Approved: April 29, 2005
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on March 22, 2005 in Room 231-N of the Capitol.

All members were present.

Committee staff present:
Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Norm Furse, Office of Revisor of Statutes
Whitney Nordstrom, Committee Secretary

Conferees appearing before the committee:
Representative Peggy Mast
LeVeta Adams
Cheryl Sullenger
Linda Cramer
Michelle Herzog
Mike Farmer
Jeann Gawdun
Kathy Ostrowski
Marsha Strahm
Brenda Mitchell
Dr. Herbert Hodes
Sarah London
Dr. Irene Bettinger
Jana Mackey
Julie Burkhart
Mark Pederson
Gary Baker

Others attending:
See attached list.

Hearing on HB 2503

HB 2503– Regulation, licensing and standards for operation of abortion clinics

Upon calling the meeting to order the Chair announced there would be a hearing on **HB 2503**, an act concerning abortion clinics; providing for regulations, licensing and standards for the operation thereof; providing for violations and authorizing injunctive actions. First Chairperson Barnett asked Terri Weber, Kansas Legislative Research Department, to give a brief overview of the bill.

As there were no questions and/or comments for Ms. Weber, the Chair called upon the first proponent conferee to testify, Representative Peggy Mast. A copy of Representative Mast's testimony is (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Representative Mast, Chairperson Barnett called upon the second proponent conferee to testify, LeVeta Adams. A copy of Ms. Adam's testimony is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Adams, the Chair called upon the third proponent conferee to testify, Cheryl Sullenger. A copy of Ms. Sullenger's testimony is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Sullenger, Chairperson Barnett called upon the fourth proponent conferee to testify, Linda Cramer. A copy of Ms. Cramer's testimony is (Attachment 4) attached

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hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Cramer, the Chair called upon the fifth proponent conferee to testify, Michelle Herzog. A copy of Ms. Herzog's testimony is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Herzog, Chairperson Barnett called upon the sixth proponent conferee to testify, Mike Farmer. A copy of Mr. Farmer's testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Mr. Farmer, the Chair called upon the seventh proponent conferee to testify, Jeann Gawdun. A copy of Ms. Gawdun's testimony is (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Gawdun, Chairperson Barnett called upon the eighth proponent conferee to testify, Kathy Ostrowski. A copy of Ms. Ostrowski's testimony is (Attachment 8, Attachment 9, Attachment 10, Attachment 11, Attachment 12, Attachment 13, Attachment 14, and Attachment 15) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Ostrowski, the Chair called upon the ninth proponent conferee to testify, Marsha Strahm. A copy of Ms. Strahm's testimony is (Attachment 16) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Strahm, Chairperson Barnett called upon the tenth proponent conferee to testify, Brendan Mitchell. A copy of Mr. Mitchell's testimony is (Attachment 17) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Mr. Mitchell, the Chair called upon the first opponent conferee to testify, Dr. Herbert Hodes. A copy of Dr. Hodes's testimony is (Attachment 18) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Dr. Hodes, Chairperson Barnett called upon the second opponent conferee to testify, Sarah London. A copy of Ms. London's testimony is (Attachment 19) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. London, the Chair called upon the third opponent conferee to testify, Dr. Irene Bettinger. A copy of Dr. Bettinger's testimony is (Attachment 20) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Dr. Bettinger, Chairperson Barnett called upon the fourth opponent conferee to testify, Jana Mackey. A copy of Ms. Mackey's testimony is (Attachment 21) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Mackey's, the Chair called upon the fifth opponent conferee to testify, Julie Burkhart. A copy of Ms. Burkhart's testimony is (Attachment 22) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Ms. Burkhart, Chairperson Barnett called upon the sixth opponent conferee to testify, Mark Pederson. A copy of Mr. Pederson's testimony is (Attachment 23) attached hereto and incorporated into the Minutes as referenced.

As there were no questions and/or comments for Mr. Pederson, the Chair called upon the seventh opponent conferee to testify, Dr. Gary Baker. A copy of Dr. Baker's testimony is (Attachment 24) attached hereto and incorporated into the Minutes as referenced.

Senator Haley motioned to table legislation until a later date. There was no second. Motion died.

MINUTES OF THE Senate Public Health and Welfare Committee at 1:30 P.M. on March 22, 2005 in Room 231-N of the Capitol.

Senator Wagle motioned to pass legislation favorably with the amendment of annually. Senator Palmer seconded the motion. With five votes in favor and the rest against Motion Passed.

Adjournment

As there was no further business, the meeting was adjourned at 2:30 p.m.

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.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: March 22, 2005

NAME	REPRESENTING
Sylvie Rueff	Dr Gary Baker M.D.
Barbara Duke	Kansas Choice Alliance
Jana Mackey	NOW
Herbert Hodes, MD	Self
Mark Pederson	Sherman Zaremski / Aid For Women
Marsha Strahm	Concerned Women of Am.
Mike Farmer	Kansas Catholic Conference
Claire Renshaw	Kansas For Life (KFL)
Michelle Gawdun	Kansans For Life (KFL)
Jeanne Gawdun	KFL
Kathy Ostrowski	KFL Legislative Research Director
Cheryl Sullenger	operation Rescue
LINDA CRAMER	SELF
Michele Herzog	True Majority Women Speaking for Women
Charles Mossman	Kansas Chiro. Assn

STATE OF KANSAS

PEGGY MAST
REPRESENTATIVE, 76TH DISTRICT
765 ROAD 110
EMPORIA, KANSAS 66801
(620) 343-2465

ROOM 446-N CAPITOL BLDG.
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE-CHAIR: HEALTH & HUMAN SERVICES
UTILITIES
SOCIAL SERVICES BUDGET

TESTIMONY ON HB 2503

I want to thank the committee for their indulgence once again on a bill that is not a pleasant one to deal with. I regret that this bill had to come before this committee again this year after being heard for the past three years, but the need for this legislation has not changed. As a matter of fact, recent developments have exposed that this issue is one that must be addressed and we must pass this legislation to help prevent future injury to more women and to ensure they have decent health care.

For three years I have proposed that another female be in the room when a woman is examined for pregnancy and when the abortion takes place. For three years, we have heard opposition on this issue even though women have told me of sexual abuse when the examination was performed.

For three years we have tried to obtain enforceable standards for abortion clinics in order to ensure a sanitary environment, and proper health standards were in place. We were finally able to get an inspection on a clinic that had been exposed months before and our greatest fears were confirmed. The condition inside the clinic was outrageous! The staff was untrained, medicine was not properly labeled or stored. Medications that had been expired were found, and perhaps the most disconcerting finding to me was the fact that frozen human tissue was stored next to food items in the freezer. I don't think that Kansans are ready to accept this, yet the Board of Healing Arts made only a token attempt of addressing the problem. I also received recent pictures of the practitioner taking out the medical waste and transporting it to someone else's dumpster on his way home.

I won't belabor this issue. We all know that it needs to be addressed. With that, I stand for questions.

Senate Public Health & Welfare
3-22-05
Attachment #1

2

March 14, 2005

Dear Concerned Legislators:

My name is LaVeta Adams and I am the Board Secretary of an adoption agency and women's resource center on Arkansas City, Kansas. We provide prenatal information, free pregnancy testing, guidance regarding abortion, and adoption guidance. I have been with this agency as a volunteer since 1997 and as a board member since 1999.

The testimony I would like to present today is in regards to House Bill 2503. In 1987 I had an abortion. It was by far my most horrible experience. I was raped by my first cousin. Several medical professionals told me that there was no chance for my baby to live a normal life and that it would have mental and or physical birth defects. I went through with the abortion in a abortion hospital. The doctor used instruments which had not been steralized properly which resulted in infections. I physically contracted a sexually transmitted disease from that procedure. I contracted trechinosis from the abortion procedure. Other complications included various infections such as mastritus, and I am facing the reality of being sterile from the procedure. The infections I had were so severe I faced having surgury. I was fortunate that my OB doctor was able to give me the right medications to keep me from having those surgeries.My husband and I have been married for eleven years and have never concieved. I have to live daily knowing that my decision may have caused me to never be able to have a child again. It has also affected my mental health as I will never forget the medical trauma I went through. The abortion and the complications resulting from the abortion were much worse for me than experiencing the rape. Unregualted abortion and abortion procedures do hurt women. I was one of those women who have been hurt from abortion. Please support House Bill 2503 and regulate abortion so other women don't have to go through the events I went through.

Thank you,
LaVeta Adams

Do You Yahoo!?
Tired of spam? Yahoo! Mail has the best spam protection around
http://mail.yahoo.com

Senate Public Health & Welfare
3-22-05
Attachment #2

Testimony of Cheryl Sullenger to be given at the
Kansas Senate Public Health and Welfare Committee

Cheryl Sullenger P.O. Box 781045, Wichita, KS 67278; voice: 316-634-1037; fax: 316-634-1045

My name is Cheryl Sullenger. I live in Wichita, Kansas and am the Outreach coordinator for Operation Rescue. I have been involved in the pro-life ministry for over 21 years. I also spend time outside the city's abortion clinics offering practical help and alternatives to women seeking abortions. While engaged in these activities I have witnessed a number of times when ambulances have arrived at George Tiller's Women's Health Care Services, an unlicensed, unregulated "doctor's office" where dangerous late-term abortion are performed.

There have been times when I have not been at the abortion clinic, but other sidewalk counselors on site have called me to let me know that ambulances have arrived to transport women to the hospital. When that happens, I go immediately to Wesley Medical Center where I have videotaped and photographed ambulances from Tiller's rushing women into the emergency room. We document these occasions so that the public will understand the outrageous number of life-threatening complications that are occurring at these unregulated abortion facilities.

Since **January, 2004**, I have witnessed **five times** when a patient at Tiller's WHCS had to be rushed to the emergency room with apparent life-threatening abortion complications. We know that these are life threatening injuries because we have possession of a video tape that George Tiller made in 1996 for women considering abortion for fetal abnormality. On this video, Tiller tells his audience that women are transported to the hospital when their abortion complications are so serious that he cannot treat then at his so-called "hospital-like" clinic.

Injury # 1: On February 17 of this year I received a phone call and was notified that an ambulance had just arrived at Women's Health Care Services. I went to Wesley Medical and too the following photograph of the woman that had been transported from WHCS.

The woman was not moving and it is unknown what happened to her. I know this is the same woman that left WHCS because the people on site reported the ambulance number to me and this is that ambulance.

February 17, 2005. Photo by Cheryl Sullenger

Senate Public Health & Welfare
3-22-05
Attachment #3

Injury # 2: On January 13, 2005, I received a similar call and I went immediately to the hospital. There I saw emergency workers frantically attempting to get an injured woman into the ER as fast as they could. They were very grim and looked highly concerned and in a very serious rush. **We later learned that this woman, a 19-year old Texas resident with Down's Syndrome, in fact died from her abortion-related complications during the third day of her late-term abortion procedure.**

Photo taken January 13, 2005 by Judi Weldy.

This photo, by Brenna Sullenger, is out of focus because Sullenger suspected how serious this young lady's injuries were from the demeanor of the EMTs and was shaking because she was so upset.

Injury #3: On September 2, 2004, I received another call from sidewalk counselors. I arrived at Wesley Medical Center and videotaped the ambulance entering and unloading a woman on a gurney who was rushed into the Emergency Room. I was met there by Troy Newman who took the following still photo showing abortionist George Tiller stepping out of the ambulance dressed in surgical attire. I observed this woman writhing in pain as she was wheeled in to the ER.

September 2, 2004. Photo by Troy Newman.

