Approved: March 17, 2004
Date

MINUTES OF THE HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairman William Mason at 1:30 p.m. on February 17, 2004 in Room 313-S of the Capitol.

All members were present except:
Representative Broderick Henderson
Representative Judy Morrison
Representative Candy Ruff

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

Conferees appearing before the committee:
Jennifer McAdam, Planned Parenthood Kansas & Mid-Missouri
Mark Pederson, Aid for Women of Kansas City
Anna Holcombe, Kansas National Order of Woman
Willow Eby, Central Women's Services, Wichita
Janice McMillen, President, The League of Women Voters of Kansas & Main Stream Coalition
(written testimony)

Others attending:
See Attached List.

HB 2751 - Hearing continued, Regulation, licensing and standards for the operation of abortion clinics

OPPONENTS:

Jennifer McAdam, Planned Parenthood Kansas & Mid. Missouri, opposed the bill stating that abortion in Kansas is safe and that there have been no deaths due to "induced termination of pregnancy" in Kansas since 1980 (Attachment 1). She spoke of the differences in Planned Parenthood guidelines and **HB 2751.** In conclusion she stated that protecting women's health was not the true intention of the bill but rather was a part of an effort to make abortion more expensive and less available.

Discussion followed regarding standards of Planned Parenthood, perceived lack of accurate record keeping and the fiscal impact of the bill.

Mark Pederson, Aid For Women of Kansas City, stated that **HB 2751** is not protective legislation for women, but is erosive to access of already safe medical care to further the 'legal yet inaccessible" Pro Life agenda (Attachment 2). He spoke about the impact the fiscal note would place on the six phone-listed abortion providers in Kansas adding that if abortion services are important, the State should license gratis. Included with his testimony were cost sheets, and additional resource information.

Julie Burkhart, Women's Healthcare Services rose in opposition to the bill and read into the record the testimony of George R. Tiller, MD, DABFP, (Attachment 3).

Anna Holcombe, Kansas, NOW testified that 43% of all women will have had at least one abortion by the time they are 45 years old (Attachment 4). She provided information on frequency and the reasons women seek abortions. She voiced concern that **HB 2751** would increase the risk of unsafe illegal abortions among low income women.

Willa Eby, a registered nurse testified that there were a variety of services, from Pap Smears to early term abortions, offered at the Central Women's Services, Inc. in Wichita (Attachment 5). She suggested that if outpatient, office-based surgeries are dangerous and require additional regulation, then the legislation

should encompass all such surgeries.

Written testimonies from Janice McMillen, The League of Woman Voters of Kansas (Attachment 6) and Main Stream Coalition (Attachment 7) were distributed. Written rebuttal testimony was received from Kathy Ostrowski, Kansans for Life, February 18 with a request that it be included in the February 17 minutes(Attachment 8). Copies of this testimony were distributed to the Committee on February 23.

The hearing was closed on **HB 2751.**

HCR 5033 - Constitutional amendment: state recognizes only marriage between a man and a woman.

Representative Williams made a motion to pass **HCR 5033** out favorably. Representative Ostmeyer seconded the motion.

Representative Williams made a motion to amend **HCR 5033** with a three part balloon amendment (Attachment 9). Representative Novascone seconded the motion.

Discussion followed regarding the definition and ramifications of using the term civil unions and the intent of using civil unions for benefits for partners.

The motion carried (12-6).

Representative Rehorn made an amendment to line 41, changing general election in November to primary election in August. Representative Lane seconded the motion.

Discussion followed regarding similar processes for other constitutional amendments and the importance of the election date.

Representative Edmonds made a substitute motion to advance **HCR 5033**, as amended. Representative Dahl seconded the motion. The motion carried.

It was noted that Representative Freeborn was absent, however had requested to be notified if there was a vote on **HCR 5033.** She was called and returned to the Chamber for the vote.

The meeting adjourned at 2:54 p.m. The next meeting is scheduled for February 18.

HOUSE FEDERAL & STATE AFFAIRS COMMITTEE GUEST LIST

DATE Feb 17, 2004

NAME	REPRESENTING
Willow Eby	Central Womens Service
Mark Pederson	Aid For Women, Zaremski, MD
Julie Blacklart	UHCS
Anna Holcombe	NOW lobbbyist
Joseph McAdam	
Jennifer M. Adam	Planned Parenthood
Erin Land	Sen Adkins intern
Ellie Drews	Ks. Livestock Assoc.
Ron Nelson	Nelson & Booth
Don Reynolds	Midwest Bioethics Center
Steve Johnson	Kansas Gas Service
Fred Lucky	Kansas Hosp. Assoc.
Mike Pepoon	Sedgwick Co.
Erik Sartorius	City of Overland Park
Randall Allen	Ks. Assoc. of Counties
Glancey	KDOR
Gene Wahl	

18th

Planned Parenthood®
of Kansas and Mid-Missouri

Testimony by

Jennifer McAdam
Kansas Public Affairs Director/Lobbyist
Planned Parenthood of Kansas and Mid-Missouri

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

On February 17, 2004

in Opposition to House Bill 2751

HS Federal & State Affairs
February 17, 2004
Attachment 1

4401 W. 109th St., Suite 200 • Overland Park, KS 66211 • (91

My name is Jennifer McAdam. I am the Kansas Public Affairs Director and Lobbyist for Planned Parenthood of Kansas & Mid-Missouri. Thank you, Representative Mason and members of this committee, for giving me the opportunity to discuss HB 2751 and my opposition to it.

Planned Parenthood operates three health centers in Kansas, in Wichita, Hays, and Lawrence. We also operate eight centers in Missouri. We are affiliated with Comprehensive Health of Planned Parenthood of Kansas & Mid-Missouri in Overland Park, an ambulatory surgical center licensed by the Kansas Department of Health and Environment (KDHE). Comprehensive Health provides comprehensive reproductive health services, including abortion care. In 2003, Planned Parenthood provided family planning and related care to over 30,000 women and men; comprehensive health provided abortion care to 4,000 women.

Proponents of HB 2751 would have you believe that abortions are dangerous. They claim they simply want to improve the safety of abortion care in Kansas by enacting Planned Parenthood's medical standards and guidelines into law. Both claims are disingenuous at best and intentionally dishonest at worst. This bill is unnecessary and unwise.

Abortion in Kansas is safe – far safer than other surgical procedures

Abortion is among the safest surgical procedures in this country. According to KDHE, there have been no deaths – zero – due to "induced termination of pregnancy" in Kansas since 1980, the earliest records they maintain. We know of no deaths since *Roe v. Wade* was decided 30 years ago. In contrast, according to KDHE, 106 people have died in Kansas just since 1990 from "misadventures to patients during surgical and medical care." 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.

