Approved: March 10, 2003
Date

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL AND STATE AFFAIRS.

The meeting was called to order by Chairperson Bill Mason at 1:30 p.m. on February 20, 2003 in Room 313-S of the Capitol.

All members were present.

Committee staff present: Russell Mills, Legislative Research Department
Mary Torrence, Office of Revisor of Statutes
Rose Marie Glatt, Committee Secretary

Conferees appearing before the committee:

Proponents:
Representative Peggy Long
Dr. Laura Kenny, M.D., Private Citizen
Kathy Ostrowski, Kansans For Life
Mike Farmer, Exec. Director, Kansas Catholic Conference
Jeanne Gawdun, Kansans For Life, presented written testimony of Denise Burke, Americans United For Life
Judy Smith, State Director, Concerned Women for America (written testimony only)

Opponents:
Mark Pederson, Abortion Provider
Jennifer McAdam, Planned Parenthood of Kansas
Sylvie Rueff, National Organization of Women
Julie Burkhart, Women's Health Care Services, presented written testimony of George R. Tiller, M.D., DABFP
Willow Eby, Central Women's Services

Others attending: See Attached

HB 2176 - Standards for the operation of abortion clinics

Staff reviewed **HB 2176** that would require the Secretary of Health and Environment to adopt standards for the operation of abortion clinics; providing penalties for violations and authorizing injunctive actions.

Representative Long stated that **HB 2176** takes the regulation of abortion clinics up to a minimal standard of oversight (Attachment 1). There are currently seven abortion providers in the state; only one of them is registered as an ambulatory care center, the rest set their own standards. She spoke of the experiences two women had with abortion clinics. Good health care in Kansas should include responsible health inspections and oversight of abortion clinics.

Dr. Laura Kenny, M.D., an Obstetrician/Gynecologist from Overland Park, KS spoke in support of **HB 2176** Attachment 2). Abortion is one of the most frequently performed surgical procedures in Kansas, yet it is the least regulated. The bill would establish regulation and accountability for clinics and offices where abortions are performed and document to Kansans that they are meeting minimum standards promulgated by the abortion industry itself.

Kathy Ostrowski, Kansans For Life, expressed support for **HB 2176**, stating that she represented women intimidated and injured by abortion who demand an end to favoritism in medical policing in Kansas (Attachment 3). She spoke of several abortion clinics in Kansas, where doctors were proven incompetent, and women received substandard care. She provided newspaper articles and advertisements relating to the issue.

Mike Farmer, Executive Director of the Kansas Catholic Conference stated that the bill 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 (Attachment 4). It will protect Kansas women's lives by mandating that abortion providers meet minimum health and safety requirements. He urged the committee to pass **HB 2176.**

Jeanne Gawdun, Kansans For Life, presented the written testimony of Denise Burke, staff counsel with Americans United For Life, a national public interest law firm with a practice in bioethics law. She offered testimony as an expert in constitutional law and on laws regulating abortion clinics

(Attachment 5). **HB 2176** substantially complies with existing laws regulating abortion clinics in Arizona, South Carolina, and Texas. These laws have repeatedly been upheld as constitutional, withstanding multiple legal challenges.

Her testimony consisted of information concerning:

- Constitutionality of abortion clinic regulations and the status of current litigation
- Prevalence of abortion clinic regulation in other states
- Source of regulatory standards for abortion clinics
- Evidence of substandard care at abortion clinics
- Answers to common objections
- Recommendation for change or amendment

In conclusion, she stated that **HB 2176** embodies national abortion care standards, furthers the State of Kansas's legitimate interest in "preserving and protecting the health" of women and prescribes medically appropriate, minimum standards for abortion clinics.

It was noted that written testimony from Concerned Women For America (Attachment 6) was distributed..

Discussion followed clarifying the issues relating to; responsibilities of the Board of Healing Arts; the need for statutes verses rules and regulations; number of abortions performed in Kansas annually. The committee expressed concern over the lack of accurate statistics, and Kathy Ostrowski agreed to try to provide additional information.

Mark Pederson, Manager, Abortion Clinic in Kansas City rose in opposition to **HB 2176** (Attachment 7). He stated that the bill is not protective legislation; it is another installment of whittling away a woman's access to abortion. If reasonable regulations could be formulated they should come from the Kansas Board of Healing Arts and applied to all physicians, e.g. Kansas Medical Society's Guidelines for Office-Based Surgery and Special Procedures, 2002".

Jennifer McAdam, Planned Parenthood of Kansas expressed her opposition to **HB 2176** (Attachment 8). She expressed concern over the language in the bill, stating that "abortion" is not defined, sections 1 and 3 conflict with each other, and section 1 would violate patient and physician privacy. The regulations may result in increased costs of abortion and a reduction in the number of abortion providers, both of which may cause women to perform self-induced abortion and defeat the purpose of legislation that seeks to make abortion safer.

Sylvie Rueff, Kansas National Organization for Women, opposes the passage of **HB 2176,** stating it would put Kansas women at greater risk by increasing the financial and travel burdens for women seeking safe, and legal abortions, by increasing physicians's costs and reducing the number of clinic sites in Kansas (Attachment 9).

Julie Burkhart, Women's Health Care Services, read the testimony of Dr. George Tiller who is opposed to **HB 2176** (Attachment 10). He stated that the bill would further limit the number of abortion providers by increasing the cost, regulation, and restriction of this integral component of reproductive medicine. According to the KDIE's Center for Health and Environment Statistics, out of the 106 deaths in the state of Kansas that were attributed to surgical and medical care between 1990 and 2001, none of the deaths were due to abortion services.

Willow Eby, R.N., Central Women's Services, rose in opposition to **HB 2176** (Attachment 11). She stated that the main goal of pro-choice supporters and abortion providers is to ensure the safety and privacy of women seeking abortions, and the bill does not have any true intentions of making reproductive healthcare any easier or safer for Kansas women. She suggested that instead of focusing on the politically unpopular topic of abortion, legislators should focus on the type of facility, such as office-based surgery, and make regulations that can truly benefit all people seeking any type of outpatient care.

Discussion followed clarifying the issues relating to: total number of abortions and percentage of out-of-state clients, distance traveled to clinics, and standards set by Planned Parenthood

Requests from the committee follow:

- Sylvie Rueff, National Organization of Women, was asked to provide the source of the data contained in her testimony. She agreed to do so.
- Jennifer McAdam, Planned Parenthood, was asked to provide information, as soon as possible, of any of their affiliates across the country that may have experienced problems regarding

regulations that would be enacted with the bill.

- Staff was ask to clarify the intent of language of **HB 2176**, on page 6, lines 5 through16 regarding who would receive the misdemeanor in case of a violation. Would it be the owner, tenant, private entity group, clinic director, or specific physician?
- Julie Burkhart, Women's Health Care Services, was asked whether there were any procedures in place, that require abortion clinics to track and report clients that have experienced problems, within 72 hours following a procedure, requiring visits to other doctors or hospitals. She agreed to check with the doctor and provide that information. Staff was asked to verify if there were any such reports at this time.
- Jennifer McAdam agreed to provide information on the bill, page 4, line 4 regarding what medical personnel is available throughout the procedure.

The hearing on **HB 2176** was closed.

The meeting adjourned at 3:15 p.m. with the next meeting scheduled for February 24, at 1:30 p.m. in room 313-S.

HOUSE FEDERAL & STATE AFFAIRS COMMITTEE GUEST LIST

DATE February 20, 2003

NAME	REPRESENTING
Peggy Long	Representative
Jeanne Gawdun	KFL (Kansans for Life)
Kathy Ostrowski	KFL "
Laura Kenny	KFL "
Mary Kay Culp	KFL "
Judy Smith	CWA of KS
Shar Hoffman	"
Judy Day	
Bettie Thompson	
Greg Foser	Kansas Dept. of Health and Environment
Mike Farmer	Kansas Catholic Conference
Karen Benzel	Rep. Navarrete (Intern)
Mark Pederson	Aid for Women Central Family Medicine, KCKS
Willow Eby	Central Womens Services
Julie Blackhart	Women's Health Care Svcs,
Jennifer Mc Adam	Planned Parenthood of KS & Mid-MO
Sylvie J. Rheeff	NATIONAL ORGANIZATION FOR WOMEN
Catherine Walberg	
Chris Mann	Topeka Capital Journal
Anthony Bush	Topeka Capital-Journal

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE-CHAIR: HEALTH & HUMAN SERVICES
MEMBER: UTILITIES
JUDICIARY

TESTIMONY HB 2176
February 20, 2003

Mr. Chairman and esteemed members of the committee. I have been a House member since 1997 and since that time have had the opportunity to speak on behalf of many issues and author many bills. Today, however, you have given me the opportunity to speak on behalf of something that is truly one of the most important pieces of legislation that has come before me.

HB 2176 is a simple bill in that it takes the regulation of abortion clinics up to a minimal standard of oversight. It is a large bill in that it will affect the care and quality of abortion practices in the state of Kansas. There are currently seven abortion providers in the state and only one of them is registered as an ambulatory care center. The rest of them are free to set their own standards. Please let me explain why that is not a good idea.

Melodie was only 17. She was frightened and ashamed when she found that she was pregnant. Her only desire was to be accepted and loved and now she felt unacceptable to her 30 year old lover and unloved and rejected by him because of her pregnancy. Abortion seemed like the only answer to her. When she arrived in the clinic; she was not in the state of mind to evaluate her surroundings for cleanliness or appropriate accommodations in case of an emergency. She was in crisis. When the abortionist made inappropriate comments to her during the evaluation - there was no one to turn to. It was not mandated that there be another person in the room during the exam. She was ashamed. She may never share that abuse for a long time if ever unless she were to find someone she trusted enough to let it out. Did she survive the abortion? Well, the answer to that is yes, and no. She lived to tell me about it, but she later died when she hung herself in one of our state hospitals. Melodie deserved to be treated with respect. She deserved to be given good professional care. Melodie was a beautiful young woman to those of us who came to love her.

Last year, I gave testimony before the Senate committee on this same bill and afterwards was approached by a young high school student who had the bill in hand. She approached me pensively and we talked about the bill along with several of her friends. She then stated "You are doing the right thing." She told me that her sister had died having an abortion. I later found out that it was her best friend. It was rather a sudden thing and I did not get the facts. Since that time I have talked with her three times and

talked with her mother once. She told me that she was going to send written testimony for today, but she backed out.

If a movie theatre sells nothing more than popcorn and pop, they are subject to inspection by KDHE. Physicians perform invasive procedures during an abortion and are not subject to oversight in their clinics today. There is truly something wrong with this picture.

If we stand for good health care in Kansas. We will stand for responsible health inspections and oversight of our most vulnerable women. Thank you for the opportunity to deliver this and I urge your support of HB 2176.

Respectfully,

Peggy Long

Testimony of Laura Kenny, M.D.
Before the House Federal and State Affairs Committee
House Bill 2176 – Proposed Clinic Licensing
February 20, 2003

Mr. Chairman and Members of the Committee, Thank you for this opportunity to address you regarding HB 2176.

I'm Dr. Laura Kenny. I'm a Board Certified Obstetrician/Gynecologist with 14 years of private practice experience in Overland Park. For the past two years I have held an administrative position with a managed care company. A significant part of my current role involves quality improvement and quality oversight of the providers of health care. I'm here today because I am concerned about the quality of care that women are receiving when they undergo abortions and the lack of quality oversight surrounding this procedure.

Abortion is one of the most frequently performed surgical procedures in this state, yet it is one of the least regulated. All other surgical procedures that I know of that require the same degree of skill and carry the same amount of risk as abortion, are performed in licensed facilities or hospitals, where they are required to meet certain quality standards and are subjected to peer review. The techniques that are used to perform abortions, specifically D&Cs or D&Es, are the same techniques that obstetrician/gynecologists use to empty the uterus when a woman's baby dies or when the woman has an incomplete miscarriage.

Reputable Ob/Gyns doing these procedures would thoroughly examine the patient prior to the procedure, use well-maintained equipment, work with properly trained staff, and have a protocol for managing unexpected complications. When these procedures are performed on women who have lost their pregnancies, they are virtually always done in outpatient surgical facilities or hospitals because there is risk associated with them. They are done in facilities which are regulated by the KDHE, which are subjected to inspections and are held to specific quality standards. Emptying the uterus of a pregnant woman, whether the fetus is alive or dead, is not a simple low risk procedure.

Abortions, for a number of reasons that don't have anything to do with the difficulty of the procedure or the risk associated with the procedure, are usually performed in physician offices or clinics. These abortions carry the same risk of injury or death as the surgical procedures which are being performed in outpatient surgery centers or hospitals, yet there is currently no mechanism to monitor or regulate what is happening in physician offices or clinics from a quality stand point.

Women believe that legal abortion equals safe abortion. They believe that the quality standards that apply to other surgical procedures also apply to abortion.

In reality while we have made abortion legal, we have not made it any safer than it was when it was not legal. Legal abortion does not equal safe abortion.

Only adherence to sound quality medical standards and guidelines will reduce the risk inherent in the surgical procedures themselves that are used for abortion.

Currently, abortion procedures remain free from the type of review, regulation, and accountability that is an integral part of the rest of the medical profession. Abortion services for the most part remain out of the medical mainstream and as such are not subjected to the same scrutiny as virtually all other surgical procedures. Unfortunately, this lack of accountability has allowed some providers to place women seeking abortions in very dangerous positions.

I remember seeing a woman in the emergency room who had a tubal pregnancy. She had been having pain for sometime but assumed that was normal after her abortion. By the time I saw her she had sustained so much internal bleeding that she nearly died. I remember wondering why the physician that did the abortion never checked the pathology report to be sure he had removed her pregnancy, why he never saw her back after her abortion, why he never did a follow up pregnancy test to be sure she wasn't still pregnant. Any one of those actions might have led him to the diagnosis of tubal pregnancy and intervention before the patient was in a life-threatening situation.

HB 2176 would establish regulation and accountability for clinics and offices where abortions are being performed. This bill outlines the minimal standards required to provide quality care to women and gives the KDHE the ability to enforce these standards. The standards set forth in this bill are the same standards set forth by Planned Parenthood, the National Abortion Federation, and the American College of Obstetricians and Gynecologists. Any reasonable physician providing quality care to women should be meeting these standards already.

These are not standards that are difficult to attain. They are basic quality requirements that can be accomplished by physicians providing abortions in their offices or clinics.

For example, the bill requires the clinic to have personal trained in CPR. It requires the physician to have admitting privileges at a hospital and be able to admit a patient if a complication occurs. It requires the staff to check the patient's blood count prior to the surgical procedure. It mandates proper sterilization of equipment and proper medical supervision of patients in the post-operative recovery period. It requires a through and complete exam prior to the procedure. It requires follow-up of the patient after the procedure. It mandates proper maintenance, use and calibration of equipment. This bill will also give KDHE the power to enforce compliance with these standards.

HB 2176 is good legislation. It will allow those who provide abortion services to document to the people of Kansas that they are meeting the minimum standards promulgated by the abortion industry itself. This is the expectation of the women who are seeking abortion services. I believe that it is our obligation to assure these women that they are receiving care that at minimum meets these standards.

I strongly encourage you to support this legislation and welcome any questions you might have.

HB 2176 - CLINIC LICENSING

2003 KANSAS LEGISLATIVE SESSION

KANSANS FOR LIFE
AND
AMERICAN UNITED FOR LIFE

(785-234-2998)

FEBRUARY 20, 2003

Session of 2003

HOUSE BILL No. 2176

By Representatives P. Long, Barbieri-Lightner, Bethell, Brunk, Burgess, Burroughs, Campbell, Carter, Dahl, DeCastro, Decker, Faber, Freeborn, Gatewood, Goering, Goico, Henry, Howell, Huebert, Hutchins, Huy, E. Johnson, Kauffman, Landwehr, Larkin, Mays, McCreary, McLeland, Merrick, F. Miller, Jim Morrison, Judy Morrison, Myers, Novascone, Osborne, Ostmeyer, Patterson, Pauls, Phelps, Powell, Powers, Reardon, Schwab, Shriver, Shultz, Siegfreid, Svaty, Swenson, Tafanelli, Thimesch, Vickrey, Wilk, D. Williams and J. Williams

February 4

AN ACT concerning abortion clinics; standards for the operation thereof; providing penalties for violations and authorizing injunctive actions. Be it enacted by the Legislature of the State of Kansas:

Section 1.

(a) As used in this section:

(1) ''Secretary'' means the secretary of health and environment.

(2) ''Abortion clinic'' means a facility, other than an accredited hospital, in which five or more first trimester abortions in any month or any second or third trimester abortions are performed.

(3) ''Department'' means the department of health and environment.

(4) ''Physician'' means a person licensed to practice medicine and surgery in this state.

(b) The secretary shall adopt rules and regulations for an **abortion clinic's physical facilities**. At a minimum these rules and regulations shall prescribe standards for:

(1) Adequate private space that is specifically designated for interviewing, counseling and medical evaluations.

(2) Dressing rooms for staff and patients.

(3) Appropriate lavatory areas.

(4) Areas for preprocedure hand washing.

(5) Private procedure rooms.

(6) Adequate lighting and ventilation for abortion procedures.

(7) Surgical or gynecologic examination tables and other fixed equipment.

(8) Postprocedure recovery rooms that are supervised, staffed and equipped to meet the patients' needs.

(9) Emergency exits to accommodate a stretcher or gurney.

(10) Areas for cleaning and sterilizing instruments.

(11) Adequate areas for the secure storage of medical records and necessary equipment and supplies

(12) The display in the abortion clinic, in a place that is conspicuous to all patients, of the clinic's current license issued by the department.

=there was an error in alphabetizing here; the corrected letter has an asterisk=

(c*) The secretary shall adopt rules and regulations to prescribe **abortion clinic supplies and equipment standards**, including supplies and equipment that are required to be immediately available **for use or in an emergency**. At a minimum these rules and regulations shall:

(1) Prescribe required equipment and supplies, including medications, required for the conduct, in an appropriate fashion, of any abortion procedure that the medical staff of the clinic anticipates performing and for monitoring the progress of each patient throughout the procedure and recovery period.

(2) Require that the number or amount of equipment and supplies at the clinic is adequate at all times to assure sufficient quantities of clean and sterilized durable equipment and supplies to meet the needs of each patient.

(3) Prescribe required equipment, supplies and medications that shall be available and ready for immediate use in an emergency and requirements for written protocols and procedures to be followed by staff in an emergency, such as the loss of electrical power.

(4) Prescribe required equipment and supplies for required laboratory tests and requirements for protocols to calibrate and maintain laboratory equipment at the abortion clinic or operated by clinic staff.

(5) Require ultrasound equipment in those facilities that provide abortions after 12 weeks' gestation.

(6) Require that all equipment is safe for the patient and the staff, meets applicable federal standards and is checked annually to ensure safety and appropriate calibration.

(d*) The secretary shall adopt rules and regulations relating to **abortion clinic personnel**. At a minimum these rules and regulations shall require that:

(1) The abortion clinic designate a medical director of the abortion clinic who is licensed to practice medicine and surgery in Kansas.

(2) Physicians performing surgery in an abortion clinic are licensed to practice medicine and surgery in Kansas, demonstrate competence in the procedure involved and are acceptable to the medical director of the abortion clinic.

(3) A physician with admitting privileges at an accredited hospital in this state is available.

(4) A licensed nurse is present during any examination performed by a physician on a patient.

(5) A registered nurse, nurse practitioner, licensed practical nurse or physician assistant is present and remains at the clinic when abortions are performed to provide postoperative monitoring and care until each patient who had an abortion that day is discharged.

(6) Surgical assistants receive training in counseling, patient advocacy and the specific responsibilities of the services the surgical assistants provide.

(7) Volunteers receive training in the specific responsibilities of the services the volunteers provide, including counseling and patient advocacy as provided in the rules and regulations adopted by the director for different types of volunteers based on their responsibilities.

(e*) The secretary shall adopt rules and regulations relating to the medical **screening and evaluation of each abortion clinic patient**. At a minimum these rules and regulations shall require:

(1) A medical history including the following:

(A) Reported allergies to medications, antiseptic solutions or latex.

(B) Obstetric and gynecologic history.

(C) Past surgeries.

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

(3) The appropriate laboratory tests including:

(A) For an abortion in which an ultrasound examination is not performed before the abortion procedure, urine or blood tests for pregnancy performed before the abortion procedure.

(B) A test for anemia.

(C) Rh typing, unless reliable written documentation of blood type is available.

(D) Other tests as indicated from the physical examination.

(4) An ultrasound evaluation for all patients who elect to have an abortion after 12 weeks gestation. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that the person completed a course in the operation of ultrasound equipment as prescribed in rules and regulations. The physician or other health care professional shall review, at the request of the patient, the ultrasound evaluation results with the patient before the abortion procedure is performed, including the probable gestational age of the fetus.

(5) That the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rules and regulations and shall write the estimate in the patient''s medical history. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file.

(f*) The secretary shall adopt rules and **regulations relating to the abortion procedure**. At a minimum these rules and regulations shall require:

(1) That medical personnel is available to all patients throughout the abortion procedure.

(2) Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rules and regulations.

(3) Appropriate use of local anesthesia, analgesia and sedation if ordered by the physician.

(4) The use of appropriate precautions, such as the establishment of intravenous access at least for patients undergoing second or third trimester abortions.

(5) The use of appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.

(g*) The secretary shall adopt rules and regulations that prescribe **minimum recovery room standards.** At a minimum these rules and regulations shall require that:

(1) Immediate post procedure care consists of observation in a supervised recovery room for as long as the patient's condition warrants.

(2) The clinic arrange hospitalization if any complication beyond the management capability of the staff occurs or is suspected.

(3) A licensed health professional who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remains on the premises of the abortion clinic until all patients are discharged.

(4) A physician with admitting privileges at a licensed hospital in this state remains on the premises of the abortion clinic until all patients are stable and are ready to leave the recovery room and to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary. A physician shall sign the discharge order and be readily accessible and available until the last patient is discharged.

(5) A physician discusses Rho(d) immune globulin with each patient for whom it is indicated and assures it is offered to the patient in the immediate postoperative period or that it will be available to her within 72 hours after completion of the abortion procedure. If the patient refuses, a refusal form approved by the department shall be signed by the patient and a witness and included in the medical record.

(6) Written instructions with regard to postabortion coitus, signs of possible problems and general aftercare are given to each patient. Each patient shall have specific instructions regarding access to medical care for complications, including a telephone number to call for medical emergencies.

(7) There is a specified minimum length of time that a patient remains in the recovery room by type of abortion procedure and duration of gestation.

(8) The physician assures that a licensed health professional from the abortion clinic makes a good faith effort to contact the patient by telephone, with the patient's consent, within 24 hours after surgery to assess the patient's recovery.

(9) Equipment and services are located in the recovery room to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the hospital.

(h*) The secretary shall adopt rules and regulations that prescribe **standards for follow-up visits**. At a minimum these rules and regulations shall require that:

(1) A postabortion medical visit is offered and, if requested, scheduled for three weeks after the abortion, including a medical examination and a review of the results of all laboratory tests.

(2) A urine pregnancy test is obtained at the time of the follow-up visit to rule out continuing pregnancy. If a continuing pregnancy is suspected, the patient shall be evaluated and a physician who performs abortions shall be consulted.

(i*) The secretary shall adopt rules and regulations to prescribe minimum abortion clinic **incident reporting**. At a minimum these rules and regulations shall require that:

(1) The abortion clinic records each incident resulting in a patient's or viable fetus' serious injury occurring at an abortion clinic and shall report them in writing to the department within 10 days after the incident. For the purposes of this paragraph, ''serious injury'' means an injury that occurs at an abortion clinic and that creates a serious risk of substantial impairment of a major body organ.

(2) If a patient's death occurs, other than a fetal death properly reported pursuant to law, the abortion clinic shall report such death to the department of health and environment not later than the next department business day.