Injury # 4: On June 4, 2004, I was sidewalk counseling outside WHCS when an ambulance arrived. I followed the ambulance from WHCS to Wesley Hospital. Again, I was videotaping the events while Troy Newman took the still photos you see here. The fate of this woman is unknown.

June 4, 2004, Photo by Troy Newman. A woman is being taken to the ambulance at the rear of WHCS. I am pictured across the fence in the middle with a video camera to my face.

George Tiller, seen here in a navy blue shirt and tan pants, helps wheel one of his patients into the Wesley Medical Center Emergency room after emergency transport from his abortion mill, Women's Health Care Services in Wichita.

Injury # 5: On January 23, 2004, I received another phone call that an ambulance had arrived at WHCS. By the time I arrived at Wesley Medical center, the woman had already been transported inside, but I noticed that Tiller's clinic manager had followed the ambulance and was parked in the emergency Room parking lot, making the link between the clinic and the ER. It is unknown what happened to this woman.

The black Nissan Altima in the foreground is registered to a woman who was Tiller's clinic manager at that time. She no longer is employed by Tiller. This photo was taken by Cheryl Sullenger minutes after an ambulance delivered a woman to Wesley's ER from Tiller's mill on January 23, 2004.

In all I have seen **five women** transported from Tiller's abortion mill to the hospital of emergency care all in a **13 month time period**. One of those women tragically died. At the request of Shelley Wakeman, Disciplinary Counsel for the Kansas State Board of Healing Arts (KSBHA), I filed a complaint against George Tiller with the KSBHA and requested an investigation into the abortion death. I received an immediate response that an investigation had

been launched. That was two months ago. I have heard nothing since. In the mean time, another abortion injury occurred.

Some will tell you there is no way to know if the woman's death was abortion related, but I can assure you that it was. We know Tiller's schedule and practices intimately from study, experience, investigative research, and from Tiller's own words recorded on videotape.

Texas woman, we will call Anna (not her true name) came to Wichita on Monday, January 10, 2005, and checked into the La Quinta Hotel. This is where all of Tiller's out of state patients stayed at that time. On Tuesday morning, she was taken to Tiller's clinic where, with the use of ultrasound here pre-born baby's heart was injected with a muscle paralyzer. Anna was then sent back to the hotel to await the onset of labor. Later, on Thursday or Friday, she would have returned to the clinic to expel her dead child. However, something went terribly wrong on Thursday, January 13, and three days into a dangerous late-term abortion, this young lady suffered fatal complications and died at the hospital later that day.

She did not deserve what happened to her. Neither did the other women who suffered serious complications requiring emergency hospitalization. We may never fully know the fate of these women or what complications they suffered. But their stories prove one thing beyond any reasonable doubt: These clinics ARE NOT SAFE.

We do not know the state inside these places because they are not inspected. We do not know if they are following any kind of standards or even if the employees so much as wash their hands, because there is no standard that they must meet nor penalties for providing shoddy services. If clinic regulation had been in place, perhaps young Anna would still be with us today.

I would like to conclude with Anna's Story that I wrote and published on our web site at www.operationrescue.org. Through careful research, I was able to determine who this young lady was, and how loved she was by those who knew her. Her story is a tragedy that must not be repeated. **In memorial to Anna, please pass HB 2503 and help insure that there are no more pf these needless tragedies.**

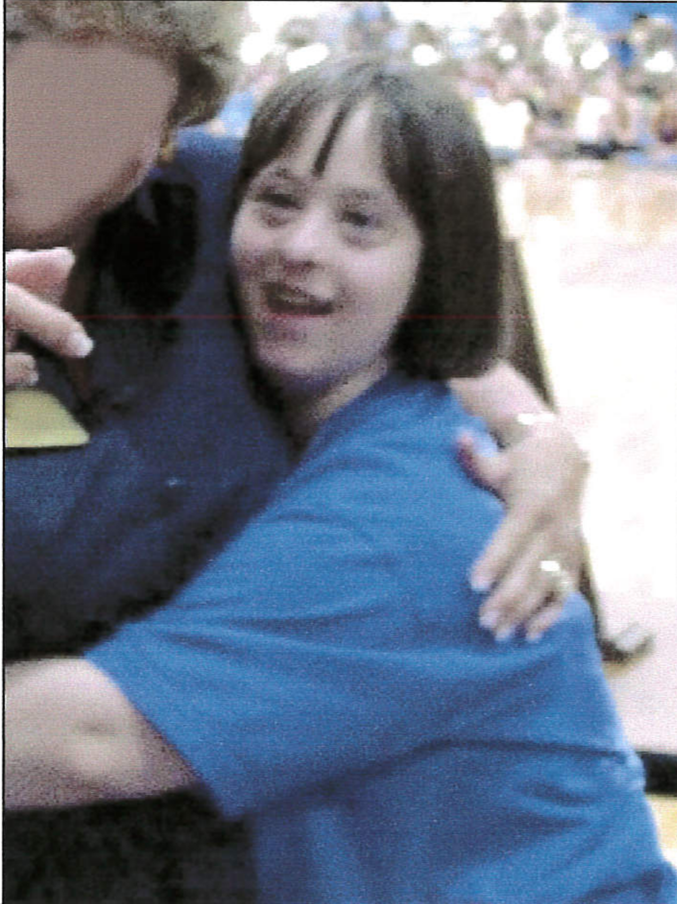
"Anna's" Story

Victim of fatal abortion was loved by family, community

[A young lady died from complications arising from an abortion at George Tiller's infamous late term abortion mill, Women's Health Care Services, on January 13, 2005. As a memorial to her, we want to share with you some of the details of her all-too-short life, uncovered by Operation Rescue researchers. All information contained herein was obtained from public records and documents, however, out of courtesy to the grieving family, we have changed the young lady's name and withheld the name of her hometown.]

Anna was born on May 30, 1985 in Austin, Texas, but spent most of her life in a small Texas town. Anna had Down's Syndrome, but that did not stop her from embracing life and living it to the fullest. Anna was raised by her loving family, which consisted of her mother, father, and sister.
Anna became involved in sports early in her life to help her meet people and make friends. She became very involved in the Special Olympics and that involvement continued until her untimely death.

Anna graduated from the Special Education Program of her hometown high school in 2004. While in high school, Anna became the inspirational member of the girl's soft-ball team, serving as their bat girl. Team members were never allowed to get down during a tough game because Anna would meet them at the dugout with hugs, telling them that she loved them. This kept spirits high and eventually Anna's team won a state championship, something of which Anna and her family were especially proud.



"Anna," one of God's "Angels"
May 30, 1985 – January 13, 2005

In life, Anna was a joy to be around, and if you were near her, it meant that you would be the recipient of her many hugs. She was the center of attention when she walked into a room because of her outgoing and loving spirit.

Tragically, sometime in 2004, Anna was sexually assaulted. As a result, Anna became pregnant. She was taken to George Tiller's Women's Health Care Services in Wichita, Kansas, for an abortion in the late stages of her pregnancy. But something went wrong, and a 911 call was placed by Tiller employee Marguerite Reed, who was evasive with the dispatcher and placed him on hold for 45 critical seconds while she inquired about how much she should tell him. Upon arrival, the ambulance crew determined that Anna's condition warranted emergency transport with all haste to Wesley Medical Center's Emergency Room, where according to her obituary, she died of heart failure later that day. OR staffers photographed the ambulance and George Tiller's arrival at the ER and broke the story of her death in the media.

A Grand Jury from the State of Texas is investigating crimes committed against Anna, and the Attorney General of the State of Kansas has launched an investigation into her death in Wichita.

She was loved by all who knew her and her death has left a void in the lives of her family and community.

Anna was buried on January 21, 2005, after a private funeral service held in her hometown. In her obituary, Anna was called "one of God's angel's." The heartbreaking nature of Anna's needless and untimely death compels Operation Rescue continue to work towards seeking justice for Anna and protection for other pregnant women and their pre-born babies so that Anna's tragedy is not repeated.

Further documentation is available at http://operationrescue.org/.

(4)

From: "Linda Cramer" <lcramer8@cox.net>
To: <whitneyn@house.state.ks.us>, <carrolln@house.state.ks.us>
Date: 3/21/2005 12:42:00 PM
Subject: Testimony for tomorrows hearing for HB2503

Secretary of the Senate Public Health and Welfare Committee;

Hello Ms. Houston, here is my testimony that I will be sharing at the hearing tomorrow afternoon regarding HB 2503. I have copied this from the email message that I sent out last week and hope that this is acceptable.

Thank you for the opportunity to share my story before the committee tomorrow. Could someone please email or call me with instructions and specifics on where I need to be and how the process will work. I have not done anything like this before and I am a little nervous and would feel better to have the details. You can reach me at 316-260-5418.

Testimony

It is of great importance that you pass HB 2503. I had an abortion by Mr. George Tiller when I was 18 years old and suffered complications.

After the procedure I was sent home with basic postoperative instructions that included a phone number to call if I experienced any problems. As the hours passed, I started having more and more pain and bleeding. This became so severe that I called the contact number that I had been given. They were very rude and wouldn't help me or let me come back in to see what was wrong. I was told that some pain and bleeding was normal, but this was not normal - it was very serious and I was bleeding badly and in terrible pain. I called several times and it wasn't until I told them that I was going to the hospital that they finally, begrudgingly, told me they would see me again.

When I went back to Mr. Tiller's clinic they said I would have to pay again if I wanted the anesthesia to put me to sleep. I could not afford this so I had to go through the whole ordeal without. I was in terrible pain while Tiller tried to fix what he had done wrong. I was crying out in pain and Tiller angrily told me to be quiet because I was going to scare the other women in the clinic with my crying out. He and the staff were very upset with me. I was told several times that is was all my fault and that I was going to make Mr. Tiller look bad. It was a horrible experience.

Why must women have to go through this when regulations would help cut down on this unacceptable treatment? It was not my fault, I didn't botch the abortion, Tiller did!! Although I was never told what the complications were, I was never able to have children and have suffered the rest of my life over this. I was one of the more fortunate ones though; I didn't lose my life over the error in procedure. Why can abortionists in Kansas perform major procedures without any kind of guidelines? A vet has more regulations than an abortionist. How many more women will have to be injured or maimed so badly that they die before you pass a law requiring abortionists to meet regulations? I was a naive young lady who went through this horrific experience alone. I was made to feel so ashamed and guilty over what happened that I didn't tell anyone at the time what had happened and how I was treated. This is important for the abortionist to shame us into silence and sweep it under the rug for no one to ever see. If there were regulations and other people involved, then maybe I could have gotten the help I needed to heal physically and mentally after the mistakes made and covered up by Mr. Tiller.

I am not the first or the last woman who has been injured or even died after being receiving an abortion. Please vote yes for HB 2503 so that abortionists in Kansas will be regulated and held accountable. Abortion may be legal but it is not safe and especially in Kansas where there is great need for regulations for these doctors.

Please help us women by passing HB 2503!!!! Thank you.

Senate Public Health & Welfare
3-22-05
Attachment #4

March 22, 2005

STATEMENT

As a woman of the state of Kansas I am appalled that a bill such as H.B. 2503, the Women's Protection Act would have to be re-introduced year after year. Why, after four years are we stalling to protect women? To even debate over whether or not to regulate a certain medical industry is beyond my wildest imagination. I hope this year you'll find it in your heart to protect Kansas women from unregulated healthcare.

Here in Wichita at the Women's Health Care Center, Dr. George Tiller's abortion clinic, we have witnessed first hand five emergency medical vehicles leaving his practice within the last thirteen months with one abortion related death on a nineteen year old down syndrome woman. Currently Tiller, Kansas' largest abortion provider is involved in a grand jury investigation by the state of Texas and is being investigated in our own state.