Where is the public health crisis that HB 2751 is supposed to address? The Kansas Board of Healing Arts is the regulatory agency for all office-based surgery. The board receives only one or two complaints each year concerning abortion providers. Bill proponents suggest this number is low because some women are ashamed about their abortions. But women have made complaints about other extremely personal health care problems. Since 1999, four surgeons have been disciplined for inappropriate behavior including inappropriate sexual behavior with their patients. None were abortion providers. The board reports that far more cosmetic surgeons are sued for medical malpractice than abortion providers.

If proponents of HB 2751 are interested in protecting women's health, why aren't we regulating office-based surgery to protect Kansans getting face lifts?

Planned Parenthood guidelines vs. HB 2751

I want to dispel the fiction that HB 2751 simply reflects Planned Parenthood's standards. Our CEO and Vice President for Clinical Services have compared HB 2751 with our *Manual of Medical Standards and Guidelines*. While some of the standards are similar, there are many substantial differences. HB 2751 is modeled after legislation passed in Arizona in 1999. Our two-pound *manual* is revised at least annually and usually more often. The current version was updated in August 2003. The "standards" in HB 2751 are thus already five years out of date. HB 2751 is currently seven pages long; the abortion care section of our manual is 34 pages, with many additional attachments.

Most importantly, however, a statute regulating the practice of medicine is vastly different than medical standards and guidelines in three other ways.

First, medical standards are established by medical experts. HB 2751, in contrast, was developed by medical laypeople (for purely political reasons, I might add). Planned Parenthood's national medical committee, comprised of forty distinguished physicians, nurses and other leading health

professionals, establishes Planned Parenthood's standards. The committee includes experts in all areas of reproductive health, including obstetrician/gynecologists, endocrinologists, gynecologic oncologists, surgeons, pharmacists, anesthesiologists, pathologists and others.

How many of you or your colleagues – or lobbyists for Kansans for Life – have similar credentials?

Second, medical standards are revised constantly because medical practice and technology change constantly. Planned Parenthood's medical committee meets throughout the year to evaluate the latest advances in medical technology and practice. They review the professional literature. They review the latest findings of the FDA, AMA, ACOG, NIH, CDC and other professional advisory groups. All this is considered when updating the *Manual of Medical Standards and Guidelines*. The Kansas legislature, in contrast, meets annually for about 90 calendar days, followed by a three to eleven day wrap up session.

If HB 2751 is enacted, will the Kansas legislature meet throughout the year to update it? The Arizona legislature apparently has not. As only one example, HB 2751 – again, modeled on Arizona's law – requires "ultrasound equipment in those facilities that provide abortions after 12 weeks' gestation". Planned Parenthood's standards now require ultrasound in first trimester procedures in several circumstances. At Comprehensive Health, ultrasound evaluations are performed before every abortion.

The standard of care has and will continue to change. How quickly will the Kansas legislature convene to change HB 2751 when magnetic resonance or computerized tomography techniques evolve to replace gynecologic sonography? Will you even know when that change is needed?

Third, medical standards advise practicing physicians on the latest advancements in medicine and advise them on standards of practice. But they always respect the responsibility of the treating physician to assess each patient in each situation and to apply his or her professional judgment. This bill does neither. Instead, it mandates standards which may quickly become out of date and does not provide the physician to use his or her professional judgment that the patient requires something different. The American College of Obstetricians and Gynecologists has written *Guidelines for for Women's Health Care*. Within the manual it states, "The information in *Guidelines for Women's Health Care* should not be viewed as a body of rigid rules. The guidelines are general and intended to be adapted to many different situations... Variations and innovations that improve the quality of patient care are to be encouraged rather than restricted..."

Rather than single out abortion care, we should focus on making all surgery safer. The Kansas Medical Society recently published its *Guidelines for Office-Based Surgery and Special Procedures*. A twenty-one-member task force, representing twelve medical specialties, developed the guidelines after reviewing guidelines and materials from other states and national medical specialty organizations. The Board of Healing Arts subsequently adopted those *Guidelines* in October of last year. They are far superior to HB 2751 because they apply to all medical specialties; they were written by physicians, who know best how to practice medicine; and they are professional standards and guidelines.

You heard testimony yesterday from advocates with a single agenda—to close clinics providing abortion in Kansas. Where are the facts? I question the credibility of a witness who is not willing to come forward either to the legislature or to the Board of Healing Arts with her concerns. The testimony provided by bill proponents yesterday was based purely on conjecture and innuendo. Where is the objective indication of any problem or the proof that abortion, above all other medical procedures must be regulated by the Kansas Department of Health and Environment? All independent data from KDHE and from KBHA point to the safety of abortion care in Kansas—above

all other surgical care. If anything, yesterday I heard a case made for regulation of all office-based surgical procedures.

No one advocates more strongly for women's health than Planned Parenthood. No one is more committed to protecting women's health than Planned Parenthood. No one provides women's health care more safely than Planned Parenthood.

Let's be honest. Protecting women's health is not the true intention of HB 2751. It is part of the effort by opponents of abortion to make abortion more expensive and less available.

I have no respect for those who knowingly use deception and dishonesty to advance the anti-choice agenda. HB 2751 is deceptive and dishonest. It is bad public policy and does not deserve your support.

Mark Pederson, Abortion clinic manager for Aid For Women (Zaremski, MD) of Kansas City, KS, 800-626-9184

House Bill 2751 is not 'protective' legislation for women; it is erosive to access of already safe medical care, to further the 'legal yet inaccessible'[1] proLife agenda. The HB2751 proponents allege medical problems with abortion clinics as the presumption for this bill's necessity but where are the facts? They have ignored the more numerous problems elsewhere compared to abortion providers. I will admit things that need improving, but there is NO medical crisis. This is much like the now debunked proLife theory that abortion causes breast cancer.[2]

This bill is a Trojan Horse. No matter how innocuous these targeted regulations may appear now, once they are in place any further restrictive changes to the regulations, and we mindful of how contentious abortion issues are, abortion providers will have little chance for input. If three years from now an egregious restriction of '6-foot wide' hallways and doors for gurney access is added under §1(b)(9) for example, most abortion providers in Kansas will be closed. Or if under §1(d)(3) local hospitals refuse privileges to abortion provider for political reasons, not medical skill, also no more abortions. Those are a few examples.

This bill's previous incarnation as HB2176 was vetoed last year by the Governor. Nothing has changed.

The American College of Obstetrics and Gynecology (ACOG) has stated, "...ACOG opposes unnecessary regulations that limit or delay access to care," and "The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous."[3]

A twelve specialty task force within the Kansas Medical Society (KMS) drafted a broad-based, "Guideline for Office-Based Surgery and Special Procedures" and was retified by KMS in 2002. It was to be incorporated into BOHA's regulations applicable to all physicians. I dont' know of the BOHA status of these guidelines.

The fiscal note for HB 2751 is reported to be $291,000. Last year's fiscal note for HB2176 was for 193,000, and when shouldered amongst 6 phone-listed abortion providers in Kansas yields a burden of a $32K-49K/year licensing fee. Hospitals and ambulatory surgical centers (ASC) pay nothing for their licensing and Adult Daycare facilities pay $50 plus $15 per bed for their licensing! If abortion services are important, the State should license gratis.

