Approved: April 4, 2003
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE.

The meeting was called to order by Chairperson Senator Susan Wagle at 1:30 p.m. on March 25, 2003 in Room 231-N of the Capitol.

All members were present except: Senator Nancey Harrington

Committee staff present: Mr. Norm Furse, Revisor of Statutes
Ms. Margaret Cianciarulo, Administrative

Conferees appearing before the committee: Ms. Sylvia Raeff, National Organization for Women, Lawrence Chapter
Ms. Willow Eby, R.N. reading testimony for the Center for Reproductive Rights
Mr. Mark Peterson, Manager, Clinic Manager for S. Zaremski, MD
Representative Peggy Long
Ms. Kathy Ostrowski, State Legislative Director, Kansans for Life
Ms. Jeanne Gawdun, reading testimony for Ms. Denise M. Burke, Esq., Americans United for Life
Mr. Mike Farmer, Executive Director, Kansas Catholic Conference

Others attending: See attached guest list

Continued Hearing on HB 2176 - an act concerning abortion clinics; providing for regulations licensing and standards for the operation thereof; providing penalties for violations and authorizing injunction actions

Upon calling the meeting to order, the Chair announced she would continue the hearing on the above bill and would be calling on the last three opponents listed on yesterday's hearing agenda that were unable to testify due to lack of time.

The Chair then recognized Ms. Sylvia Rueff for the Kansas National Organization for Women, the Lawrence Chapter, who stated that their organization believes Targeted Regulation of Abortion Provider (TRAP) bills, such as this one, are discriminatory, there are no other regulations in Kansas statute that cover medical service for any other surgical procedures for people or animals, and to single out regulation by statute providers of abortion procedures, which are uniquely for women, is discriminatory. A copy of her testimony is (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

Ms. Willow Eby, R.N. was the next opponent conferee. Ms. Eby read testimony for the Center for Reproductive Rights that listed their reasons why they oppose the bill (ex. An unnecessary measure, will not serve women's health, violates constitutional rights and informational privacy rights, and costly to the State). A copy of her testimony is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

The final opponent to testify was Mr. Mark Peterson, Clinic Manager for S. Zareznski, M.D out of Kansas City, Kansas, who stated that, in 31 years from 1971 to 2001, there has been 314,000 abortions and one documented anesthesia-and-food choking-related death with an abortion in Kansas and this bill would not have prevented this death. A copy of his testimony is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

The Chair then recognized the first proponent, Representative Peggy Long, who cited incidences, told first hand, about two seventeen year olds who died after suffering from a perforated uterus and questions opponents who stated that it would cost too much money to have someone in the room when a woman is examined, yet she knows of no other physician's office where this is not common practice. A copy of her testimony is (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

The second proponent was Dr. Laura Kenny, who stated that 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. She also stated that 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. A copy of her testimony is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

Next was Ms. Kathy Ostrowski, State Legislative Director for Kansas for Life, who offered a list of Kansas licensed practitioners to support the bill, malpractice filings against abortionist Robert Crist, an information bulleting from Kansas for Life showing how Planned Parenthood failed inspections in Kansas and Missouri. A copy of booklet she provided is filed in Senator Wagle's office.

The fourth proponent was from Ms. Jeanne Gowdun who read testimony for Americans United for Life from Ms. Denise Burke, staff counsel. Ms. Burke offered specific testimony on:

1) the constitutionality of abortion clinic regulations and the status of current litigation;

2) the prevalence of abortion clinic regulations in other states;

3) the national abortion care standards and protocols that form the basis of **HB 2176** an other similar laws; and

4) evidence of substandard care that generally supports the need for abortion clinic regulations.

Finally, she stated, she would attempt to answer common objections to or misunderstandings of laws regulating abortion clinics and suggest amendments to subsection (o) to cure potential constitutional infirmities. A copy of her testimony is found in the booklet provided by Ms. Ostrowski and again, filed in Chairperson Wagle's office.

The last proponent called to testify before the Committee was Mr. Mike Farmer, Executive Director of the Kansas Catholic Conference, who stated that the bill enables legislation that directs the Secretary of KDHE to adopt rules and regs for an abortion clinic's facilities and when drafting this bill last year, the regulations that were used came directly from clinic regulations used by the abortion industry itself that 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 his testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

As there were no neutral testimony, written testimony was offered from Ms. Judy Smith, State Director of Concerned Women of America, and from Senator Nick Jordan with an attachment. A copy of both are (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

The Chair then asked for questions or comments from the Committee. Questions and a comment came from Senators Barnett, Haley, Wagle, and Brownlee for Dr. Kenney ranging from why does the first trimester abortions need to be regulated, how many deaths in Kansas clinics over the last decade because of the procedure (answered by Ms. Ostrowski), how many abortions have been performed in Kansas in the last 15 years, do we increase the cost of making one free of a crises pregnancy, if there are complications or a death that occurred from an abortion is that registered or listed as something as a different medical malady rather as a result of an abortion, to the difficulty in trying to determine all of the morbidity and mortality related to abortions.

Action on the above bill HB2176

The Chair closed the hearing and asked that the Committee work the bill. She then asked Mr. Furse to distribute a balloon indicating several new amendment to the bill and asked Senator Barnett to explain them. A copy of the balloon is (Attachment 8) attached hereto and incorporated into the Minutes as referenced.

An overview of Senator Barnett's explanation of the amendments is as follows:

1) In regards to language on page 1, beginning on line 25, the issue was raised that the legislation is not distinguishing between medical and surgical abortions, so some suggested language would be as written in which "surgical abortions or where a surgical procedure for an abortion is the standard protocol for a failed medical abortion." and striking the language of "five or more first trimester abortions, etc."

A discussion ensued between Senators Wagle, Brungardt, and Steineger as to the usage of the language of "five or more used", the concern being, in Kansas the question is why would you treat an abortion facility different than a physicians office and the answer being that we are dealing with surgical procedures and typically a facility that offers surgical procedures is regulated by KDHE. The statement was made that there plenty of facilities where surgical procedures take place that are not regulated as a clinic, they are regulated by practice acts and whether the licensed is a practitioners.

2) Beginning on page 2, line 43 and the top of page 3 line 1, they are addressing the issue that was heard in testimony regarding the issue of someone being present in the examining room. This language would be struck and new language would read to include another individual be present in the room during a pelvic exam or during the procedure if the physician is a male, then the other individual will be female.