(3) Incident reports are filed with the department of health and environment and appropriate professional regulatory boards.

(j*) The department of health and environment shall not release personally identifiable patient or physician information obtained under this section.

(k*) The rules and regulations adopted by the secretary pursuant to this section do not limit the ability of a physician or other health care professional to advise a patient on any health issue.

(l*) The provisions of this act and the rules and regulations adopted pursuant thereto shall be in addition to any other laws and rules and regulations which are applicable to facilities defined as abortion clinics under this section.

(m*) A violation of this section or any rules and regulations adopted under this section is a **class B person misdemeanor.**

(n*) In addition to any other penalty provided by law, whenever in the judgment of the secretary of health and environment any person has engaged, or is about to engage, in any acts or practices which constitute, or will constitute, a violation of this section, or any rules and regulations adopted under the provisions of this section, the secretary shall make application to any court of competent jurisdiction for an order enjoining such acts or practices, and upon a showing by the secretary that such person has engaged, or is about to engage, in any such acts or practices, an **injunction, restraining order or such other order** as may be appropriate shall be granted by such court without bond.

(o*) Reports filed under this act with the secretary or the department and risk management reports or records of abortion clinics shall constitute **open records** except that information in such reports or records shall be made available in a manner that does not identify patients of the clinic.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

Kansans for Life

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Good afternoon Mr. Chairman and members of the committee,

I am Kathy Ostrowski, state legislative director of Kansans for Life, speaking in support of HB 2176. I am here to represent women intimidated and injured by abortion who demand an end to favoritism in medical policing in Kansas--especially for a procedure that was ostensibly made legal so it would be safe.

Currently there are 7 known abortion clinics in Kansas. Six of these clinics are considered physician offices, under the statutory authority of the State Board of Healing Arts. One abortion clinic, Planned Parenthood of Kansas Mid-Missouri at Overland Park, has chosen to become licensed as an ambulatory surgical center [ASC], regulated by KDHE. This clinic that chose to be designated an ASC, was seriously deficient in its inspections last May. It still had not corrected 4 areas of violations 5 months later. This deficiency status holds no penalty for the physicians or facility, just the possible loss of licensure, which is voluntary anyway.

HB 2176 would mandate that clinics performing any second or third trimester abortions, or performing more than 5 first trimester abortions in any month, be defined as abortion ambulatory surgical centers. This definition exceeds that of an ASC. Further, HB 2176 would make inspection reports of abortion clinics available to the public, as is required in our neighboring state, Missouri.

Indeed, after Missouri passed their abortion clinic law in 1992, it found numerous deficiencies in one clinic including insects in the recovery room and staff dispensing relaxant drugs to women, not only prior to counseling, but in one documented case prior to a negative pregnancy test. We have reason to believe things are just as bad if not worse in Kansas.

While malpractice itself is not the focus of HB 2176, there is a connection between a pattern of negligence and a lack of adherence to basic medical protocols. I will comment first about Kansas abortionists and then about their facilities.

I first saw the face of "safe and legal" abortion in Kansas in March 1992, when Dr. Knarr drove up to Topeka to open a "women-care" clinic. This "safe-and-legal" abortionist took a boxy suction machine out of his dirty car trunk and literally stumbled into his new office. This was his manner of "providing" abortions -- have machine, will travel.

Knarr was so obviously impaired to any impartial observer that it was horrifying that he would be conducting surgery. Abortion may seem to be a simple procedure, but it's done in an area of the body that's very unforgiving. Phone calls about his condition fell on deaf ears at the Board of Healing Arts.

It was only after a "whistle-blowing" affidavit from a former Knarr employee revealed drug parties and a laundry list of professional atrocities, that the Board began formal investigations. *(See attachment "whistle-blowers")* In April 1993, clinicians diagnosed Knarr as narcissistic, out-of-touch with reality and impaired by drugs. Against their warnings to stay in treatment, Knarr left the diagnostic facility and aborted women that next day. Again, frantic calls to the Board provided no action to come out and stop him. And at this time this "safe-and-legal" abortionist was acquiring malpractice suits at a rate of one every 3 months.

In March of 1994, the Board (and in 1996, the Missouri Board) suspended Knarr for medical incompetence, negligence, missing narcotics, drug violations, deception on license renewals, lack of insurance, loss of hospital privileges and more.*(See attachment "petition")* The Board had discovered that Knarr was a felon and forbidden to write most drug prescriptions by the DEA [federal Drug Enforcement Agency]. Knarr told the Board his business partner, Sherman Zaremski, had been writing drug prescriptions for him for the past 10 years.

Zaremski did not produce the records for the Board, which fined him and ordered him to write a kind of "term paper"about record-keeping. They declared him "publicly censured" although the media and public were never told. Today, this 72-yr-old pulmonary (lung) doctor continues abortions at Aid For Women clinic in KCK and once a week in Wichita. *(See attachment, Outrageous Zaremski)* Knarr's rental property manager and clinic guard, Mark Pederson, will again be testifying against clinic licensing laws in his current role as Zaremski's clinic manager. Pederson admitted in testimony to the Senate Fed-State committee last year that he has no formal medical training.

But before leaving this group, let me point out that when Knarr was in hot water, his abortion route gained two more "safe-and-legal" practitioners – neither of them Ob/Gyn doctors- Dr. Neuhaus and Dr.Rajanna. Rajanna (currently advertising in the Kansas City yellow pages as "Affordable Abortion") reactivated his Kansas license to assist Knarr and incurred a wrongful death lawsuit within the year. Since

then, Rajanna has been disciplined and fined by the Board for drug handling problems. *(See attachment, "phone book ad")*

Neuhaus has the qualifications to be a "poster girl" for clinic licensing. *(See attachment "Public never knew")* Unbeknownst to the public, she was restricted by the DEA and was "providing" abortions in Lawrence and Wichita under these terms, that she:

1. have her entire staff randomly tested for drugs on an ongoing basis;
2. limit prescriptions to one lesser dangerous class of medication;
3. pay an outside practitioner to review her prescriptions & patient release procedures;
4. take classes with her staff to learn advanced CPR;
5. pay an anesthesiologist to assist her with certain abortions;
6. be sure to meet with patients before procedures and before they were medicated;
7. correct her information/consent forms;
8. stop violating the Women's Right to know Law.

Neuhaus was twice declared "a danger to the public" by the Board of Healing Arts, but they never closed her down! Neuhaus bemoaned her financial burdens whenever new instructions were issued from the Board on how she should be practicing medicine. In the end, she couldn't meet the conditions of providing ordinary medical care. She has voluntarily quit – who knows what community somewhere may now be suffering from her "safe and legal" abortion cost-cutting?

The emphasis by abortionists on economic viability was examined in a December 2000 article in the New York Times, a paper not known for a pro-life perspective:

> "**[clinic] owners save money by training a low paid staff** to do everything but the actual surgery, from drawing blood to doing lab tests...when the doctor comes, a parade of patients is ready for the procedure...
>
> Abortion providers say, unlike other areas of medicine, where prices have surged over the years, competition among abortion clinics has kept prices so low that an abortion in many cities costs less now than it did 25 years ago, without even adjusting for the nearly 500% inflation in medical services. **If abortion had kept up with inflation in medical services, a $300 abortion in 1972 would cost $2,251 today.**
>
> "The fees are not set by the cost of the services but by the cost of the competition," said Dr. Warren Hern,*[Colorado late-term abortionist]* "the competition for patients is absolutely ruthless." www.nytimes.com/2000/12/30/science/30ABOR.html

In KCK, Zaremski and Rajanna are 3 blocks apart with Dr. Taliaferro approximately 1½ miles north. In Overland Park, Dr. Hodes is just 2 blocks from Planned Parenthood [Dr.Crist and Dr.Yeoman]. In Wichita, Dr.Tiller and his associates are 4 miles from the Central Women's Services, the former practice of Neuhaus, now a once-a-week stop for Zaremski.

Knarr, Neuhaus, Rajanna and Zaremski are not Ob/Gyns, but being an Ob/Gyn is no assurance of standardized policies or less malpractice. Behind the fancy front doors in Overland Park are Ob/gyns with extensive malpractice settlements. Dr. Hodes has been sued regularly for the last 25 years, Cases include a deaf woman claiming she couldn't reach clinic help when suffering abortion complications and a woman who nearly lost her child because her Rh factor had not been properly handled following abortion.*(see 2 page-attachment "abortion injuries & deaths")*

In the Senate Fed-State committee last year, Planned Parenthood [PP] denied knowledge of Crist's horrifying malpractice record, despite the fact that it includes 3 abortion deaths in Texas and Missouri while he was licensed and practicing in Kansas. Lawsuit settlements were made to the families of all 3 women after years of legal wrangling. One victim had a reaction to medication that was not noted in her medical history. One girl bled to death at the home of her sister, who repeatedly was assured by Crist's office that the bleeding was OK. The third woman was not even supposed to be eligible for her April 1997 abortion based on her blood test, by both national PP standards and Crist's personal standard as stated in a deposition. Crist faces an April trial for a near-death abortion and an August surgical malpractice trial on behalf of a mother of four left in a coma for over 2 years.

Let me take a moment to look at a few abortion clinics licensed in Missouri. As I have mentioned briefly before, in 1992, state health inspectors went to a Springfield Missouri clinic which, up until the month before, was one location that Crist aborted at. At the time, October 1992, Knarr was using this site as part of his "route". The report listed numerous violations, including: staffers were not trained, the nurse didn't know CPR, there was rust on the operating table and bugs in the recovery room! This was 19 years after Roe ostensibly made abortion "safe" by making it legal.

Two years later, this same location was inspected following mishandling of post abortion complications. The woman nearly died, because baby parts had been left inside her. Clinic staffers insisted she had to be driven to their distant sister facility in Little Rock, Arkansas since the abortionist was not on site there in Missouri. Luckily, the patient went to the nearest emergency room, where her life was saved. [This is the kind of "advice" still given today by Dr. Hodes, *(see attachment "consent for elective")* whose website consent form says: "If I have any problems after the abortion...I understand that if I seek alternate treatment...I may not hold either doctor responsible for subsequent medical expenses or any other loss experienced thereof...failure to have a post-abortion exam within 3 weeks shall absolve the doctors of all medical, legal and financial responsibility." This language would not stand up in

court...but how would a non-lawyer know this?]

Other atrocities in this 1994 state inspection: staffers not current in CPR, understanding state law, infection control or reporting of abuse; large gaps in medical histories and discharge summaries; informed consent information not fully presented; deficient physical exams; and women given relaxant drugs prior to counseling and even prior to pregnancy testing!

Our last look at Missouri clinic licensing reports is the one filed after the 1997 death of the woman supposedly ineligible to have been have a PP abortion. The deficiencies included the fact that Crist wasn't CPR certified and that the clinic lacked the instruments, drugs, machines and trained personnel necessary for an anesthesia-related emergency. This inability to treat a patient emergency was the cause of the highly publicized death of a young mother during her Kansas abortion by Dr. Dennis Miller – 9 years earlier. *(See attachment "abortion bad news")*

Currently in Kansas, PP's clinic is voluntarily licensed as an ambulatory surgical center [ASC]. In May of 2002, responding to an initial complaint, KDHE went onsite to PP where they found 11 areas of deficiencies, of which 4 were still uncorrected 5 months later. *(See attachment "KDHE Summary")*

I believe the Board of Healing Arts does not have the will, much less the budget, to police substandard practitioners. They don't inspect these abortion clinics/ doctor offices. They only respond to official complaints and act slowly in the fear of being counter-sued by the doctors. All the abortion clinics but one [PP of Overland Park] have remained under the authority of the Board to avoid inspections and the professional requirements of licensing. The Board sits at the pleasure of the governor. There is no incentive for them to expose substandard operations in abortion clinics when the current governor has received over 10 years of financial support from Dr. Tiller *(see attachment "Sebelius")*

Clinic licensing is a protection for Kansas women that will be automatic and not subject to the winds of political change. Women have no guarantee that their abortionist is doing his job correctly when he knows he answers to no one and is not randomly inspected. Many abortion clinics are set in inner city areas where the women have neither the financial means, or a natural inclination to buck the system. The "shame" factor, like that of rape victims, prevents many valid lawsuits from being filed, much less going through to trial. The rare lawsuits that do get filed, are settled with mandatory "no-tell" clauses.

Abortion clinic licensing can't prevent bad practitioners from practicing, but it can control the harm they do to women. *(See attachment "talking points")* Kansas needed HB 2176 years ago; let's pass it now. Thank you for your attention.

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 RhoGAM**given [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**

2-19-93 - TOPEKA

Petition calls Knarr incompetent

By BILL BLANKENSHIP
The Capital-Journal

State medical licensing authorities allege the operator of Topeka's only abortion clinic, Dr. William Malcolm Knarr, failed to provide proper medical care to four patients.

The allegations of professional incompetency are part of a 12-count petition filed Friday by the Kansas State Board of Healing Arts.

The board a week ago suspended Knarr, a doctor of osteopathy, from the practice of medicine and surgery and directed staff to prepare the petition for revocation of his license.

The petition identifies the patients only by their initials — A.S., S.E., T.C. and T.R. — and doesn't detail the acts of medical incompetency.

Continued from page 1-A

rendered medical care to a female patient at a standard below that acceptable at the medical center.

A health professional familiar with the case told the newspaper the 20-year-old woman required an emergency hysterectomy as a result of complication of an abortion.

An associate of Knarr's performed the abortion, but Knarr was called to Bethany's emergency room when the woman arrived there with signs of shock. Knarr sutured several lacerations on the woman's cervix.

Nurses in attendance would tell a hospital review panel Knarr admitted the woman to the intensive-care unit only at their urging.

The woman's medical condition deteriorated, and the hospital tried unsuccessfully to reach Knarr at his home. Knarr told reviewers his phone was out of order because of redecorating, but the health professional said it wasn't the first instance the hospital was unable to contact Knarr.

An obstetrics consultant took over the woman's care and found her cervix sutured shut. The specialist determined the woman's uterus should be removed. The woman recovered.

Knarr said "his actions had nothing to contribute with the outcome in that case," but the trustees disagreed and barred Knarr from admitting gynecological patients.

Trustees later stripped Knarr of his family practice privileges.

Knarr called the action by Bethany "politically motivated" because he performs abortion. He threatened to sue but didn't, according to Wyandotte County District Court records.

The petition filed Friday and a previous order say there is adequate evidence Knarr is impaired because of substance abuse or dependance.

Knarr takes a prescription drug for severe headaches but denies it affects his ability to practice medicine. However, the report of an inpatient evaluation at a Georgia hospital supports the conclusion Knarr is impaired, the board said.

The petition also alleges Knarr:

- Performed unnecessary tests or services.
- Didn't maintain malpractice insurance coverage during 1991.
- Wrote prescriptions in the name of a Springfield, Mo., clinic or in the name of one of the office staff in violation of federal regulations.
- Prescribed or administered drugs without the required federal registration.
- Didn't properly monitor drugs resulting in the loss of viles of Sublimaze, a narcotic.

The petition again raises Knarr's 1970 felony conviction in Oklahoma for the sale of marijuana and LSD and possession of hashish. Knarr pleaded guilty in May 1984 of failing to disclose those drug convictions on a federal application.

Knarr also didn't disclose the Oklahoma conviction when he applied for his Kansas license in 1981. Knarr didn't divulge either conviction when he applied in September 1984 for medical staff privileges at Bethany.

Knarr also has a Missouri medical license, but a check Friday with the Missouri Board of Registration for the Healing Arts showed the document was current and without restrictions.

However, the petition does cite the Feb. 27, 1992, suspension of Knarr's obstetrical and gynecological privileges at Bethany Medical Center in Kansas City, Kan.

The Capital-Journal reported in a March 22, 1992, copyrighted story Knarr lost those privileges after the hospital's trustees determined he

Continued on page 9-A, col. 1

Imagine this coming from any other medical profession...

(OUTRAGEOUS content from Zaremski's Aid for Woman Abortion Website)

$20 off - Tuesdays and Thursdays
Discounts for cash ($1.50 off every $50)

To parents: "If you try to dissuade your daughter from getting an abortion, you may earn the permanent hate of your daughter...it could get you sued when she turns 18...You are responsible for your child's health...not doing so is considered neglect...If you do not wish to be responsible for her possible post-abortion health care costs, you may emancipate her...Welcome to parenthood."

About Judicial bypass: "This is an option when you do not want to tell your parents...or you do not wish to involve them...A judicial bypass does not cost you...Kansas taxpayers pay for your attorney [who] will set up your appointment...the judge is kind....[he] will grant you a waiver as long as he does not hear any frivolous silly answers."

On the Consent form:

About father and child support: "the father of your pregnancy is responsible for child support if you decide to continue and could be tracked down with his Social Security Number through the IRS and New Hire laws that have been implemented in most states under new Unemployment laws. Currently, child support is difficult to collect if they do not have a regular job, or work for unreported cash payments."

About the Women's Right to know provisions: "...KDHE has published a booklet of color photos of what the pregnancy looks like at different stages, and a directory of abortion alternatives. The anti-abortion legislators who got this law passed feel you will be better *informed* by seeing these graphic photos and the long list of alternatives. So that we do not have to pass the cost of mailing additional information to you WE REQUIRE you to receive these booklets at least 24-hours before coming to the clinic by going to your local Kansas public library, our clinic, our website www.aidforwomen.com, or by calling KDHE at 1-888-744-4825 (785-291-3744) and request that they send you those books. You are not required to read them, but only if you wish. You will sign a form here stating that the following information (two handbooks titled, If you Are Pregnant and If You Are Pregnant, A Directory of Available Services) "...was presented to you in writing at least 24 hours before the abortion..." by Sherman Zaremski, MD, who is a performing physician. If you wish, we will mail out separately the two booklets to you."

From second main page: "The 'prolifers' forced KDHE to publish and distribute these booklets (at taxpayer's expense), and we the provider were expected to absorb the cost of mailing this heavy literature (a half pound!)"

Aid For Women BROCHURE:

"DO NOT STOP at the "Crisis Pregnancy Center" in a red brick building on the left side of the street next to a gas station. They are anti–choice pro-life protestors."

"If under 18...those not wanting to inform their parents can get a "Judicial By-pass". It's a little more paperwork but it is confidential and is successful."

ALTH

ily Planning

vate Office

Abortion Providers - (Cont'd)

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD 4401 W 109th St-- 913 345-1400
*See Display Ad Next Page

Some businesses may include such words as "guarantee", "authorized", "certified", "accredited", as part of their firm name. These may not be intended to imply a specific authorization, certification or accreditation in connection with their business. If in doubt, ask the business or company for details.

Enron would still be around if it had the kind of help Neuhaus got from regulators & the media!

Public Never Knew Abortionist's Real Problems

On September 11, 2002, abortionist Kris Neuhaus closed her doors in Lawrence, Kansas. Neuhaus once told the media she kept a pistol close by and security for her office was run like a paramilitary operation. In contrast, documents from state and federal regulatory agencies indicate her medical practice was in shambles and what she really needed at her side was a trained doctor instead of a gun. Let's look at the hidden record of a physician who couldn't even succeed as an abortionist.

44 year-old Neuhaus, [full name: Ann Kristin Eisenbise Neuhaus Caddell] graduated from KU Med school, acquiring a Kansas medical license in 1987. She worked part time in a variety of clinics until 1993 when she joined infamous Malcolm Knarr 's abortion practice just at the time the drug-impaired Knarr was losing his Kansas medical license. Eventually, Neuhaus settled into abortion sites in Wichita and Lawrence.

DRUG AGENCY FORCES RESTRICTIONS

In June 1997, Neuhaus' annual license renewal applications to the Kansas State Board of Healing Arts began to indicate she had some disciplinary and/or malpractice issues. In March of 1999, the DEA (Federal Drug Enforcement Agency) entered into a legal "memoranda of agreement" with Neuhaus—meaning a settlement with stiff sanctions. Since the records of this action are closed to the public, KFL contacted the DEA in Washington D.C. Their legal department explained this "agreement" is a settlement commonly used to avoid the time and expense of a trial when the DEA has solid criminal evidence and the accused knows it.

Within 6 months, Neuhaus signed a similar settlement with the Kansas Board, acknowledging her DEA violations. In October 1999, this Board formally declared a set of restrictions to her practice as outlined by the DEA. Among other instructions, she was prohibited from prescribing all but one controlled substance drug, and had to hire an outside pharmacist to review her record-keeping, with reports sent to the Board. There was a list of specific staff procedures mandated. Neuhaus also would not be allowed to hire anyone with a drug abuse background and had to pay for random drug screens for her entire staff and security guards (which would include her husband, the security director.)

Surely, Kansas women, even so-called pro-choicers, would have liked to know the abortion staff had to be regularly checked for drug use!

RANDOM DRUG TESTING OF STAFF REQUIRED

So 3 years ago, Neuhaus eluded drug-related trials at the state and federal levels, was put under harsh restrictions, and had the luxury of all this being hidden from the public. With the exception of Kansans For Life, no one thought it newsworthy that the government was micro-managing an abortion business.

Thus, without media coverage, none of Neuhaus' clients, including minors, could have known the abortion staff was not following standard medical protocols. Most people would avoid involvement with a physician stripped of nearly all her prescription privileges. Surely Kansas women, even so-called pro-choicers, would have liked to know the abortion staff had to be regularly checked for drug use!

The state regulatory Board is a self-governing entity granted enormous powers which they use to achieve their own goals. And as happens most of the time, they withhold vital information from the public. Historically, the American press thought it their mission to keep watch over such entities. Not anymore. Throughout the Board's subsequent emergency orders, investigations, and legal actions to revoke Neuhaus' license, the media never quoted from, much less uncovered, pertinent Board documents. More often than not, in Neuhaus coverage, the reporter's story angle was based on the carefully spun remarks of her attorney, rather than quoting the damning language in so many of these Board documents.

DECLARED IMMINENT DANGER TO THE PUBLIC

In August 2000, 10 months after receiving government limitations which were not revealed to the public, Neuhaus came to a Board meeting to request leniency. The Board not only denied her request, but, after questioning her, they judged her incompetent, an imminent danger to the public, and subject to an emergency hearing.

The Board was shocked at her inability to manage complications, but the media soft-pedaled it as a temporary bureaucratic problem for which Neuhaus just needed to produce some paperwork. Most press reports were taken from the Lawrence Journal World's articles, which portrayed Neuhaus as merely being hassled in her choice of medication—and, by implication, because she "provided" abortions. The media never revealed her DEA violations and the Feds' demands that she keep a drug-free staff and pay an independent practitioner to watch over her. To preserve the image of abortion as "safe", the media shamelessly sacrifices women's health and safety.

August 14th, 2 days after Neuhaus' appearance, the Board filed an emergency legal document, which addressed her lack of training in resuscitating medicated patients. But although they wrote that her medical practice constituted a danger to the public—they never shut her down! What other medical specialty gets that kind of kid-glove treatment? The Board ordered that any Neuhaus abortions which would use conscious sedation (narcotics) would require the presence of a hired licensed anesthesiologist.

BOARD DIDN'T CLOSE HER

Frequently, Neuhaus refers to having been shut down by the Board—but it's just not true! We wish they had done so! It was her

"The Neuhaus case makes it painfully clear why we must reject candidates such as Kathleen Sebelius, and Attorney General candidate Chris Biggs who have received money from Kansas abortionists including infamous late-term abortionist George Tiller, and why we must work to elect Tim Shallenburger and Phill Kline!"

Mary Kay Culp, Ex. Dir.
Kansans for Life

Paid for by the Kansans for Life Political Action Committee. Craig Bardsley, Treasurer

3-16

unwillingness (or inability) to pay for qualified medical personnel which dictated her temporary closure. [A 12/27/00 New York Times article explained how abortionists hold down their prices by hiring unqualified, low-paid staff and by cutting corners respectable physicians wouldn't dream of doing. The average national price of a first trimester abortion is $300 -- practically the same as it was 30 years ago! To match the way all other medical costs have risen, that abortion would cost $2,300.]