In the 1970's and 1980's only hospitals did the abortions and could not keep up with the demand, so therefore free-standing abortion clinics arose as a safe and more economical alternative. Then in the 1990's, hospitals were forced out of doing abortions because of mergers with religious affiliations, and by anti-abortion restrictions placed upon state-funded hospitals, relegating abortions to only private clinics. If you want abortions done in a hospital setting, allow state-funded hospitals to do abortions.

There has been one documented anesthesia-related death from aspiration of food during an abortion in Kansas in 32 years from 1971 to 2002 (out of 325,900 abortions).[4,5] This bill would not have prevented that death and our patients still occaisionally eat or chew gum before surgery and lie to us. In 13 years from 1990 to 2002 there were 1,608 food-aspiration deaths[6], 323 'Complications from Surgical and Medical Care' deaths[7], and 37 birth-related deaths (out of 494,650 births).[8] This bill does not address ANY of these other deaths. In 7 years from 1994 to 2000 there were 33 disciplinary actions for Sexual Improprieties from non-abortion providers versus ZERO from abortion providers.[9,10] Where is the problem?

As regards last year's anecdotal story of a suicide after an abortion, abortions do not cure psychological problems, nor do they cause them; abortion is merely a medical procedure.[11] Besides which this bill doesn't address psych problems anyway. There will always be some regrets for decisions we make in life, and such is the nature of freedom. One should not take away freedoms merely to avoid regrets; God gives us freedom to regret and improve.

And finally, abortions done in a regular doctor's office are a good medical resource allocation. Very few surgical abortions need the total resources of an ASC setting (non-surgical abortions even less so), and those that do are referred over to them. Specific proscriptive laws are usually implemented by regulation not statute.[12] Reasonable changes should come from BOHA regulations and be applied to all physicians. I thank you for your time.

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."[13] More than 1 million female and 1 million male sterilizations are done annually.[14]

Of a U.S. national study done 1977 to 1981, the mobidity risk from sterilization was about 9-10 per 100,000 of which only 1-2 of those were attributable to the actual sterilization surgery, the rest is attributed to General Anesthesia.[15]

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[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] American College of Obstetrics and Gyneclogy Executive Board, Statement of Policy, 1993 and re-affirmed 2000.

[4] Kansas Catholic Conference written testimony in support of HB 2819, March 21, 2002, Abortion Malpractice in Kansas and verified by my talking with the abortion doctor. Her 1988 death was caused by aspiration of vomit during anesthesia. She had eaten prior to surgery contrary to protocols.

[5] "Table 24. Reported Abortions And Abortion Ratios, Kansas and the U.S. 1971-2002", KDHE Center for Health and Environmental Statistics, Office of Health Care Information. http://www.accesskansas.org/uaa/hci/as02/AS02TAB24.PDF

[6] http://kic.kdhe.state.us/kic/cgi-bin/death/death.exe, "Pneumonitis due to solids and liquids" (though not necessarily surgery related)

[7] Ibid., "Other external causes, (113. Complications of medical and surgical care)"

[8] Ibid., "Pregnancy Complications, (90. Pregnancy with abortive outcome {ectopics} =3, 91. Other complications of pregnancy/childbirth/pueperium=34)" (The non-abortion alternative)

[9] Disciplinary Action Table, 1994-2000, Kansas Board of Healing Arts. Data for 2001-2003 not available yet. Negative Disciplinary Actions: 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.

[10] Patrick Herrick, MD, PhD written proponent statement about HB2819 in 2002 and HB2176 in 2001, "Kansas Board of Healing Arts final board actions over the last 5 years involve over 25% of known abortionists in the state."

[11] http://www.prochoice.org/Facts/Factsheets/FS8.htm

[12] 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

[13] 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.

[14] Ibid., pg. 827.

[15] Novak's Gynecology, 13th ed., published Lipincott Williams & Wilkins, Philadelphia, PA, c. 2002, p. 273.

Aid For Women

720 Central Avenue, Kansas City, Kansas, 913-321-3350, 800-626-9184

Appointment Days and Times:

Monday 1p Tuesday 9a, 1p Thursday 9a, 1p, 4p Friday 9a, 1p Saturday 8a

You will be re-scheduled if more than 15 minutes late. EXPECT TO BE HERE 3-4 HOURS.

Cash-discount Fees for Abortion

Weeks of pregnancy are as determined by our sonography given as last-menstrual-period (LMP), not from conception, and using the National Abortion Federation (Queenan) sonography scale. Twelve weeks or more must be Tuesday, Thursday, or Friday mornings only.

Surgical Abortions include antibiotics prescription, sonogram, and twilight sleep:

5 through 8 weeks (<bpd 1.0cm)	$330
9 through 11 weeks (bpd 1.0-1.8cm)	$360
12 through 13 weeks (bpd 1.9-2.4cm) without/with laminaria	$430/480
14 weeks (bpd 2.4-2.7cm) with or without laminaria	$480
15 weeks (bpd 2.8-3.0cm) with laminaria	$530
16 weeks (bpd 3.1cm only) with laminaria	$650

Medical Abortions include follow-up visits. $50 refund upon completion:

Methotrexate injection/misoprostol (≤7.0w LMP)(2-3 visits, 1-2 weeks)	$350
Mifepristone/misoprostol, FDA plan (≤7.0w LMP)(three pills)(3 visits, 1 week)	$650
Mifepristone/misoprostol, Alternative plan (≤9.0w LMP)(one pill)(2 visits, 1 week)	$400

Other Services:

Ultra-sound sonography for gestational dating only (included with procedure)	$100
Rhogam, if blood-type is A-,B-,O-, or AB- , mini-dose (<12w)/full dose (≥12w)	$50/100
Statutory counseling for minor women (included with procedure)	$50
Labwork, counseling, and sterile tray (included with procedure)	$60

Other Rules and Information

Cash, money orders, and credit cards (with State ID) (MC/Visa/Discover/AmEx) are acceptable forms of payment. NO CHECKS ACCEPTED. Credit card prices are cash discount prices plus $1.50 for the first $50 and each $50 thereafter. You must pay up front before the procedure. If you want to file your insurance with us, we will file it and then reimburse you later.

Fees include sonography, twilight sleep sedation, laboratory tests, and one cycle of birth control pills. If it is determined by ultrasound that you are not pregnant, or are too far gestationally for our clinic, we will only charge you for the sonography. If however you change your mind later to not have an abortion we will deduct fees for the services done: sonography, labwork/sterile tray, and if applicable, the statutory counseling for minors. Fees from our previous sonogram within 30 days can be applied towards an abortion later. When laminaria are indicated, we will collect the laminaria fee before the procedure and refund the fee if not used. When minors come for a Judicial Waiver, sonography fees are collected first, and then if less than 16 weeks, the fees for statutory counseling.