3) Dropping down to line 26 on page 3, testimony was heard from Dr. Hodes regarding whether a test should be performed for anemia and Senator Barnett, speaking as a doctor himself, indicated he could think of instances where it would not be necessary, so they would be inserting "as indicated" to give the physician that judgement.

4) On page 4, beginning on line 31, Senator Barnett also felt there were inconsistencies about admitting privileges found earlier in the bill (still in section 1) and yet it is still important that someone be there when the patient is in recovery or before discharge, so the new language would read to include a "nurse shall remain" on the premises as well as the physician until all patients are "discharged" and the physician "or nurse" shall be readily accessible and available until the last patient is discharged.

Senators Brownlee asked regarding the word "nurse " as used here, is it defined in a certain way? Senator Barnett suggested taking from the Planned Parenthood's language in the green sheet, top of line 3 of the booklet Ms. Ostrowski provided. The Chair asked Mr. Furse if they needed to define this. Mr. Furse said that this could be placed in the definition section, keeping in mind that for the most part, these subsections are directions to the Secretary to adopt rules and regs. Dr. Kenney felt the intent was to have someone there that could resuscitate the patient should something occurred. Ms. Ostrowski stated that there are lawsuits pending regarding a traveling physician and patients being left in the care of someone not qualified. Mr. Peter Brownlie stated that nurses who are trained appropriately can handle the situation, because it is not essential for a physician to be on site in the recovery room at all times. Senator Barnett agreed and offered often, in other ambulatory care centers, if the physician is gone, they will by phone, authorize admission and the nurse may call the order in. He stated, he was just trying to be consistent with what others practiced in the State.

5) there were two items raised yesterday, the first on page 6, where one of the Senators raised the issue of criminal fines and wondered about the consistency of this compared to other hospitals and surgery centers, so language developed to make this consistent with licensure revocation and not criminal penalty and at the top of page 7, the misdemeanor B is stricken and is replaced with the information on page 6 of the balloon. Senator Barnett stated that Mr. Furse has reviewed current statutes for other facilities and felt this would fit nicely. Mr. Furse stated that this was a modification the hospital statutes.

The Chair recognized Senator Jordan who asked, "if the license is revoked, what happens, do they continue to operate unlicensed?" Mr. Furse stated that the language of the bill requires that each clinic would be required annually to obtain a license and again, language could be added to specifically say they could not operate without a license. He felt that the implication was here. Senator Jordan asked what happens to facilities, such as hospitals, when they loose their license? Mr. Furse said that they cannot operate. Senator Jordan then said that if the legislature is going to be consistent, he would suggest to add some kind of language to state that these types of clinics also could not operate if their license had been revoked. The Chair did say that the new language on page 6 takes this into account.

The Chair then asked Mr. Furse that in order to enforce this, would there also be a need to add that the facility could no longer operate if their license has been revoked? Mr. Furse said it would not hurt, even though the implication was there, stating that they are required annually to obtain a license, but the language does not say that no abortion clinics may operate unless it has a license.

The Chair asked the Committee if there would be objection to first dealing with the criminal penalty (pages 6 and 7) after Senator Barnett explained the second issue, to explain to those here, regarding how practice technology and imaging changes, so language was suggested that the Secretary periodically share review and update current practice technology standards under this Act and based on current practice or technology, adopt, by rules and regulation, alternative practice or technology standards found by the Secretary to be as effective as those enumerated in this act. And again, trying to allow for change and not have an obsolete bill in a year or two.

The Chair then asked Mr. Furse where he felt the language of revoking the license should be? Mr. Furse replied that, based on the policy idea, the Committee needed to insert in front of the word "each", in line 29, that no abortion clinic shall operate in the State unless it has a currently effective license.

Action on HB 2176 - an act concerning abortion clinics

Senator Brownlee made a motion to:

1) adopt the balloon on page 6 and include the additional language that upon the revocation of a license, that the facility would be closed,

2) strike the misdemeanor on page 7, and

3) and inserting new language on page 6 line 29, that no abortion clinic shall operate in the State unless it has a currently effective license.

Senator Harrington seconded the motion and the motion carried.

Senator Haley asked what the violation was and the Chair answered if there was a substantial failure to comply, they could loose their license to operate rather than a misdemeanor.

The Chair then asked the Committee to return to page 1 of the bill and deal with the first amendment only.

Senator Brownlee made a motion to adopt the amendment on page 1, striking the section "five or more first trimester abortions".

Senator Haley asked for discussion. The Chair said she believed it had gone through the courts, and felt she and Senator Barnett were concerned that to justify the need for this bill the Committee might apply it to surgical abortions or to facilities where medical abortions were performed and it is required when a medical abortion fails that a surgical abortion takes place. She mentioned that in the Planned Parenthood guidelines, the National Abortion Federation provided what their standards are for a medical abortion stating:

"A medical abortion is irreversible once the mifepristone or methorexate has been taken. Deciding to continue a pregnancy to term is not an option at any point after taking the first medication. The embryo is not expelled after using these medications, a suction procedure, which is a surgical abortion, must be done to empty the uterus and complete the abortion".

The Chair stated, that even in a clinic where they are only doing medical abortions, they have to be able to do a surgical abortion immediately if the medical abortion is not complete. To clarify, Senator Harrington asked if this language would include medical abortion? Mr. Brownlee stated that medical abortion requirements certainly are FDA requirements and standard requirements are that a surgical abortion be available in a backup instance, but does not have to be performed in the same physical facility in which the medical abortion was provided. The primary rationale for the development of a medical abortion is for that service to be provided in non-surgical facilities.

The Chair asked how soon after a medical abortion do you have to have the suction take place? Mr. Brownlee stated it varies depending upon when it is discovered, that if fact that the medical abortion was not successful. The FDA requirements are that there be a surgical facility within 15 miles of the cite from where the medical abortion is provided. The Chair asked if the FDA also limits the number of weeks which you can perform a medical abortion to seven weeks? Mr. Brownlee stated that this standard is changing right now and does not know if it is moving to 9 weeks as a result of research and experience. She asked if he would object if the Committee limited this to seven weeks for a medical abortion? Mr; Brownlie said he would because, at this point, the standard is moving to 9 weeks, but if the Committee would be willing to again convene and amend this law as the standards change, he would agree to this.