IMPROPER INTAKES & CHECKOUTS

Two weeks later, August 29th, the Board filed yet another emergency legal document which stated Neuhaus wasn't doing exams or medical histories correctly, and wasn't properly monitoring or releasing medicated women. Again, the media underplayed the gravity of Neuhaus' inability to practice medicine and showed no concern for the extreme danger presented to her clients.

For another ten months, the Board played cat and mouse with her, sending Neuhaus and her staff to instructional classes and warning her not to preload medications into unmarked syringes. And then they found she was still not following orders.

The Board specifically used the records of Neuhaus' patients for claims of medical negligence and breaking Kansas' abortion law. In the 5 patient cases the Board chose, she didn't even complete the very minimum medical consent and information steps in the Women's Right To Know Law. But while the Board was starting legal proceedings to revoke her license, they left Neuhaus' offices open.

During this time period, Neuhaus moaned constantly about her lack of money to pay school loans and legal fees. She also talked as if she would have to shut down because of threats to her life. This story was probably accepted by the general public, who were never told how the state and DEA were babysitting Neuhaus—at taxpayers' expense. While promoting her sob story, the media ignored her medical deficiencies—even blatant, inexcusable ones like the inability to resuscitate!

FORCED TO FIX PROCEDURES TO AVOID TRIAL (AGAIN)

Neuhaus shut down her Wichita business in May 2001 during negotiations to avoid trial and achieve a settlement with the Board. By June 2001, Neuhaus signed off on her third government-forced settlement. She accepted the patient complaints as factual, and agreed to yet another set of orders—among them: (1) to correct the informed consent form which is to be signed, dated and witnessed; (2) to meet with the patient and review consent information outside the procedure room and before patient is prepped; (3) to insure that a printed and dated sonogram is filed, along with other record-keeping improvements. These procedures are so basic that respectable doctors wouldn't dare omit them. But she had. And she didn't lose her license.

So what caused Neuhaus to close her last office? She said it was finances. And it was finances, but in this sense: she wasn't qualified to do the real money-making abortions and she couldn't afford to buy the staff required for abortions with sedation. It's hard enough to make money as a physician when the Feds strip you of the ability to prescribe medications; it's even harder to survive as an abortionist when you keep getting caught cutting corners!

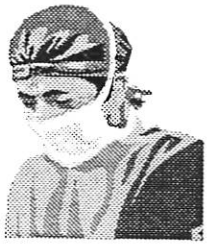
Neuhaus had been hanging on to her license by a thread, and she still had to pay for the random drug testing, pharmacist reviews, higher wages and more costly training to adhere to national guidelines. Plus she had to dedicate one staffer solely to watching over patients. And don't forget that expensive paramilitary security!

So what does the hidden record of Kris Neuhaus show? (1) the priority of the State Board of Healing Arts is to preserve the licensee, her property and her privacy—even when they think she's a public danger; (2) the media protects the false image of abortion as safe and pro-woman; and (3) the abortion industry is all about money.

Neuhaus documentation available at KFL.

Who monitors abortionists?

What is the Kansas Board of Healing Arts? It's the state agency that permits or denies licenses, and in other ways regulates physicians, chiropractors, nurses, etc. The purpose of the Board is "to exclude the incompetent or unscrupulous from the practice of the healing arts."



What powers does thus Board have? They can call upon every county attorney in the state, and the attorney general, to help with investigations and surveillance. The Board also asks the legislature to enact certain laws.

Is the Board political? All 15 members are appointed by the governor.

Did the Board get a bad rating from a consumer group? Yes, Public Citizen, a spin-off group from Ralph Nader, rates all states' medical boards. This spring, they gave Kansas a "D" for quality of physician information available to citizens. In most states, you can get info with a mouse click. But not Kansas.

When the board profiles a doctor, are all negative things hidden? Pretty much. Annual license renewal forms have a place for physicians to self-report limitations, settlements and other punishments. In the past, citizens could at least see whether the doctor answered yes or no to the question of whether he lost lawsuits or was disciplined. Now, even the questions the Board asks about are blocked !

Are secret settlements, which buy off bad publicity, part of the public record? No--neither in hard copies or online. The Board does not keep a public access file on doctors who are impaired or those in the process of being sued, which is what Public Citizen and other groups advocate. To research doctors' lawsuits, you must know the counties in which they were filed or the names of the persons filing the suits--and the Board will not assist in this.

Will the Board push for Kansas legislation that enables secret insurance settlements to be revealed? Doubtful–but KFL will push for it!

MILLER: Abortion INJURIES & DEATH

INJURY DENIED A woman (name shielded in 6/3/90 Kansas City Star) had her cervix punctured during her Miller abortion in 1985. To her complaints of infection and pain, Miller "said there was nothing wrong." New doctors had to hospitalize the woman and remove the fetal tissue that Miller had missed. Lawsuit was settled for $75,000.

----------*same year*, 1985

DEVASTATED LIFE Another woman (name shielded in 6/3/90 Kansas City Star) had a combination abortion/ligation from Miller in 1985, but he added a bowel perforation. The infection caused hysterectomy & removal of three feet of intestine which she said devastated her personal life, including divorce. Miller, in deposition, said "I wouldn't do anything different." Lawsuit settled in 1988 for $200,000.

--------*2 more malpractice suits settled @ near $3 million, then* March'88

MOM SEES TEEN DIE 18 yr old mother, Erna **FISHER,** died during her 3/30/88 abortion, while holding her own mother's hand. Abortionist Miller continued removing tissue while the teen jerked, turned rigid and suffocated on her own vomit. Miller knew the pain-killing medicine could cause vomiting; and he admitted he hadn't checked to see if she had eaten. He made no attempt to clear her airway or administer oxygen. His assistant ran for smelling salts. Paramedics noted **Miller wasn't doing CPR or anything when they arrived.,"Since I didn't know what was going on, I don't think it would have made any difference," said Miller** later. Fisher was DOA at the hospital. During the trial , Miller's actions were labeled **grossly negligent** by the expert.. On 12/14/89, #89-C2080, Wyandotte County, Kansas, was settled for $475,000.*[KCStar 6 3 90, 5 10 88]*

HODES: Abortion INJURIES

----------*at least 4 malpractice suits before this*, April '81

NO HELP for DEAF MOM Wanda **MAELZER** suffered an incomplete abortion by Hodes 4/25/81. Maelzer, husband & 2 children are deaf mutes. On 4/27/81, Maelzer repeatedly tried to contact Hodes' emergency number for a medical treatment. Her calls were unanswered--she eventually spent one week hospitalized for removal of remaining fetus and massive infection, causing permanent injury. #C0107883, Johnson County, Kansas, also sued Fox Hill Clinic, Overland Park; dropped without record of any out of court settlement.

----------*at least 5 more malpractice suits before this*, Sept.'90

BOTCHED ABORTION Karen **RAIDL** had an incomplete abortion by Hodes 9/27/90, with 7 wks pain & bleeding, remedied by D&C surgery from Dr. Howard Ellis, long time KSBHA member, who would not testify vs. Hodes as treating physician, or expert witness. Case#92C-10205, Johnson Cty, KS dropped, assumed settled; unrecorded.

----------*at least 6 more malpractice cases before this filed*, Sept.'00

Rh DISASTER Jacque Keast **GARRETT** had a D&E abortion by Hodes 8/22/96 with Rh error entered into her chart. Garrett was not given necessary Rh medication causing multiple blood transfusions in utero, and after birth, to save life of subsequent child. She sued for damages and deprivations of future children. #00CV04517 in Johnson County, Kansas, was settled for an undisclosed amount, per attorney of record.

ISSUES

No CPR from Abortionist as patient dies -1988 & 1997!

Missouri investigators noted that the 1997 dying patient had been in cardiac arrest and that Crist was not doing CPR. This is the situation 9 years before when Miller had his patient die while he provided no CPR. Investigators pointed out deficiency of Crist not having a cardiac monitor and required resuscitative equipment--another echo of what was missing during Miller's abortion death.

Clinic ignored own criteria for patient safety. The 1997 dead woman was ineligible for abortion based on her blood hemoglobin -- but was aborted anyway. Her low hemoglobin violated the clinic's guidelines as well as Crist's standard, as stated only 6 months earlier in his deposition for another malpractice case.

Recovery room blame shuffling. When questioned about patients leaving while hemorrhaging, Crist describes the nursing staff as experienced in checking blood loss during recovery after abortion. Yet staff depositions in a prior case stated that they were unsure as how to assess blood loss. The recovery room nurse stated that she personally dismissed the patients. Crist admitted monitoring machine wasn't always connected to patients.

Missouri finds clinic abuses, goes in to correct. Bugs, rust, unsterile conditions, uncredentialed staff and missing CPR certification was found by investigators in '92. Revisited in '94, these problems, among others: patients were being drugged prior to signing consent; medical histories & physical exams were deficient; policies & instructions for minors were missing; hospital privileges were not in place; patients were not properly examined & discharged.

Missouri women flock to Kansas. Missouri has double the residents of Kansas but the same amount of abortions--that's because they send 5,200 of their women here every year as part of our 6,000 out-of-state abortions. Because Missouri is regulated, Kansas becomes attractive to abortionists for these reasons:
1) Cheaper, tho not safer, to set up a location with no state licensing oversight.
2) Kansas residency is not required to access the judicial bypass system for minors;
3) Three Kansas clinics have no ob/gyn doctor. (The Missouri guidelines specify ob/gyn board certified or eligible for practitioners., & nurse for office manager.)

Kansas Board of Healing Arts involvement. The Board has fined and disciplined Rajanna, Zaremski & Miller for drug and/or record-keeping violations--they have the 3 KCK locations fearing oversight. The Board is ordering Neuhaus how to counsel, examine, monitor, dismiss and keep records in her Lawrence abortion site. They also take random drug tests of her entire staff! The problem is, they need a triggering incident--like Neuhaus being DEA restricted--or Zaremski's partner going to trial--otherwise they don't have authority to go on site.

CRIST: Abortion INJURIES & DEATHS

TEEN DEATH. Severely retarded 19 yr old Diane **BOYD,** after her 10/22/81 abortion by Crist, suffered breathing depression and died the next day. Her mother charged **no one checked Diane's medical history** showing she took anti-psychotic drug Thorazine. Boyd's abortion medication, Sublimaze & Valium, are contra-indicated for Thorazine. The medical examiner ruled death caused by reaction to Sublimaze. Boyd's mother also accused Crist of **negligence**, choosing a risky method for 2nd trimester abortion, having **no resuscitative, heart-monitoring or general anesthetic equipment on site.** The original lawsuit also sued the state of Missouri. #812-11077 in St. Louis, was dropped 6/16/87. Second suit, #83-01711, settlement unverified. *[Kansas City Star 11 6 91 & Scarlet Survey, Sherlock, 1997, pg. 207]*

---*5 months later*- March'82

HEMORRHAGE After Crist 3/82 abortion, Tamara **SCHAEFER** hemorrhaged & needed corrective surgery. She & her mom called clinic about excessive bleeding, to no avail.#CV84-2759 in Jackson Cty, MO; settled for her 5/85.

---*7 months later*- October'82

INCOMPLETE ABORTION Beth **O'NEILL** was released from Crist abortion hemorrhaging, and was hospitalized to remove remaining fetus. Her lawsuit. #CV83-12872 in Jackson County. MO. settled for her 7/85.

---*2 months later*- December'82

TOXIC INFECTION After Crist abortion, Mary Shoemaker/**TOMPKINS** suffered sepsis, permanent tubal obstruction, uterine perforation, hospitalization. Lawsuit #832-05476 in St. Louis, MO, settled for her 9/19/86.

---*1+ year later*-April'84

STERILIZED to SAVE LIFE Connie **JOHNSON,** hemorrhaging from 4/84 Crist abortion, sued him for negligence, perforation of her uterus, sepsis and an emergency hospital sterilization that day to save her life. Crist's recovery room nurse, when deposed, admitted that she was unable to determine amount of patient blood loss, that she didn't always record information into patient files, and that she herself discharged patients. Johnson's suit, #872-0037 in St. Louis, MO, assumed settled but unverified.

---*1 year later*- April'85

EMERGENCY SURGERY on MINOR Carla **PAIRETT**, a minor aborted 4/4/85 by Crist, had complications & corrective surgery at hospital. Lawsuit for failure to provide proper information, evaluation, care & surgical standards, was settled $24,000 for Pairett 10/30/86. Case #85-64815 in Harris County, Texas..

---*6 months later*- October'85

ABORTION ENDS at HOME Hanna **WISNIAKOWSKI** expelled mangled fetus at home, 2 days after Crist abortion, 10/2/85. She sued for corrective hospital treatment & trauma from seeing baby without hands and leg. She did not prevail; summary judgment for defendant 10/9/89. Case #86-023219 in Harris County, Texas.

---*5+years later*- April'91

Rh OMISSION found TOO LATE Nancy **FRANEK** had Crist abortion 4/91; wasn't given Rh correction dose. Impaired condition undiscovered until subsequent pregnancy. Unable to overcome statute of limitations for remedy. Lawsuit #93-062507,Harris County, TX [refer to settlement, Garrett v HODES "Rh case", next page]

---*4 months later*- August'91

TEEN TRAUMA 18 yr old Chrystal Dawn **MATSON**, aborted 8/1/91 by Crist, suffered post-abortion hemorrhage, infection & psychological trauma. Matson alleged incomplete, untruthful consent information about the "contents of her uterus"; failure to provide a proper, monitored recovery especially in light of her excessive bleeding; and failure to properly diagnose and hospitalize her. She also sued for the wrongful death of a 25wk baby boy born alive and dismembered, who then bled to death. On 11/3/97, suit #93-052946, Harris County, Texas, was settled for undisclosed amount. Final order 3/13/98.

---*2 months later*- October'91

NEAR-DEATH ABORTION Carol Ann **CUTLER** had D&E abortion 10/4/91 by Crist. Houston TV televised her at hospital, unnamed, where she had been recovering for one month. She told reporters her doctors had said she would have been dead within 24 hours from infection, had she not checked herself into the hospital. She had signed for a first trimeseter D & C, but was given a riskier 2nd trimester D&E. Cutler sued for permanent disability, disfigurement, physical impairment; and pain & suffering. #93-50728 in Harris Cty, TX. Confidential settlement/atty of record. *[11 6 91 Houston Chronicle]*

---*1 month later*- November'91

TEEN DEAD After 11/2/91 2nd trimester Crist abortion , Latachie **VEAL** was sent home without provisions to monitor though bleeding heavily and complaining of severe pain. Her family's attorney stated that they had attempted in vain to get help from the clinic, which said, "Don't worry, this is normal." The teen **literally "bled out" in a few hours** and stopped breathing. Veal was dead on arrival at Ben Taub hospital. Coroner said Veal's uterus never contracted after abortion. In a 1996 deposition [malpractice suit from Matson], Crist admitted that failure of uterus to "clamp down" was a common source of hemorrhage. He also admitted no rules for checking patient's blood loss during recovery time and said the nurses were very experienced in checking and he didn't have to be there. Concerning the death, Crist says he's a victim of media hype. Suit #93-056300,Harris Cty. TX: confidential settlement/atty. *[HoustonChron.11 6 91,11 11 91;Houston Post11 12 91]*

---*2 months later*- January'92

TEEN BOTCHED, emergency STERILIZED Latosha **BOBB** had 2nd trimester Crist abortion 1/31/92. Her mother walked into the procedure room and found Crist working on her daughter with a "pan of blood between her legs". Crist had perforated her uterus, and the mother demanded immediate hospitalization; an emergency hysterectomy was done at Ben Taub hospital . Consent was defective including Crist's not signing it and that the consent form signed by teen did not match the abortion procedure. #94-002956 Harris Cty, TX. Confidential settlement/atty record *[2 9 92Houston Chronicle]*

---*5 years later*- April'97

MOTHER DEAD 22 yr old Nicole **WILLIAMS** died at the ending of her Crist abortion 4/25/97. Medical examiner rules amniotic embolism. Issues: ambulance delay & findings of 4/30/97 Health Dept. investigation: **Crist not certified in CPR , no cardiac monitor, missing resuscitative equipment.** The victim had been tested for blood hemoglobin;her low reading made her ineligible for abortion by clinic guidelines.[complete report is public] Lawsuit #992-01174, St. Louis, MO, pending.*[KansasCityStar4 27 97]*

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:* ____/____/____

The Miller Mishaps
pt. 1 in a series

ABORTION
It's always Bad News

Since 1983, anesthesia complications from abortion have emerged as the **most frequent cause of abortion deaths.** A 1993 Alan Guttmacher survey showed 1/3 of abortion facilities offered general anesthesia, which accounts for twice as many deaths as local anesthesia.
Interdisciplinary Research Bulletin, 9/96

The responding ambulance paramedic found Miller cradling Fisher in his arms. ***"He wasn't doing CPR or anything," said the paramedic,*** *who estimated Fisher had not breathed for up to 8 minutes. Erna Fisher was DOA- dead on arrival- at a nearby hospital.* KCStar6/30/90

The expert witness said **Miller was grossly negligent**; but Miller's only punishment, 8 months later from the Bd. of Healing Arts, was **the order to stay out of his office for 1 year!**
KCCStar6/30/90

The death of Erna Fisher came before ***Miller had paid off the lawsuit for the horrific death of 21 yr.old Lisa Allen*** *following Miller's botched abortion & misdiagnosis.* KCStar6/30/90

KANSAS CITY STAR
SUNDAY, June 3, 1990

A Kansas doctor's medical mishaps

By Bill Dalton

Erna Fisher was 18 yrs. old, 18 weeks pregnant and already a mother when she anxiously stepped into Dr. Dennis W. Miller's office for an abortion the afternoon of Mar. 30, 1988.

Within minutes, the operation turned fatal. Fisher's mother--who held her daughter's hand because Erna was frightened--said Erna jerked upright, then went rigid, apparently from a seizure. A medical assistant ran for smelling salts.

Miller continued removing tissue, unaware that his patient had vomited and was choking to death. Later, Miller acknowledged he had prescribed a painkiller he knew could cause vomiting. He admitted not asking the young woman whether she had eaten. During the operation and afterward, while waiting for an ambulance, he did not check her airway or offer her oxygen.

"Since I didn't realize what was going on, I don't think it would have made any difference," Miller stated later in a sworn deposition.

Miller settled with Fisher's heirs last Dec. for $475,000, according to court records. He denied any liability, which malpractice lawyers say is routine.

Other patients in Miller's care have suffered serious complications. *The Kansas City Star* found that since 1987, Miller has settled six malpractice lawsuits, with five claims totaling nearly $2 million. The other settlement was undisclosed.

"Six or seven lawsuits and settlements for $2 million would be greater than average," said Homer Cowan, administrator of a state plan for Miller and other doctors who often are considered such high risks that they cannot buy malpractice coverage from private companies.

Kansas insurance records show a state-run fund will pay more than $1 million of the claims for Miller. He is one of only three practicing Kansas doctors who have had claims against the fund exceeding $1 million. Two others with claims exceeding $1 million faced disciplinary actions and no longer practice medicine, officials say.

Miller, 41, continues to practice medicine at his office in Kansas City, Kan., and at Comprehensive Health for Women in Overland Pk.

"We have a lot of confidence in him. He knows how to provide excellent abortion services and is very good," said Adele Hughey, director of Comprehensive Health for Women.

SUMMARY: KDHE - Licensed Ambulatory Surgical Center Inspections at Planned Parenthood of Kansas Mid-Missouri in Overland Park

(initial inspection triggered by complaints to KDHE)

May 24, 2002- DEFICIENCIES

SO125– no policy for **patients' access to their own medical records**

SO150– patients are not informed of their **right to direct a grievance** or a complaint to the licensing department

SO155– no policy that would mandate the **reporting of abuse, neglect and exploitation**

SO320– no minutes were kept of **medical meetings**

SO340– failed to review and grant medical **staff privileges** at least every 2 years

SO365– failed to provide education to staff as to the type of incidents to report; staff had been instructed to leave medical records in the risk manager's office if any complications or unusual events occurred. Staff admitted they would not necessarily report **medication or treatment errors** to the risk manager.

SO485– failed to assure that only authorized personnel had **access to medical records**. Several boxes of medical records were stored in open boxes in an unlocked, open room accessible for copying purposes. There were also boxes of lab results stored in a hallway against a back wall, accessible to all staff and patients.

SO530– failed to initiate and maintain infection control: no education in the cause, effect and transmission of infection. Facility failed to establish **infection control** program based on CDC and KDHE guidelines.

SO575– failed to require **initial medical exams** and periodic health assessments for personnel

SO580– no policy for control of **communicable disease** and failed to maintain immunization histories for personnel; failed own policy on annual TB and chest x-rays; no written policies on sending TB results to KDHE

SO715– **outdated drugs** were available for administration to patients, including steroids, sedatives and antibiotics. Narcotics were not routinely accounted for; a drawer of bulk, **uncounted narcotics** was accessible to nursing staff

Oct.18, 2002- DEFICIENCIES remaining upon re-inspection

SO155– still no policy **mandating administrator to report any incident** of abuse, neglect or exploitation of patients

SO320– facility still failing to conduct medical **staff meetings**

SO575– personnel still not required to have **initial medical exam** and periodic assessments

SO580– still **no immunization** histories for personnel

Pro Kan Do PAC
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Julie Burkhart, Chair
Carrie Klaassen, Treasurer

November 15, 2002

Dear Friend of Choice,

I would like to take this opportunity to thank you for your unfaltering support that you have provided over the last four months. As we celebrate our victory of once again protecting the right to reproductive choice, I want you to know that this could not have been possible without all of you. I asked you to stand with me and fight once again and you answered that call with dedication and conviction.

With your financial, moral and spiritual support, we were able to identify 35,000 essential pro-choice voters who had a historically lower turnout in non-presidential election years. After identifying those voters we were able to utilize so much of your volunteer time to make personal phone calls to those voters to motivate them to get to the polls this Election Day. Each of those identified voters also received follow-up phone calls to ensure that they remembered how important their vote was this year. In addition to our Get Out the Vote phoning efforts, we were also able to canvass highly democratic neighborhoods to remind people to vote and offer those who needed it, a ride to the polls. We know from the election results that our efforts were instrumental in ensuring Kathleen Sebelius' victory.

We have been victorious and now have an ally in the highest office in the state. For the past week, we thought that the race for Attorney General might be [illegible] were counted it was confirmed

Sebelius has received over $35,000 in contributions from infamous partial *birth abortion doctor George Tiller.*

- $23,000 to her Bluestem PAC (Campaign Finance Reports)
- More than $14,000 directly to her campaigns since 1994 (Kansas Government Ethics Commission)

Tiller has started a pro abortion PAC called Pro Kan Do to help Sebelius

- In a Sept. 9, 2002 fundraising letter, Tiller says he personally contributed $200,000 to the Pro Kan Do PAC, whose purpose is to defeat Shallenburger

Most Sincerely and Cordially,

George R. Tiller, MD DABFP

3-23

INFORMATION BULLETIN FROM **KANSANS FOR LIFE**

LIFE DECISIONS

HB 2176

TALKING POINTS IN FAVOR OF ABORTION CLINIC LICENSING

The new licensing law **would require abortion recovery rooms be properly supervised, staffed and equipped**.

--just the opposite was the situation in the Kansas City office where young Erna Fisher died during her 1988 abortion at the hands of Kansas practitioner Dennis Miller

--just the opposite was the situation, according to the Missouri licensing agency, in the St. Louis clinic where Nichole Williams died following her 1997 abortion from Kansas practitioner Robert Crist

--just the opposite was the situation of Kansas abortionist Kristin Neuhaus in Wichita and Lawrence through 2002 according to the disciplinary files of the Kansas Board of Healing Arts

The new licensing law **would insure that Rh factor protocol was followed properly**.