For our surgical abortions we offer local anesthesia and twilight sleep anesthesia. Local anesthesia numbs the cervix, you feel the intense uterine cramping for about 5-7 minutes, period-like cramping after that, and you can drive yourself home. Twilight sleep, also known as conscious sedation, uses an additional hypnotic drug to make you fall asleep, forget the cramping if you feel it, but a support person must accompany and drive you home. Some women with a narcotics tolerance may not go to sleep. Twilight sleep can leave you feeling drunk and dry-mouth'ed, sometimes nauseous. Patients who are 12 weeks or more must do twilight sleep, and may be a two-part, all-day procedure, so be prepared for a long stay. Aid For Women belongs to the **National Abortion Federation** which sets standards for quality care. If you do not have your abortion with us, be sure to have it at a clinic which is a NAF member.

abfee24.wpd, Effective 6-15-2003

❀ Central Family Medicine/Aid For Women ❀

Abortion Patient Checklist

1. Bring your 24-Hour Consent Form and identification (Driver's License or State ID).

2. NO GUM, MINTS, CANDY or SUGARLESS CANDY of any sort. You are supposed to be hungry.

3. NO EATING OR DRINKING for 4 HOURS BEFORE your appointment. Plain water is okay.

4. Wear comfortable clothing: short-sleeve shirt, loose-fitting pants, regular panties.

5. Do not drink alcoholic beverages for 24-hours before your visit. Also, no drugs.

6. NO CHILDREN ALLOWED in the clinic. Find a babysitter or get rescheduled.

7. Fees will be collected first. Any adjustments to fees will be collected before the abortion.

8. Women with Rh-negative blood type (A-, B-, O-, AB-) will need a Rhogam shot. The cost is either $50 if you are under 12 weeks, or $100 if you are 12 weeks and over.

9. Twilight sleep sedation: Support Person MUST STAY. If they leave, you are rescheduled.

10. Due to limited seating, please bring only one Support Person.

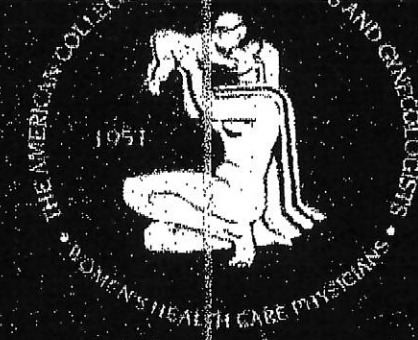
11. Plan to be here approximately 4 hours.

12. Please come on-time. Arrive more than 15 minutes late, you are rescheduled.

13. Minors (less than 18 years old) also need to bring someone 21 years of age or older for counseling, and either your Judicial Waiver or your Notarized Parental Notification form with birth certificate proving parentage.

2004

of Selected Publications



THE AMERICAN COLLEGE OF
OBSTETRICIANS AND GYNECOLOGISTS
WOMEN'S HEALTH CARE PHYSICIANS

Code of Professional Ethics

of the American College of Obstetricians and Gynecologists

Obstetrician–gynecologists, as members of the medical profession, have ethical responsibilities not only to patients, but also to society, to other health professionals, and to themselves. The following ethical foundations for professional activities in the field of obstetrics and gynecology are the supporting structures for the Code of Conduct. The Code implements many of these foundations in the form of rules of ethical conduct. Certain documents of the American College of Obstetricians and Gynecologists, including Committee Opinions and *Ethics in Obstetrics and Gynecology*, also provide additional ethical rules. Selections relevant to specific points are set forth in the Code of Conduct, and those particular documents are incorporated into the Code by reference. Noncompliance with the Code, including referenced documents, may affect an individual's initial or continuing Fellowship in the American College of Obstetricians and Gynecologists. These documents may be revised or replaced periodically, and Fellows should be knowledgeable about current information.

Ethical Foundations

I. The patient–physician relationship: The welfare of the patient *(beneficence)* is central to all considerations in the patient–physician relationship. Included in this relationship is the obligation of physicians to respect the rights of patients, colleagues, and other health professionals. The respect for the right of individual patients to make their own choices about their health care *(autonomy)* is fundamental. The principle of justice requires strict avoidance of discrimination on the basis of race, color, religion, national origin, or any other basis that would constitute illegal discrimination *(justice)*.

II. Physician conduct and practice: The obstetrician–gynecologist must deal honestly with patients and colleagues *(veracity)*. This includes not misrepresenting himself or herself through any form of communication in an untruthful, misleading, or deceptive manner. Furthermore, maintenance of medical competence through study, application, and enhancement of medical knowledge and skills is an obligation of practicing physicians. Any behavior that diminishes a physician's capability to practice, such as substance abuse, must be immediately addressed and rehabilitative

409 12th Street, SW
PO Box 96920
Washington, DC 20090-6920

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III. Conflicts of Interest

1. Potential conflicts of interest are inherent in the practice of medicine. Conflicts of interest should be resolved in accordance with the best interest of the patient, respecting a woman's autonomy to make health care decisions. If there is an actual or potential conflict of interest that could be reasonably construed to affect significantly the patient's care, the physician must disclose the conflict to the patient. The physician should seek consultation with colleagues or an institutional ethics committee to determine whether there is an actual or potential conflict of interest and how to address it.
2. Commercial promotions of medical products and services may generate bias unrelated to product merit, creating or appearing to create inappropriate undue influence. The obstetrician–gynecologist should be aware of this potential conflict of interest and offer medical advice that is as accurate, balanced, complete, and devoid of bias as possible (6, 7).
3. The obstetrician–gynecologist should prescribe drugs, devices, and other treatments solely on the basis of medical considerations and patient needs, regardless of any direct or indirect interests in or benefit from a pharmaceutical firm or other supplier.
4. When the obstetrician–gynecologist receives anything of substantial value, including royalties, from companies in the health care industry, such as a manufacturer of pharmaceuticals and medical devices, this fact should be disclosed to patients and colleagues when material.
5. Financial and administrative constraints may create disincentives to treatment otherwise recommended by the obstetrician–gynecologist. Any pertinent constraints should be disclosed to the patient.

IV. Professional Relations

1. The obstetrician–gynecologist's relationships with other physicians, nurses, and health care professionals should reflect fairness, honesty, and integrity, sharing a mutual respect and concern for the patient.
2. The obstetrician–gynecologist should consult, refer, or cooperate with other physicians, health care professionals, and institutions to the extent necessary to serve the best interests of their patients.

V. Societal Responsibilities

1. The obstetrician–gynecologist should support and participate in those health care programs, practices, and activities that contribute positively, in a meaningful and cost-effective way, to the welfare of individual patients, the health care system, or the public good.
2. The obstetrician–gynecologist should respect all laws, uphold the dignity and honor of the profession, and accept the profession's self-imposed discipline. The professional competence and conduct of obstetrician–gynecologists are best examined by

professional associations, hospital peer-review committees, and state medical and licensing boards. These groups deserve the full participation and cooperation of the obstetrician–gynecologist.