Senator Barnett asked Mr. Brownlee to check the language which would require that the standard protocol for a medical abortion was a surgical procedure and that this is what would be impacted by this wording. Mr. Brownlee felt the wording "standard protocol" was vague and did not indicate the actual facility and the physical location where an abortion is provided, as long as it is clear that it is where the surgical procedure is in fact provided. Senator Barnett indicated that was his intent as well. Senator Barnett asked Mr. Furse if he had any suggestions? Mr. Furse felt they were looking at language that says that surgical abortions are performed or where a surgical procedure for an abortion would take place and the physical facility is the standard protocol. If the protocol is to go to a different location or go to a hospital then this definition would not pick this up, but if the protocol is to do the surgical procedure in the facility also, then this would pick this up.

Senator Brownlee then withdrew her first motion and moved to adopt the language stating where surgical abortions are performed or where a surgical procedure for an abortion is to take place in the facility is the standard protocol for a failed medical abortion. Mr. Furse said this would clarify that it is in the abortion clinic location that the surgery would take place, if it is not, then it would be excluded from the definition of abortion clinic. Senator Haley said his understanding that what Senator Barnett was bringing us, was to

define surgical versus medical abortions and we would not want to have the same regulation apply for surgical as we do medical. He stated this was his reason for making a motion so that we get medical procedures outside the realm of **HB2176**. Senator Steineger seconded, there were four who did not favor, so the motion did not pass.

The Chair recognized Senator Brownlee who suggested that the abortion clinic mean a facility other than an accredited hospital and where surgical abortions are performed. The Chair stated she was thinking that the way this was written, it would also regulate a clinic that did medical and surgical abortions, because a medical abortion, as stated before, if not successful, the patient must have a surgical abortion. Senator Brownlee stated in that case, they would fall under this act and the surgical abortion would have to be done in a licensed clinic. The Chair stated that they are already covering second and third trimester abortion which believed there were no issues, and are they all surgical are they not? Senator Barnett said yes and he would support Senator Brownlee's conceptual amendment.

The Chair then asked Senator Brownlee restate the motion. Senator Brownlee made a motion to adopt the amendment that reads as "the abortion clinic means a facility other than an accredited hospital and where surgical abortions are performed. Senator Barnett seconded the motion and the motion carried

The Chair then asked the Committee to turn to page 3, dealing with the language of the female in the room if this physician is a male and the test for anemia as indicated. Senator Wagle made a motion to adopt both amendments (line 1 and line 26) as presented by Senator Barnett. Senator Brownlee seconded the motion and the motion carried.

The Chair asked the Committee to move on to page 4. She said she thought Senator Barnett was trying to attain something similar to the current practice. Senator Brownlee made motion to adopt these but would like to add to this motion that "nurse" be conceptually appropriately defined or described in this amendment. A discussion ensued with Senators Brownlee, Haley, Barnett, and Wagle and Dr. Kenny regarding what type of nurse would be able to assist after the physician has left, what was the intent, is the standard to high or to low, ACLS certification, and addresses the issue of CPR.

The Chair again asked Senator Brownlee to restate her motion. Senator Brownlee made a motion to adopt the balloon on page 4 with the conceptual addition that the nurse be an RN and ACLS trained. However, Senator Barnett stated there could be ARNPs, PA's, but felt that the ACLS certified would be what we would want to adopt and leave the definition out of this. The Chair then asked if Senator Brownlee would amend the conceptual motion to allow a nurse who is ACLS trained.

Senator Brownlee made a motion to adopt the balloon on page 4 with the conceptual addition that the nurse be ACLS trained. Senator Harrington seconded the motion and the motion carried.

The Chair then asked the Committee if there were any more amendments requested on this bill? As there was none. Senator Harrington made a motion to move the amendment out favorably. Senator Brownlee seconded the motion The Chair asked for comments. Senator Haley commented that the Committee had not yet gotten to the point of understanding what this bill does, stating he felt the Committee did not know where the stats are, whether or not we are raising the costs, and would like to make a motion to make an interim study to look at the cost of this. The Chair stated a substitute motion for interim studies has been requested, seconded by Senator Brungardt, as there were more "no's" than "I's" and the motion was defeated. The Chair said the Committee was now back on the original motion and asked if the bill be passed out favorably as amended? The Chair stated it appears that the "I's" have it. Senator Haley asked for a division. The Chair then stated a request has been made for a division and asked the Committee to raise their hands if they were for the bill and passing it out amended as favorably. The Chair counted six as in favor and three as opposed. The Chair stated the motion passed and that Senator Haley is recorded as a no, and asked if others want to be recorded. As there was none, the Chair thanked the Committee.

Adjournment

As it was after 2:30 p.m., the Chair adjourned the meeting. Adjournment was at 2:35 p.m. The next meeting is on call of the Chair

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Tuesday, March 25, 2003

NAME	REPRESENTING
Mark Pederson	Aid For Women Zavemski, MD
Sylvie J. Rueff	KANSAS N.O.W
Jennifer McAdam	PPKM
PETER BROWNLIE	PPKM
Willow Ely	Center for Reproductive Rights
[illegible]	Sen. Brungardt
K. OSTROWSKI	KFL - Legis. Director
Jeanne Gawdun	KFL
Mike Farmer	Kansas Catholic Conference
J. M. Byrnes	Sen. Salmans
Sarah Samuelson	Rep. Becky Hutchins
Jennifer Gordon	El Centro Inc
Travis Barnhart	KNASW
Erin Rutschmann	KNASW
Ruth Hausmann	Sen. Lyon
Jodie Anspaugh	Sen. Brownlee

Testimony for the Public Health and Welfare Committee of the Kansas Senate
March 24, 2003

In opposition to HB 2176, an act concerning abortion clinics

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

Chair Wagle and Members of the Committee,
Kansas NOW opposes the passage of this bill.

- The National Organization for Women believes **Targeted Regulation of Abortion Provider (TRAP) bills, such as this one, are discriminatory.** There are no other regulations in Kansas statute that cover medical service for any other surgical procedures for people or animals. To single out for regulation by statute providers of abortion procedures, which are uniquely for women, is discriminatory.

