care providers but was simply instruction to state's fiscal officers not to allocate public funds for abortion counseling, state-employed health professionals and private nonprofit corporations providing abortion services were no longer adversely affected by section and there was no longer case or controversy before a court. Webster v. Reproductive Health Services, 109 S.Ct. 3040.

188.210.

(1987) United States District Court for the Western District of Missouri Central Division, on March 17, 1987, held that section 188.210 was unconstitutional and the state was permanently enjoined from enforcing this provision. Reproductive Health Services v. William L. Webster, 655 F. Supp. 1300 (W.D. Mo. 1987).

(1988) United States Court of Appeals for the Eighth Circuit affirmed the district court's judgment that this section is unconstitutional. Reproductive Health Services v. William L. Webster (Nos. 87-1641 and 87-2157, July 13, 1988).

(1989) United States Supreme Court reversed the holding of the lower courts and held that prohibition of use of public funds to perform or to assist in performing nontherapeutic abortions was not a violation of the U.S. Constitution. Webster v.Reproductive Health Services, 109 S.Ct. 3040

188.215.

(1987) United States District Court for the Western District of Missouri Central Division, on March 17, 1987, held that section 188.215 was unconstitutional and the state was permanently enjoined from enforcing this provision. Reproductive Health Services v. William L. Webster, 655 F. Supp. 1300 (W.D. Mo. 1987).

(1988) United States Court of Appeals for the Eighth Circuit affirmed the district court's judgment that this section is unconstitutional. Reproductive Health Services v. William L. Webster (Nos. 87-1641 and 87-2157, July 13, 1988).

(1989) United States Supreme Court reversed the holding of the lower courts and held that prohibition of use of public funds to perform or to assist in performing nontherapeutic abortions was not a violation of the U.S. Constitution. Webster v. Reproductive Health Services, 109 S.Ct. 3040.

Chapter 189

AID TO LOCAL GOVERNMENTAL HEALTH FACILITIES

Sec.

189.030. State Board of Health to approve proposed allocations—letter of approval to chief fiscal officers and director—to revise allocations by June fifteenth.

189.095. Hospitals which qualify for certain medicaid funds are ineligible to receive certain payments—hospitals may elect to reject, when—division of medical services to use funds which would have gone to hospital—division may issue rules and regulations.

189.030. State Board of Health to approve proposed allocations—letter of approval to chief fiscal officers and director—to revise allo-

20-15

TESTIMONY

DATE: April 10, 2002

TO: Senate Federal and State Affairs Committee

FROM: Denise M. Burke
Staff Counsel, Americans United for Life (AUL)

SUBJECT: House Bill 2819, Regulation of Abortion Clinics

1. I have thoroughly reviewed House Bill 2819, relating to the proposed regulation of abortion clinics in the State of Kansas, and am testifying as a constitutional expert. I appreciate this opportunity to comment on the constitutionality of House Bill 2819. To date, the U.S. Supreme Court has not ruled definitively on the constitutionality of state abortion clinic regulations. However, under existing case law, it is my opinion that House Bill 2819 is constitutional and is consistent with existing legal requirements and constitutional precedent. Moreover, House Bill 2819 is a valid exercise of the State's right to ensure that women are not receiving substandard care at abortion clinics. The provisions of this bill will protect the lives and health of Kansas women by mandating compliance with accepted medical standards for abortion care and by ensuring that abortion providers meet minimum health and safety requirements.

2. Currently, seventeen states and Puerto Rico regulate, to some degree, clinics and doctors' offices providing abortions at any stage of gestation; however, the type, manner and degree of regulation varies widely.[1] During the 2001 legislative session, Louisiana's governor signed a bill providing for the regulation of abortion clinics in that state. Since 1995, South Carolina, Texas and Arizona have enacted comprehensive abortion clinic regulations, mandating minimum standards of care and covering such diverse areas as staff qualifications, procedures to provide emergency care, sanitation, infection control, minimum equipment standards, quality assurance and proper maintenance of patient records. These regulations, along with abortion clinic regulations in Tennessee, are being challenged in federal court.

3. While final decisions have not been issued in these cases, all the interim decisions have consistently upheld the constitutionality of comprehensive abortion clinic regulations. In April

[1] Those states are Alabama, Arizona, Arkansas, Connecticut, Florida, Kentucky, Michigan, Mississippi, Missouri, Nebraska, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, and Wisconsin. Further, eight states have abortion clinic regulations applicable to abortions performed after the first trimester: Alaska, Georgia, Hawaii, Indiana, Minnesota, New Jersey, South Dakota, Utah and Virginia. Finally, three other states have enacted abortion clinic regulations, but the regulations are not being enforced pursuant to an opinion issued by the respective state Attorneys General: California, Illinois and Oklahoma.

2000, the District Court for the Middle District of Tennessee upheld the state's abortion clinic regulations against a challenge that they unduly burden a woman's right to choose an abortion. The court correctly noted that the regulations governed the conduct of physicians and did not have a direct, substantial or prohibited impact on women seeking abortions. Similarly, in August 2000, the Fourth Circuit Court of Appeals upheld South Carolina's abortion clinic regulations, reversing a lower court's decision. The Fourth Circuit determined that the regulations were constitutional under U.S. Supreme Court precedent, did not violate equal protection guarantees under the Fourteenth Amendment, and did not unduly burden a woman's right to choose or seek an abortion. In February 2001, the U.S. Supreme Court tacitly agreed with the court's rulings when it refused to hear the abortion industry's appeal of the South Carolina case. Later, in April 2001, the Fifth Circuit Court of Appeals determined that Texas's abortion clinic regulations did not violate equal protection guarantees. A district court in Houston had already determined that the Texas regulations did not unconstitutionally burden a woman's right to choose or seek an abortion. Moreover, these regulations have withstood other legal challenges including challenges based on the Establishment Clause, vagueness, improper delegation of state licensing authority and alleged violations of patient privacy.

4. Kansas's proposed abortion clinic regulations are based, in large part, on Arizona's abortion clinic regulations. Arizona's regulations were passed in 1999 and are derived from standards and protocols developed by the National Abortion Federation (NAF), the Planned Parenthood Federation of America (PPFA), and Planned Parenthood of Central and Northern Arizona (PPCNA) (one of Arizona's largest abortion providers and an affiliate of PPFA). Currently, Arizona's abortion clinic regulations are being challenged and are in the early stages of litigation. Oral arguments on motions for summary judgment are set for April 8, 2002. While I cannot say how the court in Arizona will rule on these challenges, I can compare Arizona's regulations to other sets of regulations that have been found to be constitutional, namely the regulations enacted in South Carolina and Texas. Arizona's regulations are less onerous than those enacted in South Carolina and Texas. For example, South Carolina's regulations mandate a certain type of paint to be used on the walls of the clinic and require that a woman be given access to religious counseling prior to her abortion. Conversely, Arizona's regulations do not contain such detailed requirements. Instead, Arizona's regulations provide for a minimum standard of care for abortion practice - a standard of care abortion providers are free to exceed - and utilize the abortion industry's own standards in defining that standard of care. While South Carolina and Texas utilized national abortion protocols and standards in developing their respective abortion clinic regulations, they did not rely exclusively on these standards. For these reasons, I am hopeful that Arizona's abortion clinic regulations will withstand constitutional scrutiny and will be upheld.

5. If I can be of any further assistance, please feel free to contact me at 210-256-2730.