How many more women need to be injured, how many more have to die before something is done to regulate and oversee the abortion industry in Kansas?

I feel that a dog is more protected than women in the state of Kansas, as a vet's office is regulated and put through the highest scrutiny to provide adequate safety measures and cleanliness.

On a personal note I want to let you know about a funeral I was invited to attend. This was not an ordinary funeral though, as you see, the woman's body who lay in the coffin was the body of Carolina Gutierrez, a young woman who died a horrendous death due to the abortion she received at the Maber Medical Center in Miami, Florida.

Two days after her abortion on December 19, 1995, Carolina lay in critical care; infection (blood poisoning) raging through her body after her uterus was punctured numerous times. The abortionist of record, Dr. Luis Marti fled the country with all medical records. His failure to return her calls for help the night of Carolina's abortion allowed the physical crisis to escalate where she had to be rushed by fire rescue to Jackson Memorial Hospital.*

A hysterectomy was necessary because of the infection, yet her condition worsened. On February 1, after several postponements, she faced surgery once again-an amputation of both feet and her legs below the knees due to gangrene, due to unsterile equipment. She had been in a state of induced sleep since the beginning of her seven weeks' hospitalization. Her hands, too, became swollen and turned black, the mark of gangrene; amputation would occur after the fingers fell off.

February 5 at 9:55am, Carolina took her last breath. A tragic death. She left behind a very distraught husband and two very sad little children.

Senate Public Health & Welfare
3-22-05
Attachment #5

It was a funeral I will never forget. Her husband Jose asked me to please share Carolina's story anytime I could get the chance and to show her picture. He said to tell anyone I could that abortion may be legal, but it is definitely not safe.

You may say, but that was Florida; but how do you know a tragic death like Carolina's has not occurred here in Kansas since we do not have a regulated abortion industry to protect women in our state?

As a woman I ask you to make sure this essential measure passes out of committee for a vote to make sure there are no more deaths such as happened at Tillers' on January 13 and that there will not be a story such as Carolina's in the state of Kansas. This is the only right and reasonable thing to do!

Please do not tell me you care about women if H.B. 2503 does not leave committee. This will show me you are more concerned about rights than about the protection of women in the state of Kansas and abroad, since women come from around the world to Wichita to receive late term abortions.

You have a responsibility to all women in Kansas. Will you show us how much you care about protecting women, or will you show us how much more you care about a woman's right?

Please, for the health, safety and protection of women, vote for H.B. 2503.

Thank you,

Michele Herzog
The True Majority, Director
620-752-3890
*Sun Sentinel, Tuesday, February 6, 1996

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

Testimony In Support Of HB2503

Chairman Barnett and members of the committee:

Thank you for the opportunity to testify in support of House Bill 2503, which would implement minimum health and safety standards for abortion clinics that operate in Kansas. My name is Mike Farmer and I am the Executive Director of the Kansas Catholic Conference, the public policy office of the Catholic Church in Kansas.

Abortion is an invasive, surgical procedure that can lead to numerous and serious medical complications. Because there are no uniform state collection requirements for data on abortion complications, the actual risk of medical complications are impossible to accurately quantify.

Numerous ex-clinic employees agree that 75-80% of women ordinarily do not return to the abortionist for a follow-up exam. Add to that the fact that roughly half of the women undergoing abortion in Kansas don't even live here. Therefore it is even more important that abortion clinics meet minimum health and safety requirements.

Abortion clinics in Kansas are unregulated. There are five known abortion businesses operating out of seven locations in Kansas. Six of the seven locations are not inspected nor require any licensing from the state because they are considered "doctor offices" under the authority of the Kansas Board of Healing Arts. The seventh, the Planned Parenthood facility in Overland Park, has a license under the Kansas Department of Health & Environment to operate as an Ambulatory Surgical Center. The ASC license is voluntary and seems to carry no penalties for violations; for example, KDHE did not levy any fine or close Planned Parenthood doors in 2002 when it was cited for numerous deficiencies. (see page 3)

The state Healing Arts Board is charged with granting or denying licenses to practitioners, not facilities. But even in that charge, the Board is lenient. The Board has not removed the license of Kansas City abortionist Krishna Rajanna even when they showed Rajanna to be severely out of compliance with the Board's Guidelines for Office-Based Surgery. The Board spent one year arriving at a finding of fact that was plainly evident in photos of the clinic made public last April by the Attorney General's office.

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

MOST REVEREND JOSEPH F. NAUMANN, D.D.
Chairman of Board
ARCHDIOCESE OF KANSAS CITY IN KANSAS

MOST REVEREND PAUL S. COAKLEY, S.T.L., D.D.
DIOCESE OF SALINA

MOST REVEREND JAMES P. KELEHER, S.T.D.
BISHOP EMERITUS - ARCHDIOCESE OF KANSAS CITY IN KS

MICHAEL P. FARMER
Executive Director

REVEREND MSGR. ROBERT E. HEMBERGER, J.C.L.
DIOCESAN ADMINISTRATOR - DIOCESE OF WICHITA

MOST REVEREND EUGENE J. GERBER, S.T.L., D.D.
BISHOP EMERITUS - DIOCESE OF WICHITA

MOST REVEREND GEORGE K. FITZSIMONS, D.D.
BISHOP EMERITUS - DIOCESE OF SALINA

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

Senate Public Health & Welfare
3-22-05
Attachment # 6

At that presentation, it was pleaded that all legislators ignore politics and enact clinic licensing. Unfortunately, that didn't happen and now an abortionist without certification in addressing cardiac events and resuscitation emergencies is permitted to stay open for business. That was the situation Missouri found (see page 3) after a Planned Parenthood abortion patient died when under the care of an abortionist without this same certification.

There are six current abortionists who reside in Kansas and of those six, three (Zaremski, Rajanna and Tiller) have disciplinary files with the Board, and two others (Hodes and Crist) have amassed at least 40 malpractice suits. There have been at least 4 known, litigated, deaths following abortions from Kansas-licensed practitioners: 1988 in Kansas City, 1991 in Houston, and 1981 and 1997 in St. Louis. Now we await confirmation as to the cause of death of a 19-year-old Texas woman who died on or about Jan. 13, 2005, having been rushed by ambulance to Wesley hospital from George Tiller's abortion clinic.

The regulatory standards embodied in HB 2503 are derived from standards and protocols promulgated by abortion providers and abortion advocacy groups, specifically the Planned Parenthood Federation of America and the National Abortion Federation. The language of HB 2503 bill has been upheld repeatedly in circuit courts and district courts. For more information on court decisions and answers to commonly raised objections, I encourage the committee to review the testimony of Denise M. Burke, a senior litigation counsel with Americans United for Life, with extensive experience in constitutional law and abortion jurisprudence.

The Kansas Catholic Conference unreservedly supports passage of HB 2503 and would urge you to recommend this bill favorable for passage.

Planned Parenthood of Mid-Missouri Eastern Kansas

Sample excerpts of how Planned Parenthood failed inspection in Kansas:

5-24-02 KDHE Inspection

"based on record reviews and staff interview, the facility failed to establish a policy that would allow patients the right to access the information in their medical record." 28-34-521 (a) (4)

"facility failed to provide education to facility staff related to reporting of reportable incidents. 28-34-55a (e)

"Staff...would not necessarily report medication or treatment errors" 28-34-55a (e)

"failed to assure that only authorized personnel had access to medical records" 28-34-57(b)

"boxes of medical records stored in an unlocked open room" 28-34-57(b)

"facility failed to initiate and maintain an ongoing infection control program" 28-34-58a (a)

"facility failed to require medical examinations upon employment and subsequent medical exams or health assessments thereafter" 28-34-58a (b)

"employee files ...failed to have immunization histories" 28-34-58a (b)

"outdated drugs dispersed among other drugs on the shelves in Pharmacy" 28-34-59a (h)

"bulk narcotics...nurses have access to these narcotics they are not counted by nursing" 28-34-59a (h)

Sample excerpts of how Planned Parenthood failed inspection in Missouri:

6-24-97-inspection by Missouri Department of Health following death of abortion patient; the physician is abortionist Robert Crist at Planned Parenthood in St. Louis

"facility failed to see that all licensed personnel are CPR certified. The physician involved in the medical emergency failed to have CPR certification" 19 CSR 30-30.060(1) (B) 11.D

"Facility failed to have the necessary emergency equipment immediately available to the procedure room as required by 19CSR 30-30.060(3)(L)"

"the facility failed to have the necessary equipment needed in a respiratory and cardiac arrest situation" 19CSR 30-30.060(3)(L)

"the patient was in cardiac arrest...no CPR was attempted by the provider" 19CSR 30-30.060(3)(L)

"facility failed to have the necessary emergency endotrachial equipment available" 19CSR 30-30.060(3)(L)

"An abortion was performed on patient whose hemoglobin was 8.0. the facility policy indicates that anyone in the first trimester that has a hemoglobin of 8 should be ineligible for the procedure" 19CSR 30-30.060(3)(L)

"On 4-30-97 ...22 year old patient who had an abortion, began seizing, lost consciousness and ceased to breathe....patient was transferred to an acute care hospital via ambulance where she later died." 19CSR 30-30.060(3)(L)

Kansans for Life

State Affiliate of National Right to Life

Senate Public Health and Welfare Committee. March 22, 2005
Chairman Barnett and committee members,

I am Jeanne Gawdun, representing Kansans for Life, here in **support of HB 2503,** the Women's Health Protection Act. HB 2503 passed the Senate in 2003 as HB 2176. HB 2503 retains the same tightly crafted language that has been approved 5 times in federal courts.

Given recent, tragic events at Kansas abortion clinics, it is critical that the State exercise its right and obligation to protect the health and safety of women at Kansas abortion clinics.

In contrast to the OBS Guidelines of the Board of Healing Arts (or any rules emanating from them) HB 2503 ensures that abortion providers meet minimum health and safety requirements every minute their doors are open and mandates compliance with accepted medical standards specific to abortion care.

The Rh factor abortion protocol is a provision in HB 2503 that has no parallel in the OBS Guidelines. For example, in the last 3 years, 2 out of 6 resident abortionists have violated that Rh protocol: abortionist Krishna Rajanna was fined by the Board and abortionist Herb Hodes (who appeared to this committee in opposition to HB 2176) was successfully sued.

Despite the denials of abortion clinic conferees, courts repeatedly affirm that the provisions of HB 2503 accurately reflect the minimum standards of the abortion industry. Abortion clinics cannot rationally argue that following their own industry standards is burdensome and cost-prohibitive.

Rules and regs emanating from HB 2503 are the floor, not the ceiling. Under this bill, physicians are always free and, in fact, encouraged, to exceed these rules and the standard of care they prescribe. If Planned Parenthood follows numerous and more stringent abortion standards, as their conferee claims, HB 2503 will not tie their hands.

The Board of Healing Arts licenses personnel, not facilities. In contrast, HB 2503 requires each abortion clinic to secure an operational license from KDHE, which would inspect facilities and could close doors when deficiencies warranted. The Board's Feb.12, 2005 "disciplinary" action against KCK abortionist Rajanna allows him to remain open while factually non-compliant with the Board's OBS Guidelines and while uncertified in cardiac life support / emergency resuscitation (ACLS).

Planned Parenthood's Kansas-licensed abortionist Robert Crist and his staff tragically lacked emergency certification during the April 1997 death of his abortion patient. This was Crist's third, known, litigated abortion death.