- **There is no safety problem with abortion as it is in practice in Kansas today**. The risk to Kansas women having abortions is far less than the risks associated with pregnancy and childbirth.[i] Where abortion is administered in a medical environment the risk of fatality is less than .01%.

- **This is a bad bill**. It is ill advised, poorly written, and riddled with vagueness. A similar bill that was passed by the legislature in Arizona has been in their state court system since 1999. Kansas can ill afford a protracted court case at this time.

- **This bill would increase the risk of unsafe illegal abortions among women in need**. The affect of this bill would be to make safe abortions unaffordable for even more of those women and their families who are in need; for whom healthcare, childbirth, and, indeed, life itself is most difficult to afford.

"There aren't 'women who have abortions' and 'women who have children.' Those are the same women at different parts of their lives." - Rachel Atkins, PA. MPH, Executive Director, Vermont Women's Health Center.

- 43% of all women will have had at least one abortion by the time they are 45 years old.[ii]

- Doctors have performed abortions for women from 8 to 53 years old. [iii]

- 26.6% of abortions are for women with annual household incomes below poverty level. [iv]

- 6 out of 10 abortions are for women who were using birth control that failed[v]

- More than 40% of the women who have abortions describe themselves as Catholic, or describe themselves as born-again or Evangelical Christians.[vi]

- In the U.S. more than 16,000 women have abortions each year because they became pregnant as the result of rape or incest.[vii]

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- Abortion is not used as a primary form of birth control. If abortion were used as a primary form of birth control, a typical woman would have at least 2 or 3 pregnancies per year ...[viii]

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 twelve times safer than childbirth.[ix] There is no need to single out abortion providers for regulation by statute.

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[i] Preliminary Findings Comparison of Kansas Mortality ICD-9 vs. ICD-10, 1990-1999, Research Summary, Center for Health and Environmental Statistics Kansas Department of Health and Environment, March 2002, pages 24, 32.

[ii] Henshaw, S. K., Unintended Pregnancies in the United States, Family Planning Perspectives, 1998, 30:24-29, 46.

[iii] Interview with Dr. George Teller, July 1998

[iv] Jones, R. K., Darroch, J. E., Henshaw, S. K., Patterns in Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001, Perspectives on Sexual and Reproductive Health, 2002, 34:5, 226-235

[v] Jones, R. K., Darroch, J. E., Henshaw, S. K., Contraceptive use among U.S. women having abortions in 2000-2001, Perspectives on Sexual and Reproductive Health, 2002, 34:5, 294-301. "Fifty-four percent (54%) of women who had abortions in 2000 said they had used contraception in the month they conceived."

[vi] Jones, R. K., Darroch, J. E., Henshaw, S. K., Patterns in Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001, Perspectives on Sexual and Reproductive Health, 2002, 34:5, 226-235. " Twenty-seven percent (27.4%) of women having an abortion identified themselves as Catholic... Thirteen percent identified themselves as "born again" or evangelical, three-fourths of whom were Protestant."

[vii] Alan Guttmacher Institute & Physicians for Reproductive Choices, An overview of Abortion in the United States, January 2003. "Each year at least 10,000-15,000 abortions occur among women whose pregnancies were the result of rape or incest."

[viii] Dudley, Susan, Ph. D., Women Who Have Abortions, NAF Fact Sheet, January 1996. "...30 or more during her lifetime."

[ix] Preliminary Findings Comparison of Kansas Mortality ICD-9 vs. ICD-10, 1990-1999, Research Summary, Center for Health and Environmental Statistics Kansas Department of Health and Environment, March 2002, pages 24, 32.

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March 24, 2003

VIA FAX AND U.S. MAIL

Senate Public Health and Welfare Committee
Senator Susan Wagle, Chair
300 SW 10th Ave., Room 128-S
Topeka, KS 66612-1504

Re: House Bill 2176

Dear Chairwoman Wagle and Committee Members:

The Center for Reproductive Rights (formerly the Center for Reproductive Law and Policy) firmly opposes House Bill 2176 and urges you *not* to vote the bill out of committee. Lawyers from the Center for Reproductive Rights have successfully litigated numerous cases around the country concerning similar targeted restrictions of abortion providers (or "TRAP") laws, and have provided legal expertise to legislators, advocates and governors about this issue. Given our knowledge and experience, we believe that HB 2176 is an unnecessary, harmful and costly measure and urge you to oppose it for the reasons discussed below.

A. HB 2176 Is An Unnecessary Measure.

The sponsors of HB 2176 have failed to demonstrate any logical rationale or need for this bill. Legal abortion is one of the safest surgical procedures in this country; and in Kansas there has not been a *single* death attributed to abortion over the past ten years (unlike the 100+ deaths over the same time period that are attributable to other medical procedures). Therefore, HB 2176 fails to respond to any existing need, and rather is an unnecessary bill that will simply harass abortion providers without any resulting health benefit.

B. HB 2176 Will Not Serve Women's Health.

Enacting HB 2176 will not serve women's health. Rather than focusing on the specific practice of abortion clinics and the needs of the women these clinics serve, this bill will regulate abortion clinics as general ambulatory surgical centers, imposing requirements that are unrelated to the practice of abortion and unresponsive to women's needs. Abortion clinics in Kansas have been diligently protecting women's health (as the above statistics demonstrate) and these generic

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regulations will not provide any additional protection. Therefore, instead of attempting to legislate the practice of medicine, as the sponsors of HB 2176 would have you do, this committee should defer to the existing knowledge, expertise and practices of abortion doctors in Kansas and oppose this bill.

C. HB 2176 Will Pose an Undue Burden on Women in Kansas.

The real goal of the sponsors of HB 2176 is to make it harder for women in Kansas to access abortions. If HB 2176 is enacted, six out of seven existing abortion clinics in Kansas will have to make extensive changes to comply with the law, such as undergoing extensive renovations, purchasing additional equipment, hiring new staff, establishing new protocols and systems, and so forth. All these changes will be quite costly. These clinics will thus be faced with a choice of complying with these changes (but then passing the costs onto their patients) or going out of business. Either way, access to abortions will decrease – either because there are fewer providers, or because abortions will become prohibitively expensive. The true effect of HB 2176 will be to make it difficult for women in Kansas to exercise their constitutional right to choose abortion.