--just the opposite happened to Nancy F, following her 1991 abortion by Robert Crist, according to her lawsuit for injury and permanent impairment; Rh situation discovered at the birth of subsequent child

--just the opposite happened to Jacque G, following her 1996 abortion from Kansas practitioner Herb Hodes, according to her lawsuit for Rh medical complications, near-death of subsequent child and her lost fertility

The new licensing law **would insure that ultrasound evaluation was made on pregnancies past 12 weeks.**

--just the opposite is the policy of 75-year-old Kansas abortionist Arthur Taliaferro, who does not publicly advertise that his KCK office offers abortions up to 16 weeks gestation without ultrasound exams

The new licensing law **would require a nurse be present during patient exam and that proper nurse or physicial assistant be present at all times for all patients during and after procedures**.

--just the opposite is the position of 72-year-old Kansas abortionist Sherman Zaremski because of the subsequent rise in cost, said his clinic manager in testimony to legislative committees in 2002

The new licensing law **would require the abortionist to have hospital privileges and be able to cope with emergencies, including immediate transfer to hospital**.

--just the opposite happened in the near-death abortion alleged by "Jane Doe", going to trial April 2003 against Planned Parenthood's medical director Robert Crist, because she was left in his St.Louis clinic too long, and finally was shipped, without detectable pulse or blood pressure, to a hospital in a silenced ambulance

The new licensing law **would require that inspections be made public record, while maintaining patient privacy.**

--just the opposite happens with the Board of Healing Arts where inspections are rare and not made public

--just the opposite happens with the ambulatory surgical center inspections and risk management surveys done by KDHE at the Overland Park Planned Parenthood facility

The new licensing law **would make non-compliance a class B misdemeanor and would give to KDHE the power to authorize injunctions and restraining orders to halt clinic law-breaking.**

--just the opposite is true for the current oversight pattern of Board of Healing Arts where Kansas abortionist Kris Neuhaus was twice described a danger to the public, but was never shut down.

--just the opposite is true for the Overland Park Planned Parenthood facility which had numerous KDHE deficiencies in May 2002 that were still not corrected 5 month later and for which there are no fines or criminal penalties for Kansas abortionists Ronald Yeomans and Robert Crist.

Contact Jeanne Gawdun, 785-234-2998, **KANSANS FOR LIFE**, 919 S. Kansas Ave. Topeka, KS

3-24

Condensed Abortion Protocol

Planned Parenthood of Central and Northern Arizona

COPY

Planned Parenthood
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] Board
No. 1
Date 10-18-07

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

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.

3-27

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of Central and Northern Arizona
5651 North Seventh Street
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(602)277-7526

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. If a continuing pregnancy is suspected, the patient will be evaluated and a physician provide abortion services will be consulted

STATE REGULATION OF ABORTION CLINICS

State	Definitions, Requirements and Exemptions	Citation	Enforcement Status
Alabama	"Abortion and reproductive health centers" are defined as "hospitals" and are subjected to licensing and regulation by the State Board of Health. Law applies to abortion providers, including private physicians, at all stages of pregnancy. These regulations impose minimum standards for clinic administration, professional qualifications, patient testing and physical plant. *Exemptions*: Providers who perform fewer than 30 abortions per month for at least ten months of a calendar year and who do not advertise as "abortion providers."	ALA. CODE § 22-21-20 (2001) ALA. ADMIN. CODE rr. 420-5-1-.01 to 420-5-1.04 (2001)	In effect. An Alabama appellate court has determined that a private physician's office that performs a minimum number of abortions may be regulated. *Tucker v. State Dep't of Public Health*, 650 So. 2d 910 (Ala. Civ. App. 1994).
Alaska	The law applies to abortion providers at all stages of pregnancy and mandates minimum standards for clinic administration, professional qualifications, patient testing and physical plant. Law requires that abortions be performed in a hospital or facility approved by the Alaska Department of Health and Social Services during the first trimester and only in a hospital during the second and third trimesters.	ALASKA STAT. §§ 08.64.105, 18.16.010 (a)(2) (2001); ALASKA ADMIN. CODE tit. 7, § 12.370 (2001) ALASKA ADMIN. CODE tit. 7, §§ 12.370, .900 (2001) ALASKA ADMIN. CODE tit. 12, §§ 40.120, .130. .080, .090 (2001)	Not enforced. Although the law remains on the books, the Alaska Attorney General has determined that it is largely unconstitutional and uneforceable. *See* Alaska Op. Att'y Gen. No. J-66-816-81 (Oct. 7, 1981) (concluding that the requirement that all abortions be performed in a hospital or other approved facility is invalid since it does not exclude the first trimester of pregnancy (citing *Sendak v. Arnold*, 429 U.S. 968 (1976))); Alaska Op. Att'y Gen. No. 366-028-85 (July 24, 1984) (stating that the regulation of other aspects of the provision of first trimester abortions is "obviously problematic.") A strict second trimester hospitalization requirement has been found unconstitutional. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983).
Arizona	The law applies to abortion providers, including private physicians, at all stages of pregnancy and mandates minimum standards for clinic administration, professional qualifications, patient testing, the performance of abortion procedures, maintenance of patient records, and physical plant. *Exemptions*: Providers who perform fewer than 5 first trimester abortions in any month and no second or third trimester abortions.	ARIZ. REV. STAT. ANN. § 36-449.01, .02, .03 (2001) ARIZ. ADMIN. CODE R9-10-1501 to R9-10-1514 (2001)	Enjoined pending outcome of litigation. Regulations have been substantially upheld and case is on appeal to Ninth Circuit. *Tucson Women's Clinic v. Eden*, No. CIV 00-141 TUC RCC (D. Ariz. Oct. 1, 2002). District court invalidated requirement that patients be treated with "respect" as unconstitutionally vague; a requirement that state officials be given assess to regulated clinics "anytime during business hours" as contrary to Fourth Amendment; and two provisions allowing state officials to access unredacted patient records and ultrasound prints as a violation of informational privacy rights.
Arkansas	The law applies to abortion providers at all stages of pregnancy and to any facility in which the "primary function" is the willful termination of pregnancy. The law mandates minimum standards for clinic administration, professional qualifications, patient and employee testing and physical plant. The law also requires that any abortion performed after the 20th week of pregnancy be performed in a licensed hospital.	ARK. CODE ANN. §§ 20-9-302 (a), (b) (2001) Ark. State Bd. of Health, Rules and Regulations for Abortion Facilities § 3 –12 (approved Aug. 2, 1999)	In effect.

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State	Definitions, Requirements and Exemptions	Citation	Enforcement Status
California	The law applies to abortion providers, including private physicians, at all stages of pregnancy. The law mandates minimum standards for clinic administration, professional qualifications and physical plant. A separate statute further requires that all be abortions be performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH) and be approved, in advance, by a hospital committee upon finding that there is a substantial risk that continuance of the pregnancy would gravely impair the woman's physical or mental health or the pregnancy resulted from rape or incest.	CAL. CODE REGS. tit. 22, §§ 75040 to 75047 (West 2001) CAL. HEALTH & SAFETY CODE § 123405 (West 2001) (accreditation requirement)	In effect; however, the accreditation and committee approval requirements are not enforced. Although the law remains on the books, the California Attorney General has concluded that the requirement that all abortions be performed in hospitals that have been accredited by JCAH is invalid. *See* 74 Op. Cal. Att'y Gen. 101 (1991). A requirement that an accredited hospital perform abortions and the interposition of a hospital committee for approval has been ruled unconstitutional *Doe v. Bolton*, 410 U.S. 179 (1973).
Colorado	No law		
Connecticut	Law applies to outpatient clinics at all stages of pregnancy and mandates minimum standards for clinic administration, professional qualifications and patient testing.	CONN. GEN. STAT. ANN. § 19 a –116 (2001) CONN. AGENCIES REGS. §§ 19-13-D45, *et seq.*; 19 a –116-1 (2001)	In effect.
Delaware	No law		
District of Columbia	No law		
Florida	The law applies to abortion providers at all stages of pregnancy and mandates minimum administrative requirements. *Exemptions*: Law does not apply to a hospital or a private physician's office, provided the physician's office is not used "primarily for the performance of abortions."	FLA. STAT. ANN. §§ 390.011, 390.012 (2000) FLA. ADMIN. CODE ANN. r.59A-9.019, *et seq.* (2000)	In effect.
Georgia	Law applies to abortion providers at all stages of pregnancy and mandates minimum administrative requirements. The law also requires that all second and third trimester abortions be performed in a hospital or ambulatory surgical center. Further, only dilation and evacuation (D&E) procedures may be performed in an ambulatory surgical center.	GA. COMP. R. & REGS. r. 290-5-32-.01, *et seq.* (Harrison 2000) GA. CODE ANN. § 16-12-141 (Harrison 2000)	In effect.
Hawaii	Law applies to abortion providers, including private physicians, at all stages of pregnancy. The law requires that all abortions be performed in a hospital.	HAW. REV. STAT. ANN. § 453-16 (Bender 2000)	Not enforced. Although the law remains on the books, the Hawaii Attorney General has concluded that it is unconstitutional and unenforceable. *See* Haw. Op. Att'y Gen. No. 74-17 (Oct. 10, 1974). Strict first and second trimester hospitalization requirements have been found to be unconstitutional. *Doe v. Bolton*, 410 U.S. 179 (1973); *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983).
Idaho	Law applies to abortion providers, including private physicians, in the second trimester of pregnancy. The law requires that all second trimester abortions be performed in a hospital.	IDAHO CODE § 18-608 (2000)	Not enforced. Although the law remains on the books, the Idaho Attorney General has concluded that it is unconstitutional and unenforceable. *See* Idaho Op. Att'y Gen. No. 98-1 (Jan. 26, 1998). Strict first and second trimester hospitalization requirements have been found to be unconstitutional. *Doe v. Bolton*, 410 U.S. 179 (1973); *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983).

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State	Definitions, Requirements and Exemptions	Citation	Enforcement Status
Illinois	Law applies to abortion providers, including private physicians, at all stages of pregnancy; however, requirements vary depending on the stage of pregnancy. The regulations mandate minimum standards for clinic administration, patient testing, professional qualifications and physical plant. The applicable law, the Ambulatory Surgical Treatment Center Act (ATSCA), defines any facility in which an abortion is performed as an "ambulatory surgical center."	210 ILL. COMP. STAT. ANN. 5/3, *et seq.* (2001) ILL. ADMIN. CODE tit. 77 §§ 205.330, 205.540 and 205.710 (2001) (codifying consent decree)	In effect. Consent decree, following extensive litigation, limits enforceability of regulations. *See Ragsdale v. Turnock*, 734 F. Supp. 1457 (N.D. Ill. 1990). ATSCA, in its entirety, applies only to facilities that perform abortions after 18 weeks of pregnancy and use general, epidural or spinal anesthesia or "require incisions that expose the patient to risk of infection." Facilities that only perform abortions prior to 18 weeks of pregnancy and use only local anesthesia must be licensed and are subjected only to administrative rules for "Limited Procedure Specialty Centers."
Indiana	Law applies to abortion providers, including private physicians, during the second trimester of pregnancy. The law requires that abortions after the first trimester be performed in a hospital or ambulatory outpatient surgical center.	IND. CODE ANN. §§ 16-18-2-1, 16-18-2-14 and 16-34-2-1 (West 2000) IND. ADMIN. CODE tit. 410, r. 15-2.5 (West 2000)	In effect.
Iowa	No law		
Kansas	No law		
Kentucky	Law applies to abortion providers, including private physicians, at all stages of pregnancy. The regulations mandate minimum standards for clinic administration, professional qualifications, patient and employee testing and physical plant.	KY. REV. STAT. ANN. §§ 216B.015(1), 216B.020(2)(b), 216B-0431, 216B.0435 311.720(1) (Michie 2001) KY. ADMIN. REG. 20.360	In effect.
Louisiana	Statute defines "an outpatient abortion facility" as any facility other than a hospital in which any second trimester or five or more first trimester abortions per month are performed. Law, passed during 2001 legislative session, applies to abortion providers, including private physicians, at all stages of pregnancy. *Exemptions*: Providers who perform fewer than 5 first trimester abortions in any month and no second or third trimester abortions.	LA. REV. STAT. ANN. § 40:1299.35.1(1) (West 2001) H.B. 949, 2001 Reg. Sess. (La. 2001)	Pending promulgation of administrative rules and enforcement. Administrative regulations are being drafted and will be issued for public comment. In 1999, the Louisiana legislature had deleted the exemption for abortion clinics from its statute concerning the licensing of ambulatory surgical centers. *See* LA. REV. STAT. ANN. § 40:2134 (West 2001). However, a federal district court later determined that abortion clinics were not "ambulatory surgical centers" under that statute. *Causeway Med. Suite v. Foster*, No. 99-2069 (E.D. La. Aug. 2, 2000)
Maine	No law		
Maryland	No law		
Massachusetts	Law applies to abortion providers, including private physicians, after the 12th week of pregnancy and mandates minimum administrative requirements. Law requires that all abortions performed after the 12th week of pregnancy be performed in a hospital authorized to provide facilities for general surgery.	MASS. GEN. LAWS ANN. ch. 111, § 51 and ch. 112, §§ 12k, 12Q (West 2001)	Not enforced. A strict second trimester hospitalization requirement has been found unconstitutional. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983). Further, the Massachusetts Appeals Court has twice "suggested" that the second trimester hospitalization requirement is unenforceable, by holding that a mature minor had the right to choose to have a second trimester abortion in a clinic rather than in a hospital. *See In re Moe*, 469 N.E.2d 1312 (Mass. App. Ct. 1984) and *In re Moe*, 517 N.E.2d 170 (Mass. App. Ct. 1987)

State	Definitions, Requirements and Exemptions	Citation	Enforcement Status
Michigan	Law regulates abortion providers as "freestanding surgical outpatient facilities." Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, professional qualifications and physical plant. *Exemption*: Physician's offices and facilities where less than 50 percent of the patients annually served undergo abortion procedures.	MICH. COMP. LAWS ANN. §§ 333.20115, 333.17015 (a), (b) (West 2001) MICH. ADMIN. CODE rr. 325.3801, *et seq.* (West 2001)	In effect.
Minnesota	Law applies to abortion providers, including private physicians, after the first trimester of pregnancy. Law also requires that all abortions after the first trimester be performed in a hospital or "abortion facility." *Exemptions*: Private physician's offices whose practices are not "devoted primarily to" the performance of abortion procedures.	MINN. STAT. ANN. §§ 145.411, *et seq.*; 145.4131 (West 2000) MINN. rr. 4615.3400, 4615.3600 (West 2000)	In effect.
Mississippi	Law defines an "abortion facility" as a doctor or organization providing abortion services to 10 or more patients in any one-month period of time or 100 or more abortions during any calendar year and those facilities that advertise as abortion providers. Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, professional qualifications, patient and employee testing and physical plant requirements. Law also requires that abortions after the 15th week of pregnancy be performed at a licensed hospital or an ambulatory surgical facility. *Exemptions*: Abortion facilities that perform fewer than ten abortions per month and fewer than 100 abortions per year. However, it does not exempt any provider who "markets" itself as an abortion provider.	MISS. CODE ANN. § 41-75-1, *et seq.* (2001) MISS. CODE R. 12 000 034 (2001)	In effect. Discrete portions of the law were preliminary enjoined. *See Pro-Choice Mississippi v. Thompson*, No. 3:96CV596BN, bench op., (S.D.Miss. Sept. 27, 1996). Court enjoined 1500 foot zoning prohibition; portion of the definition of "abortion facility" that pertained to advertising; requirement that abortion providers receive training through an AMA-approved residency program; and requirement of a transfer agreement with a local hospital. Majority of the statute was not enjoined and remains in effect.
Missouri	Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, professional qualifications, patient and employee testing and physical plant. Law also requires that all abortions after the 15th week of pregnancy be performed in a hospital. *Exemptions*: Facilities in which either the number of patients having abortions represents 50 percent or less of the total patients treated or 50 percent or less of the total facility revenue is from abortions or abortion-related procedures.	MO. ANN. STAT. §§ 188.010, *et seq.* (West 2000) MO. CODE REGS. ANN. tit. 19, § 30-3010, *et seq.* (West 2000)	In effect, except for hospitalization requirement. A federal appeals court has ruled that the second trimester hospitalization requirement is unconstitutional. *Reproductive Health Services v.Webster*, 851 F.2d 1071 (8th Cir. 1988), *rev'd on other grounds*, 492 U.S. 490 (1989).
Montana	No law		

State	Definitions, Requirements and Exemptions	Citation	Enforcement Status
Nebraska	Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, professional qualifications, employee testing and physical plant. *Exemptions*: Health care facilities that never perform ten or more abortions during a calendar year.	NEB. REV. STAT. § 71-416 (2001) NEB. ADMIN. CODE tit. 175, ch. 7 §§ 001, *et seq.* (2001)	In effect.
Nevada	No law		
New Hampshire	No law		
New Jersey	Law applies to abortion providers, including private physicians, after the first trimester of pregnancy. Law requires that all second trimester abortions, except for dilation and evacuation (D&E) procedures, be performed in licensed hospital. The law also requires that all D&E procedures performed between 15 and 18 weeks of pregnancy be performed in a licensed ambulatory care facility or a licensed hospital. Additional regulations apply to D&E procedures performed after 18 weeks of pregnancy.	N.J. ADMIN. CODE tit. 13, § 13:35-4.2 (2001)	In effect.
New Mexico	No law		
New York	Law applies to abortion providers, including private physicians, after the first trimester of pregnancy and requires that all abortions after 12 weeks of pregnancy be performed in a hospital on an in-patient basis.	N.Y. PUB. HEALTH LAW § 4164 (2001)	Not enforced. The General Counsel for New York has concluded that the second trimester hospitalization requirement would be unconstitutional, if enforced. *See* Letter from Henry Greenberg, General Counsel, State of N.Y. Dep't of Health, to Erin Walker (Mar. 10, 1997). A strict second trimester hospitalization requirement has been found unconstitutional. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983).
North Carolina	Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, professional qualifications, patient testing and physical plant. Law further requires that all abortions after the 20th week of pregnancy be performed in a licensed hospital.	N.C. GEN. STAT. ANN. § 14-45.1 (2000) N.C. ADMIN. CODE tit. 10, rr. 3E.0101-.0402 (2000)	In effect.
North Dakota	Law applies to abortion providers, including private physicians, after the 12th week of pregnancy. Law requires that all abortions after 12 weeks of pregnancy be performed in a licensed hospital.	N. D. CENT. CODE § 14-02.1-04(2) (2000)	Not enforced. Although the law remains on the books, a federal court has entered a declaratory judgment that the statute is unconstitutional and unenforceable. *Miks v. Olson*, No. A3-82-78 (D.N.D. Aug. 25, 1983).
Ohio	Law applies to abortion providers, including private physicians, after the 14th week of pregnancy. Law requires that immediate post-abortion care be provided in a hospital.	OHIO REV. CODE ANN. § 2919.11(2001) OHIO ADMIN. CODE §§ 3701-47-01, 3701-47-02 (2001)	Not enforced. A strict second trimester hospitalization requirement has been found to be unconstitutional. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983).

State	Definitions, Requirements and Exemptions	Citation	Enforcement Status
Oklahoma	Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, patient testing and physical plant. Law also requires that all abortions after the first trimester be performed in a "general hospital."	OKLA. STAT. ANN. tit. 63, § 1-701(1), *et seq.* (West 2001) OKLA. ADMIN. CODE § 310-600 (West 2001)	In effect, except for second trimester hospitalization requirement. A federal court has enjoined the second trimester hospitalization requirement, *see Reproductive Servs. v.Keating*, No. 98-CV-447-H (N.D. Okla. Dec. 16, 1998). This ruling superceded one by the Oklahoma Supreme Court that held that *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), had overruled *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983) which had ruled that a strict second trimester hospitalization requirement was unconstitutional. *See Davis v. Fieker*, 952 P.2d 505 (Okla. 1997).
Oregon	No law		
Pennsylvania	Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, professional qualifications, patient testing and physical plant. Law also requires that all abortion after the first trimester be performed in a hospital.	18 PA. CONS. STAT. ANN. §§ 3201 – 3214 (2000) 28 PA. CODE §§ 29.31-.43 (2000)	In effect. A strict second trimester hospitalization requirement has been found unconstitutional. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983).
Rhode Island	Law applies to abortion providers, including private physicians, at all stages of pregnancy. The minimum standards imposed on providers are based on gestational age at which the abortions are performed. (a) For providers performing first trimester abortions, law mandates minimum standards for clinic administration, patient testing and physical plant. (b) For providers performing abortions between 14 and 18 weeks of pregnancy, law mandates minimum standards for clinic administration, professional qualifications, patient and employee testing and physical plant. Law specifies that all abortions prior to the 14th week of pregnancy may be performed outside of a hospital or a freestanding ambulatory surgical center, but only when hospital emergency back-up services are available. Law also requires that abortions performed between the 14th and 18th week of pregnancy must be performed in a hospital, a licensed freestanding ambulatory surgical center, a licensed physician's office or a freestanding surgical facility. Law further requires that abortions after 18 weeks of pregnancy must be performed in a hospital or ambulatory surgical center.	R.I. GEN. LAWS ANN. §§ 23-4.7-1, 23-17-4 (2001) R.I. CODE RR. 14 000 009, 14 090 006 (2001)	In effect.

State	Definitions, Requirements and Exemptions	Citation	Enforcement Status
South Carolina	Law defines an "abortion clinic" as a facility that performs any second trimester or 5 or more first trimester abortions per month. Law mandates minimum standards for clinic administration, professional qualifications, patient and employee testing and physical plant. "Abortion clinics" must be licensed by the state. Law applies to abortion providers, including private physicians, at all stages of pregnancy.	S.C. CODE ANN. §§ 44-7-130(22), 44-41-75 (2000) 61-12 S.C. CODE ANN. REGS.200, *et seq.* (200 0)	In effect. In 2000, law was upheld as constitutional, surviving challenges claiming created an "undue burden" on women seeking abortions and violated constitutional equal protection guarantees. *See Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001). In a second round of litigation, the regulations were, again, found to be constitutional. The Fourth Circuit found that the regulations did not involve illegal delegation of state licensing authority, did not violate the doctrine of "separation of church and state," were not unconstitutionally vague, and did not violate patients' or providers' rights to informational privacy. *See Greenville Women's Clinic v. Com'r, S.C. Dep't of Health and Environmental Control*, 2002 U.S. App. LEXIS 19275 (4th Cir. Sept.19, 2002). Plaintiffs intend to again request U.S. Supreme Court review of the case.
South Dakota	Law applies to abortion providers, including private physicians, after the 12th week of pregnancy. Law mandates minimum standards for clinic administration and physical plant. Law requires that all abortions between 12 and 24 weeks of pregnancy be performed in a hospital, or if one is not available, in a licensed physician's medical clinic or office.	S.D. CODIFIED LAWS § 34-23A-1, *et seq.* (2001)	Hospitalization requirement was determined to be unconstitutional. *Parenthood of Minnesota and South Dakota v. Barnett*, (D.S.D. , Aug. 14, 2002). On September 12, 2002, State requested that the court reconsider its rulings or, in the alternative, dismiss the case.
Tennessee	Law defines any facility used to terminate a pregnancy as an "ambulatory surgical treatment center." Law imposed facility-specific administrative requirements. Law applies to abortion providers, including private physicians, at all stages of pregnancy. A separate statute requires that all second trimester abortions be performed in a hospital. *Exemptions*: Physicians' offices that do not perform a "substantial number" of abortions.	TENN. CODE ANN. § 68-11-201, *et seq* (2001) TENN. CODE ANN. § 39-15-201, *et seq* (2001) (second trimester hospitalization requirement)	Not enforced. A federal court has permanently enjoined the enforcement of the law against certain providers due to the vagueness of the phrase, "substantial number." *Bristol Reg'l Women's Ctr., P.C. v. Tenn. Dep't of Health*, No. 3:99-0465 (D. Tenn. Oct. 22, 2001). However, the court, in dicta, found that the regulations did not create an "undue burden" on the abortion right. Although the law remains on the books, the Tennessee Attorney General has concluded that the administrative requirements imposed solely on abortion facilities are unconstitutional and unenforceable. *See* Tenn. Op. Att'y Gen. No. 89-123 (Sept. 26, 1989). The Tennessee Supreme Court has struck down the second trimester hospitalization requirement as unconstitutional under the state constitution. *Planned Parenthood of Middle Tennessee v. Sundquist*, 38 S.W.3d 1 (Tenn. 2000).