HB 2503 mandates emergency equipment and trained personnel, reflecting a national abortion standard ignored by Kansas abortionists Kristin Neuhaus, Krishna Rajanna, Malcolm Knarr, Robert Crist and Dennis Miller. All were found deficient in trained emergency personnel, adequate resuscitative equipment and medical protocols. Evidence was advanced in lawsuits, reports by the Missouri Health Department and findings of the Kansas Healing Arts Board.

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929A S Kansas Ave Topeka, KS 66612 785-234-2998 Fax 785-234-2939
www.kfl.org kansansforlifetp@aol.com

The abortion procedure rooms and staff were deficient in Kansas abortionist Dennis Miller's abortion office during the March 1988 death of his abortion patient. Miller suffered no major penalty from the Kansas Healing Arts Board.

The surviving family's lawsuit alleged Planned Parenthood's Robert Crist lacked sufficient equipment and emergency protocols during the death of his October 1981 abortion patient. The Missouri Board of Health found Crist deficient in equipment and emergency protocols during the death of his April 1997 abortion patient. Crist suffered no penalty, in either case, from the Kansas Healing Arts Board.

Despite critics claims to the contrary, HB 2503 is not "unprecedented"—HB 2503 substantially complies with existing laws regulating abortion clinics in Arizona, Louisiana, South Carolina, and Texas. The law in SC is much more comprehensive and detailed and the U.S. Supreme Court has twice refused to hear an appeal of that law. Arizona's law is enjoined by mutual agreement, with only 4 out of 100 provisions "in limbo"--none of which substantially affect this bill.

17 states license at least some facilities that perform abortions (either as an "abortion facility," "an ambulatory surgical center," or other): AL, AZ, AR, FL, GA, IL, KY, LA, MI, MS, MO, NC, OH, PA, SC, TX and UT.

HB 2503 requires the reporting of injuries within ten days and deaths within 24 hours to the KDHE. In contrast, the OBS Guidelines of the Board of Healing Arts only requires death and injuries be reported every 3 months to a Kansas Medical Society committee. While quarterly reports may suffice for risk management objectives, certainly the prompt reporting of HB 2503 better serves the public.

Clinics are motivated to hide negative outcomes from the public. Planned Parenthood brazenly denies the abortion patient deaths of their abortionist, despite KFL documentation 4 years running in hearings of this bill. At their press conference last week, when asked about published KDHE-reported clinic deficiencies in 2002, Planned Parenthood's manager claimed "they never happened."

If HB 2176, identical to HB2503, had been enacted, and not vetoed by Governor Sebelius, Kansans for Life believes the numerous injuries from George Tiller's Wichita abortion clinic (indicated by ambulance runs) would have triggered KDHE intervention and possibly prevented the Jan.13, 2005 Tiller clinic death.

We ask you to please pass favorably out of committee HB 2503, the Women's Health Protection Act. Thank you, I stand for questions.

[Common objections to licensing laws are addressed in a memo from Americans United for Life, attached with this testimony.]

Testimony of Denise M. Burke, Esq.
On House Bill 2503 – Proposed Abortion Clinic Regulations March 2005

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

Denise M. Burke, Senior Litigation Counsel, Americans United for Life
(210) 520-1622 dmburke@AUL.org Website: www.AUL.org

ANSWERS TO COMMON OBJECTIONS TO HB 2503:

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

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

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

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

Simply, this is not a legitimate legal argument against the necessity for or appropriateness of abortion clinic regulations. These exact same arguments have been made to and were summarily rejected by three federal courts. *See Tucson Woman's Clinic v. Eden*, No. CIV 00-141-TUC-RCC (D. Ariz. Oct. 1, 2002); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000) ("*Greenville I*"); and *Women's Medical Center of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001). Moreover, abortion clinic regulations, like HB 2503, are designed to specifically address and meet the needs of abortion patients. OSHA standards, CLIA standards, state physician licensing standards, and other federal or state regulations are not designed to meet the specific medical needs of women undergoing abortions.

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

Federal courts have also summarily and repeatedly rejected such arguments. In litigation surrounding abortion clinic regulations enacted in South Carolina, Tennessee, and Texas, different federal courts heard, analyzed, and rejected similar claims. *See Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000) ("*Greenville*

I");*Bristol Reg'l Women's Ctr., P.C. v. Tenn. Dep't of Health*, No. 3:99-0465 (D. Tenn. Oct. 22, 2001); and *Women's Medical Center of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001).

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

Once again, similar complaints have been heard, analyzed, and rejected by federal courts that have recently decided constitutional challenges to abortion clinic regulations. *See Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000) ("*Greenville I*") and *Women's Medical Center of Northwest Houston v. Bell*, 248 F.3d 411 (5th Cir. 2001).

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

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

Finally, even assuming that the proposed regulations would raise the costs of abortions and/or result in fewer providers (and we have no evidence that this will actually occur in Kansas should these regulations be enacted), the U.S. Supreme Court has held that "[t]he fact that a law which serves a valid purpose, one not designed to strike at the [abortion] right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S at 874. HB 2503 serves a legitimate purpose, the protection and preservation of maternal health; therefore, these arguments once again fail.

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

Given that the regulations are based on national abortion care standards endorsed by groups such as Planned Parenthood and NAF, this argument is puzzling at best. Presumably, many abortion providers in Kansas are Planned Parenthood affiliates, members of NAF or are aware of and/or subscribe to the standards promulgated and endorsed by these organizations. Seemingly, it would be safe to assume that abortion providers in Kansas who are concerned about women's health and are interested in providing the best quality care to their patients would already be complying with, if not exceeding, the ***minimum*** standards required under HB 2503. Thus, if they are already providing quality care consistent with nationally accepted standards and protocols, they should have no problem complying with the proposed regulations, passing the mandated inspections, and obtaining a license.

Kansans for Life
State Affiliate of National Right to Life

(3)

Testimony in support of HB 2503 March 22, 2005
Senate Health Committee
Chairman Barnett and members:
Good afternoon. I am Kathy Ostrowski, Legislative Research Director of Kansans for Life, here to testify in support of HB 2503.

There is no other procedure comparable to abortion. The 4th Circuit opined, "The rationality of distinguishing between abortion services and other medical services when regulating physicians or women's healthcare has long been acknowledged by Supreme Court precedent, beginning with Roe itself," [Greenville 1] Abortion is "rationally distinct" and "inherently different from other medical procedures" said the Supreme Court.[Harris, 448 U.S. at 325]

It is a grave mistake for opponents to compare abortions with tonsillectomies, which are not performed in offices, or with colonoscopies, which don't pose the same risk. Abortion is an invasive surgical procedure that fairly often leads to numerous and serious medical complications. The Abortion Practice 101 textbook says, "there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion." [Hern, 1990] There's no uniform, state collection requirement for data on abortion complications, so actual risks are impossible to accurately quantify. There have been 5 abortion patient deaths from Kansas-licensed abortionists in 1981, 1988, 1991, 1997 and 2005. An abortion injury in Wichita Feb.17, 2005 may turn out to be another death.

Not only is abortion dangerous, the abortionists in this state have an atrocious track record. Kansans for Life research shows that Kansas abortionists need supervision at a magnitude unlike any other specialty physician. Since 1994, 13 abortionists resided in Kansas. 9 of those 13 {69%} have had disciplinary actions taken against them from federal and/or state regulatory agencies. Of the remaining four, 2 work at "upscale" abortion sites in Overland Park, where 1 abortionist has been sued at least 18 times for malpractice and the other 22 times.

Abortion patients are vulnerable. Dr. Brendan Mitchell (testimony attached) states he has had many patients with a history of abortion complain that they were given flawed consent information, that the ultrasound and other medical equipment appeared antiquated, and that the facility was unsanitary. Obviously, there is a social stigma associated with abortion for many patients that places them at greater risk for substandard care or even abuse. Many abortion providers operate on a cash basis with no insurance coverage involved, eliminating quality assurance or facility standards that an insurance company would place on its participating providers.

Women deserve state inspection of clinics with a mechanism that prevents clinics from operating while deficient. The Board of Healing Arts took one year to "discipline" a Kansas City abortion clinic that was so filthy that law officers, called to the clinic for another matter, refused to be seated. In his testimony to the House Health committee March 16, one of the law officers described roaches on the counter, dried blood on the floor, and a chaotic, cluttered and completely shocking medical office.

Even when they are spoon-fed information from informants, the Board of Healing Arts is unable to close deficient facilities. Instead, they engage in drawn out litigation to impose limitations to their license-holders. Meanwhile, the deficient clinics remain open--even in the case when the Board declared the abortionist "an imminent danger to the public". One notorious abortionist's medical license was finally suspended, but his assembly-line clinics live on with 3 replacement abortionists. Notably, none of the replacements have ob-gyn training. Again, a licensing law, HB 2503, solves this.

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The claim that the Board can sufficiently police abortion clinics is not true! (see attached KFL Press Release, p.3-4) The Board openly admits a KCK clinic is substandard but because the abortionist needs money to fix it, they allow him stay open for business. The Board's actions seem to have little deterrent value--allegations about abortion clinic deficiencies in 1992 match clinic deficiency allegations in 2003! (see attached chart) Any additional rules or regs the Board adopts based on OBS Guidelines can be ignored, enforced selectively, or abandoned in the future; not so for HB 2503.

NOW HERE'S THE KEY ARGUMENT FROM OPPONENTS: "Any licensing law imposed on abortion clinics is discriminatory and only bearable if all other medical facilities are similarly treated." This Equal Protection argument seemed to hold for awhile in the 1980's. But now 17 states specifically license abortion facilities and the formulaic language of HB 2503 has been upheld 5 times in federal court. MOST IMPORTANTLY, the Supreme Court refused to review the 4th circuit holdings that permitted South Carolina's licensing laws ONLY for abortion clinics (i.e. there were not 4 Supreme Court judges who wanted a review, although this is a Court that is 6-3 supportive of Roe) And the laws the Supreme Court twice chose to let stand are much more detailed than HB 2503!

> No authority exists to support a conclusion that abortion clinics or abortion providers have a fundamental liberty interest in performing abortions free from governmental regulation. See, e.g., Birth Control Centers, Inc. v. Reizen, 743 F.2d 352, 358 (6th Cir. 1984).

HERE'S THE DEFENSE OF "SELECTIVE" or "PIECEMEAL" LEGISLATION:

> [79] We thus conclude that South Carolina has a rational basis for regulating abortion clinics while not regulating other healthcare facilities. See Williamson v. Lee Optical, 348 U.S. 483, 489 (1955) ("The problem of legislative classification is a perennial one, admitting of no doctrinaire definition. . . . [T]he reform may take one step at a time, addressing itself to the phase of the problem which seems most acute to the legislative mind. . . . The legislature may select one phase of one field and apply a remedy there, neglecting the others").
> In each of these instances, persons falling on one side of the line are treated differently from those on the other. But this result is inherent in legislation. Under rational-basis review, we need to determine only whether the line is drawn in a manner that reasonably furthers the legislative concern. Greenville Women's Clinic v. Bryant, 222 F.3d 157 (4th Cir.(S.C.) 2000)

The 4th Circuit found that clinic licensing serves a valid purpose in safeguarding the health of women. The state's protective obligation does not end at the door of the abortion clinic

> The $23-$75 increased cost per abortion attributable to compliance (for South Carolina)...was, we held, an incidental effect that, while making abortions modestly more expensive, did not unduly burden a woman's right to make the abortion decision. Id. at 169-72.