D. HB 2176 Violates the Constitutional Rights of Abortion Providers.

Equal Protection: Because HB 2176, like most TRAP laws, singles out abortion providers and targets them with regulations that are not similarly imposed on other medical practices, HB 2176 violates the constitutional rights of abortion providers under the equal protection clause of the Constitution (which requires that similarly situated entities be treated equally).

Search and Seizure: In addition, because HB 2176 seems to authorize unlimited inspections of abortion facilities – without requiring a search warrant or proof of potential legal violation, and regardless of whether patients are in the facility at the time - HB 2176 violates providers' rights to be free from unreasonable search and seizure under the Fourth Amendment of the Constitution.

Due Process: Finally, HB 2176 unfairly imposes vague (and inconsistent) requirements on providers. For example, two different sections of the bill impose conflicting rules about the availability of doctors with admitting privileges - Section 1(d)(3) merely requires that "a physician with admitting privileges at an accredited hospital in this state is *available*" (emphasis added); whereas Section 1(g)(4) requires that "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.*" (emphasis added). Despite the fact that the two provisions pose conflicting requirements, doctors will be penalized with criminal misdemeanor sanctions if they fail to comply. By imposing criminal penalties for failure to comply with laws that are too confusing to comply with, HB 2176 violates the due process rights of providers.

E. HB 2176 Violates Informational Privacy Rights.

Because HB 2176 authorizes unlimited, random inspections of abortion facilities by the state – without any specific exclusion for patient records – HB 2176 poses a serious threat to patient confidentiality. Even though the bill includes a provision in Section 1(l) that information received via inspections shall "not be disclosed publicly in such manner as to identify individuals," the fact that inspectors may view confidential records, without patient consent, violates the right to medical privacy and poses a serious threat to patient confidentiality. In addition, such random inspections are likely to deter women from safely seeking abortion services.

F. "TRAP" Laws Have Been Successfully Challenged In Court or Overturned by State's Attorney Generals.

A number of TRAP laws around the country have been successfully challenged in court, or have been struck down by attorney general opinions, for the same reasons that HB 2176 is defective.

For example, a federal district court struck down part of Arizona's TRAP scheme (enacted in 1999 but never enforced), on October 1, 2002, in response to litigation brought by the Center for Reproductive Rights. Arizona's law, like HB 2176, would have allowed warrantless inspections of abortion clinics and unauthorized review of patient records. The court found that the law violated the Fourth Amendment rights of physicians to be free from unlawful searches, and violated the constitutional rights of patients to confidential medical information. The case is now on appeal to the 9th circuit.

The Center for Reproductive Rights similarly successfully challenged Louisiana's TRAP law, which was enacted in July 1999, and like HB 2176, treated abortion clinics like ambulatory surgical centers. In August 1999, the court issued a preliminary injunction preventing enforcement of the law, and in August 2000, a federal district court judge issued a permanent injunction, finding that abortion facilities are not the same as ambulatory surgical centers and should therefore not be forced to submit to their regulatory requirements.

South Carolina's TRAP law has been partially enjoined since 1996, due to litigation brought by the Center for Reproductive Rights. Like HB 2176, South Carolina's law allows for unauthorized inspection of patient records. After extensive litigation, on October 31, 2001 the district court ruled that sections of South Carolina's TRAP law violated privacy rights; this decision was reversed by the 4th Circuit, and the case is now on appeal to the U.S. Supreme Court.

Other challenges to TRAP schemes have been at least partially successful in several other states recently, including Oklahoma, Tennessee and Texas.

And in many states, TRAP laws have been examined by state attorney generals and have been rendered unenforceable due to attorney general opinions. These states include Alaska, California, Connecticut, Hawaii and Idaho.

G. HB 2176 Will Be Costly To The State and Taxpayers.

Given the poor success rates in courts and attorney general departments, it is clear that TRAP laws are difficult to defend, and states incur significant expense in attempting to do so. For example, the state of South Carolina has incurred considerable expense defending its TRAP law over the past 9 years. In these tight budget times, it would be irresponsible for Kansas to enact a similarly defective law, which would require sizeable state dollars to defend.

In addition to litigation costs, HB 2176 will also impose other state costs, including staff salaries to inspect facilities and provide enforcement. Given that HB 2176 is an unnecessary measure, these additional expenses cannot be justified.

H. Conclusion.

For these numerous reasons, we urge you *against* voting HB 2176 out of your committee. Please do not hesitate to contact us with any questions.

Sincerely,

Priscilla Smith
Director, Domestic Legal Program*

**Admitted only in California*

Erica Smock
Legislative Counsel**

Admitted only in California and Oregon

Senate Federal & State Affairs (Amended HB 2176) Objections 24 March 2003, 1:30pm

Mark Pederson, Clinic Manager for S. Zaremski, MD, Kansas City, KS, 800-626-9184.
National Abortion Federation member

Amended House Bill 2176 is not 'protective' legislation for women; it is another installment of whittling away women's access to abortion, 'legal yet inaccessible' per proLife statements[1]. The bill's proponents cite numerous problems associated with abortion clinics but where are the facts? This is a non-issue, much like the supposed proLife "fact" that abortion causes breast cancer, forced into several states informed abortion consent laws, and recently debunked this month by the National Cancer Institute.[2] Where is the hard data showing problems with abortion providers compared to non-abortion providers, and why does the data collection of HB2176 apply only to abortion providers and not all physicians? According to the Board of Healing Arts Negative Disciplinary Actions (NDA) data, non-abortion providers were more of a problem. There were 209 NDA's from 1994 to 2000, of which the 33 Sexual Misconducts were all from non-abortion providers.[3,4] Where is the medical crisis that needs fixing?

In the 70's and 80's hospitals did the abortions and could not keep up with the demand, and therefore free-standing abortion clinics arose as a safe and more economical alternative. Then in the 1990's, hospitals were forced out of the abortion business by private hospital buy-outs by anti-abortion interests, and by restrictions placed upon state-funded hospitals from doing abortions, relegating them to only private clinics and doctor's offices.

There has been one documented anesthesia-and-food-choking-related death[5] with an abortion in Kansas in 31 years from 1971 to 2001, and 314,000 abortions.[6] This bill would not have prevented this death. There were 303 non-abortion-related deaths from 1990-2001 due to 'Misadventures to Patients During Surgical and Medical Care' in Kansas.[7] There have been 34 birth-related deaths and 455,310 births from 1990 to 2001.[8,9] This bill does not address any of these other deaths. National mortalities are 11.8 per 100,000 births and 0.6 per 100,000 abortions.[10,11] Allegations of abortion malfeasance are twisted by avoided available facts.