3. The obstetrician–gynecologist should strive to address through the appropriate procedures the status of those physicians who demonstrate questionable competence, impairment, or unethical or illegal behavior. In addition, the obstetrician–gynecologist should cooperate with appropriate authorities to prevent the continuation of such behavior.

4. The obstetrician–gynecologist must not knowingly offer testimony that is false. The obstetrician–gynecologist must testify only on matters about which he or she has knowledge and experience. The obstetrician–gynecologist must not knowingly misrepresent his or her credentials.

5. The obstetrician–gynecologist testifying as an expert witness must have knowledge and experience about the range of the standard of care and the available scientific evidence for the condition in question during the relevant time and must respond accurately to questions about the range of the standard of care and the available scientific evidence.

6. Before offering testimony, the obstetrician–gynecologist must thoroughly review the medical facts of the case and all available relevant information.

7. The obstetrician–gynecologist serving as an expert witness must accept neither disproportionate compensation nor compensation that is contingent upon the outcome of the litigation (8).

References

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2. American College of Obstetricians and Gynecologists. Sexual misconduct. In: Ethics in obstetrics and gynecology. 2nd ed. Washington, DC: ACOG; 2004. p. 101–3.
3. American College of Obstetricians and Gynecologists. Informed consent. In: Ethics in obstetrics and gynecology. 2nd ed. Washington, DC: ACOG; 2004. p. 9–17.
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7. American College of Obstetricians and Gynecologists. Commercial enterprises in medical practice. In: Ethics in obstetrics and gynecology. 2nd ed. Washington, DC: ACOG; 2004. p. 83–5.
8. American College of Obstetricians and Gynecologists. Expert testimony. In: Ethics in obstetrics and gynecology. 2nd ed. Washington, DC: ACOG; 2004. p. 116–7.

September 20, 2002

Dear Colleague,

The College has developed the Expert Witness Affirmation, a document that calls for an expert witness to affirm, among other things, that he or she has relevant expertise and will provide true and impartial testimony based on generally accepted standards. Fellows who testify as expert witnesses are professionally obligated to adhere to the principles enunciated in the affirmation.

Expert witnesses play an important role in the civil justice system. Members of the College serve as expert witnesses on behalf of both plaintiffs and defendants in medical liability cases. By providing testimony that is fair and accurate, the expert witness can contribute to a just outcome in the case at hand and improve the quality of women's health care services overall. Too often, however, the College learns about expert witness testimony that is neither fair nor accurate. Such testimony has negative ramifications beyond the case in which it is given; moreover, it contributes to the current professional liability crisis and discredits our specialty.

The enclosed new document relies on the principles already expressed in ACOG's policy statement, "Ethical Issues Related to Expert Testimony by Obstetricians and Gynecologists" and ACOG's Code of Professional Ethics.

The Expert Witness Affirmation is a document that Fellows who testify should sign and give to the attorney representing the party on whose behalf they intend to testify. During litigation, the affirmation can be used to examine the expert witness: witnesses who have signed the affirmation can use it to bolster their qualifications on direct examination; conversely, witnesses who chose not to sign it can be cross-examined about their failure to do so.

Fellows who have been named as a defendant in professional liability cases should make defense counsel aware of the Expert Witness Affirmation as well as ACOG's Code of Professional Ethics and the statement, "Ethical Issues Related to Expert Testimony by Obstetricians and Gynecologists."

Sincerely,

Charles B. Hammond, MD

Charles B. Hammond, MD, FACOG
President

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
409 12TH STREET SW WASHINGTON DC 20024-2188
MAILING ADDRESS: PO BOX 96910 WASHINGTON DC 20090-6920
202/638-5577

Expert Witness Affirmation

As a member of the medical profession and the American College of Obstetricians and Gynecologists, I affirm my duty, when giving evidence or testifying as an expert witness, to do so solely in accordance with the merits of the case. Furthermore, I declare that I will uphold the following professional principles in providing expert evidence or expert witness testimony:

1) I will always be truthful.

2) I will conduct a thorough, fair and impartial review of the facts and the medical care provided, not excluding any relevant information.

3) I will provide evidence or testify only in matters in which I have relevant clinical experience and knowledge in the areas of medicine which are the subject of the proceeding.

4) I will evaluate the medical care provided in light of generally accepted standards, neither condemning performance that falls within generally accepted practice standards nor endorsing or condoning performance that falls below these standards.

5) I will evaluate the medical care provided in light of the generally accepted standards which prevailed at the time of the occurrence.

6) I will provide evidence or testimony that is complete, objective, scientifically based, and helpful to a just resolution of the proceeding.

7) I will make a clear distinction between a departure from accepted practice standards and an untoward outcome.

8) I will make every effort to determine whether there is a causal relationship between the alleged substandard practice and the medical outcome.

9) I will submit my testimony to peer review, if requested by a professional organization to which I belong.

10) I will not accept compensation that is contingent upon the outcome of the litigation.

Name: _____

Signature: _____

American Board of Obstetrics and Gynecology Certification Date: _____

American Board of Obstetrics and Gynecology Recertification Date, if applicable: _____

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

ABORTION POLICY

The following statement is the American College of Obstetricians and Gynecologists' (ACOG) general policy related to abortion, with specific reference to the procedure referred to as "intact dilatation and extraction" (intact D & X).

1. The abortion debate in this country is marked by serious moral pluralism. Different positions in the debate represent different but important values. The diversity of beliefs should be respected.

2. ACOG recognizes that the issue of support of or opposition to abortion is a matter of profound moral conviction to its members. ACOG, therefore, respects the need and responsibility of its members to determine their individual positions based on personal values or beliefs.

3. Termination of pregnancy before viability is a medical matter between the patient and physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities.

4. The need for abortions, other than those indicated by serious fetal anomalies or conditions which threaten maternal welfare, represents failures in the social environment and the educational system.

The most effective way to reduce the number of abortions is to prevent unwanted and unintended pregnancies. This can be accomplished by open and honest education, beginning in the home, religious institutions and the primary schools. This education should stress the biology of reproduction and the responsibilities involved by boys, girls, men and women in creating life and the desirability of delaying pregnancies until circumstances are appropriate and pregnancies are planned.

In addition, everyone should be made aware of the dangers of sexually transmitted diseases and the means of protecting each other from their transmission. To accomplish these aims, support of the community and the school system is essential.

The medical curriculum should be expanded to include a focus on the components of reproductive biology which pertain to conception control. Physicians should be encouraged to apply these principles in their own practices and to support them at the community level.

Society also has a responsibility to support research leading to improved methods of contraception for men and women.

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

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5. Informed consent is an expression of respect for the patient as a person. It particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within caring relationships.