State	Definitions, Requirements and Exemptions	Citation	Enforcement Status
Texas	Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, professional qualifications and physical plant. *Exemptions*: Private physicians who perform fewer than 300 abortions per year.	TEX. HEALTH & SAFETY CODE ANN. §§ 245.001, *et seq.* (2000) 25 TEX. ADMIN. CODE §§ 139.1-139.60 (2000)	In effect; 1999 amendments enjoined pending outcome of litigation. Law was upheld as constitutional, surviving challenges claiming it was an "undue burden," violated equal protection guarantees and was, in its entirety, unconstitutionally vague. *Women's Med. Ctr. of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001). Discrete provisions of the law were found to be unconstitutionally vague and can be "severed." Case has been remanded to the federal district court in Houston where the State has moved for summary judgment.
Utah	Law applies to abortion providers, including private physicians, during the second trimester of pregnancy. Law mandates minimum requirements for clinic administration, professional qualifications, patient and employee testing and physical plant. A separate statute requires that all second trimester abortions be performed in a hospital.	UTAH CODE ANN. §§ 26-21-1, *et seq.*: 76-7-313 (2001) UTAH ADMIN. CODE R432-600 (2001) UTAH CODE ANN. § 76-7-302 (2001) (second trimester hospitalization requirement)	In effect. A strict second trimester hospitalization requirement has been found unconstitutional. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 461 (1983).
Vermont	No law		
Virginia	Law applies to abortion providers, including private physicians, after the first trimester of pregnancy. Law requires that all second trimester abortions be performed in a licensed general hospital or outpatient hospital.	VA. CODE ANN. § 18.2-73 (2001) 12 VA. ADMIN. CODE §§ 5-410-10, 5-410-1260 (2001)	In effect. The U.S. Supreme Court upheld the constitutionality of the law, finding it to be reasonably related to the state's compelling interest in protecting maternal health. *Simopoulos v. Virginia*, 462 U.S. 506 (1983). The court distinguished this law from an unconstitutional "strict" second trimester hospitalization requirement because it allowed for an "outpatient hospital" as an alternative to a general hospital.
Washington	No law		
West Virginia	No law		
Wisconsin	Law applies to abortion providers, including private physicians, at all stages of pregnancy. Law mandates minimum standards for clinic administration, professional qualifications, patient testing and physical plant. Law also requires that all abortions after the first trimester be performed in a hospital.	WIS. STAT. ANN. § 69.186 (2001) WIS. ADMIN. CODE § 11.01, *et seq.* (2001)	In effect, except for second trimester hospitalization requirement. A federal district court held that the second trimester hospitalization requirement is unconstitutional and unenforceable. *Christensen v. Wisconsin Medical Board*, 551 F.Supp. 565 (W.D. Wis. 1982). However, the provision remains on the books.
Wyoming	No law		

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February 20, 2003

TESTIMONY IN SUPPORT OF HB 2176

Chairman Bill Mason
House Federal and State Affairs Committee

Mister 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 2176, which would, if enacted, implement minimum health and safety standards for abortion clinics that operate in Kansas.

HB 2176 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. This bill would go a long way to protect women from receiving substandard care at abortion clinics. It will protect Kansas women's lives by mandating that abortion providers meet minimum health and safety requirements.

When drafting this bill last year, the regulations that were used came directly from clinic regulations used by the abortion industry itself. They were modeled after standards and protocols developed by the National Abortion Federation, the Planned Parenthood Federation of America, and Planned Parenthood of Central and Northern Arizona. A copy of this information was made available to members of the committee last year and included: "2000 Clinical Policy Guidelines" from the National Abortion Federation; "Manual of Medical Standards and Guidelines" from Planned Parenthood Federation of America, Inc.; and "Condensed Abortion Protocol" from Planned Parenthood of Central and Northern Arizona.

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." I challenge the validity of that argument and I am aware that another conferee has or will provide factual information to this committee in that regard. Abortion is not as safe as is so often claimed.

Finally, as I mentioned in my testimony last year, a comparison between HB 2176 and the current standards being enforced for Kansas veterinary clinics would show that even the veterinary clinic standards are much more restrictive than those that would be implemented by the passage of this bill. Surely everyone would agree that we value the health and safety of women more than that of our dogs and cats.

A minimum set of standards has to be better than no standards at all. Please vote YES on HB 2176. The women of Kansas deserve no less.

Testimony of Denise M. Burke, Esq.
Before the House Committee on Federal and State Affairs
On House Bill 2176 – Proposed Abortion Clinic Regulations
February 20, 2003

CHAIRMAN MASON AND MEMBERS OF THE COMMITTEE:

I am Denise M. Burke, staff counsel with Americans United for Life (AUL), a national public interest law firm with a practice in bioethics law. I have extensive experience in constitutional law and abortion jurisprudence including the constitutionality of laws regulating abortion clinics. In the area of abortion clinic regulation, my experience has included legislative work, litigation, and the publication of articles on clinic regulation. Since 2000, I worked with numerous states on proposed abortion clinic regulation bills. I have consulted with legislators, participated in the drafting of bills, provided committee testimony, and served as a media spokesperson. Moreover, I have been appointed as a Special Deputy Maricopa County (Phoenix, Arizona) Attorney and have successfully defended Arizona's abortion clinic regulations against constitutional challenges.

I have thoroughly reviewed House Bill 2176 (HB 2176), relating to the proposed regulation of abortion clinics in the State of Kansas, and am testifying in this proceeding as an expert in constitutional law and as an expert on laws regulating abortion clinics. I appreciate this opportunity to testify as to the constitutionality of HB 2176 and the vital importance of abortion clinic regulations.

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 HB 2176 is substantially constitutional and is consistent with existing legal requirements and constitutional precedents. As I will discuss later in my testimony, I believe that subsection O needs to be amended to come into compliance with existing constitutional precedents.

HB 2176 substantially complies with existing laws regulating abortion clinics in Arizona, South Carolina, and Texas. These laws have repeatedly been upheld as constitutional, withstanding multiple legal challenges. HB 2176 also substantially mirrors Louisiana's law regulating abortion clinics that was passed in 2001 and will be implemented later this year.

Furthermore, HB 2176 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.

To assist you in evaluating HB 2176, I am providing specific testimony on (1) the constitutionality of abortion clinic regulations and the status of current litigation; (2) the prevalence of abortion clinic regulation in other states; (3) the national abortion care standards and protocols that form the basis of HB 2176 and other similar la
substandard care that generally supports the need for abortion clinic r

attempt to answer common objections to or misunderstandings of laws regulating abortion clinics and suggest amendments to subsection O to cure potential constitutional infirmities.

CONSTITUTIONALITY OF ABORTION CLINIC REGULATIONS AND THE STATUS OF CURRENT LITIGATION:

The clear purpose of HB 2176 and the proposed abortion clinic regulations are to ensure that women have access to ***safe*** abortions. The U.S. Supreme Court has repeatedly recognized that maternal health is a legitimate interest to support regulations regarding abortion. *See e.g. Roe v. Wade*, 410 U.S. 113, 150 (1973) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 875-76 (1992).

Abortion is an invasive, surgical procedure that can lead to numerous and serious medical complications. These complications include, among others, bleeding, infection, uterine perforation, blood clots, cervical tears, incomplete abortion ("retained products"), adverse reactions to anesthesia, fertility problems, emotional problems and death. The risks for second trimester abortions are even greater than those for first trimester abortions. The possibility of hemorrhage, in particular, increases with later-term abortions. The treatment for complications in connection with a second trimester abortion is more radical including hysterectomy, other reparative surgery, or blood transfusions.[1]

Moreover, because there are no uniform, state collection requirements for data on abortion complications, the actual risk of medical complications in connection with abortion are impossible to accurately quantify. As the author of a leading abortion textbook writes, "[T]here are few surgical procedures given so little attention and so underrated in its potential hazard as abortion."[2]

Recently, comprehensive abortion clinic regulations from Arizona, South Carolina, and Texas have been substantially and repeatedly upheld by federal courts. *See Tucson Woman's Clinic v. Eden*, No. CIV 00-141-TUC-RCC (D. Ariz. Oct. 1, 2002); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000) (*"Greenville I"*); *Greenville Women's Clinic v. Com'r, S.C. Dep't of Health and Environmental Control*, 2002 U.S. App. LEXIS 19275 (4th Cir. Sept.19, 2002) (*"Greenville II"*); and *Women's Medical Center of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001). In the case of the South Carolina law which is more detailed and, arguably, more onerous than that proposed in HB 2176, the regulations were twice upheld by the Fourth Circuit Court of Appeals and, significantly, the U.S. Supreme Court has refused to review the case.

HB 2176 is in substantial compliance with the regulations upheld in each of these three cases. Moreover, the proposed regulations are nearly identical to those substantially upheld in *Tucson Woman's Clinic v. Eden* (the Arizona case).

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[1] Information on abortion complications is drawn from depositions, responses to interrogatories, and other discovery in *Tucson Woman's Clinic v. Eden*, No. CIV 00-141-TUC-RCC (D. Ariz. Oct. 1, 2002).

[2] Warren M. Hern, *Abortion Practice* 101 (1990).

PREVALENCE OF ABORTION CLINIC REGULATION IN OTHER STATES:

It is important to note that a majority of states have laws regulating the provision of abortions. Currently, 35 states have laws on the books that regulate – to varying degrees - the facilities that provide abortions or that require that certain abortions be performed in hospitals or ambulatory surgical centers. Obviously, when a law requires that certain abortions be performed in specific types of facilities, the provision of (only) those abortions are subject to the regulatory standards applicable to those types of facilities (hospitals or ambulatory surgical centers).

Twenty-four states[3] have enacted laws regulating the provision of abortions at any stage of pregnancy. The scope of and specific requirements contained in these regulations vary widely. For example, Alabama, Arizona, Arkansas, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, South Carolina, Texas, and Utah, among others, have enacted comprehensive abortion clinic regulations providing minimum health and safety standards in areas such as staffing, post-operative care, clinic administration, sanitation, equipment (including equipment for medical emergencies), and physical plant. Meanwhile, a few states, such as Florida and Georgia, have imposed only minimal administrative requirements on abortion clinics. Currently, twenty-two of these laws are enforced or are enforceable (having been declared constitutional or never having been legally challenged). Despite the fact that they remain on the books, the abortion clinic regulations in Alaska and Tennessee are not currently enforced.[4]

Ten states[5] have enacted laws that require that later-term abortions (typically, after 12 weeks of pregnancy or more) be performed in ambulatory surgical centers or hospitals. Most of these laws have been declared unconstitutional or are not enforced by virtue of a deliberate decision by state officials. However, these laws remain on the books.[6] Conversely, four of these laws – those in Indiana, Minnesota, New Jersey and Virginia – are currently enforceable. Importantly, the U.S. Supreme Court upheld Virginia's law requiring that second-trimester abortions be performed in hospital or ambulatory surgical centers in 1983.[7]

Finally, Hawaii's law requiring that all abortions be performed in hospitals is not enforced per an opinion by the Hawaii Attorney General issued in 1974.[8]

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[3] States which regulate (to some degree) the provision of all abortions are Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, and Wisconsin.

[4] Alaska's law is not enforced per a 1981 opinion by the Alaska Attorney General. *See* Alaska Op. Att'y Gen. No. J-66-816-81 (Oct. 7, 1981). Similarly, Tennessee's law is not enforced per a 1989 opinion by the Tennessee Attorney General. *See* Tenn. Op. Att'y Gen. No. 89-123 (Sept. 26, 1989). However, a federal district court has determined that the Tennessee regulations were unenforceable ***only as to abortion certain abortion providers***. In making this determination, the court rejected claims by abortion providers that the regulations were unduly burdensome. *See Bristol Reg'l Women's Ctr., P.C. v. Tenn. Dep't of Health*, No. 3:99-0465 (D. Tenn. Oct. 22, 2001).

[5] States, which regulate (to some degree) the provision of later-term abortions, are Idaho, Indiana, Massachusetts, Minnesota, New Jersey, New York, North Dakota, Ohio, South Dakota, and Virginia.

[6] Those that have been declared unconstitutional or are not currently enforced are Idaho, Massachusetts, New York, North Dakota, Ohio, and South Dakota.

[7] *Simopoulos v. Virginia*, 462 U.S. 506 (1983).

[8] Haw. Op. Att'y Gen. No. 74-17 (Oct. 10, 1974).

Information regarding existing state regulation of abortion clinics is further summarized and discussed in the legislative packets that you have been provided. These packets contain a chart with citations to current state laws and a brief description of the scope and enforceability of specific, state abortion clinic regulations.

SOURCE OF REGULATORY STANDARDS FOR ABORTION CLINICS:

The regulatory standards embodied in HB 2176 and in other states' abortion clinic regulations, including those enacted in Arizona, Louisiana, South Carolina, and Texas, are derived, in substantial part, from standards and protocols promulgated by abortion providers and abortion advocacy groups. The legislative packets that you have been provided contain a "condensed protocol" from a Planned Parenthood affiliate, Planned Parenthood of Central and Northern Arizona (PPCNA). The standards contained in this condensed protocol are, in turn, drawn from standard operating protocols used and endorsed by the Planned Parenthood Federation of America. Moreover, they also reflect the character and scope of operating guidelines endorsed by the National Abortion Federation (NAF).

A careful comparison of the condensed protocol and HB 2176 reveals significant similarities. In fact, HB 2176 carefully tracks and incorporates the requirements for abortion care summarized in the PPCNA "condensed protocol." The abortion clinic regulations from Arizona, Louisiana, Texas and South Carolina also track and incorporate similar standards.

The use of national abortion care standards and protocols in drafting Kansas's proposed abortion clinic regulations is significant. In upholding South Carolina's abortion clinic regulations, the Fourth Circuit Court of Appeals noted, with approval, that the regulations were "little more than a codification of national medical- and abortion-association recommendations designed to ensure the health and appropriate care of women seeking abortions." *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000). The same rationale and support exists for Kansas's proposed regulations.

EVIDENCE OF SUBSTANDARD CARE AT ABORTION CLINICS:

During the course of this hearing, you have been provided with testimony and evidence of substandard care that Kansas women have received at abortion clinics. Unfortunately, this evidence only "scratches the surface." There is ample evidence to establish that women in Kansas and elsewhere – all too often – receive substandard care at the nation's abortion clinics. In support of this assertion, I am providing eight "case studies" that describe actual events at abortion clinics in several other states over the past 10 years. This is by no means an exhaustive list of incidents, emergencies, or deaths that have occurred at the nation's abortion clinics. Sadly, these events are representative of the type of care that some women receive at abortion clinics:

Arizona: In April 1998, Lou Anne Herron, a 32 year-old mother with two children, bled to death from a two-inch laceration in her uterus. Her uterus was lacerated during a late-term abortion. Ms. Herron was approximately 26 weeks pregnant at the time of the abortion, two weeks over

the legal limit for an abortion in Arizona. Prior to the abortion, multiple ultrasounds were done and manipulated to make it appear that Ms. Herron was less than 24 weeks pregnant.

After the abortion, as she lay in what medical assistants described as a "pool" of blood that soaked the bedding and ran down her legs, Ms. Herron was heard crying for help and asking what was wrong with her. While this was going on, her abortion provider, John Biskind, was eating lunch in the break room, refusing requests to check her condition. He later left Ms. Herron bleeding and unconscious to visit his tailor and callously refused to return to the clinic when paged and told of Ms. Herron's deteriorating condition. Ms. Herron died after hemorrhaging for nearly three hours. Sadly, a hospital emergency room was less than 5 minutes down the street.[9]

In February 2001, John Biskind was convicted of manslaughter in Ms. Herron's death and is currently serving a five-year prison sentence. Ms. Herron was not the first abortion patient to die under Biskind's care. In 1996, another woman died when Biskind punctured her uterus during an abortion.

Ms. Herron's tragic and preventable death galvanized bipartisan support for regulating Arizona's abortion clinics. Arizona's abortion clinic regulations were signed into law in 1999 and were substantially upheld as constitutional by a federal district court in October 2002.[10] Arizona's abortion clinic regulations have come to be known as "Lou Anne's Law" and served as a model for Louisiana's abortion clinic regulations that were enacted in 2001. Significantly, Arizona's law also served as a model for HB 2176 and for bills being considered in other states during this legislative session.

California: In 1997, abortion provider Bruce Steir punctured Sharon Hamptlon's uterus during a second-trimester abortion and left her—while she was unstable and vomiting blood—in order to catch a flight to San Francisco, according to Riverside County prosecutors. Ms. Hamptlon later died, and Steir was charged with second-degree murder, in large part, for failing to provide even rudimentary post-operative care. Steir eventually pled guilty to the lesser offense of involuntary manslaughter and was sentenced to six months in jail, ultimately serving less than four months of his sentence.[11]

Louisiana: In 1999, an undercover news team entered a Baton Rouge abortion clinic and videotaped rusty surgical instruments and blood-spattered surgical tables and floors, prompting

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[9] Phoenix Police Department Report, dated July 15, 1998; testimony of Dr. John I. Biskind, *State v. Biskind*, No.CR99-00198 (Ariz. Superior Ct), dated February 13, 2001.

[10] Arizona's abortion clinic regulations are currently on appeal before the U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit"). In substantially upholding these regulations against multiple constitutional challenges, the district court determined that four specific provisions (out of more than one hundred specific rules and definitions) of the regulations and one subsection of the enabling legislation were unconstitutional. These rulings are being appealed and a judgment from the Ninth Circuit is not expected until 2004. However, it is important to note that provisions similar to those struck down by the district court in Arizona are contained in the South Carolina and Texas abortion clinic regulations and that these provisions were upheld as constitutional.

[11] Burke, "Courts Provide Hope in Fight for Life," *American Feminist*, Winter 2003.

Governor Mike Foster to issue an Executive Order declaring a public health emergency[12] and, later in 2001, to sign Louisiana's abortion clinic regulations into law.

Nebraska: In December 2002, the *Omaha World-Herald* reported that several Planned Parenthood abortion clinics in Nebraska were placed on probation after surprise inspections by the Nebraska Health and Human Services System turned up serious health violations, including evidence that patient gowns and bed linens were not properly sanitized, that the clinics allowed staff to give injections and medications without proper training, and that the clinics lacked a program for preventing, controlling, and investigating infections and communicable diseases.[13]

New York: In 2000, a Long Island City, New York abortion clinic was ordered to cease all operating room procedures for three weeks after State Health Department investigators found "serious systemic problems that pose a significant risk to vulnerable women." Their findings included hasty abortions (one every five minutes), inadequate nursing staff, faulty equipment, and inadequate employee screening.[14]

South Carolina: In 1994, several women testified before the General Assembly of the South Carolina legislature that, when they walked into some of the state's abortion clinics, they encountered bloody, unwashed sheets, bloody cots in recovery rooms, and dirty bathrooms. Clinic workers testified that the remains of unborn children were not disposed of properly, but rather rinsed down sinks.[15] This compelling testimony contributed to the passage of South Carolina's abortion clinic regulations. As I have previously indicated, these regulations have been upheld – twice – by the Fourth Circuit Court of Appeals.

Texas: During investigations by police and state health officials, witnesses disclosed that abortion clinic personnel without medical licenses or any formal medical training were performing abortions.[16]

Virginia: On November 16, 2002, a 26 year-old woman died at an Alexandria abortion clinic. The Alexandria Police Department is investigating the death.[17]

Abortion clinic regulations, such as HB 2176, are designed to prevent these or similar tragedies and to ensure that women are receiving quality care at abortion clinics.

ANSWERS TO COMMON OBJECTIONS:

Opponents of abortion clinic regulations typically raise the following complaints and I would like to take this opportunity to respond briefly and directly to the substance of those complaints:

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[12] *News*, WAFB, Baton Rouge, Louisiana (February 4, 1999); Executive Order MJF 99-5, *Declaration of Public Health and Safety Emergency*, dated February 5, 1999.
[13] Report, *Pro-Life Infonet*, (www.prolifeinfonet.com), January 23, 2002.
[14] Gallagher, "Women Deserve the Facts on Abortion," *Newsday* (Long Island, NY newspaper), January 17, 2003.
[15] Dial, "Abortion: A Dirty Industry," *Citizen Magazine* (July 2001).
[16] *Id.*
[17] Press Release, Alexandria Police Department, dated November 16, 2002.

(1) The regulations unfairly single out abortion providers for regulation.

Federal courts have repeatedly held that abortion is "rationally distinct from other routine medical services." *See e.g. Greenville Women's Clinic v. Bryant*, 222 F.3d at 172-75 and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. at 852. Therefore, the State of Kansas may chose to regulate abortion while leaving other types of medical or surgical procedures unregulated. As the Fourth Circuit noted in *Greenville Women's Clinic v. Bryant*, "In adopting an array of regulations that treat the relatively simple medical procedures of abortion more seriously than other medical procedures, [the State] recognizes the importance of abortion practice while yet permitting it to continue, as protected by the Supreme Court's cases on the subject." *Greenville Women's Clinic v. Bryant*, 222 F.3d at 175.

(2) Abortion providers are already licensed by the State and are regulated under OSHA, CLIA, and other federal and state regulations. Thus, there is no need for specific abortion clinic regulations.

Simply, this is not a legitimate legal argument against the necessity for or appropriateness of abortion clinic regulations. These exact same arguments have been made to and were summarily rejected by three federal courts. *See Tucson Woman's Clinic v. Eden*, No. CIV 00-141-TUC-RCC (D. Ariz. Oct. 1, 2002); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000) ("*Greenville I*"); and *Women's Medical Center of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001). Moreover, abortion clinic regulations, like HB 2176, are designed to specifically address and meet the needs of abortion patients. Neither OSHA standards, CLIA standards, state licensing standards, nor any other federal or state regulations are designed to meet the specific medical needs of women undergoing abortions.

(3) The regulations will create an undue burden on women seeking abortion.

Federal courts have also summarily and repeatedly rejected such arguments. In litigation surrounding abortion clinic regulations enacted in Arizona, South Carolina, Tennessee, and Texas, four different federal courts heard, analyzed, and rejected similar claims. *See Tucson Woman's Clinic v. Eden*, No. CIV 00-141-TUC-RCC (D. Ariz. Oct. 1, 2002); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000) ("*Greenville I*"); *Bristol Reg'l Women's Ctr., P.C. v. Tenn. Dep't of Health*, No. 3:99-0465 (D. Tenn. Oct. 22, 2001); and *Women's Medical Center of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001).

(4) The regulations will increase the costs of abortions and/or drive some providers out of business.

Once again, similar complaints have been heard, analyzed, and rejected by federal courts that have recently decided constitutional challenges to abortion clinic regulations. *See Tucson Woman's Clinic v. Eden*, No. CIV 00-141-TUC-RCC (D. Ariz. Oct. 1, 2002); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000) (*"Greenville I"*); and *Women's Medical Center of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001).

The "abortion right" is the right of the "woman herself – not her husband, her parent, her doctor or others – to make the decision to have an abortion." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S at 877. It is not the "right" of the woman to pay a certain price for an abortion or the "right" of abortion providers to remain in practice or to have a financially lucrative practice.