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 we will refer them.

Nearly identical to an abortion, a D&C after a miscarriage is often done in ObGyn offices, and at one-fifth the cost of a hospital. 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. Other unregulated office procedures that are at least as complex as abortion include *Sigmoidoscopy* (short-distance colon scope), *Colonoscopy* (long-distance colon scope), *Gastroscopy* (esophagus/stomach scope), *Bronchoscopy* (into the lungs scope), *Vasectomy* (local anesthesia only), *Laparoscopy* (through abdomen to scope abdominal organs, tubal ligations included), *Intra-uterine biopsy* (endocervical and endometrial, for unexpected vaginal bleeding diagnosis), *D&C* (after incomplete spontaneous abortions), and *IUD insertions*. These have risks with anesthesia, infection, hemorrhage, opportunity for sexual impropriety, can be done outpatient in a doctor's office, and are not currently regulated differently than an abortion. "Four of the 10 most commonly performed operations in the USA are dilation and curettage (D&C), tubal sterilization, abdominal hysterectomy, and vaginal hysterectomy."[12] More than 1 million female and 1 million male sterilizations are done annually.[13]

The American College of Gynecologists (ACOG), the National Abortion Federation (NAF), and the Planned Parenthood Federation of America (PPFA) object to such regulations. We are a NAF member meeting inspection standards, and we still disagree with these regulations. Why do the proponents try to claim this bill only follows regulations we already use? Standards, yes, recommendations, no; Recommendations are twisted into requirements by the bill (see hematocrit, or personnel requirements). Multiple sections were added to be tedious (see lighting & ventilation, or durable supplies checklists).

The goal of patient protection is good, but this legislation does not provide that. Reasonable changes should come from a Board of Healing Arts regulation and applied to all physicians, e.g. Kansas Medical Society's "Guidelines for Office-Based Surgery and Special Procedures, 2002". And specific proscriptive laws are usually implemented by regulation not statute (see Kansas Board of Healing Arts, State Board of Examiners in Optometry, Kansas Dental Board, Kansas Board of Cosmetology, and the Kansas Board of Veterinary Examiners.)[14]

I thank you for your listening time. If you have any other questions, please ask.

Senate Public Health & Welfare Committee
Date: March 25, 2003
attachment 3-1

Quick thoughts
-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 therapeutic 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[10,11] and does not need more regulations.
-Why do abortion patients know so little about contraception? **Lack of sex education.**

---

[1] Targeted Regulation of Abortion Providers (TRAP), The Center For Reproductive 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] National Cancer Institute website article dated 3-21-03, **http://cis.nci.nih.gov/fact/3_75.htm**
[3] Disciplinary Action Table, 1994-2000, Kansas Board of Healing Arts. Data for 2001 and 2002 not available yet. Negative Disciplinary Actions (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.
[4] Patrick Herrick, MD, PhD in 2002 written proponent statement about HB2819 same as this year's HB2176, "Kansas Board of Healing Arts final board actions over the last 5 years involve over 25% of known abortionists in the state."
[5] 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 1988 death was caused by aspiration of vomit during anesthesia. She had eaten prior to surgery contrary to protocols.
[6] "Reported Abortions by Place of Residence Kansas", 1971-2001, KDHE Center for Health and Environmental Statistics, Office of Health Care Information.
[7] "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.
[8] http://kic.kdhe.state.ks.us/kic/death.html
[9] http://kic.kdhe.state.ks.us/kic/birth.html
[10] 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.
[11] "Safety of Abortion", Susan Dudley, National Abortion Federation, c. 1996.
Also, CDC Pregnancy-Related Mortality Surveillance --- United States, 1991--1999,
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm
[12] Therapeutic Gynecologic Procedures, Chapter 45, L. Russell Malinak, MD & James M. Wheeler, MD, from Current Obstetric & Gynecologic Diagnosis & Treatment, pg. 822, Edited by Martin L Pernoll, Ralph C. Benson.
[13] ibid., pg. 827.
[14] Kansas Board of Healing Arts, http://www.ksbha.org/regs.html
Specific proscriptions fall under rules and regs. See Physician Assistants, Short Term Treatment of Obesity, or Light-based Medical Treatment' [usually plastic surgery using laser knife or Lasix eye surgery];
State Board of Examiners in Optometry, http://www.terraworld.net/kssbeo/Statutes.htm
Specific proscriptions fall under rules and regs. See Minimum Standards For Ophthalmic Services;
Kansas Dental Board, http://www.accesskansas.org/kdb/legislation.html
Specific proscriptions fall under rules and regs. See Sedative and General Anaesthesia;
Kansas Board of Veterinary Examiners, http://www.accesskansas.org/veterinary/policies.html

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HOUSE OF
REPRESENTATIVES

TESTIMONY MARCH 25, 2003
HB 2176
CLINIC LICENSURE

Madam Chairman and esteemed members of the committee. Knowing that you have much ground to cover, I will be brief in my comments today regarding HB 2176. I must say, it was very enlightening to sit through the testimony offered up yesterday on this bill. In the course of seven years, this was the first time I have been accused of being disingenuous and even dishonest. As a matter of fact, I have rarely seen such disrespect for our body since coming into the legislature. It seemed apparent by the comments made against the legislature, that the abortion industry does not hold us in high regard, nor does it have respect for the authority that has been granted to us by the citizens of the great state of Kansas.

With that off of my chest, I would just like to comment about some of the statements that I heard yesterday. This type of legislation has passed not only in Arizona, but in South Carolina, Texas, and Louisiana as well. Some statements were made yesterday that cried out "Show us the proof". Didn't O.J. Simpson say something like that? If this legislation is not necessary, why have I heard two stories last year that told first hand about two seventeen year olds who died after suffering from a perforated uterus? One call came from a health care official who told of a code blue coming from a clinic in Wichita. The first responders picked up the patient, but it is reported that she did not survive the trip to the hospital. The second incident was a young student that sat in on the testimony in the Senate committee last year. She followed me out of the hearing and approached me. She stated that her sister had received an abortion and had died. I have since talked with her by phone on three occasions and spoken with her mom as well. Perhaps one day, she will be strong enough to stand up and testify to this fact.