We don't need new licensing and regulation for 2,300 doctor offices, we need abortion clinic licensing to protect women in 7 abortion clinics. 2/3 of Kansas resident abortionists have disciplinary problems, not counting malpractice and wrongful death lawsuits. No other medical professionals have that ratio of problems! No evidence has been presented that any other specialty, performed in offices, is as hazardous as abortion. The current mind of the federal courts support state licensing legislation directed to abortion.

The evidence against substandard abortion clinics is unparalleled. To gloss over that concern is to mock the problem. To artificially broaden the scope of oversight mutes the message that it is women in abortion clinics that need protection. They will not be likely to file lawsuits that might serve to end abuses. The state does not need to "justify" or "balance" clinic laws by dragging others into unnecessary supervision. Please find HB 2503 favorable to pass out of committee. Thank you. I stand for questions.

Proponent, House Bill 2503 March 15,2005
House Committee on Health and Human Services
Dear Chairman Morrison and committee members,

My name is Detective William Howard. I joined the Kansas City Kansas Police Department in 1982. I am here today to testify truthfully about events that I witnessed at an abortion clinic while performing my lawful duties as an officer. I am only here to relay the facts of my official investigation and do not represent either side of the issue of abortion by virtue of my role in the community.

On September 18th, 2003 my partner and I went to investigate a theft reported by **Dr. Krishna Rajanna, at the Affordable Medicine Clinic at 1030 Central Ave, in KCK.** Dr. Rajanna took us to the rear area, which could be described as a break room, to discuss employees he held responsible for money missing from his business. During this interview phase, my partner and I made these observations.

First, the doctor had an unkempt appearance. Dr. Rajanna lacked personal hygiene. His hair was messy, hands dirty, and his clothing was wrinkled and stained. He put on old, used foot booties while we were there.

The clinic was dirty inside. As we proceeded through the facility I noted the back area was very dark and dingy looking with poor lighting and smelling musty. We entered the "break room" to interview Rajanna. There were dirty dishes in the sink and on the tabletop, trash everywhere, and roaches crawling across the countertops, with a smell of a stench in the room. Frankly, I was reluctant to sit down. I noted there weren't containers for medical waste with universally recognized hazardous waste labels on them. On the way out my partner observed that the "procedure room" was filthy. He told me that he saw dried blood on the floor and the room looked "nasty" to him.

The clinic was disorganized. Papers and other miscellaneous documents were strewn about causing there to be "clutter" everywhere. Dr. Rajanna apparently kept very poor records. He could not recall when these alleged thefts had occurred nor was he organized enough to locate any documents to support his allegations. I also noticed that the assistants seemed to be running everything though they were barely out of their teens. There were no credentials on the wall. One spoke only Spanish. I looked at the patient sign-in sheet as part of the investigation and it consisted merely of notebook paper.

This general lack of a professional and sanitary environment starkly contrasted with all my experiences inside other doctor offices.

It was determined that Dr. Rajanna' theft charges could not be substantiated. Bank employees told us Dr. Rajanna has such loose record keeping practices concerning payroll checks that fraud could never be verified. Apparently the employees are allowed to write out their own payroll checks because Dr. Rajanna's printing is difficult to read. I was also given several checks to verify this for comparison and his signature is indeed a scribble mark.

I received full co-operation from the Employees accused of the theft. They were initially treated as suspects, given their Miranda rights and provided us with full statements. In a statement to me one

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witness/suspect related how Dr. Rajanna was a filthy man who did not properly sterilize his equipment. The medical equipment was cleaned with Clorox and water then put in a "dishwasher". The aborted fetuses were placed inside Styrofoam cups and put in the refrigerator freezer next to TV dinners. The female witness went on to describe of how she and other girls actually witnessed Rajanna microwave one of the aborted fetuses and stir it into his lunch. I have heard that some Middle Easterners eat the placenta from birth and that they believe that this adds longevity to life. I thought "Maybe" this could be what she was referring to. This witness claimed other employees who had seen him do the very same thing.

The initial witness related that she felt that she had been terminated because she was pregnant. She was repeatedly encouraged to terminate the pregnancy and told that she would not serve as a good representative of this clinic by carrying the pregnancy to term. According to this witness, she was starting to feel compassion for the females who were being summarily ushered in and out without adequate recovery time.

I became so disturbed by the condition of this medical clinic that I contacted District Attorney Nick Tomasic and requested a meeting to discuss these issues. Bare in mind, I am an experienced police officer who has worked in every aspect in law enforcement and had spent my last five years in the homicide unit where I worked countless community deaths. I thought I had heard and seen every vile, disgusting crime scene but was in for a new shock when I started this investigation. Nick Tomasic permitted me an appointment so I brought the witness directly to him where she gave him a first person statement of her account. I repeatedly warned her not to lie or exaggerate. The witness was also told that she could be prosecuted for any false statements made from this moment forward, but that the prior statements would not be prosecutable. She told the exact same story to DA Tomasic as she had told us.

I was informed that no laws had been violated. After this Meeting, Mr. Tomasic told me that he would have his staff research the information for any law violations. Later, Mr.Tomasic provided me a list of 3 numbers and agencies that I could contact to complain to about this clinic. I personally contacted the numbers on the list. One of the people I talked with was a female from Board of Healing Arts. I no longer have her name or any of the numbers I called regarding this investigation, but I believe I contacted Board of Healing Arts and someone from hazardous waste disposal center. I do not recall the third agency. The person at the Board, whose name I don't know, related that numerous complaints had been made about the clinic but no laws have been violated. Finally, I gave this list of phone numbers to the witness and advised her that she could contact these numbers to describe the environment she had worked in and this was my very last contact with anyone involved with this investigation.

In March of 2004, I learned that an official investigation was underway and was requested to give a statement. My partner has testified as to these same events April 30, 2004, before a group of Senators here at the Capitol at the request of Sen. Kerr. Thank you for your time, I stand for questions.

Krishna Rajanna

Abortion Clinic Sterilization Room

The "bio-hazard" area contains two dishwashers, one of which drains into a vanity (partially seen in picture).

Atop one of the dishwashers is a tray of supposedly sterile surgical instruments adjacent to a pot of moldy food and open trash containers.

Beside the dishwashers is a blood stained, dirty toilet with a strainer attached for emptying fetal remains from a suction machine.

The stack of cups is for fetal storage (see refrigerator pictures). Trash bags are open. Bleach is also seen, which a staffer claimed was often substituted for sterilization of the surgical instruments.

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Krishna Rajanna

Abortion Clinic Back Door/Fire Exit

The back door/fire exit is blocked with bio-hazardous trash, open drugs, and a gas lawn mower.

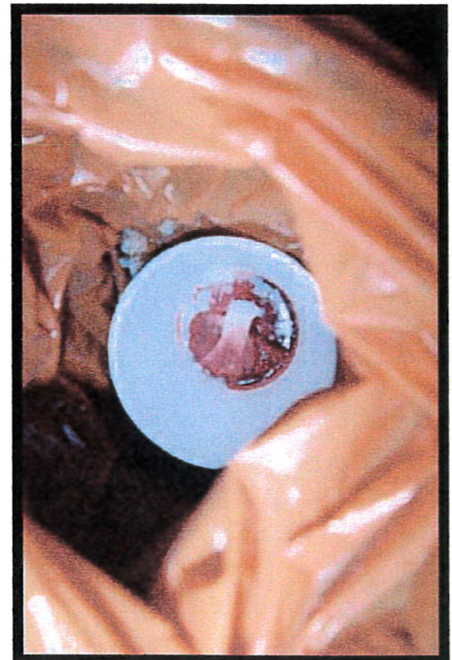
One Attorney-General affidavit from a physician compares these areas of extreme clutter and disarray (see break room and "biohazard" area pictures) as the kind found in the homes of those who suffer from hoarding syndrome.

Krishna Rajanna

Abortion Clinic Refrigerator

Against OSHA regulations, refrigerators in the clinic commingle food, drugs, injectables, biological tissue and fluids.

Most fetal parts are kept in cut-off milk cartons and disposable drinking cups stored inside plastic bags.



Krishna Rajanna

Abortion Clinic Break Room/Doctor's Office

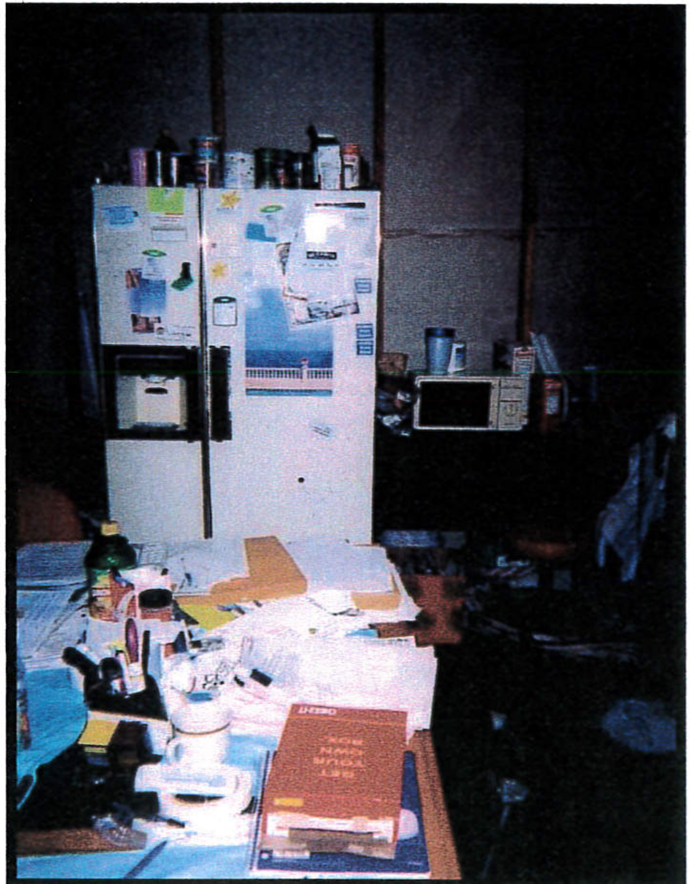
Rajanna's desk/ lunch table is covered with paperwork and empty food and drink containers.

The refrigerator houses food, drugs, and fetal parts (see refrigerator pictures)

Above the refrigerator are caustic chemicals and food. File boxes are adjacent to the refrigerator and under the microwave. Walls are unfinished with exposed wiring.

What one doctor told the Attorney General's Inspector about his reaction to the clinic's photos:

DoctorLC: "There are multiple partitions to divide areas instead of walls... Unfinished walls devoid of sheetrock with exposed wiring... Impressive lack of sanitation (and inability to be sanitized)... items are seen piled, stacked, and crammed on most available surfaces... in the procedure room, biohazard room, storage room and the breakroom/Dr. office...."