   A pregnant woman should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion. The information conveyed should be appropriate to the duration of the pregnancy. The professional should make every effort to avoid introducing personal bias.

6. ACOG supports access to care for all individuals, irrespective of financial status, and supports the availability of all reproductive options. ACOG opposes unnecessary regulations that limit or delay access to care.

7. If abortion is to be performed, it should be performed safely and as early as possible.

8. ACOG opposes the harassment of abortion providers and patients.

9. ACOG strongly supports those activities which prevent unintended pregnancy.

The College continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman. Viability is the capacity of the fetus to survive outside the mother's uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible attending physician.

Intact Dilatation and Extraction

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

ACOG believes the intent of such legislative proposals is to prohibit a procedure referred to as "intact dilatation and extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

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

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X. Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy.

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The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

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

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother.

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

Approval by the Executive Board
General policy: January 1993
Reaffirmed: September 2000
Intact D & X statement: January 1997
Combined: September 2000

WOMEN'S HEALTH CARE SERVICES, P.A.

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

Carrie Klaege
Administrative Director

Cathy Reavis
Patient Coordinator

17 February 2004

Julie Burkhart
Women's Healthcare Services

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 34 and 31 years respectively, my observation is the TRAP (targeted regulations against abortion providers) bill is not about public safety. The sole purpose of HB 2751 is to further limit the number of abortion providers by unnecessarily increasing the cost, regulation and restriction of this surgical healthcare experience.

Since those opposed to abortion have been, up until now, unable to make abortion illegal, they resort to tactics of prejudicial restrictions on abortion providers to accomplish their goal of eliminating all abortions in Kansas. Another year is upon us and another attempt is made by the anti-abortionists to further their goal of making all abortions illegal, ridiculously expensive and unavailable in Kansas. Last year they attempted to say that abortion was so dangerous that it required special licensing requirements for office based surgery. This accusation was unsubstantiated last year and apparently is a non-issue this year.

Let's examine the objective record and ignore the hubris.

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

By way of comparison, the Healthcare Stabilization Fund of Kansas reports that in the same five years mentioned above, medical liability insurance carriers (malpractice insurance companies) have paid out a total of $151,074,000 to settle malpractice insurance claims in Kansas. Obviously, the malpractice awards for abortion related problems are miniscule in comparison to the resources allocated for other malpractice settlements. Further, these figures indicate that 0.198 percent of malpractice payments in Kansas are a result of abortion awards - that's only two-tenths of one percent of all malpractice awards in Kansas that are attributable to abortion settlements.

Secondly, medicine and surgery are and will always be fraught with risks and hazards. Let's look at the record regarding abortion services.

If we can believe the testimony given in the past by Mike Farmer of the Kansas Catholic Conference, there have been 27 malpractice suits filed against abortion providers since 1980. During the same period, physicians have performed 293,489 abortions in Kansas. These figures mean that during this 20+ - year time frame, one lawsuit was filed for every 10,868 abortions preformed in Kansas. When compared to the rate at which lawsuits are filed for the rest of obstetrics (one in a hundred deliveries), this is a sterling record of safety. In my practice, even in late term patients, abortion may be between 51 and 116 times safer for a woman than full term delivery according the Center for Disease Control, Joint Program for Study of Abortion Criteria. And, according to the KDHE's Center for Health and Environmental Statistics, out of the 109 unfortunate deaths that were attributed to surgical and medical care between 1990 and 2001, none of the deaths were due to abortion services in the State of Kansas.

5107 East Kellogg
Wichita, Kansas, USA 67218

Telephone
316-684-5108

Toll Free in US
800-882-0488

Facsimile
316-684-0052

www.drtiller.com

HS Federal & State Affairs
February 17, 2004
Attachment 3

WOMEN'S HEALTH CARE SERVICES, P.A.

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

Carrie Klaege
Administrative Director

Cathy Reavis
Patient Coordinator

Since abortion services ARE safer than full term delivery and motherhood, what in the world is this safety mantra all about? Under the guise of safety for the public, it is an attempt to control women.

The anti abortion zealots know, women know and you and I know that if you can deny women birth control (Just say NO) ahead of time, Emergency Contraception at the time of the initiation of pregnancy and abortion services after the pregnancy is established, then someone other than the pregnant woman will decide when she can become a mother and a parent. This choice of when and under what circumstances a woman will become a mother and a parent is the most precious liberty possessed by women. We must not let it be dissipated.

If this committee is REALLY CONCERNED about reducing the number of abortions the Legislature can first act quickly and affirmatively on making the "Morning After Pill" an over the counter drug. With this one stroke, the Legislature would reduce the number of abortions that result from unplanned and unwanted pregnancy by the thousands. Second, they can mandate birth control coverage in every insurance policy that covers Viagra. Third, they could mandate that every woman who is treated in an emergency room for rape or assault be offered the "Morning After Pill".

Secondly, if this committee and the Legislature were REALLY CONCERNED about public safety, health and welfare for all Kansans, it would use the "Gut and Go" process. Then the committee would substitute verbatim the "Office Based Surgery Guidelines" formulated by the Kansas Medical Society and acknowledged by the Kansas State Board of Healing Arts. These physician created guidelines were developed to protect all patients undergoing outpatient surgery and not just to make abortion services more unavailable and more expensive as a political agenda. Until then, this piece of legislation is a tactic for the control of women's lives and has nothing to do with public safety.

Finally, the proponents of this bill have claimed that HB 2751 is identical to other TRAP legislation that has passed muster in five other states. I would like to set the record straight. This bill originated in Arizona in 1999, where it has never been enacted. Over the past 5 years, as TRAP has moved through the court system, tens of thousands of taxpayer dollars have been spent defending this inherently flawed bill.

On a personal note, in providing outpatient abortion services for 31 years, including some of the most challenging and difficult clinical situations, I have not had one successful malpractice judgment against my practice. On the other hand, given the nature of medical malpractice litigation in the USA today, I suspect that I will have one before I retire: Patients are not perfect, Medicine is not perfect, Physicians are not perfect and neither am I.

Thank you for the opportunity to present testimony to the committee on this incendiary and contentious issue.

George R. Tiller, MD, DABFP
Medical Director and Abortion Provider
Women's Health Care Services, P.A.
Wichita, Kansas

5107 East Kellogg
Wichita, Kansas, USA 67218

Telephone
316-684-5108

Toll Free in US
800-882-0488

Facsimile
316-684-0052

www.drtiller.com

Federal and State Affairs Committee, Kansas House of Representatives

February 17, 2004

Testimony presented by Anna Holcombe, for the Kansas National Organization for Women (NOW)

P. O. Box 1061, Lawrence, KS 66044 Ph: 785-550-9176

In opposition to HB 2751, an act concerning abortion clinics

Chairperson Mason and Members of the Committee,

I represent the Kansas National Organization for Women. Kansas NOW chapters are located throughout the state. Kansas NOW advocates women's comprehensive health care, with a primary focus on preventing unwanted pregnancies. As a component of our advocacy for women's comprehensive health care, we also support women's right to safe, legal abortion.