I have heard over and over again that abortion should be "Safe, legal, and rare." In Kansas, abortion is not rare. In Kansas, it is very legal; even up until the first breath of the baby. Now lets make abortion safe. I thought about our soldiers who had been taken captive in a foreign land only recently and immediately the captivity of women who have suffered shame, sexual abuse, and the same arrogance from the abortion practitioners that we have seen here, came to my mind. Opponents of this bill have stated that it would cost too much money to have someone in the room when a woman is examined. I know of no other physician's office where this is not common practice.

I urge you to pass HB 2176 and offer protection and respect to the most vulnerable women in our society.

Respectfully,

Peggy L. Long

Peggy L Long

Senate Public Health & Welfare Committee
Date: March 25, 2003
Attachment 4-1

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.

Senate Public Health & Welfare Committee
Date: March 25, 2003
Attachment 5-1

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.

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

March 25, 2003

TESTIMONY IN SUPPORT OF HB 2176

Chairman Susan Wagle
Senate Public Health and Welfare Committee

Madame 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.

Senate Public Health & Welfare Committee
Date: March 25, 2003
Attachment 6-1

MOST REVEREND GEORGE K. FITZSIMONS, D.D.
DIOCESE OF SALINA

MOST REVEREND JAMES P. KELEHER, S.T.D.
Chairman of Board
ARCHDIOCESE OF KANSAS CITY IN KANSAS

MOST REVEREND THOMAS J. OLMSTED, J.C.D., D.D.
DIOCESE OF WICHITA

MOST REVEREND RONALD M. GILMORE, S.T.L., D.D.
DIOCESE OF DODGE CITY

MOST REVEREND EUGENE J. GERBER, S.T.L., D.D.
RETIRED

MOST REVEREND MARION F. FORST, D.D.
RETIRED

MICHAEL P. FARMER
Executive Director

MOST REVEREND IGNATIUS J. STRECKER, S.T.D.
RETIRED

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.

Beverly LaHaye
Chairman

Judy Smith
State Director

March 24, 2003

Chairperson Wagle and Members of the Committee:
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 and that regulation be under the scrutiny of an agency that can actually do something should infractions occur.

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

Judy Smith, State Director, Concerned Women for America of Kansas

CONCERNED WOMEN FOR AMERICA
OF KANSAS

P.O. Box 11233 Shawnee Mission, KS 66207
Ph/Fax: (913) 491-1380 Email: director@kansas.cwfa.org

Senate Public Health & Welfare Committee
Date: March 25, 2003
Attachment 7-1

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

2-4

AN ACT concerning abortion clinics; **providing for regulation, licensing and** 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.

surgical abortions are performed or where a surgical procedure for an abortion is the standard protocol for a failed medical abortion

(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.

Senate Public Health & Welfare Committee
Date: March 25, 2003
Attachment 8-1

8-2

1 (9) Emergency exits to accommodate a stretcher or gurney.
2 (10) Areas for cleaning and sterilizing instruments.
3 (11) Adequate areas for the secure storage of medical records and
4 necessary equipment and supplies.
5 (12) The display in the abortion clinic, in a place that is conspicuous
6 to all patients, of the clinic's current license issued by the department.
7 ~~(b)~~ (c) The secretary shall adopt rules and regulations to prescribe
8 abortion clinic supplies and equipment standards, including supplies and
9 equipment that are required to be immediately available for use or in an
10 emergency. At a minimum these rules and regulations shall:
11 (1) Prescribe required equipment and supplies, including medica-
12 tions, required for the conduct, in an appropriate fashion, of any abortion
13 procedure that the medical staff of the clinic anticipates performing and
14 for monitoring the progress of each patient throughout the procedure
15 and recovery period.
16 (2) Require that the number or amount of equipment and supplies
17 at the clinic is adequate at all times to assure sufficient quantities of clean
18 and sterilized durable equipment and supplies to meet the needs of each
19 patient.
20 (3) Prescribe required equipment, supplies and medications that shall
21 be available and ready for immediate use in an emergency and require-
22 ments for written protocols and procedures to be followed by staff in an
23 emergency, such as the loss of electrical power.
24 (4) Prescribe required equipment and supplies for required labora-
25 tory tests and requirements for protocols to calibrate and maintain lab-
26 oratory equipment at the abortion clinic or operated by clinic staff.
27 (5) Require ultrasound equipment in those facilities that provide
28 abortions after 12 weeks' gestation.
29 (6) Require that all equipment is safe for the patient and the staff,
30 meets applicable federal standards and is checked annually to ensure
31 safety and appropriate calibration.
32 ~~(c)~~ (d) The secretary shall adopt rules and regulations relating to
33 abortion clinic personnel. At a minimum these rules and regulations shall
34 require that:
35 (1) The abortion clinic designate a medical director of the abortion
36 clinic who is licensed to practice medicine and surgery in Kansas.
37 (2) Physicians performing surgery in an abortion clinic are licensed
38 to practice medicine and surgery in Kansas, demonstrate competence in
39 the procedure involved and are acceptable to the medical director of the
40 abortion clinic.
41 (3) A physician with admitting privileges at an accredited hospital in
42 this state is available.
43 (4) [~~A licensed nurse is present during any examination performed by~~]