Current Kansas Abortion clinics

7 locations: 6 resident abortionists with 3 non-resident abortionists

3-21-05

KCK

*720 Central, KCK; *Central Family Medicine* 913-321-3343
Sherman Zaremski,KS license 04-13172, disciplinary file KSBHA [not an OB/GYN]
www.aidforwomen.org

*1030 Central,KCK; *"Affordable Abortions"* in yellow pages, 913-342-6789
Krishna Rajanna, KS license 04-15624, disciplinary file KSBHA [not an OB/GYN]

Wichita

*5101 E Kellogg, Wichita; *Women's Health Services* 316-684-5108
George R Tiller,KS license 04-14025, disciplinary file KSBHA [not an OB/GYN]
out-of-state staff who fly-in on alternate weeks:
Shelley Sella, (California)KS license 04-29603,
Leroy Carhart, (Nebraska)KS license 04-24866 [not an OB/GYN]

*3013 East Central,Wichita; *Central Women's Services Inc.* 316-688-0107
Sherman Zaremski, *above*, travels here for Wednesdays only abortions

Overland Park

*4840 College Blvd.Overland Park; *Center for Women's Health* 913-491-6878
Herb Hodes, KS license 04-14447 multiple malpractice suits
Tracie Nauser(his daughter) KS license 04-26188 www.hodesnauser.com

*4401 W 109th Overland Park; *Planned Parenthood,Mid-Missouri-EastKS,* 913-345-1400
Robert Crist, KS license 04-13176 [2 abortion deaths in Missouri, 1 in Texas] multiple malpractice suits
Orrin C. Moore, (New York) KS license 04-19844

Lawrence

*1420 Kasold Drive, Lawrence 66049; *Planned ParenthoodMMEK*, 913-832-0281
Robert Crist, KS license 04-13176, *above* travels here for Tuesdays only abortions

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Former KS abortionists:
Dale Clinton died July 1998
Norman Harris (Florida) retired,
Malcolm Knarr, suspended
Joseph Manley, suspended
Dennis Miller not currently aborting
Ann Kristin Neuhaus not active
Arthur Taliaferro died May 2004
Ronald Yeomans retired

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Gov.Sebelius vetoed abortion clinic licensure in 2003, claiming Kansas enjoys the highest medical standards. Two abortion employee whistleblowers, 11 years apart, describe just the opposite.

How an abortion clinic employee in 1992 described the operation of a Kansas abortionist, W. Malcolm Knarr.
"Susie's"document on file at BOHA. For summary see http://www.abortionviolence.com/VIOL-KS.HTM

Cash discounts
Knarr's abortion seekers at 720 Central, were given discounts for traveling a certain number of miles and on certain days. *(item 6, pg 2)*

Violated informed consent
Knarr staff violated the 1992 abortion law about information delivered to woman 8 hours prior to procedure. *(item 7, pg 3)* Knarr avoided full info disclosure. *(item 8, pg 3)*

Improper counseling
1992 abortion counseling provisions were violated and hidden. No RN, LPN or licensed social worker provided counseling. *(item 12, pg 4)*

Medically untrained staff
A receptionist without medical training was doing IVs within first month of employment *(item 2-pg 1)* and was told to comfort crying women in pain. *(item 27, pg 8)*

Important test mishandled
RhoGAM given improperly.*(item 13, pg 5)*

Fetal tissue mishandled
Knarr never reassembled fetal parts to see if any remained in woman. The solid contents of suction abortions, caught in a gauze bag, were put into cups. *(item 21, pg 7)*

Med waste mishandled
The bloody pads & drapes from under the aborted women, and the used rubber gloves, were thrown into garbage. *(item 22, pg 7)*

Sink used for blood
Knarr had blood drawn in kitchen with blood poured down the sink. *(item 35, pg 10)*

How an abortion clinic employee in 2003 described the operation of a Kansas abortionist, Krishna Rajanna.
"Ruby" told her story to law officers and the DA, who found her to be credible. Ruby took photos.

Cash discounts
Rajanna, 1030 Central, gave discounts on Wednesdays. Knarr's former partner, abortionist Zaremski, 720 Central, advertised for discounts on Tuesday and Thursdays.

Violated informed consent
Rajanna violated proper information delivery as ordered in 1997 Women's Right to Know law.

Improper counseling
Minors were counseled via phone at Rajanna's. No RN, LPN or licensed social worker was onsite. A CNA was sometimes employed.

Medically untrained staff
Ruby was hired as a receptionist, but within days was brought into surgical room to do IVs, witness abortions and help calm upset women.

Important test mishandled
Rh factor test done by Rajanna staffer who was not taught procedure variants that invalidate results.

Fetal tissue mishandled
Rajanna never reassembled fetal parts to see if any remained in woman. He stored abortion contents in cartons and cups in refrigerator, next to needles, drugs, and open food.

Med waste mishandled
The bloody pads & drapes from under the aborted women, used rubber gloves, blood test specimens & other medical waste were thrown into garbage. Rajanna placed trash in his car each night. No bio-hazardous waste containers were inside clinic.

Sink used for blood
Rajanna dishwasher output from bloody instruments pours into sink, not floor drain.

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OSHA violations
Knarr's offices were cited by OSHA for violations, which he did not correct. *(item 36, pg 10*

Poor personal hygiene
Knarr was always disheveled with dirty fingers and stained coat. *(item 25, pg 8)*

Chaotic clinic
Knarr's office was generally disorganized with no clearly defined manager. There was fighting over petty matters. *(item 30, pg 9)*

Rushed assembly-line
After the procedure, Knarr would shout at the staff to get patients up and out ASAP. *(item 27, pg 9)*

Life-saving training deficient
Life support equipment for constant monitoring required for drugs Knarr utilized was not onsite and staffers were not CPR trained. *(item 34, pg10*

Violations drug protocol
Knarr violated drug sample usage. *(item 39, pg 11)*

No follow-up
80% of Knarr patients did not return for mandatory follow-up exam. *(item 26, pg 8))*

Staffers unpaid
Knarr summarily withheld money owed to staffers, claiming it was legal. *(item 37, pg 11)*

Whistleblower framed
"Susie" felt Knarr tried to frame her, using open drug vial. *(item 42, pg 12)*

Knarr hired Rajanna from Feb.1994 til Jan.1995
Rajanna was then fired by Knarr, in part, because Rajanna was unable to obtain hospital privileges. *[Civil action 99C462, Wyandotte County, Div.3]*
Knarr and Rajanna are not Ob/Gyn doctors.

OSHA violations
Rajanna's office has hazardous cleaners not kept in closed storage; exposed wiring; a gas lawn mower inside premises; passageways and exit blocked

Poor personal hygiene
Rajanna was always disheveled with dirty fingers and stained coat.

Chaotic clinic
Rajanna's office (which was the kitchen) was disorganized with the premises looking like a trashed frat house. Staff kept own record of hours worked, with arguments about proper pay.

Rushed assembly-line
After each abortion, Rajanna staff quickly removes IV, pulling client's slacks back up (with pad) and helping her stand and walk haltingly, groggily to "recovery couch". No attendant, no wheelchair, no final doctor contact or exam.

Life-saving training deficient
Rajanna staff was not CPR certified, and necessary resuscitative equipment is not onsite. Vitals are checked before procedure and once after wards, but not during procedure or recovery as is proper.

Violations drug protocol
Rajanna drug closet accessible to staff, who were never asked for criminal record or job references

No follow-up
3/4ths of Rajanna patients never returned for mandated checkup.

Staffers unpaid
Rajanna summarily withheld money owed to staffers.

Whistleblower framed
"Ruby" feels she was "framed" in a false police report of theft.

Susie and Ruby don't know each other. Ruby has never heard about Susie's report, and vice-versa. Both women were financially strapped, needed the job, but finally felt they had to tell someone about conditions. Neither woman was paid or coerced.

2-21-05 For more information call Kansans for Life at 1-800-928-5433

TIMELINE: **Kansas State Board of Healing Arts**
in the Matter of **ANN K. NEUHAUS, M.D. (Lic. 04-21596)**

June 29, 1993- First record of Neuhaus practicing in Topeka (License application renewal for 1993-1994).

Jan. 18, 1994- Neuhaus, medical director of abortion clinic in KCK, locks herself and 5 employees in clinic, because of a dispute with employee Malcolm Knarr. (See Topeka Capital Journal article, 1-19-94)

June 30, 1996- last Kansas license application renewal for Neuhaus with clean disciplinary record.

Oct. 18, 1999- KBHA STIPULATION, AGREEMENT & ENFORCEMENT ORDER **Neuhaus breaks DEA regulations for controlled substances** including failure to keep complete and accurate records. Board restricts her to use of only 1 drug (Valium) and requires administration log with duplicate prescription copies reviewed monthly by outside pharmacist. They also order random drug testing of her entire staff & security guards and that Neuhaus not hire anyone with a substance abuse history.

Aug. 12, 2000- KBHA MEETING, Administrative proceeding V, closed session to discuss refusal to grant Neuhaus' request for permission to use additional drug. Issue emergency order classifying Neuhaus as **imminent danger to public**.

Aug. 14, 2000- FINAL ORDER: Board reacts to Neuhaus' testimony that she relies heavily on staff to manage complications; that she is not certified in cardiac life support; that she neglects to insert IV lines during sedation.

Aug. 29, 2000- KBHA EMERGENCY ORDER-states that Neuhaus is an immediate threat, not limited to the likelihood of patient injury; she is **not following the standards of care** for non-anesthesiologists when giving sedation. Specifically, she **omits the following**: a proper patient history (including adverse drug reactions), focused exam, monitoring of vital signs, patient dismissal evaluation & an accurate medication record.

Sept. 7, 2000- KBHA RESPONSE from counsel issued to Neuhaus request to terminate limitations. Request is without comprehensive account of how she exactly plans to address deviations of standards of care. There is no evidence that Neuhaus' staff is competent in resuscitation. Board requests a hearing and monitoring of Neuhaus concerning deviations of care.

Sept. 11, 2000- KBHA TERMINATION OF EMERGENCY ORDER: Neuhaus promises to complete a course in Advanced Cardiac Life Support training and staff will complete basic Life Support course; Board will monitor compliance. **Allowed back in full practice.**

Dec. 4, 2000- PETITION TO REVOKE, SUSPEND or OTHERWISE LIMIT LICENSE: Patients A.B. & S.D. were not evaluated, examined, monitored, recorded & discharged properly; informed consent gestational information not conveyed to them 24 hrs. prior to procedure. Patients C.L. & H.S. allege all the same as A.B. & S.D. plus failure to obtain written documents. Patient A.G. gave limited consent to abortion without sedation. When she **withdrew consent and tried to leave, Neuhaus & staff sedated her and aborted her**. A.G.'s informed consent was violated and all the proper protocols omitted from the above patients were also omitted from her. **Neuhaus kept unmarked pre-drawn syringes** in her practice, contrary to standards of care.

Feb. 2, 2001- AMENDED PETITION restates Dec.4 petition with minor correction

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March 15, 2001- MOTION TO CONTINUE April 11-13 hearing, based on an undocumented, non-specific "threat" coupled with the assertion that Neuhaus had experienced hostilities in a prior Holy Week. That such assertion is patently false as can be demonstrated from KBHA records along with police & media reports. (See attached letter from KFL to KBHA.)

April 4, 2001- MOTION GRANTED, continued until June 20-21, 2001

April 28, 2001- Settlement offer to avoid trial presented (per Mark Stafford, Disciplinary Counsel.)

May 10, 2001- Neuhaus announces closing Wichita office

June 15, 2001- AGREED INITIAL ORDER maintains the facts and conclusions of 8/29/00 and 9/11/00 that Neuhaus deviated from the standard of care regarding informed consent, sedation and monitoring of patients. The limitations described on 10/18/99 remain in force, such that Neuhaus must: 1) dedicate one staffer to monitoring sedation and addressing emergencies; 2) improve record-keeping; 3) have a printed, dated sonogram as part of every medical record; 4) improve the informed consent form, and have it signed, dated, timed and witnessed during appointment for procedures; 5) meet with patients outside of procedure room, reviewing informed consent prior to patient's physical preparation for procedure.