Further, in evaluating challenges to abortion clinic regulations, federal courts have repeatedly determined that the simple fact that the regulations may inconvenience some abortion providers and/or may result in an expenditure of time and money to come into compliance with the regulations does not create a burden on the ***woman seeking an abortion*** and, therefore, do not invalidate such regulations.

Finally, even assuming that the proposed regulations would raise the costs of abortions and/or result in fewer providers (and we have no evidence that this will actually occur in Kansas should these regulations be enacted), the U.S. Supreme Court has held that "[t]he fact that a law which serves a valid purpose, one not designed to strike at the [abortion] right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S at 874. HB 2176 serves a legitimate purpose, the protection and preservation of maternal health; therefore, these arguments once again fail.

(5) The regulations are purposely designed to make it difficult for abortion providers to obtain a license.

Given that the regulations are based on national abortion care standards endorsed by groups such as Planned Parenthood and NAF, this argument is puzzling at best. Presumably, many abortion providers in Kansas are Planned Parenthood affiliates, members of NAF, or are aware of and/or subscribe to the standards promulgated and endorsed by these organizations. Seemingly, it would be safe to assume that abortion providers in Kansas who are concerned about women's health and are interested in providing the best quality care to their patients would already be complying with, if not exceeding, the ***minimum*** standards required under HB 2176. Thus, if they are already providing quality care consistent with nationally accepted standards and protocols, they should have no problem

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complying with the proposed regulations, passing the mandated inspections, and obtaining a license.

I hope that I have adequately responded to these common objections. If other complaints or objections are raised during this committee hearing or should you require additional information, I would be happy to respond.

RECOMMENDATION FOR CHANGE OR AMENDMENT:

Finally, I suggest that subsection O, regarding the availability of risk management and other types of reports as "open records" be deleted or amended. In light of existing legal precedent, I do not believe that the provision adequately provides protection for many types of patient information, including patient identifying information and information from patient medical records.

Subsection J of HB 2176 provides that "the department of health and the environment shall not release personally identifiable patient or physician information." However, subsection O appears to contradict this requirement to maintain confidentiality. Subsection O states that "records of abortion clinics" shall constitute "open records" which means they would be available, in part or in whole, to the public. However, there is no definition of what is meant by "records of abortion clinics" in either subsection O or in the definition section of HB 2176, subsection A. As written, subsection O could be construed to mean that patient medical information, excerpts from patient medical records, patient identifying information, provider identifying information, or any other information obtain from abortion clinics would be available to the public as an "open record" and would not, therefore, be kept confidential as required in subsection J. This contradiction must be remedied – subsection O can easily be deleted or amended.

You can delete the provision without compromising the aim of the bill - to protect women's health and to ensure that Kansas women are not receiving substandard care at state abortion clinics. Alternatively, you could amend subsection O to specify what types of reports and/or "records of abortion clinics" would be available to the public as "open records." You should also specifically provide (again) that patient medical and identifying information will not, under any circumstances or in any form, be made available to the public and will always be treated as confidential by the Department of Health and the Environment. I do not believe that the provision as written adequately or specifically protects patient medical or identifying information. As written, the provision only appears to attempt to protect a patient's identity in some fashion, but it does not do so appropriately or adequately. **Failure to cure this discrepancy could result in the law – in part or in its entirety - being struck down as unconstitutional and in violation of patients' constitutional, informational privacy rights.**

I would be happy to review any amendments to subsection O and help to ensure that it is constitutionally adequate and appropriate.

CONCLUSION:

HB 2176 is substantially constitutional under existing legal precedents. There is one minor problem (with subsection O) that can be easily remedied. Further, HB 2176 substantially complies with laws regulating abortion clinics in Arizona, South Carolina, and Texas – laws that have withstood repeated legal challenges. It embodies national abortion care standards, furthers the State of Kansas's legitimate interest in "preserving and protecting the health"[18] of women, and prescribes medically appropriate, minimum standards for abortion clinics. Thank you for the opportunity to testify as to the constitutionality of HB 2176 and the general need for abortion clinic regulation.

[18] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. at 875-76.

Beverly LaHaye
Chairman

Judy Smith
State Director

Mr. Chairman and Committee members:

Abortion: safe but rare. This statement reflects wishful thinking on the part of policy-makers and abortion proponents. Those who favor abortion rights often use this slogan as a shield to obscure the real facts. The facts are that women continue to die and suffer complications from abortions. Abortion is a surgical procedure that carries risks of perforating the uterus, infection, hemorrhage and other complications. The opportunity lies before you to do something about half of the slogan…to make abortion safer…to require the abortion industry to give credence to their motto by submitting to the same regulations as all other surgical care centers.

The legitimate function of government is to protect the health and safety of its citizens and that duty is being thwarted by a mentality that says *any regulation* of the abortion industry is tantamount to harassment; that abortion clinics are accurately self-reporting statistics about injuries and complications in the abortion procedures performed; and that the performance of abortions is sacrosanct and above regulation. The abortion industry made its case thirty-some years ago by claiming that "women were dying in back-alley abortions." Women are still dying, being rendered sterile and suffering complications from abortions **now**. Because of a deficiency of reporting requirements, abortion deaths and complications are often not reported as such. In addition to the industry's "immunity" from proper reporting, abortion complications are often under-reported because of lack of follow-up care; shame or anxiety on the part of the woman that someone will find out about her abortion. Millions of dollars flow through abortion clinics across this country; yet states are reluctant to regulate clinics because they are uniquely insulated by the abortion industry's claim to the so-called Constitutional "right to choose." Yet the Supreme Court has never put abortion clinics or providers outside of the State's "legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child." [*Planned Parenthood v Casey, 505 U.S. 833, 852 (1992) at 846]* Another Court opinion, *Greenville Women's Clinic v. Bryant* illustrates that the Constitution does permit health and safety regulation of abortion clinics and services. [*Greenville Women's Clinic,* 222 F.3d 157 (4th Cir. 08/15/000), *cert. den'd Feb 26, 2001]* The regulations in question were to promote proper sanitation, housekeeping, maintenance, staff qualifications, emergency equipment and procedures to provide emergency care, medical records and reports, laboratory, procedure and recovery rooms, physical plant, quality assurance, infection control and information on and access to patient follow-up care necessary to keep women safer. To the ordinary person, these requirements seem like a no-brainer in light of the intense scrutiny given veterinarian clinics, beauty parlors, barbers and nail technicians. Most reasonable people see that a medical procedure such as abortion should be regulated and under scrutiny by the state to protect the health and safety of women, rather than trusting the industry to regulate itself. The South Carolina regulations largely codify accepted standards by the medical community. Even physicians challenging this law noted the regulations support appropriate standards of medical care.

As a women's organization, we ask you to protect those women who choose abortion by requiring that abortion clinics follow safe medical practices; accurate and complete reporting; and proper protocol for ensuring emergency care should a serious complication arise.

Women deserve better than the words of a cleverly devised slogan. Women deserve to be protected.

CONCERNED WOMEN FOR AME
OF KANSAS

P.O. Box 11233 • Shawnee Mission, KS 66207 • Phone/Fax (913) 491-1380 • Email: jud

HB 2176 Objections 20February2003, 1:30pm, Room 31[illegible]uth

Mark Pederson, Manager, Aid For Women, Kansas City, KS, 800-626-9184, National Abortion Federation member

House Bill 2176 (HB 2819 in 2002) is not protective legislation; it is another installment of whittling away womens' access to abortion, 'legal yet inaccessible' per proLife statements[1]. This bill's proponents cite numerous problems associated with abortion clinics and they are wrong. This is a non-issue. The proponents are the same ones who forced an 8-hour wait, then a 24-hour wait, and banned abortions in state-funded hospitals. Since religious hospitals will not do abortions either, abortions have been relegated to small private clinics and doctor's offices. Last year I incorrectly quoted "...only three abortion-related deaths in Kansas in 21 years, so abortions have been and still are safer than any other surgical procedure," but I have been corrected by further information. There were 4 'deaths due to Pregnancy with Abortive Outcomes' since 1980 per KDHE statistics: they were ectopic-pregnancy-related deaths, not abortion-related[2]. Therefore one Kansas abortion death in 1988[3] out of 314,000 Kansas abortions in 31 years[4]. The proposed regulations would not have prevented that one 1988 death (patient ate before anesthesia). As far as other problems with abortion doctors, this proposed bill won't fix them, and proponents of HB 2176 fail to acknowlege the many failures by non-abortion providing doctors in Kansas that still will not be fixed by this bill. For example, there were 106 non-abortion-related deaths from 1990-2001 due to 'Misadventures to Patients During Surgical and Medical Care' in Kansas[5]. Do we not care about those deaths?

With regards to a claim by bill proponents that abortion providers are causing a disproportionate amount of discplinary actions with the Board of Healing Arts[6], just review BOHA's Negative Disciplinary Actions (NDA's) on the backpage, which include Final Actions, of non-abortion providers versus abortion providers: non-abortion providers account for 98% of all BOHA actions[7]. HB2176(c)(4) requires chaperones for the patient. After looking at 33 sexual misconduct NDA's by non-abortion providers versus the zero of abortion providers[7], this highlights HB2176's misplaced concerns. Chaperones should be required by BOHA for all intimate exams of any gender, but an LPN or RN ("...licensed nurse...") level of education shouldn't be required.

From our perspective, what are abortion providers doing right? Abortions done in a doctor's office are a good medical resource allocation. Very few abortions need the total resources of a hospital. Clinic doctors screen patients for suitability to exclude high-risk health problems that truly require the support of an ambulatory setting and will refer them to same. From 1971 to 2001 Kansas clinics and doctor's offices have helped 314,000 women with this affordable, accessible healthcare.

Nearly identical to an abortion, a simple dilation and curettage (D&C) after a miscarriage is often done in OB/GYN offices. An abortion is a simple 15 minute procedure done under either local anesthesia or conscious sedation if desired, done more often than many other office procedures and is well suited for a modern doctor's office. The American College of Gynecologists (ACOG), the National Abortion Federation (NAF), and the Planned Parenthood Federation of America (PPFA) object to such regulations. The fact that NAF and PPFA guidelines were borrowed in-part and used out-of-context to formulate this bill is insulting to those groups, and aggravated by the impression that proponents foster of our acceptance.

Also, there are no checks and balances on the appointed regulators, and no abortion provider peer-review in this bill. Other states' abortion clinics fought regulations requiring a morgue (!), Neonatal Intensive Care Unit on-site(!), air-exchange requirements, air-pollutant particle-size limitations, door and hallway height and width requirements, yard cleanliness, and in-house blood banking(!). Here, the lack of 'adequate lighting and ventilation', HB2176(b)(6), has not been associated with any abortion deaths that I know and what professional building doesn't have heating, cooling, and lights? And why does a non-surgical mifepristone abortion require this kind of attention? HB2176 is resplendent with these gaffs.

We currently provide a wide range of medical services in our general practice office which also serves Medicaid and Medicare patients. Yet to subject our clinic to more regulation than other office-based surgery is both unnecessary regulation, indifference to other surgical injuries, and treading close to UnEqual Protection.

The goal of patient protection is good, but this legislation does not provide that. If reasonable regulations can be formulated it should come from a Kansas BOHA regulation and applied to all physicians, e.g. Kansas Medical Society's "Guidelines for Office-Based Surgery and Special Procedures, 2002".

I thank you for your time.

Hs Federal & State Affairs
Date: 2-20-03
Attachment # 9
Page 1

-Why are women coming to abortion clinics instead of hospitals to get abortions? **Lower cost & better service.**
-Why are state-funded hospitals banned from providing abortions? **To make abortions safer ?!**
-Why do abortion clinic patients hide health factors that would require an in-hospital abortion? **Cost.**
-Why does a simple D&C at a hospital cost five times more than a similar procedure at an abortion clinic?
Better resource allocation at private doctor's office.
-Why is full-term delivery, 9-14 times more dangerous than abortion, allowed at homes?
Good question. Abortion is much safer than childbirth[8,9] and does not need more regulations.
-Why do abortion patients know so little about contraception? **Lack of sex education.**

Kansas Board of Healing Arts Negative Disciplinary Actions (BOHA NDA's: includes Final Orders and Stipulations; Reasons: Standard of Care, Unprofessional Conduct, Sexual Misconduct, Violation of Pharmacy Act, Prescribing Practices, Alcohol and/or Drugs, Professional Incompetency, Disciplinary Action in other States, and Fraud)[7]

1994 37 NDA's, 9 of a sexual nature, none abortion-related: Brooks, Davis, Forshee, Henderson, Hogan, Lado, Nash, Patel, Williams (application denied). Abortion provider Zaremski received short-term suspension for poor record keeping with a General Practice patient who happened to be an abortion provider. Abortion provider Knarr suspended for Unprofessional Conduct.

1995 24 NDA's, 2 of a sexual nature, none abortion-related: Cabrera, Nance.

1996 34 NDA's, 6 of a sexual nature, none abortion-related: Grote, Lester, Masferrer, Matney, Samson, Syring. Abortion provider Miller reprimanded and fined for pre-signing pain medication scripts.

1997 32 NDA's, 5 of a sexual nature, none abortion-related: Oehlecker, Parra, Chow, Rhoads, Lester.

1998 30 NDA's, 3 of a sexual nature, none abortion-related: Wilson, Schroff, Smith.

1999 25 NDA's, 3 of a sexual nature, none abortion-related: Lortz, Reese, Ricke.

2000 27 NDA's, 5 of a sexual nature, none abortion related: Howell, Maloney, O'Bryant, Schlossman, Stevens. Abortion provider Rajanna fined for incorrectly packaging free antibiotics for abortion patients.

209 BOHA reprimands in 7 years. And only 4 abortion-related reprimands despite persistent anti-choice efforts against abortion providers. Not quite the 25% figure that Herrick painted.

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[1] Targeted Regulation of Abortion Providers (TRAP), The Center For Reporductive Law and Policy, New York, NY, May 1999 handout. "For example, anti-abortion extremist Mark Crutcher, founder of Life Dynamics Incorporated, urges that abortion can be made unavailable by regulating it out of business. His goal, he wrote, is to create 'an America where abortion may indeed be perfectly legal but no one can get one.'"

[2] "Deaths Due to Pregnancy with Abortive Outcome, ICD-9 630-639, ICD-10 000-008", Kansas Occurrence Data, Kansas Department of Health and Environment Center for Health and Environmental Statistics, 1990-2001. Also from correspondance with KDHE, "...from 1980 to 1989, two deaths due to 'pregnancy with an abortive outcome' ICD-9 codes 630 - 639 were recorded. Both the deaths, one in 1984 and one in 1983, were due to ectopic pregnanacies." KDHE statistics at KIC downloaded in 2002 show 2 more deaths from 'Pregnancy with Abortive Outcome' in 1992, and 1997, for a total of 4 ectopic-related deaths since 1980.

[3] Kansas Catholic Conference written testimony in support of HB 2819, March 21, 2002, Abortion Malpractice in Kansas* and verified by talking to Dennis Miller, MD. Her death was aspiration of vomit into the lungs during anesthesia. She had eaten prior to surgery contrary to protocols.

[4] "Reported Abortions by Place of Residence Kansas", 1971-2001, KDHE Center for Health and Environmental Statistics, Office of Health Care Information.

[5] "Deaths Due to Misadventures to Patients during Surgical & Medical Care, ICD-9 Codes 870-876", Kansas Occurrence Data, Kansas Department of Health and Environment Center for Health and Environmental Statistics, 1990-2001.

[6] Patrick Herrick, MD, PhD in 2002 written statement about HB2819 same as this year's HB176, "Kansas Board of Healing Arts final board actions over the last 5 years involve over 25% of known abortionists in the state,"

[7] Disciplinary Action Table, 1994-2000, Kansas Board of Healing Arts. Data for 2001 and 2002 not available yet.

[8] 1990 Year Book of Obstetrics and Gynecology, Year Book Medical Publishers, Inc., Chicago, Illinois, c. 1990, p.41 referring to previously published report, "Maternal Mortality in the United States: Report From the Maternal Mortality Collaborative", Rochat RW, Koonin LM, Atrash HK, Jewett JF, Maternal Mortality Collaborative (Centers for Disease Control, Atlanta; Havard Univ) Obstet Gynecol 72:91-97, July 1988.

[9] "Safety of Abortion", Susan Dudley, National Abortion Federation, c. 1996.

Targeted Regulation of Abortion Providers: Avoiding the "TRAP"
by Bonnie Scott Jones, Staff Attorney, Center for Reproductive Law and Policy, New York, NY
October 2001, Item: B022, Phone: 917-637-3600. http://www.crlp.org/pub_art_trap.html

Executive Summary

TRAP stands for Targeted Regulation of Abortion Providers. 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.

Anti-choice legislators and government officials claim they target abortion providers in order to make abortion safer. However, legal abortion is one of the safest surgical procedures in this country. Singling out abortion with discriminatory TRAP measures serves only the anti-choice goal of making abortion prohibitively expensive and increasingly difficult to obtain.

TRAP laws do not fill any alleged "loophole"; instead, they take abortion providers outside of mainstream regulatory schemes and subject them to more burdensome requirements.

* 17 states and Puerto Rico have enforceable TRAP schemes that apply to abortion providers even if they perform abortions only in the first trimester of pregnancy;

* TRAP regulations impose additional levels of government intrusion and oversight for the politically unpopular abortion procedure including:

> permitting state agencies to copy and remove patient records; mandating unique structural and administrative specifications for offices where abortions are performed, such as doorway widths, hourly air exchange rates, and other regulations that are not medically warranted.

* TRAP laws deter physicians from becoming or remaining abortion providers by subjecting them to criminal and civil penalties, exposing them to harassment, and intruding significantly into their practice of medicine, resulting in reduced access for women to abortion services;

*Such regulations significantly raise the cost of providing abortions, thereby increasing abortion prices, which may cause some women to delay or even forego desired abortions;

*TRAP laws may unconstitutionally violate women's right to choose abortion, to informational privacy, and to equal protection of the law;

*TRAP laws may also violate the constitutional rights of abortion providers in three ways: by subjecting them to vague criminal laws, unreasonable searches, and violating their guarantee to equal protection of the law.

I. WHAT ARE TRAP LAWS?

TRAP refers to laws that single out physicians' offices and outpatient clinics in which abortions are performed and subject them to purported health requirements that are not imposed on comparable medical facilities. TRAP laws are different from other abortion specific laws (such as waiting periods and parental involvement requirements) which

attempt to influence the pregnant woman's decision in a purported effort to promote the state's interest in potential life. TRAP laws do not aim to inform the woman's decision or protect potential life; they regulate the medical aspects of the abortion procedure in a purported effort to safeguard the pregnant woman's health. Because TRAP laws address the medical, rather than decisional, aspects of the abortion procedure, they target the aspects of abortion that are just like many other medical procedures.

II. WHICH STATES HAVE TRAP LAWS

Numerous states have TRAP laws on their books. Some of these laws were passed many years ago, while others are part of a recent wave of new TRAP legislation. These TRAP schemes are not all alike; rather, they vary considerably in terms of:

* whether they apply to abortions performed during any stage of pregnancy or only to post-first trimester procedures;
* whether they exempt private medical practices;
* whether they apply to providers of any number of abortions or only to providers who perform more than a certain number of procedures;
* whether they apply to both surgical and medical abortion or just surgical abortions;
* the degree of burdens and governmental oversight they impose.

A. TRAP Laws Applicable to Abortions in Any Trimester

Currently, 17 states and Puerto Rico have enforceable TRAP schemes that apply to abortion providers even if they perform abortions only in the first trimester of pregnancy.[1] Six other states have similar laws on their books, but do not enforce them against first trimester abortion providers because a state attorney general or court has concluded that doing so is unconstitutional.

States with Enforceable Trap Schemes Applicable to Abortions At Any Stage of Gestation Including First Trimester

Alabama	Michigan	Puerto Rico
Arizona*	Mississippi	Rhode Island
Arkansas	Missouri	South Carolina*
Connecticut	Nebraska	Tennessee*
Florida	North Carolina	Texas*
Kentucky	Pennsylvania	Wisconsin

* currently being challenged in court and may be unenforceable pending the result of the lawsuit

States with Unenforceable Trap Schemes Applicable to Abortions At Any Stage of Gestation Including First Trimester

Alaska (pursuant to opinion of attorney general)	Illinois (permanently enjoined by federal courts)
California (pursuant to opinion of attorney general)	Louisiana (permanently enjoined by federal court)
Hawaii (pursuant to opinion of attorney general)	Oklahoma (permanently enjoined by stipulation/order)

Some of these schemes apply to physicians who perform just one abortion, even if their facility is a private physician's office. The enforceable schemes of this nature are those in Kentucky, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, and Wisconsin.[2] In Connecticut, the TRAP scheme exempts physicians' offices no matter how many

abortions are performed in them, but applies to other abortion providers regardless of the number of abortions they perform.[3] In Arkansas and Florida, physicians' offices are exempt unless they are used "primarily" to perform abortion procedures.[4] Tennessee exempts physicians' offices if they perform less than a "substantial" number of abortions per year.[5] Texas exempts physicians' offices from application of its TRAP scheme, but only if less than 300 abortions per year are performed in those offices.[6] The TRAP laws in Alabama, Arizona, Michigan, Mississippi, Missouri, and Nebraska do not exempt physicians offices, but only apply to facilities in which more than a certain number of abortions are performed.[7]

B. TRAP Laws Applicable to Abortions in Second Trimester

In addition, 15 states have enforceable TRAP schemes that are applicable to abortion providers who perform abortions in the second trimester.[8]

States with Enforceable TRAP Schemes Applicable to Second Trimester Abortions

Alaska
Arkansas
Georgia
Hawaii
Indiana
Minnesota
Mississippi
New Jersey
North Carolina
Pennsylvania
Rhode Island
South Carolina
South Dakota
Utah
Virginia

These TRAP schemes apply to post-first trimester abortion providers regardless of the number of abortion procedures that they perform and regardless of whether their facility is a private practice. For example, in South Dakota, all second trimester abortions must be performed in a hospital or licensed clinic.[9]

Ten other states have post first-trimester TRAP schemes that are not enforced because a court or state attorney general has deemed them unconstitutional.

States with Unenforceable TRAP Schemes Applicable to Second Trimester Abortions

Connecticut (pursuant to attorney general opinion)
Idaho (pursuant to attorney general opinion)
Massachusetts (state court has implied that scheme is unconstitutional, and it is apparently not enforced)
Missouri (permanently enjoined by court) (hospitalization requirement, post-16 weeks)
Montana (permanently enjoined by state court)
New York (pursuant to statement of Department of Health)
North Dakota (pursuant to stipulation in court challenge)
Ohio (apparently not enforced)
Oklahoma (pursuant to/implied by stipulation in court challenge)
Wisconsin (pursuant to stipulation in court challenge)

III. WHAT TYPES OF REQUIREMENTS DO TRAP LAWS IMPOSE?

As a general rule, laws require the licensing of facilities that provide abortions and then authorize the state health department to inspect those facilities and to ensure compliance with a range of statutory or regulatory requirements.[10] First, TRAP laws typically authorize the state's health department to license abortion providers, and to impose criminal and civil penalties on facilities not in compliance with state licensing and other laws. Generally, state health departments do not regulate the offices and clinics of physicians, and TRAP laws carve out an exception to this rule in the case of physicians that provide abortions. Following are two examples of such provisions:

Although the Health Department is empowered to license and regulation health clinics, that authority does not extend to "the residence, office, or clinic of a physician or association of physicians . . . unless ten or more abortion are performed in any one calendar week in such residence, office, or clinic."
Neb. Rev. Stat. § 71-2017.01(9)

"A person is guilty of a class 3 misdemeanor who . . . [e]stablishes, operates or maintains [an abortion clinic] unless the person holds a current and valid license . . . [and] each day that a violation continues shall constitute a separate violation" and is punishable by up to 30 days imprisonment and a fine of up to $500.
Ariz. Rev. Stat. §§ 36-431(A); 13-707(A)(3), 13-802(C)

Second, TRAP laws often explicitly authorize the state health department to searches the offices and medical records of physicians subject to the schemes. For example:

"An abortion facility licensee must "[e]nsure that the [Health] Department's director or director's designee is allowed access to the abortion clinic during the hours of operation."
Ariz. Admin. Code R9-10-1503(B)(4)

"'[Health' Department inspectors shall have access to all properties and areas, objects, records and reports [of the abortion facility], and shall have the authority to make photocopies of those documents required in the course of inspections or investigations."
S.C. Reg. 61-12 § 102-F

Third, TRAP schemes frequently impose administrative burdens by requiring written practices, policies and procedures that otherwise might not be in place or might exist only in an informal manner. Following are two examples of such burdensome requirements:

"Licensed facilities must establish and maintain a written "quality assurance program," run by a quality assurance committee of at least four staff members, who must meet at least quarterly."
25 Tex. Admin. Code § 139.8(a)

"Written policies and procedures shall include, but not be limited to: 1. Safety rules and practices pertaining to personnel, equipment, gases, liquids, drugs, supplies and services; 2. Provisions for reporting and investigating accidental events regarding patients, visitors and personnel and corrective action taken; 3. Provisions for disseminating safety-related information to employees and users of the facility . . . ."
S.C. Reg. 61-12 § 501

Fourth, TRAP schemes regularly include requirements as to the training and qualifications of staff members. Thus, Missouri requires the following:

"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."
19 CSR 30-30.060 (1)(C)(4) (Missouri)

"The abortion facility nursing service shall be under the director of a legally and professionally qualified registered nurse."