8-3

1 ~~a physician on a patient.~~
2 (5) A registered nurse, nurse practitioner, licensed practical nurse or
3 physician assistant is present and remains at the clinic when abortions are
4 performed to provide postoperative monitoring and care until each pa-
5 tient who had an abortion that day is discharged.
6 (6) Surgical assistants receive training in counseling, patient advocacy
7 and the specific responsibilities of the services the surgical assistants
8 provide.
9 (7) Volunteers receive training in the specific responsibilities of the
10 services the volunteers provide, including counseling and patient advo-
11 cacy as provided in the rules and regulations adopted by the director for
12 different types of volunteers based on their responsibilities.
13 ~~(d)~~ (e) The secretary shall adopt rules and regulations relating to the
14 medical screening and evaluation of each abortion clinic patient. At a
15 minimum these rules and regulations shall require:
16 (1) A medical history including the following:
17 (A) Reported allergies to medications, antiseptic solutions or latex.
18 (B) Obstetric and gynecologic history.
19 (C) Past surgeries.
20 (2) A physical examination including a bimanual examination esti-
21 mating uterine size and palpation of the adnexa.
22 (3) The appropriate laboratory tests including:
23 (A) For an abortion in which an ultrasound examination is not per-
24 formed before the abortion procedure, urine or blood tests for pregnancy
25 performed before the abortion procedure.
26 (B) A test for anemia.
27 (C) Rh typing, unless reliable written documentation of blood type is
28 available.
29 (D) Other tests as indicated from the physical examination.
30 (4) An ultrasound evaluation for all patients who elect to have an
31 abortion after 12 weeks gestation. The rules shall require that if a person
32 who is not a physician performs an ultrasound examination, that person
33 shall have documented evidence that the person completed a course in
34 the operation of ultrasound equipment as prescribed in rules and regu-
35 lations. The physician or other health care professional shall review, at
36 the request of the patient, the ultrasound evaluation results with the pa-
37 tient before the abortion procedure is performed, including the probable
38 gestational age of the fetus.
39 (5) That the physician is responsible for estimating the gestational
40 age of the fetus based on the ultrasound examination and obstetric stan-
41 dards in keeping with established standards of care regarding the esti-
42 mation of fetal age as defined in rules and regulations and shall write the
43 estimate in the patient's medical history. The physician shall keep original

Another individual is present in the room during a pelvic examination or during the abortion procedure and if the physician is male then the other individual shall be female

as indicated

8-4

1 prints of each ultrasound examination of a patient in the patient's medical
2 history file.
3 ~~(e)~~ (f) The secretary shall adopt rules and regulations relating to the
4 abortion procedure. At a minimum these rules and regulations shall
5 require:
6 (1) That medical personnel is available to all patients throughout the
7 abortion procedure.
8 (2) Standards for the safe conduct of abortion procedures that con-
9 form to obstetric standards in keeping with established standards of care
10 regarding the estimation of fetal age as defined in rules and regulations.
11 (3) Appropriate use of local anesthesia, analgesia and sedation if or-
12 dered by the physician.
13 (4) The use of appropriate precautions, such as the establishment of
14 intravenous access at least for patients undergoing second or third tri-
15 mester abortions.
16 (5) The use of appropriate monitoring of the vital signs and other
17 defined signs and markers of the patient's status throughout the abortion
18 procedure and during the recovery period until the patient's condition is
19 deemed to be stable in the recovery room.
20 ~~(f)~~ (g) The secretary shall adopt rules and regulations that prescribe
21 minimum recovery room standards. At a minimum these rules and reg-
22 ulations shall require that:
23 (1) Immediate postprocedure care consists of observation in a super-
24 vised recovery room for as long as the patient's condition warrants.
25 (2) The clinic arrange hospitalization if any complication beyond the
26 management capability of the staff occurs or is suspected.
27 (3) A licensed health professional who is trained in the management
28 of the recovery area and is capable of providing basic cardiopulmonary
29 resuscitation and related emergency procedures remains on the premises
30 of the abortion clinic until all patients are discharged.
31 (4) A physician ~~with admitting privileges at a licensed hospital in this~~
32 ~~state remains~~ [or nurse shall remain] on the premises of the abortion clinic until all patients are
33 ~~stable and are ready to leave the recovery room~~ [discharged] and to facilitate the trans-
34 fer of emergency cases if hospitalization of the patient or viable fetus is
35 necessary. A physician [or nurse] shall ~~sign the discharge order and~~ be readily ac-
36 cessible and available until the last patient is discharged.
37 (5) A physician discusses Rho(d) immune globulin with each patient
38 for whom it is indicated and assures it is offered to the patient in the
39 immediate postoperative period or that it will be available to her within
40 72 hours after completion of the abortion procedure. If the patient re-
41 fuses, a refusal form approved by the department shall be signed by the
42 patient and a witness and included in the medical record.
43 (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.

~~(g)~~ (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.

~~(h)~~ (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.

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

(j) (1) **The secretary shall adopt rules and regulations requiring**

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each abortion clinic to establish and maintain an internal risk management program which, at a minimum, shall consist of: (A) A system for investigation and analysis of the frequency and causes of reportable incidents within the clinic; (B) measures to minimize the occurrence of reportable incidents and the resulting injuries within the clinic; and (C) a reporting system based upon the duty of all health care providers staffing the clinic and all agents and employees of the clinic directly involved in the delivery of health care services to report reportable incidents to the chief of the medical staff, chief administrative officer or risk manager of the clinic.

(2) As used in this subsection (j), "reportable incident" means an act by a health care provider which: (A) Is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient; or (B) may be grounds for disciplinary action by the appropriate licensing agency.

(k) The secretary shall make or cause to be made such inspections and investigations of abortion clinics at such intervals as the secretary determines necessary to protect the public health and safety and to implement and enforce the provisions of this act and rules and regulations adopted hereunder. For that purpose, authorized agents of the secretary shall have access to an abortion clinic during reasonable business hours.

(l) Information received by the secretary through filed reports, inspections or as otherwise authorized under this act shall not be disclosed publicly in such manner as to identify individuals. Under no circumstances shall patient medical or other identifying information be made available to the public, and such information shall always be treated by the department as confidential.

(m) Each such clinic shall be required annually to obtain a license from the department. The secretary shall adopt rules and regulations providing for the issuance of such licenses. At a minimum such rules and regulations shall require compliance with the standards adopted pursuant to this act. The secretary shall establish by rules and regulations the fee for such licenses in the amount required to cover costs of implementation and enforcement of this act.

(n) 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.

(o) 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.

(1)

(2) The department shall deny, suspend or revoke a license in any case in which it finds that there has been a substantial failure to comply with the requirements established under this act and rules and regulations adopted pursuant thereto, a failure to report any information required to be reported under subsections (i) and (j) or a failure to maintain a risk management program as required under subsection (j), after notice and an opportunity for hearing to the applicant or licensee in accordance with the provisions of the Kansas administrative procedure act.

The secretary periodically shall review and update current practice and technology standards under this act and based on current practice or technology adopt by rules and regulations alternative practice or technology standards found by the secretary to be as effective as those enumerated in this act.

~~(l)~~ (p) [~~A violation of this section or any rules and regulations adopted under this section is a class B person misdemeanor.~~
~~(m) (q)~~] 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.

~~(n) 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.