Aug. 24, 2001- FINAL ORDER. Board adopts June 15, 2001 order as final

Sept. 10, 2002- one year later, Neuhaus announces closing Lawrence office

Summary prepared by Kansans for Life

Kansans for Life

Press Release, March 21, 2005
For immediate release
Contact: Mary Kay Culp, KFL Exec. Director
Office: 913-642-LIFE or cell: 913-406-4446

Subjects : Clinic Licensing Bill and Rebuttal Memo to Board of Healing Arts

SUBJECT #1 - Kansas House Passes Clinic Licensing Bill

For the fourth session in a row, the Kansas House passed a bill that would issue licenses to abortion clinics that pass inspection by KDHE. HB 2503, now called the Women's Health Protection Act, contains sanitation and surgical requirements that are abortion-specific and court-tested. The vote was 87-36, sufficient to override another gubernatorial veto. The bill now moves to the Senate for a hearing Tuesday, March 22 in the Health committee chaired by Sen. Jim Barnett, M.D. In the 2003 session, Sen.Barnett spear-headed passage of HB 2176, the clinic bill identical to HB 2503.

The bill was drafted from the published standards of the National Abortion Federation and Planned Parenthood. HB 2503 provides minimum standards, i.e. rules and regulations implemented by KDHE under this bill will represent the floor, not the ceiling, for standards physicians and clinics adopt. Under questioning from the House Health committee, representatives of Planned Parenthood and George Tiller stated they opposed the bill completely and would not delineate any specific provisions as faulty or onerous.

Kansans for Life Executive Director, Mary Kay Culp, said. "Contrary to opponents' wild claims, HB 2503 does not "lock into law procedures that are becoming outdated." Nor is it "unprecedented"—17 other states successfully license abortion clinics. The abortion industry seems willing to say anything to stop this bill. The plain truth is that opposing this bill means that they are unwilling or incapable of adhering to the minimum requirements of their own industry."

The Board of Healing Arts took one year to "discipline" a Kansas City abortion clinic that was so filthy that law officers, called to the clinic for another matter, refused to be seated. In his testimony to the House Health committee March 16, one of the law officers described roaches on the counter, dried blood on the floor, and a chaotic, cluttered and completely shocking medical office.

"Even when they are spoon-fed information from informants," Culp continued, "the Board of Healing Arts is unable to close deficient facilities. Instead, they just engage in drawn out litigation to impose limitations to their license-holders. Meanwhile, the deficient clinics remain open."

Kansas needs to protect women by issuing licenses for these clinics, because the practitioners running them have an atrocious track record. Kansans for Life research shows that Kansas abortionists need supervision at a magnitude unlike any other specialty physician. Since 1994, 13 abortionists resided in Kansas. 9 *of those 13 {69%}have had disciplinary actions taken against them from federal and/or state regulatory agencies. Of the remaining four, 2 are "upscale" abortion sites in Overland Park, where 1 abortionist has been sued at least 18 times for malpractice and the other 22 times.

* Dale Clinton, Malcolm Knarr, Joseph Manley, Dennis Miller. Kristin Neuhaus, Krishna Rajanna, Arthur Taliaferro, George Tiller, Sherman Zaremski.

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Talking Points and Objections Answered for HB 2503-Women's Health Protection Act

- Kansas issues a medical license that can be used for any specialty. The 74-year-old lung specialist who performs abortions in KCK and Wichita currently does not have to pass any Ob-Gyn professional test or pass any inspection of his clinics.

- By statute, the State Board of Healing Arts (BOHA) issues and withdraws licenses to people, not to facilities. Even if deficient abortionists are forced out, the assembly-line facility remains --using new doctors. In Kansas, those replacement abortionists for the past 11 years have no ObGyn certification, like the 74-year-old lung doctor.

- BOHA has a long pattern of leniency when it comes to deficient abortionists. They twice labeled Kristin Neuhaus "a danger to the public" but couldn't close her doors. Patients continued to use her clinic without notice from the Board that they were in danger.

- There are at least 5 abortion patient deaths from Kansas-licensed abortionists (1981, 1988, 1991, 1997, 2005). An abortion injury in Wichita Feb.17, 2005 may turn out to be another death.

- Some regulations generated from WHPA will pertain only to abortion (i.e. the Rh protocol). The BOHA Guidelines for office-based surgery aren't abortion-specific. Any rules and regulations BOHA imposes based from their Guidelines, are not court-tested like WHPA.

- WHPA is based on language litigated and upheld for abortion clinics--nothing similar exists in law for safety standards in other medical specialties, as it exists for abortion. There are no litigated standards for podiatry, etc, that the state may impose. Any law cobbled together with the intent to somehow regulate any and every medical specialty would be DOA in the Courts.

- Abortion supporters hide behind the cry that other clinics need regulations. No evidence has been presented that any other specialty, performed in offices, is as hazardous as abortion. The evidence against substandard abortion clinics is unparalleled.

- WHPA would not allow substandard abortion clinics (like Dr.Rajanna's office in KCK) to remain open while deficient in monitoring equipment, sanitation and emergency certification

- WHPA would require annual licensing only after passing inspection from KDHE.

- KDHE will derive rules and regulations from WHPA provisions that have been approved in 5 federal courts as reflecting the minimum standards of the abortion industry. Any future rules and regulations from the BOHA Guidelines have no such guarantees.

- KDHE will make rules from this bill that represent the floor, not the ceiling, of standards. WHPA doesn't stop individuals from exceeding those standards and adopting other protocols; it doesn't tie the hands of practitioners and it doesn't mandate practices that are outmoded.

-continued-

Press Release, March 21,2005
For immediate release

Contact: Mary Kay Culp, KFL Exec. Director
Office: 913-642-LIFE or cell: 913-406-4446

SUBJECT #2 - KANSANS FOR LIFE REBUTS STATE BOARD MEMO TO LEGISLATURE

Board attitude and actions decried; Director Buening faulted for misstatements.

Background: A joint letter from Kansans for Life and 41 Kansas legislators, dated March 8, 2005, charged the KSBHA with laxity in their year-long investigation of, and Feb.12, 2005 disciplinary action for, Kansas City, Kansas abortionist Krishna Rajanna,. Executive Director Larry Buening emailed a response Thursday evening, March 17, 2005, to legislators. No response has yet been received by Kansans for Life, but we have seen the memo and have this to say:

Charge 1: The Board openly admits the clinic is substandard and because Rajanna needs money to fix it, they are going to let him stay open for business. The memo said. "*It was the opinion of the Board that the public would derive greater benefits from the doctor expending money to improve his equipment and facility to become accredited as opposed to the payment of a larger fine.*"

This is breath-taking! The Board is willing to endanger all the women that currently walk through his doors, on the premise that next year, other women will enjoy a safer environment. Will the Board post such a warning to women on Rajanna's walls? Do they treat all practitioners this way?

Charge 2: In the memo, Buening said if the Board had determined Rajanna to be an imminent danger to the public, they would have imposed punitive measures. But the Board's punitive measures have consisted in long,drawn out litigation to impose limitations on the physician's license. While the Board wrangles with the abortionist, the dangerous clinic is open to unsuspecting women.

The Board twice labeled Rajanna's former co-employee Kristin Neuhaus *as "an imminent danger to the public"*—yet they couldn't actually close her doors. In the case of Neuhaus' boss, Malcolm Knarr, his medical license was finally suspended, but his assembly-line clinics lived on with new abortionists. Notably, none of the replacements have ob-gyn training. Again, a licensing law solves this.

Charge 3: In the memo, Buening fails to assert whether the Board actually sought out patient complaints or evaluated patient files. It strains credulity that secret facility visitations (especially if conducted during non-business hours) will unearth injured women, either onsite or long gone. The whole problem with substandard abortion clinics is the unwillingness of the women to pursue lawsuits or to be aware they may file charges with state regulatory boards.

Buening states, *"During the investigation, no patient complaint was received and no evidence of patient harm was discovered. Had the Board possessed evidence of patient harm, that fact would have been included in the order.*" At Rajanna's, the Board found pre-drawn syringes, violating the medical protocol that injections are to be drawn fresh and specific to the patient's weight. The Board also found expired medications. Why do they confidently assert there's no evidence of patient harm?

The Rajanna informant witnessed a young girl experiencing anaphylactic shock during an abortion, who was literally picked up off the table by Rajanna, carried into his car and rushed away. The patient's mother harangued Rajanna for weeks. That incident has all the earmarks of a patient needing investigation.

-continued-

Charge 4: The memo creates the impression that attaining life-saving certification for cardiac events is a new burden they gave to Rajanna. The memo says, *"ACLS certification is not a requirement that is imposed on other practitioners, it is mandatory for Dr. Rajanna."* In fact, Rajanna should have always been certified to be in accord with national abortion protocols.

According to their 2005 published guidelines, National Abortion Federation standards are intended to be applied rigidly. Their published standard for emergency procedures is "when abortion procedures are being performed, a current cardiopulmonary resuscitation (CPR)-certified staff member must be available on-site for emergency care. It is recommended that all medical staff should be current CPR-certified. The Rajanna informant was not CPR trained and she was unaware of any staffer that was.

Charge 5: The memo claims that efforts to investigate and micro-manage Rajanna have consumed sizable resources. *"The investigative case was extensive and required a substantial amount of time. Four of the Board's five FTE Special Investigators were involved in the investigation."* This is the carbon copy of the Board's fiasco to instruct and micro-manage abortionist Kristin Neuhaus.

At their June 2004 Board meeting, Board members acknowledged their investigative staff does not have the ordinary expertise, much less the budget, to inspect abortion clinics. The Board voted not to inspect abortion clinics and this makes sense since their statutory charge is to license persons, not property. The Board should attend to the hundreds of open disciplinary cases at hand; KDHE should issue licenses for abortion clinics that pass a checklist created from national abortion standards.

Charge 6: The Board's stated plan to formalize their OBS Guidelines into rules & regs does not remove the need for the clinic-licensing bill HB 2503. The Board's OBS Guidelines don't address abortion-specific protocols, like the Rh factor. Regulations that stem from the provisions of HB 2503 have already been upheld in 5 federal courts, unlike the regulations that KSBHA intends to derive from their OBS Guidelines.

The Board is a reactive agency that cannot close down a disgusting clinic, even as they could not do so when requested in September 2003 by the local DA. Clinic licensing eliminates deficient clinics.

Charge 7: Buening seriously misstated the events that brought clinic photos into the hands of the Board. His erroneous chronology frames the impression that KFL dropped off a stack of outdated photos and ran away. Buening's omissions are self-serving but the facts are thus:

In August 2003, Kansans for Life was contacted by a clinic employee who was deeply disturbed at the practices and lack of sanitation at the abortion clinic of Krishna Rajanna,. KFL gave the informant contact information for the confidential services of the Board of Healing Arts, and other employee-related state agencies. Three days before scheduled testimony about the clinic-licensing bill, KFL learned of the existence of photos taken inside the clinic. On Monday Feb.16, 2004, at the hearing in the House Fed/State committee, KFL read the allegations of the Rajanna employee and announced that photos supporting the informant's charges were being taken immediately to the Board.

KFL's Research Director, Kathy Ostrowski, talked at length Feb. 16 with the Board disciplinary investigator, Shelley Wakeman, describing the informant's credibility and KFL documentation of ongoing deficient clinics. Ostrowski stated there would be a complaint filed, not by KFL, but by the third party who had held these photos since September 2003. On Wednesday Feb.18, 2004, the gentleman who had held continuous custody of photos from the informant, took off work to hand-deliver to the Board an official complaint form, along with photo enlargements and commentary. The Board did not have the courtesy to speak to the complainant, who was anxious to provide much additional information. In fact, the Board waited until May 6 to ever call upon him.

ABORTION CLINIC LICENSING LAW PROVISIONS

Already Violated by KANSAS-Licensed ABORTIONISTS

May 4 2004. All documents on file with Kansans for Life.