- 43% of all women will have had at least one abortion by the time they are 45 years old.[1]
- 6 out of 10 abortions are for women who were using birth control that failed.[2]
- In the U.S. more than 16,000 women have abortions each year because they became pregnant as the result of rape or incest.[3]
- 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 …[4]
- More than 40% of the women who have abortions describe themselves as Catholic, or describe themselves as born-again or Evangelical Christians.[5]

Abortions are safe medical and surgical procedures practiced in Kansas today. Kansas abortion providers follow guidelines prescribed by Kansas Medical Society and The Board of Healing Arts, which allocate guidelines for all medical facilities in Kansas. In Kansas, during the year of 2000, there were 12,270 abortions. 21.4 abortions per 1000 women of reproductive age occurred in Kansas. According to KDHE, from 1990 to 2001, there have been 106 deaths due to surgical and medical care. None of these deaths were attributed to abortion services. Where abortion is administered in a medical environment, the risk of fatality is less than .01%.

HB 2751 would increase the risk of unsafe illegal abortions among low income women. 26.6% of abortions are for women with annual household incomes below poverty level. [6]

The affect of this bill would be to make safe abortions unaffordable for women and their families who are in need; for whom health care and life itself is most difficult to afford. HB 2751 puts Kansas women's health at greater risk by increasing the financial and travel burdens for women seeking safe, and legal abortions. Physicians' costs will increase, **particularly with this year's increased fiscal note**, due to onerous structural, procedural, and staff changes mandated in the bill to clinics that clinics are expected to pay. Due to some clinics' inability to pay for such changes, it is projected that there will be reduced numbers of clinic sites in Kansas. Such changes in cost and number of clinics decreases women's access to safe, legal abortions.

In addition, guidelines were written by legislators, not medical experts. Guidelines will not be properly updated in conjunction with all other medical guidelines set by medical experts on a national, state, and local level. What happens when technology changes and these guidelines stay stagnate? How is the inevitable innovations in technology and medical practice able to live in accordance with one set of guidelines, whose initial date draws back five years ago (from the Arizona 1999 bill)?

HB 2751 is unnecessary. It puts undue financial burden on those women who seek abortion in cases of failed birth control, rape, or incest.

It severely restricts women's access to safe, legal abortions, particularly women whose income is below the poverty level.

Kansas NOW believes that women, who are mothers, daughters, and/or sisters, should have access to safe, legal abortion.

Kansas NOW is the voice of your constituents.

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

[2] 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."

[3] 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."

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

[5] 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."

[6] 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

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

February 17, 2004

Representative Mason and members of the committee thank you for allowing me to speak today. My name is Willow Eby. I am a registered nurse at Central Women's Services, formerly Wichita Family Planning, a small clinic in Wichita.

We provide reproductive care including Pap Smears, testing and treatment for sexually transmitted diseases, birth control and early term abortions.

Today I am speaking to you not just for Central Women's Services but also for the many women we serve. They come from all over Kansas as well as neighboring states. They are wives, mothers, sisters and daughters; they are old and young, most often they have one or more children. Many live in poverty. Their birth control failed, they have been raped, and their bodies cannot survive this pregnancy without harm. Some did not have birth control.

These women come to us after great soul searching and many hours spent with their partners, parents, medical provider, clergy, and those people most important in their lives. They come to us when they find that they are unable to continue a pregnancy. However it is they come to us, they are each treated with compassion and respect. They receive safe medical attention and birth control education.
SAFE.
During the 28 years this clinic has been operating, there have been no deaths, no lawsuit and no major medical complications to our knowledge.
If house bill 2751 is implemented it will not make abortion safer. It is already one of the safest outpatient, office based surgeries. It will make safe legal abortion less accessible. It will drive up costs. It will send the poorest, most desperate women to cheaper illegal, unqualified, backroom cutters. They will get abortions without the benefit of trained medical doctors, and many will then die.
If you truly believe that outpatient, office-based surgeries are dangerous and require additional regulation than go back to your offices and write a bill that will encompass all such surgeries, but for the health and safety of women do not allow house bill 2751 out of this committee.

HS Federal & State Affairs
February 17, 2004
Attachment 5

THE LEAGUE OF WOMEN VOTERS OF KANSAS

To: Rep. Bill Mason, Rep. Dan Williams, Rep. Rick Rehorn and members of the House Federal and State Affairs Committee

From: The League of Women Voters of Kansas
Janis McMillen, President Janis McMillen

Date: February 18, 2004

Subject: House Bill 2751

The League of Women Voters of Kansas, with a state-wide membership of approximately 700, wishes to go on record as opposing HB 2751. The position of the League of Women Voters of the United States says, in brief:

The League of Women Voters of the United States believes that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices.

Restricting access In essence, the proposed regulations for clinics offering legal abortion services are simply designed to have the net effect of restricting access to those services. The imposition of these additional restrictions, while not having the net effect of improving safety, would impose additional costs on the few clinics that may not already meet all of the requirements of this bill. This is most likely to have a negative impact on women least able to afford this legal procedure. In 1989, a case in Illinois involving an attempt to impose restrictions on abortion clinics was recognized as effectively restricting access to abortion; it was settled by designating the clinics as special surgical clinics, and allowing them to continue performing legal abortions without meeting the rigorous construction and equipment requirements.

Safety The Kansas Board of Healing Arts has oversight for abortion clinics as well as in-office and free-standing surgical clinics. Abortion clinics in Kansas currently operate in a very safe manner under this oversight. During the period of 1990 through 2001, according to data on file with Planned Parenthood, there were no deaths due to abortion, yet other free-standing specialty surgical centers experienced over 100 deaths in the same time period.

Cost The Fiscal Note for HB 2751 estimates that for the Kansas Department of Health and Environment to carry out their prescribed duties related to this bill, it will require $291,000/year from the State General Fund. This is an increase of 30% over last year's estimate for the abortion clinic bill that was defeated. This suggests that costs will continue to escalate in order to support KDHE's functions in relation to meeting the demands of this proposed legislation.

Since 1920 the League of Women Voters has been a nonpartisan political organization that encourages the and active participation of citizens in government and influences public policy through education and adv

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February 17, 2004
Attachment 6

919 ½ S Kansas Avenue
Topeka, KS 66612

Phone & Fax: 785.234.5152
E-mail: lwvk@aol.com

MAIN
STREAM COALITION
5350 West 94th Terrace
Suite 103
Prairie Village, Kansas
66207-2520
Phone: 913-649-3326
Fax: 913-649-3285
e-mail:
info@mainstreamcoalition.org
www.mainstreamcoalition.org
A 501(c)4 Organization

To: Rep. Bill Mason, and members of the
House Federal and State Affairs Committee

From: Janis McMillen, Public Policy Chair
The MAINstream Coalition

The MAINstream Coalition is a non-partisan advocacy group of approximately 2,500 members primarily involved in church/state separation and public education issues.