Missouri Min. Stds. of Operation for Abortion Facilities § 301.3

Fifth, some TRAP laws require testing of patients or employees that may not otherwise be performed. South Carolina and Missouri, for example, contain such requirements:

> "Prior to the [abortion] procedure, laboratory tests shall include . . . [d]etermination of Rh factor (including the Du variant when the patient is Rh negative) and. . . [t]esting for Chlamydia and gonorrhea. . . ."
> S.C. Reg. 61-12 § 304-C

> "[E]ach employee shall have a pre-employment health examination by a physician. The examination is to be repeated annually and more frequently if indicated to ascertain freedom from communicable diseases."
> Missouri Min. Stds. of Operation for Abortion Facilities § 203.2

Sixth, TRAP laws frequently impose requirements as to the physical design and function of the regulated facility. The following examples illustrate these types of requirements:

> Abortion procedure and recovery rooms shall have a minimum of six air changes per hour, and "all air supplied to procedure rooms shall be delivered at or near the ceiling" and must pass through "a minimum of one filter bed with a minimum filter efficiency of 80 percent."
> 10 N.C. Admin. Code 3E.0206

> "All outside areas, grounds and/or adjacent buildings shall be kept free of rubbish, grass, and weeds that may serve as a fire hazard or as a haven for insects, rodents and other pests."
> S.C. Reg. 61-12 § 606

Finally, some TRAP schemes also include a variety of other requirements that may be difficult to interpret and impossible to comply with. Among these are the following:

> Licensed facilities must ensure that all patients are cared for in a manner that "enhances [the patient's] self-esteem and self-worth."
> 25 Texas Administrative Code § 139.51

> Licensed facilities may be fined not only for violating the explicit provisions of the regulatory scheme but also for taking any other actions which "are against the best practices as interpreted by the [Health] Department."
> S.C. Reg. 61-12 § 103-C

IV. WHAT IS WRONG WITH TRAP LAWS?

While TRAP laws may seem innocuous or well-meaning at first glance, they severely threaten women's ability to choose an abortion in a number of ways. First, by treating abortion differently from all other comparable medical procedures and subjecting it to a unique level of micro-management and government oversight, TRAP laws segregate abortion providers and patients from the rest of medical practice and relegate abortion services to a status below other health care. Second, by subjecting abortion providers to criminal and civil penalties, exposing them to harassment, and intruding significantly into their practice of medicine, TRAP laws deter physicians from becoming or remaining abortion providers. Thus, TRAP laws threaten to reduce the number of abortion providers, particularly in private practices, resulting in less access for women to abortion services. Third, by imposing requirements that significantly raise the cost of providing abortions, TRAP laws increase abortion prices, causing some women to delay or even forego desired abortions.

V. ARE TRAP LAWS CONSTITUTIONAL?

Some TRAP laws are likely to be struck down as unconstitutional if challenged in court. The likelihood of winning

such a challenge depends on the degree of burdens the TRAP scheme imposes and the extent to which it is actually tailored to the nature and relative safety of abortion procedures.

A number of TRAP laws have already been successfully challenged in federal court. In fact, prior to the Supreme Court's decision in Planned Parenthood v. Casey in 1992, court challenges to TRAP laws were nearly always successful.[11] Since Casey, there has been a handful of challenges to TRAP laws in federal courts. District courts in Louisiana and South Carolina have enjoined TRAP schemes.[12] In Louisiana, a new trap law was enacted in 2001 but the regulations have not yet been promulgated. In the South Carolina case, the Fourth Circuit reversed the district court judgment, and the U.S. Supreme Court refused to grant certiorari. Additional legal challenges are being pursued in the South Carolina case.

TRAP laws potentially violate a number of constitutional guarantees:

The Rights of the Women Seeking an Abortion:

* To Equal Protection of the Laws
* To Choose an Abortion
* To Informational Privacy

The Rights of the Abortion Provider:

* To Equal Protection of the Laws
* To be Free from Unreasonable Searches
* Not to be Subject to Vague Criminal Laws

A. Equal Protection

First, some TRAP laws violate the rights of abortion providers and their patients to equal protection of the laws. As a medical or health matter, abortion is no different from many other outpatient procedures that do not trigger state regulation. Specifically, depending on gestational age and abortion method, the procedures' risks, complications, complexity, duration, etc. are comparable to, or less significant than, those for many other medical procedures, such as completion of spontaneous abortion, minor breast biopsies, removal of subcutaneous lymphomas from various body parts. As a general principle, the equal protection clause requires treating similarly situated groups similarly.[13] In most circumstances, the states have a lot of flexibility to draw lines between groups and to enforce laws that have unequal application. Where constitutional rights are at stake, however, the states must craft their laws with precision and be able to justify burdening the constitutional rights of a singled-out group.[14] TRAP laws infringe on a woman's right to choose an abortion and therefore must be narrowly drawn to serve legitimate purposes. Some TRAP laws will not be able to meet this test because there simply is no legitimate reason for singling out abortion from all other medical procedures for the imposition of purported health regulations.

B. Unreasonable Searches and Seizures

Some TRAP laws may also violate abortion providers' right to be free from unreasonable search and seizures. Many TRAP schemes provide for inspection of regulated facilities and require that providers give the state health department access to their facilities essentially whenever the department chooses. To the extent that these schemes require providers to consent to searches without a search warrant, without a showing of a possible legal violation and regardless of whether patients are in the facility at the time, they may violate the Fourth Amendment.[15] Thus, a federal court held in 1980 that Louisiana's authorization of such searches was unconstitutional.[16]

C. Informational Privacy

Some TRAP schemes permit review and even copying of patient medical records during searches by the state health department. Such provisions create a serious threat to patient confidentiality and are likely to deter some women from safely seeking abortion services. They may also be found to violate the right of abortion patients to privacy in their personal medical information. A federal court struck down a Louisiana law permitting warrantless searches of patient records, recognizing that:[17] "Communications with patients, including records, are privileged and may not be disclosed to any third party without the patient's express consent. . . . A patient feels free to reveal data to a doctor only because she knows that it will not be revealed to anyone without her permission. Absent such a guarantee of privacy, doctors and their patients cannot realize the desired result of consultation: a discussion free of restraint."[18]

D. Right to Due Process

TRAP laws often contain very vague provisions that are difficult for providers to comply with. For example, Texas requires abortion providers licensed under its regulations to care for patients in a manner that "enhances [the patient's] self-esteem and self-worth."[19] Such TRAP laws may violate the principle of due process that a law defining a crime must give fair notice of the conduct prohibited. If it does not, then the law is void for vagueness.[20]

E. Right to Privacy

Finally, TRAP laws may violate women's right to choose an abortion. Under both Roe and Casey, purported health regulations can only be enforced if they serve the state's interest in promoting the health of abortion patients and if they have neither the purpose or effect of unduly burdening the woman's ability to exercise her decision to have an abortion.[21] TRAP laws may violate women's right to privacy with respect to both of these limitations. First, TRAP laws may impose unnecessary, costly requests that will not improve abortion safety, and will instead only reduce access to the procedure. To the extent they do so, they harm rather than promote patient health. Second, to the extent TRAP schemes significantly raise the price of abortions or decrease the availability of abortion providers, they may significantly impair the woman's ability to obtain a desired abortion. Either could have the effect of unduly burdening the woman's choice. Moreover, if a TRAP law is passed or enforced with the purpose of burdening the provision of abortions, rather than promoting maternal health, it is also improper.

Endnotes

[1] Laws triggered by second trimester abortions vary, but are triggered by abortions performed after a point in pregnancy between 12 and 14 weeks gestation.

[2] See generally Ky. Rev. Stat. Ann. § 311.720, 216B.015, 902 Ky. Admin. Regs. 20:360 et seq.; 10 N.C. Admin. Code tit. 10 § 3E.0101 et seq., N.C. Stat. Ann. § 14-45.1; 28 Pa. Admin. Code §§ 29.31, 29.33, 29.43; 18 Pa. Code § 3207; 24 L.P.R.A. § 331a (Puerto Rico); R.I. Code R. 14-000-009 § 600.2; Wis. Admin. Code § 11.04.

[3] See Conn. Agencies Regs. § 19a-13-D45 (TRAP applies only to outpatient clinics operated by corporations or municipalities).

[4] Arkansas (Arkansas Dept. of Health Rules and Regs., section 3 (not dated, amended 1999) (TRAP applies to facilities maintained for the "primary purpose of providing care in the purposeful termination of human pregnancies"); Florida (a physician's office is exempt if the office is "not used primarily" for performing abortions, A physician's office is exempt if the office is "not used primarily" for performing abortions, see Fla. Stat. Ann. section 390.011(2)(b)).

[5] See Tenn. Code Ann. § 68-11-201(3) (exemption for a physician who performs less than a "substantial number" of abortions; note that "substantial number" is not defined in the Tennessee Code or the Department of Health's regulations).

[6] See Tex. Health and Safety Code § 245.004 (physicians' offices are exempt unless they are used "primarily" for the purpose of performing abortions) (Note that this is the previous version of that statutory section. The recent amendment to this section, which changes the exemption to those physicians who perform 300 or less abortions per year, is presently enjoined.).

[7] Alabama (TRAP regulations only apply where 30 or more abortions are performed in a calendar year OR where the provider holds itself out to the public as an abortion provider through advertising or other means; see Ala. Admin. code. r. 420-5-.01(2)(b)), Arizona, (law applies to facilities performing five or more first trimester abortions per month or any second or third trimester abortions; see Ariz. Rev. Stat. Ann.

§36-449.01(2); Ariz. Admin. Code R9-10-1501(2)); Michigan (TRAP regulations only apply to physician's offices where 50% or more of the "patients annually served" undergo abortion; see Mich. Comp. Laws sec. 333.20115(2)), Mississippi (if the physician's office or other facility performs less than 10 procedures per month or 99 or less in a calendar year it is exempt from being licensed as an "abortion facility," however, a provider that holds itself out to the public as an abortion provider through advertisements or media is not exempt, regardless of number of abortions performed; see Miss. Code Ann. sec. 41-75-1(f)); Missouri (a facility is an "abortion facility" subject to regulations if number of patients having abortions is 51% greater of the total number of patients treated or seen for any health condition; or if 51% or more of revenues of the facility are from abortions or procedures related to abortions, see 19 Mo. Code Regs. Ann. tit. 19, section 30-30.050(B); and Nebraska (facilities exempt if perform less than 10 abortion procedures in any one calendar week; see Neb. Rev. Stat. § 71-2017.01(9) (defining "health clinic")).

[8] Laws triggered by second trimester abortions vary, but are triggered by abortions performed after a point in pregnancy between 12 and 14 weeks gestation.

[9] See S.D. Codified Laws § 34-23A-4.

[10] A number of exceptions exist. Wisconsin, for example, does not require facility licensing or inspections and imposes relatively minimal requirements that do not include any physical plant specifications. See Wis. Admin. Code § 11.04.

[11] See, e.g., City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983). See also, e.g., Ragsdale v. Turnock, 841 F.2d 1358, 1372-74 (7th Cir. 1988); Mahoning Women's Ctr. v. Hunter, 610 F.2d 456 (6th Cir. 1979), vacated on other grounds, 447 U.S. 918 (1980), Friendship Med. Ctr., Ltd. v. Chicago Bd. of Health, 505 F.2d 1141 (7th Cir. 1974).

[12] See Causeway Med. Ctr. v. Foster, Civ. No. 99-2069 (Section B) (E.D.La. 2000) (enjoining TRAP scheme) (decision on file with CRLP); Greenville Women's Clinic v. Bryant, 66 F. Supp. 2d 691 (D.S.C. 1999) (enjoining TRAP scheme);

[13] See, e.g., Romer v. Evans, 517 U.S. 620, 623 (1996); City of Cleburne v. Cleburne Living Ctr. Inc., 473 U.S. 432, 439 (1985).

[14] See Shapiro v. Thompson, 394 U.S. 618 (1969).

[15] See U.S. Const. amend. IV; New Jersey v. T.L.O., 469 U.S. 339, 340-41 (1985); Michigan v. Tyler, 436 U.S. 499, 504-05 (1978).

[16] Margaret S. v. Edwards, 488 F. Supp. 181, 244 (E.D. La 1980).

[17] Margaret S., 488 F. Supp. at 244.

[18] Margaret S., 488 F. Supp. at 216.

[19] 25 Texas Administrative Code § 139.51.

[20] See Grayned v. City of Rockford, 408 U.S. 104, 107-09 (1972).

[21] See Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 877 (1992) (joint opinion).

Planned Parenthood®
of Kansas and Mid-Missouri

Testimony by

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before the
Federal and State Affairs Committee
of the
Kansas House of Representatives

On February 20, 2003

in Opposition to House Bill 2176

4401 W. 109th St., Suite 200 • Overland Park, KS

Thank you Chairman Mason and members of the Committee for allowing me to speak to you about HB 2176 and Planned Parenthood's reasons for opposing it. The proponents of this bill claim that their intentions are to improve the safety of abortion procedures in Kansas. While this may be a noble intention, the standards prescribed in the bill are completely unnecessary. Rather than improve the safety of abortion, which is already one of the safest surgeries available, it would impede a woman's constitutional right to abortion by limiting access and driving up costs.

The bill contains several problems that will need to be addressed before considering its passage. In Section 1(a)(2) "abortion" is not defined. This is a problem because besides surgical abortion, some physicians only do medical abortion. Elsewhere in Kansas statute abortion is defined so broadly that if this definition were used, this bill would apply to medical abortion. Most of the provisions make little sense when applied to medical abortion, would be difficult to apply in that context and are medically unjustified. (*See attached fact sheet on medical abortion*).

Sections 1(c)(3) and 1(f)(4) conflict with each other. One requires a physician with admitting privileges to a hospital to be on the premises, the other requires the physician merely to be available. Regardless of the conflict, admitting privileges are unnecessary. All that would be needed in this situation is an agreement with a local hospital that it will accept patients in an emergency.

Sections 1(i) and (n) would violate patient and physician privacy and undercut current Kansas law which states that reports submitted to the secretary by providers "shall not include the names of the persons whose pregnancies were so terminated." Names of physicians and patients are unnecessary for the purpose of ensuring safety of the procedure and would in fact put patients and physicians at risk of being identified and harassed.

Abortion is among the safest surgical procedures. According to KDHE statistics, since 1990 there have been 106 deaths in Kansas with the cause attributed to "Misadventures to patients during surgical and medical care." There have been zero deaths due to "Induced termination of pregnancy." The three deaths attributed to "Pregnancy with abortive outcome" have all been ectopic pregnancies and have nothing to do with an abortion procedure. In fact, nationally, abortion entails half the risk of tonsillectomy; one-hundredth the risk of an appendectomy and, in the first trimester is eleven times safer than childbirth.

Other surgeries performed in Kansas are more dangerous and require deeper levels of sedation and higher doses of anesthesia. First-term abortions generally need no more than local anesthesia and take approximately fifteen minutes. Rather than single out one procedure, we should focus on making all surgery safe.

The Kansas Medical Society has recently completed *Guidelines for Office-Based Surgery and Special Procedures*. The Board of Healing Arts has since adopted the *Guidelines* in October of last year. (*See attached sheet*). The twenty-one-member task force

represented twelve medical specialties. The report was written after reviewing guidelines and materials from other states and national medical specialty organizations for six months. These guidelines are superior to HB 2176 not only because they apply to all medical specialties, but also because they were written by physicians, who know best how to practice medicine.

Clinics currently adhere to the federal rules and regulations set up by: Health Insurance Portability and Accountability Act (HIPPA), Occupational Safety & Health Administration (OSHA), Clinical Laboratory Improvement Amendments (CLIA) and others. They follow state and local health department rules as well as the rules of national accrediting agencies including: National Abortion Federation (NAF), and American College of Obstetricians and Gynecologists (ACOG).

These regulations may result in increased costs of abortion and a reduction in the number of abortion providers, both of which may cause women to perform self-induced abortion and defeat the purpose of legislation that seeks to make abortion "safer."

NATIONAL ABORTION FEDERATION

Safety of Abortion

FACT SHEET

Abortion has not always been so safe.

Between 1880 and 1973, when abortion was illegal in all or most states, many women died or had serious medical problems after attempting to induce their own abortions or going to untrained practitioners who performed abortions with primitive instruments or in unsanitary conditions. Women streamed into emergency rooms with serious complications — perforations of the uterus, retained placentas, severe bleeding, cervical wounds, rampant infections, poisoning, shock, and gangrene.

Around the world, in countries where abortion is illegal, it remains a leading cause of maternal death. In fact, many of the doctors who perform abortions in the United States today are committed to providing this service under medically safe conditions because they witnessed and still remember the tragic cases of women who appeared in hospitals after botched, illegal abortions.

Since the Supreme Court re-established legal abortion in the U.S. in the 1973 *Roe v. Wade* decision, women have benefitted from significant advances in medical technology and greater access to high quality services.[1] Generally, the earlier the abortion, the less complicated and safer it is. The safest time to have a surgical abortion is between 6 and 10 weeks from the last menstrual period (LMP).

Serious complications arising from abortions before 13 weeks are quite unusual. About 89% of the women who obtain abortions are less than 13 weeks pregnant. Of these women, 97% report no complications; 2.5% have minor complications that can be handled at the physician's office or abortion facility; and less than 0.5% require some additional surgical procedure and/or hospitalization. Complication rates are somewhat higher for abortions performed between 13 and 24 weeks. General anesthesia, which is sometimes used in abortion procedures, carries its own risks.

In addition to the length of the pregnancy, significant factors that affect the possibility of complications include:

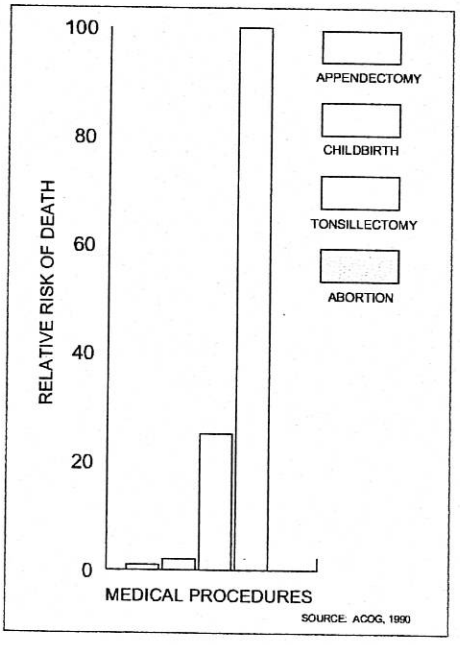
- the skill and training of the provider;
- the kind of anesthesia used;
- the woman's overall health; and
- the abortion method used.

(See *Fact Sheet: What is Surgical Abortion?*)

Although rare, possible complications from a surgical abortion procedure include:

- blood clots accumulating in the uterus, requiring another suctioning procedure, which occur in less than 1% of cases;
- infections, most of which are easily identified and treated if the woman carefully observes follow-up instructions, which occur in less than 3% of cases;
- a tear in the cervix, which may be repaired with stitches, which occurs in less than 1% of cases;
- perforation (a puncture or tear) of the wall of the uterus and/or other organs, which may heal itself or may require surgical repair or, rarely, hysterectomy, which occurs in less than 1/2 of 1% of cases;
- missed abortion, which does not end the pregnancy and requires the abortion to be repeated, which occurs less than 1/2 of 1% of cases;
- incomplete abortion, in which tissue from the pregnancy remains in the uterus, and requires the abortion to be repeated, which occurs in less than 1% of cases;
- excessive bleeding caused by failure of the uterus to contract and which may require a blood transfusion, which occurs in less than 1% of cases.

Relative Risk Of Death From Abortion



Between 13 and 16 weeks, the dilation and evacuation (D&E) procedure is significantly safer and more effective than other second trimester abortion methods. After 16 weeks, the different methods carry about the same complication rates.

One death occurs for every 160,000 women who have legal abortions. These rare deaths are usually the result of such things as adverse reactions to anesthesia, heart attacks, or uncontrollable bleeding. In comparison, a woman's risk of death in carrying a pregnancy to term is ten times greater.

If a woman has any of the following symptoms after having an abortion, she should immediately contact the facility that provided the abortion:

- severe pain;
- chills or fever with an oral temperature of 100.4° or more;
- bleeding that is heavier than the heaviest day of her normal menstrual period or that soaks through more than one sanitary pad per hour;
- foul-smelling discharge or drainage from her vagina; or
- continuing symptoms of pregnancy.

Doctors and clinics that offer abortion services provide a 24-hour number to call in the event of complications.

There are some things women can do to lower their risks of complications. The most important thing is not to delay the abortion procedure. After six weeks LMP, the earlier the abortion, the safer it is.

Asking questions is also important. Just as with any medical procedure, the more relaxed a person is and the more she understands what to expect, the better and safer her experience will be.

In addition, any woman choosing abortion should:

- find a good clinic or a qualified, licensed practitioner. For referrals, call NAF's toll-free hotline: 1-800-772-9100;
- inform the practitioner of any health problems, current medications or street drugs being used, allergies to medications or anesthetics, and other health information;
- follow post-operative instructions; and
- return for a follow-up examination.

Anti-abortion activists claim that having an abortion increases the risk of developing breast cancer and endangers future childbearing. They claim that women who have abortions without complications will still have difficulty conceiving or carrying a pregnancy, will develop ectopic (outside of the uterus) pregnancies, will deliver stillborn babies, or will become sterile. However, these claims have been refuted by a significant body of medical research.

Women have abortions for a variety of reasons, but in general they choose abortion because a pregnancy at that time is in some way wrong for them. Such situations often cause a great deal of distress, and although abortion may be the best available option, the circumstances that led to the problem pregnancy may continue to be upsetting.

Some women may find it helpful to talk about their feelings with a family member, friend, or counselor. Feelings of loss or of disappointment, resulting, for example, from a lack of support from the spouse or partner, should not be confused with regret about the abortion. Women who experience guilt or sadness after an abortion usually report that their feelings are manageable. The American Psychological Association finds no scientific support or evidence for the so-called "post-abortion syndrome" of psychological trauma or deep depression. The most frequent response women report after having ended a problem pregnancy is relief, and the majority are satisfied that they made the right decision for themselves.