Our official position on Reproductive Rights states (in part): *The MAINstream Coalition believes all children should be born loved and nurtured. Women should be allowed, without government interference, to make reproductive choices. We support a woman's ready access to abortion at the state and federal level.*

We do not support HB 2751 because it places onerous and unnecessary requirements on abortion providers. Their clinics already, for the most part, abide by the clinical requirements of the state Board of Healing Arts. There is no need to "pile on" more restrictions in order to make abortion, a legal medical procedure, less available to those who should have ready access. Providers will be forced to spend scarce dollars to meet these onerous requirements, and many may be forced to close their doors, leaving more and more communities without basic women's health care services.

HB2751 is yet another attempt by those who do not favor a woman's reproductive freedom to limit, in every way possible, her access to the medical care to which she is legally entitled.

HS Federal & State Affairs
February 17, 2004
Attachment 7

Kansans for Life

Kathy Ostrowski

www.kfl.mwires.com — State Affiliate of National Right to Life — 8

Kansans for Life - REBUTTAL SUBMISSION
HB 2751, Abortion Clinic Licensing
House Fed State Affairs hearing, Feb.18, 2004
Hon. Bill Mason and committee members:

Please ensure this rebuttal and attachments become a part of the permanent record for HB 2751. KFL attended the Feb.17, where we heard opponents' testimony which we find contains factual errors and misstatements of proponents' testimony. Some of the egregious ones:

1) Jennifer McAdam (Planned Parenthood) claimed (and was quoted in press) that no deaths from abortion ever occurred in Kansas. Every year we hear this bill, KFL has mentioned in written and/or oral testimony, the 4 known deaths during abortions done by Kansas–licensed abortionists: Erna Fisher, dead in 1988 IN KANSAS from Dennis Miller's abortion, and 3 other young, black women dead from abortions from Planned Parenthood's Robert Crist: Nichole Williams,(Missouri) Latechie Veale,(Texas) Diane Boyd (Missouri).
2) McAdam asserted vigorously that our whistleblower "Ruby" had not notified a host of authorities. This is pure speculation on her part—since she does not know Ruby she could not possibly know whom Ruby has or has not contacted.
3) McAdam erroneously that Arizona 1999 standards were the only basis of HB 2751. Last year, we delivered samples of 2000 standards for NAF and PP that match provisions of HB 2751. Except for the provision for a woman's presence in exam room, the 4th & 5th Circuit courts have upheld that this bill embodies the standards of the abortion industry.
4) McAdam repeats the mantra that abortion is safer than childbirth. There are NO studies accurately comparing the two; all studies follow aborted women for 6 weeks or less, and compare to maternal death rates which is defined as death for any reason for one full year following delivery. Additionally, since 93% of late term abortions are on non-residents, we certainly don't know all the mortality or morbidity from Kansas abortion. Reporting is not in place for this assertion.
5) Julie Burkhart (Tiller) claims that Arizona legislation is not enacted and that similar legislation is stopped in 14 states. These are the same blatant misstatements made last session about which we rebutted in Senate committee. The statement that 14 states are enjoined or not in force is incorrect.
6) Burkhart, reading Tiller's testimony said Tiller had never been successfully sued. We have at least 2 lawsuits that were settled in favor of plaintiffs against Tiller. Also, she mentioned only 2 Kansas lawsuits [in 2002?] had been awarded damages to plaintiff. These 2 cases were the court-settled type, but many cases are settled without court involvement. Actions that were settled in favor of the plaintiff are not always easy to locate and some were filed in Missouri against Planned Parenthood of Mid Missouri Eastern Kansas. Last September a lawsuit was filed in Missouri on behalf of a teen who lost 2 feet of bowel in a botched abortion done at Planned Parenthood in Overland Park.
7) Mark Pederson (Central Family Medicine) claimed that the cost for Zaremski's regular FDA-protocol and non-FDA-protocol chemical abortions was $650 and $450 respectively. www.Aidforwomen.com webpages from today and 2 months ago do not match his claim on prices. The website twice mentions Cash Discounts, again contradicting his statement they no longer have discounts.
8) Pederson claimed KFL said on Feb 16 that his boss Zaremski was on drugs for 10 years. We did not . We provided KSBHA documentation of Zaremski being disciplined for illegally prescribing drugs to his business partner, convicted felon Malcolm Knarr. Committee members may wish to ask what Pederson's qualifications are for being manager for a medical clinic, since in 1992-1994 he was Knarr's rent collector and clinic door guard. You may want to ask Pederson about the police report we included for a 20 year-old woman who called Wyandotte authorities minutes after she (claims) was hit by Pederson last November inside Zaremski's Central Family Medicine clinic.

HS Federal & State Affairs
February 17, 2004
Attachment 8

Session of 2004

House Concurrent Resolution No. 5033

By Committee on Federal and State Affairs

2-3

A PROPOSITION to amend article 15 of the constitution of the state of Kansas by adding a new section thereto, concerning marriage.

Be it resolved by the Legislature of the State of Kansas, two-thirds of the members elected (or appointed) and qualified to the House of Representatives and two-thirds of the members elected (or appointed) and qualified to the Senate concurring therein:

Section 1. The following proposition to amend the constitution of the state of Kansas shall be submitted to the qualified electors of the state for their approval or rejection: Article 15 of the constitution of the state of Kansas is amended by adding a new section thereto to read as follows:

"§ 16. **Marriage.** (a) The marriage contract is to be considered in law as a civil contract. Marriage shall be constituted by one man and one woman only and the rights, privileges and incidents of marriage shall inure only to the benefit of parties to such a marriage. All other marriages are declared to be contrary to the public policy of this state and are void.

(b) No relationship other than a marriage between one man and one woman shall be recognized by the state as being entitled to the benefits of marriage."

Sec. 2. The following statement shall be printed on the ballot with the amendment as a whole:

"*Explanatory statement.* There is currently no constitutional provision regarding the marriage relationship.

"A vote for this proposition would provide in the constitution that marriage is a civil contract between a man and a woman and that all other marriages are void, and that no relationship other than a marriage between one man and one woman shall be recognized by the state as being entitled to the benefits of marriage

"A vote against this proposition would allow the legislature to continue to determine by statute the nature of the marriage relationship." will not amend the Kansas constitution in the manner described above

Sec. 3. This resolution, if approved by two-thirds of the members elected (or appointed) and qualified to the House of Representatives, and two-thirds of the members elected (or appointed) and qualified to the Senate, shall be entered on the journals, together with the yeas and nays. The secretary of state shall cause this resolution to be published as provided by law and shall cause the proposed amendment to be submitted to the electors of the state at the general election in November in the year 2004 unless a special election is called at a sooner date by concurrent