[1]AMA Council Report. Induced Termination of Pregnancy Before and After Roe v. Wade. *Journal of the American Medical Association*, 1992, 268: 3231.

■ Statistical information in this fact sheet is based on research by the U.S. Centers for Disease Control Division of Reproductive Health, The Alan Guttmacher Institute, and other members of the National Abortion Federation.

■ **For More Information**

For information or referrals to qualified abortion providers, call the National Abortion Federation's toll-free hotline: 1-800-772-9100. In Canada: 1-800-424-2280. In Washington, DC: 202-667-5881. Weekdays, 9:30-5:30 Eastern time.

■ **For Further Reading**

Adler, N.E., *et al.* Psychological Factors in Abortion: A Review, *American Psychologist*, 1992, 47: 1194.

Gold, R.B. *Abortion and Women's Health*, New York: Alan Guttmacher Institute, 1990.

Tietze, C. & Henshaw, S.K. *Induced Abortion: A World Review, 1986.* New York: Alan Guttmacher Institute, 1986.

National Abortion Federation
1755 Massachusetts Avenue, NW, Suite 600
Washington, DC 20036
(202) 667-5881

Writer: Susan Dudley, PhD

NATIONAL ABORTION FEDERATION

What Is Medical Abortion?

FACT SHEET

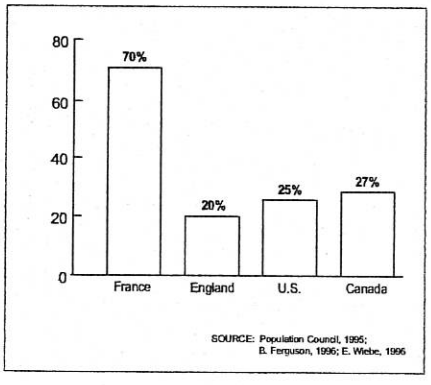
medical abortion is one that is brought about by taking medications that will end a pregnancy. The alternative is **surgical abortion**, which ends a pregnancy by emptying the uterus (or womb) with special instruments. (See Fact Sheet: *What Is Surgical Abortion?*) A medical abortion usually is done without entering the uterus. Either of two medications, methotrexate or mifepristone, can be used for medical abortion. Each of these medications is taken together with another medication, misoprostol, to induce an abortion.

Before any abortion can be done, a medical professional must confirm that a woman is indeed pregnant and determine exactly how long she has been pregnant. The length of a pregnancy is usually measured by the number of days that have passed since the first day of the woman's last menstrual period (abbreviated as LMP). Medical abortions can be performed as early as a pregnancy can be confirmed. In fact, the shorter the time that a woman has been pregnant, the better the medications will work. Because they do not work as well later in pregnancy, medical abortion is often not an option **after** seven weeks (or 49 days) LMP. After that, surgical abortion may be the safest and best option. (See Fact Sheet: *Safety of Abortion.*)

Methotrexate has been used in the US since 1953, when it was approved by the FDA to treat certain types of cancer. Since that time, medical researchers have discovered other important uses for the drug. One of these uses is to end unintended pregnancies. Although the FDA did not consider methotrexate for this specific purpose, clinicians may prescribe (and are now prescribing) methotrexate for early abortion.

Methotrexate usually is given to a pregnant woman in the form of an injection, or shot, although it can be taken orally. Methotrexate stops the ongoing implantation process that occurs during the first several weeks after conception.

Percentage of Eligible Women (≤ 7 or 9 wks LMP) Who Choose Medical Over Surgical Abortion



SOURCE: Population Council, 1995; B. Ferguson, 1996; E. Wiebe, 1996

Another medication that might be used is mifepristone. Mifepristone (or RU-486) is a newer medication that was developed and tested specifically as an abortion inducing agent. It has been used by over 500,000 women in Europe and millions of women worldwide, especially in China.

Mifepristone is taken in the form of a pill. It works by blocking the hormone progesterone, which is necessary to sustain pregnancy. Without this hormone, the lining of the uterus breaks down, the cervix (opening of the uterus or womb) softens, and bleeding begins.

A few days after taking either methotrexate or mifepristone, a second drug, misoprostol, is taken. Misoprostol tablets, which can be taken orally or put into the vagina, cause the uterus to contract and empty. This ends the pregnancy.

Methotrexate and mifepristone work in different ways, and so they will have slightly different effects on a woman's body. A clinician can help a woman decide whether medically induced abortion is the right option for her, and which of the two drugs she should use.

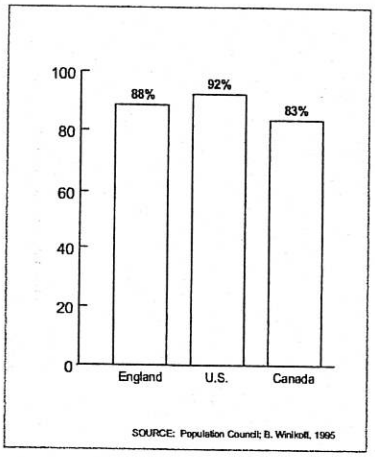
Medical abortion can take anywhere from 3 days to 3-4 weeks, and requires a minimum of two visits to the clinic or medical office. *The return visits are very important since there is no other way to be sure that the abortion has been completed.* With methotrexate, 80-85% of women will abort within two weeks. Some will take longer and may need more doses of misoprostol. With mifepristone, 95-97% of women will abort within two weeks. About 1 in 20 women who try medical abortion will need to have a surgical abortion because the medication does not work for her.

Some women will have vaginal bleeding after the first drug. This bleeding may be light, or it may be like a heavy period. The abortion provider may have the woman stay at the clinic for several hours after taking the second drug (misoprostol). The uterine contractions caused by this medication may lead to immediate

cramping that will expel the embryo, thus ending the pregnancy. A high proportion of women, however, will expel the uterine contents later, after they have left the medical facility. Many women insert the misoprostol at home and pass the tissue later. A woman considering medical abortion will need to be prepared for this possibility. The clinic staff can answer questions about what to expect.

The most common side effects of medical abortion are caused by misoprostol, the medication taken after the methotrexate or mifepristone. The side effects may include: cramps similar to those with a heavy menstrual period, headache, nausea, vomiting, diarrhea, and heavy bleeding.

Percentage of Women Who Would Choose Medical Abortion Again



The amount of bleeding that a woman has will be greater with medical abortion than with surgical abortion. Most women have cramps for several hours, and many pass blood clots as they are aborting. In some cases, the blood clots will be larger than the embryo and other tissue from the pregnancy which will also be passed, and the embryo will probably not be seen among the blood clots. For example, at 49 days LMP, the si e of the embryo will be about one-fifth of an inch. In an earlier pregnancy, it might be much smaller than that. Cramps and bleeding usually begin to ease after the embryonic tissue has been passed, but bleeding may last for one to two weeks after medical abortion.

Some women report that their first regular menstrual period after a medical abortion is heavier, or longer, or in some other way different from normal for them. By the second period after the abortion, their cycles should be back to normal.

Medical abortion is irreversible once the mifepristone or methotrexate has been taken. *Deciding to continue the pregnancy to term is not an option at any point after taking the first medication.* If the embryo is not expelled after using these medications, a suction procedure (surgical abortion) must be done to empty the uterus and complete the abortion (See Fact Sheet: *What Is Surgical Abortion?*).

The most common immediate complication of a medical abortion is heavy bleeding. For this reason, a woman must have access to a telephone and transportation in case emergency treatment is needed. Rarely, just like with surgical abortion, treatment for very heavy bleeding might require a D C or a blood transfusion.

There do not appear to be any long-term complications associated with use of these drugs to induce a medical abortion.

Because there is no way to know for sure that the abortion is complete without an examination by a health care professional, *keeping appointments with the clinic for follow-up care is very important!* In addition, a woman must report any problems she has during the medical abortion to a health care professional.

Anti-abortion activists claim that medical abortion is unsafe for women, even though the evidence confirms that medical abortion is both safe and effective. The real goal of those activists is to stop all types of legal abortion — a situation which would put the lives and health of women in danger. When abortion was illegal in the United States (from the late 1800s until 1973), more pregnant women died from complications from self-induced abortions or abortions performed by untrained practitioners than from any other cause. Today, abortion is one of the most common and safest procedures in medicine. Because earlier abortions are the safest, medical abortion is an important medical advance for women, and an option that many will choose.

- Information in this fact sheet is based on clinical research reviewed through a joint project of Planned Parenthood Federation of America and the National Abortion Federation. International statistics on acceptability of medical abortion are from research by the Population Council and other NAF members.

- **For More Information**

  For information or referrals to qualified abortion providers, call the National Abortion Federation's toll-free hotline: 1-800-772-9100. In Canada: 1-800-424-2280. In Washington, DC: 202-667-5881. Weekdays, 9:00 a.m.-7:00 p.m. Eastern time.

- **For Further Reading**

  Kaufmann, K. *The Abortion Resource Handbook*. New York: Fireside, 1997.

  Creinin, M.D., and Edwards, J. Early Abortion: Surgical and Medical Options. *Current Problems in Obstetrics, Gynecology, and Fertility*, 1997, 20:1.

National Abortion Federation
1755 Massachusetts Avenue, NW, Suite 600
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(202) 667-5881

Writers: Stephanie Mueller and Susan Dudley, PhD

KANSAS STATE BOARD OF HEALING ARTS

POLICY STATEMENT NO. 02-1

Subject: **Guidelines for Office-Based Surgery and Special Procedures**
Date: **October 12, 2002**

Whereas, there is growing concern nationwide that surgeries in non-hospital settings pose a threat to the safety of patients unless performed by qualified practitioners utilizing proper equipment, facilities, staff and procedures; and

Whereas, the Kansas Medical Society has convened a committee of experts among its membership to study methods of reducing the risk to patients undergoing office-based surgery; and

Whereas, the Kansas Medical Society House of Delegates approved the committee's Guidelines for Office-Based Surgery and Special Procedures; and

Whereas, the Board recognizes that guidelines for practitioners do not have the force and effect of state law, but if utilized by practitioners, guidelines do protect the public health, safety and welfare.

Therefore, the Board commends the work of the committee of the Kansas Medical Society, and approves the Guidelines for Office-Based Surgery and Special Procedures adopted by the House of Delegates May 5, 2002.

Howard D. Ellis, M.D.
President

Federal and State Affaires Committee of the Kansas House of Representatives
February 20, 2003

Testimony presented by Sylvie Rueff, for the Kansas National Organization for Women (NOW)
P. O. Box 1061, Lawrence, KS 66044 Ph:785-832-2992

In opposition to HB 2176, an act concerning abortion clinics

Chairperson Mason and Members of the Committee,

Kansas NOW opposes the passage of this bill as it would put Kansas women at greater risk by increasing the financial and travel burdens for women seeking safe, and legal abortions, by increasing physician's costs and by reducing the number of clinic sites in Kansas.

Women who get abortions are your mothers, your daughters, your sisters, grandmothers, aunts, wives, lovers and yourselves.

- 43% of all women will have had at least one abortion by the time they are 45 years old.
- Doctors have performed abortions for women from 8 to 53 years old.
- 26.6% of abortions are for women with annual household incomes below poverty level.
- 6 out of 10 abortions are for women who were using birth control that failed.
- 33% of the women who have abortions describe themselves as Catholic or following a Fundamentalist religion.
- In the U.S. more than 16,000 women have abortions each year because they became pregnant as the result of rape or incest.
- Abortion is not used as a primary form of birth control. If it were, a typical woman would have 2 or 3 pregnancies per year.

Abortions happen when women are failed by

- Their families,
- The men they trust,
- Their communities,
- Their governments,
- And health care sciences.

When we have a perfect world:

- When children are seen as our entire futures and valued as they should be,
- When mothering is respected as the highest of professions
- When all fathers strive to be equal to mothers in their selflessness toward their children,
- When all children are born out of love,
- When communities cherish children of all kinds,
- When people have all the health information they need,
- When medicine is 100% effective without side effects, and
- When everyone is born with equal chances for happy fulfilled lives,

Then we won't need abortions.

But, until that day, a woman of any age needs to be able to make the important personal and private decisions about bearing her children with only those people with whom she chooses to share this part of her life.

Abortion, as it is practiced in Kansas, is more than eleven times safer than childbirth. There is no need to regulate abortion providers.

WOMEN'S HEALTH CARE SERVICES, P.A.

George R. Tiller, M.D., DABFP
Medical Director

Carrie Skaggs
Administrative Director

Cathy Reeves
Patient Coordinator

February 20, 2003

Representative Bill Mason, Chair
House Federal and State Affairs Committee
State Capitol, 170 W
Topeka, Kansas 66612

Dear Representative Mason:

Thank you for allowing me to address the committee by letter. From my perspective, as a family physician and abortion provider in Kansas for thirty-three and thirty years respectively, my observation is that the TRAP bill is not about public safety.

The sole purpose of HB 2176 is to further limit the number of abortion providers by punitively and unnecessarily increasing the cost, regulation, and restriction of this integral component of reproductive medicine. Since those opposed to abortion have been, until now, unable to make abortion illegal, they seek to accomplish their goal of eliminating all abortions in Kansas by the restriction of physicians.

Let's examine the record and ignore the propaganda.

The Healthcare Stabilization Fund reports that in the past five years there have been two abortion related settlements. One settlement was for $100,000, involving a lacerated uterus. The second monetary settlement was for $200,000 , stemming from failure to administer RhoGam after an abortion. The total of all malpractice settlements made to patients for abortion related problems in the past five years in Kansas is $300,000.

On the other hand, the Healthcare Stabilization Fund of Kansas reports that during those same five years, medical liability insurance carriers have paid out a total of $151,074,000 to settle Kansas malpractice insurance claims. Furthermore, these figures indicate that 0.00199 percent of malpracti

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are a result of abortion settlements. So only two-tenths of one percent of all malpractice awards in Kansas are attributable to abortion settlements. Obviously, the malpractice awards for abortion-related problems are minuscule in comparison to the resources depleted by other malpractice payments.

Medicine and surgery are and will always be fraught with hazard. Let's now look at the record regarding Kansas abortion services.

If we can believe the testimony in support of HB 2819 given last year by Mike Farmer of the Kansas Catholic Conference, there have been twenty-seven malpractice suits filed against Kansas abortion providers since 1980. During the same time period, Kansas physicians have performed 293,489 abortions. During this twenty-plus year time frame, only one lawsuit was filed for every 10, 868 abortions performed in Kansas. When compared to the rate at which lawsuits are filed in the rest of the obstetric field, this indicates a sterling record of safety.

Finally, I would like to present a singularly compelling point. According to the KDHE's Center for Health and Environment Statistics, out of the 106 deaths in the state of Kansas that were attributed to surgical and medical care between 1990 and 2001, none of the deaths were due to abortion services.

Therefore I ask you, where is the proof that abortion services in Kansas generate excessive lawsuits? Where is the proof that these services result in enormous malpractice claims? Where is the proof that they account for maternal death rate? There is no objective evidence that the interests of public health and safety will improve by further regulation of abortion services by HB 2176.

I believe this bill is bad for Kansas women and Kansas physicians. Quite clearly, this legislative measure is intended to restrict abortion even further by eliminating several small practitioners who safely perform abortion procedures in their office-based practices.

Thank you again for the privilege of testifying before your committee.

George R. Tiller, M.D., DABFP
Medical Director and Abortion Provider
Women's Health Care Services
Wichita, Kansas

DEATHS DUE TO MISADVENTURES TO PATIENTS DURING SURGICAL & MEDICAL CARE
BY CAUSE, BY YEAR, KANSAS, 1990-2001, OCCURRENCE DATA
Table of CAUSEDS by YEAR

CAUSEDS Frequency	YEAR 1990	1992	1993	1995	1996	1997	1998	1999	2000	2001	Total
8700 - SURGICAL OPERATION	1	1	1	1	0	0	3	0	0	0	7
8704 - ENDOSCOPIC EXAMINATION	0	1	0	2	0	3	0	0	0	0	6
8705 - ASPIRATION OF FLUID OR TISSUE PUNCTURE	1	0	0	0	0	0	0	0	0	0	1
8706 - HEART CATHETERIZATION	0	1	0	0	0	0	0	0	0	0	1
8708 - OTHER	1	1	0	0	1	0	2	0	0	0	5
8741 - INFUSION AND TRANSFUSION	0	0	0	1	0	1	0	0	0	0	2
8760 - MISMATCHED BLOOD IN TRANSFUSION	1	0	0	0	0	0	0	0	0	0	1
8768 - OTHER SPECIFIED MISADVENTURES	1	1	0	0	1	1	0	0	0	0	4
Y658 - OTHER SPECIFIED MISADVENTURES DURING	0	0	0	0	0	0	0	0	1	1	2
Y818 - MISCELLANEOUS DEVICES NOT ELSEWHERE	0	0	0	0	0	0	0	1	0	0	1
Y831 - SURGICAL OPERATION WITH IMPLANT OF	0	0	0	0	0	0	0	1	1	4	6
Y832 - SURGICAL OPERATION WITH ANASTOMOSIS	0	0	0	0	0	0	0	1	2	3	6
Y833 - SURGICAL OPERATION WITH FORMATION OF	0	0	0	0	0	0	0	1	2	3	6
Total (Continued)	5	5	1	4	2	5	5	25	19	35	106

Misadventures to Patients during Surgical & Medical Care, ICD-9 Codes 870-876
Kansas Occurrence Data
Source: KDHE Center for Health and Environmental Statistics

DE[illegible]JE TO MISADVENTURES TO PATIENTS DURING SURGICAL & MEDICAL CARE
BY CAUSE, BY YEAR, KANSAS, 1990-2001, OCCURRENCE DATA
Table of CAUSEDS by Year

CAUSEDS Frequency	Year 1990	1992	1993	1995	1996	1997	1998	1999	2000	2001	Total
Y834 - OTHER RECONSTRUCTIVE SURGERY	0	0	0	0	0	0	0	2	0	1	3
Y835 - AMPUTATION OF LIMB(S)	0	0	0	0	0	0	0	1	5	0	6
Y836 - REMOVAL OF OTHER ORGAN (PARTIAL)	0	0	0	0	0	0	0	0	1	3	4
Y838 - OTHER SURGICAL PROCEDURES	0	0	0	0	0	0	0	2	2	3	7
Y839 - SURGICAL PROCEDURE UNSPECIFIED	0	0	0	0	0	0	0	8	2	9	19
Y841 - KIDNEY DIALYSIS	0	0	0	0	0	0	0	2	0	0	2
Y846 - URINARY CATHETERIZATION	0	0	0	0	0	0	0	2	1	1	4
Y848 - OTHER MEDICAL PROCEDURES	0	0	0	0	0	0	0	4	2	7	13
Total	5	5	1	4	2	5	5	25	19	35	106

Misadventures to Patients during Surgical & Medical Care, ICD-9 Codes 870-876
Kansas Occurrence Data
Source: KDHE Center for Health and Environmental Statistics

DEATHS DUE TO PREGNANCY WITH ABORTIVE OUTCOME
BY CAUSE, BY YEAR, KANSAS, 1990-2001, OCCURRENCE DATA
Table of CAUSEDS by YEAR

CAUSEDS	YEAR			
Frequency	1992	1997	2000	Total
6339 - UNSPECIFIED ECTOPIC PREG	1	1	0	2
0009 - ECTOPIC PREGNANCY UNSPECIFIED	0	0	1	1
Total	1	1	1	3

Pregnancy with Abortive Outcome, ICD-9 Codes 630-639, ICD-10 000-008
Kansas Occurrence Data
Source: KDHE Center for Health and Environmental Statistics

Central Women's Services, Inc.
3013 East Central
Wichita, Kansas 67214
316-688-0107 ◆ 1-800-678-0107

19 February 2003

Chairman Bill Mason
House Federal and State Committee
State Capitol
Topeka, Kansas 66612

Dear Chairman Mason:

Central Women's Services, known as the "other" abortion clinic in Wichita and formerly known as Wichita Family Planning, is one of the smaller private clinics that would be eliminated by the approval of this legislation. The purpose of this bill is not to improve the quality and safety of patient care, but rather to force abortion clinics to meet requirements that put an undue burden on patients and staff. Such regulations include mandating unique structural and administrative specifications that are not medically warranted. These requirements make it more difficult for women to have access to abortion and for clinics to continue to provide services. While it may seem that the bill simply suggests improvements for abortion care, it is an underhanded attempt to open the floodgates to further regulation and restriction on abortion clinics. Therefore, while abortion remains legal the clinics and providers continue to have new bills proposed against them in the effort to make it nearly impossible to have an abortion due to the clinics having to meet discriminatory regulations set up by the government.

Ensuring the safety and privacy of women seeking abortion has always been the main goal of pro-choice supporters and abortion providers. To a clinic the size of Central Women's Services, which performs an average of 30-40 abortions per month, the added cost of instituting the regulations of the proposed bill would significantly raise the cost of providing abortions, without improving the true quality or level of care a patient would receive. Lawmakers who claim to be truly concerned about the safety of women seeking abortions would enact clinic protection laws to protect women and medical staff from harassment and violence from protestors and extremists. Legislative obstacles such as mandatory waiting periods and funding bans lead to delayed abortion and in turn, subject women to increased medical risk. Central Women's Services would be forced to suspend operation or stop performing abortions altogether while they attempt to comply with the new and excessive regulations. As the number of abortion providers continues to decrease dramatically, more women will be forced to travel great distances to have an abortion. Since Wichita is the closest metropolitan city for many women from rural parts of the state these women have to figure in the extra money for travel, time off from work, childcare, which places them at greater risk for delaying abortion which increase health risks. Many of these same women are already on the low end of the economic scale where proper medical care and payment coverage is a struggle to obtain.

Abortion, as far as a medical matter, is not any different from other outpatient, office-based surgery that occurs in a normal everyday fashion. The difference is that other comparable medical procedures are not the targets of state regulation. Many of the regulations proposed in this bill are more stringent than those governing facilities where more complex procedures are performed. Compared to other types of outpatient surgery, such as tonsillectomy, abortion entails half the risk of death. In the U.S., legal abortion is one of the safest medical procedures available. The American College of Obstetricians and Gynecologists has determined that first trimester abortions may be performed safely and appropriately in a physician's office. Nearly 90% of women obtain abortions during the first trimester.

As one of the two abortion clinics in Wichita, Central Women's Services is an alternate choice to Women's Health Care Services, operated by Dr. George Tiller. Women seeking abortion services should always have the freedom of choice to healthcare where they feel more comfortable and are properly taken care of. This bill however, proposes to make abortion services an exception and allow government the ultimate authority to intrude into private medical practices to make them more expensive and increasingly difficult to obtain. Throughout the 27-year history of this

Central Women's Services, Inc.
3013 East Central
Wichita, Kansas 67214
316-688-0107 ◆ 1-800-678-0107

clinic, to our knowledge, there have been no deaths, no lawsuits, and no major medical complications requiring hospital transport. Instead of focusing on the politically unpopular topic of abortion, legislatures should focus on the type of facility, such as office-based surgery, and make regulations that can truly benefit all people seeking any type of outpatient care. Government should not disguise the bill as "preservation and protection of maternal health," when it would only affect abortion clinics by taking them out of mainstream regulatory schemes and subject them to more burdensome requirements.

At Central Women's Services a woman can receive treatment and education on how to prevent sexually transmitted infections, an unplanned pregnancy, receive medical testing and routine gynecological care, and also terminate a pregnancy if she decides that is the best option for herself. House Bill No. 2176 does not have any true intentions of making reproductive healthcare any easier or safer for Kansas women. With numbers and statistics which support that legal abortion is a safe procedure, it is hard to ignore the hidden agenda of anti-abortion supporters within the government to make it harder for women to exercise their constitutional right to choose abortion if regulatory laws aimed just at abortion providers have made abortion unavailable.

Thank you for allowing me this opportunity to testify.

Sincerely,

Willow Eby RN

Willow Eby, RN