Senate Public Health & Welfare 3-22-05 Attachment # 15

Section 1.

	Provision	Comments
(a)	**Definitions (omitted for purposes here)**	
(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) That medical personnel is available to all patients throughout the abortion procedure	· whistleblower August 2003: Rajanna is sole medical professional onsite
	(2) Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rules and regulations.	· whistleblower October 1992 :Knarr fudged gestational ages for higher prices
	(3) Appropriate use of local anesthesia, analgesia & sedation if ordered by the physician.	· whistleblower October 1992:-Knarr-medications improperly used as quick injection
	(4) The use of appropriate precautions, such as the establishment of intravenous access at least for patients undergoing second or third trimester abortions.	
	(5) The use of appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.	· whistleblower August 2003 says: Rajanna missing requisite trained staff & monitoring equipment during procedure and recovery; · BOHA Aug 2000:Neuhaus not monitoring vital signs when giving sedation
(c)	**The secretary shall adopt rules and regulations to prescribe abortion clinic supplies and equipment standards, including supplies and equipment that are required to be immediately available for use or in an emergency. At a minimum these rules and regulations shall:**	
	(1) Prescribe required equipment and supplies, including medications, required for the conduct, in an appropriate fashion, of any abortion procedure that the medical staff of the clinic anticipates performing and for monitoring the progress of each patient throughout the procedure and recovery period.	· BOHA Dec.2000:Neuhaus kept unmarked predrawn syringes against standard of care; · BOHA Feb2005: Rajanna kept unmarked predrawn syringes against standard of care
	(2) Require that the number or amount of equipment and supplies at the clinic is adequate at all times to assure sufficient quantities of clean and sterilized durable equipment and supplies to meet the needs of each patient.	· whistleblower August 2003: Rajanna staffer wipes table with alcohol, instruments rinsed in bleach in place of sterilizer

(3) Prescribe required equipment, supplies and medications that shall be available and ready for immediate use in an emergency and requirements for written protocols and procedures to be followed by staff in an emergency, such as the loss of electrical power.	· Inadequate resuscitative equipment cited to Planned Parenthood by Missouri Dept. Of Health, June 1997, following abortion patient DEATH; Board also cited Crist for CPR certification not current [Planned Parenthood of Mid Missouri Eastern Kansas employs Kansas-licensed Robert Crist as abortionist in both states, and for some time, the Medical Director]
	· Inadequate resuscitative protocol at abortion office of Dennis Miller for Erna Fisher 1988 death during abortion;staff went for smelling salts, practitioner admitted he "didn't realize what was going on", Court records show abortionist didn't know to to clear patient's airway, didn't attempt CPR" [6-3-90 KCStar; 12-9-88 BOHA action, no case number; malpractice suit settled $475,000.00 for victim Wyandotte Cty Dist Ct #87-C-3508]
	· whistleblower August 2003:Rajanna abortion procedure lacks sufficient monitoring staff and equipment
(4) Prescribe required equipment and supplies for required laboratory tests and requirements for protocols to calibrate and maintain laboratory equipment at the abortion clinic or operated by clinic staff.	
(5) Require ultrasound equipment in those facilities that provide abortions after 12 weeks gestational age of the fetus.	
(6) Require that all equipment is safe for the patient and the staff, meets applicable federal standards and is checked annually to ensure safety and appropriate calibration.	· whistleblower October 1992:Knarr did not make OSHA corrections;
	· whistleblower 2003 photos show: Rajanna office violates OSHA
(d) **The secretary shall adopt rules and regulations relating to abortion clinic personnel. At a minimum these rules and regulations shall require that:**	
(1) The abortion clinic designate a medical director of the abortion clinic who is licensed to practice medicine and surgery in Kansas.	
(2) Physicians performing surgery in an abortion clinic are licensed to practice medicine and surgery in Kansas, demonstrate competence in the procedure involved and are acceptable to the medical director of the abortion clinic.	· whistleblower charge of Knarr incompetence maintained by BOHA [#92-00073 ,#92-000205]
(3) A physician with admitting privileges at an accredited hospital in this state is available	· Knarr whistleblower charge of lost hospital privileges maintained by BOHA [#92-00073,000205];
	· Lawsuit alleges Rajanna without hospital privileges [Civil action 99C462, Wyandotte County, Div.3];
(4) 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.	

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(5) A registered nurse, nurse practitioner, licensed practical nurse or physician assistant is present and remains at the clinic when abortions are performed to provide postoperative monitoring and care until each patient who had an abortion that day is discharged.	· whistleblower August 2003: Rajanna has no onsite medical professionals other than abortionist
(6) Surgical assistants receive training in the specific responsibilities of the services the surgical assistants provide.	· whistleblower October 1992 said-Knarr- receptionists become surgical aides
	· whistleblower August 2003: receptionists without high school diplomas or medical course training become surgical aides
(7) Volunteers receive training in the specific responsibilities of the services the volunteers provide, including counseling and patient advocacy as provided in the rules and regulations adopted by the director for different types of volunteers based on their responsibilities.	· KDHE cites Planned Parenthood for failing to teach staff to inform patients of their rights May 2002;
(e) **The secretary shall adopt rules and regulations relating to the medical screening and evaluation of each abortion clinic patient. At a minimum these rules and regulations shall require:**	
(1) A medical history including the following:	· violated by Knarr (BOHA) 1994 [#92-00073,000205];
(A) Reported allergies to medications, antiseptic solutions or latex.	· BOHA Aug 2000: Neuhaus omits:proper patient history (including adverse drug reactions); focused exam, monitoring of vital signs, patient dismissal evaluation & an accurate medication record.
(B) Obstetric and gynecologic history.	
(C) Past surgeries.	
(2) A physical examination including a bimanual examination estimating uterine size and palpation of the adnexa.	
(3) The appropriate laboratory tests including: (A) For an abortion in which an ultrasound examination is not performed before the abortion procedure, urine or blood tests for pregnancy performed before the abortion procedure. (B) A test for anemia as indicated. (C) Rh typing, unless reliable written documentation of blood type is available. (D) Other tests as indicated from the physical examination.	· whistleblower October 1992 said-Knarr –omitted some lab tests, fudged some others
	· Blood hemoglobin tested and unacceptably deficient by physician self-reported standard and Planned Parenthood standards yet Crist proceeded with abortion and patient died (Missouri Board of Health August 1997; Board also cites abortionist Crist as CPR deficient) [St Louis Circ Ct Div1#992-01174-settled by PP for $150,000.00 and taxi service settled for $75,000.]
	· Rajanna faulted for improper Rh protocol (BOHA) [#01-HA-35]
	· successful lawsuit for Rh FOUL UP by Hodes settled in 2001[Johnson Cty Dist Ct Div 8 #00-CV-4517]

	(4) An ultrasound evaluation for all patients who elect to have an abortion after 12 weeks gestational age of the fetus. The rules shall require that if a person who is not a physician performs an ultrasound examination, that person shall have documented evidence that the person completed a course in the operation of ultrasound equipment as prescribed in rules and regulations. The physician or other health care professional shall review, at the request of the patient, the ultrasound evaluation re-sults with the patient before the abortion procedure is performed, including the probable gestational age of the fetus.	
	(5) That the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rules and regulations and shall verify the estimate in the patient's medical history. The physician shall keep original prints of each ultrasound examination of a patient in the patient's medical history file.	· whistleblower October 1992 said-Knarr-fudged ultrasound results
(f)	**The secretary shall adopt rules and regulations relating to the abortion procedure. At a minimum these rules and regulations shall require:**	
	(1) That medical personnel is available to all patients throughout the abortion procedure.	· whistleblower August 2003 says- Rajanna (under current investigation)- no staff trained for observation independent of abortionist
	(2) Standards for the safe conduct of abortion procedures that conform to obstetric standards in keeping with established standards of care regarding the estimation of fetal age as defined in rules and regulations.	· whistleblower October1992 said-Knarr – incident of underestimation endangers patient
	(3)Appropriate use of local anesthesia, analgesia and sedation if ordered by the physician.	
	(4) The use of appropriate precautions, such as the establishment of intravenous access at least for patients undergoing second or third trimester abortions.	
	(5) The use of appropriate monitoring of the vital signs and other defined signs and markers of the patient's status throughout the abortion procedure and during the recovery period until the patient's condition is deemed to be stable in the recovery room.	· whistleblower August 2003 says- Rajanna(under current investigation)- recovering patient not monitored

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(g) **The secretary shall adopt rules and regulations that prescribe minimum recovery room standards. At a minimum these rules and regulations shall require that:**	
(1) Immediate postprocedure care consists of observation in a supervised recovery room for as long as the patient's condition warrants.	· whistleblower August 2003:Rajanna's recovering patient watched by personal friend, not trained staffer
(2)The clinic arrange hospitalization if any complication beyond the management capability of the staff occurs or is suspected.	· Mark Pedersen of the Zaremski abortion clinic Aid for Women in KCK, admitted to the House Health & Human Services committee March 15, 2005 , that his clinic, like Rajanna, does not have hospital admitting privileges or agreement for patient transfer. He objected to the HB2503's provision which would mandate such arrangement, and said there was no problem getting an ambulance. When asked if Aid for Women had any arrangements with alternative physicians to take over for a hospital admission, he answered no.
(3) A licensed health professional who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remains on the premises of the abortion clinic until all patients are discharged.	· whistleblower August 2003: Rajanna staffers not CPR trained information from the Rajanna website "deputizes" the support person to act as the agent of the clinic during the entire time the abortion patient is at the clinic; Mr.Mark Pedersen, employed by Dr. Zaremski at the Aid for Women clinic, admitted to the House Health & Human Services committee March 15, 2005 that sedated abortion patients are NOT monitored by any medical personnel, not even a CNA. Pedersen admitted that "Aid for Women clinic cannot afford an RN at $35,000 or an LPN at $28,000." He mentioned a staffer who was" paid under $18,000". He said sedation was administered by someone whose training came "from doing it there many years."
(4) A physician or a nurse who is advanced cardiovascular life support certified shall remain on the premises of the abortion clinic until all patients are discharged and to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary. A physician or nurse shall be readily accessible and available until the last patient is discharged.	
(5)A physician or trained staff member discusses Rho(d) immune globulin with each patient for whom it is indicated and assures it is offered to the patient in the immediate postoperative period or that it will be available to her within 72 hours after completion of the abortion procedure. If the patient refuses, a refusal form approved by the department shall be signed by the patient and a witness and included in the medical record.	· settled lawsuit for abortion Rh foul up by Hodes [Johnson Cty Div.8 #00-CV-4517] settlement for permanent harm to patient and subsequent delivery · Rajanna disciplined for omitting Rh (BOHA) 2001 [#01-HA-35]; ·whistleblower October 1992 said-Knarr-administered incorrect dosage of Rh treatment
(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.	· lawsuits against Knarr 1991-1993 · lawsuit vs Hodes for patient inability to contact after hours when suffering incomplete abortion {Johnson Cty Ct 5 #60-107883]

Requirement	Comment
(7)There is a specified minimum length of time that a patient remains in the recovery room by type of abortion procedure and gestational age of the fetus.	· whistleblower August 2003 confirmed by BOHA order to correct: Rajanna patients rushed out post-procedure-single couch for "recovery"
(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.	· whistleblower October 1992:Knarr patient check up by phone not done · whistleblower August 2003: Rajanna patient check up by phone not done
(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.	· not followed by Crist –Planned Parenthood Patient left clinic w/o pulse in silenced ambulance, [St.Louis Circ Ct Div.4-#002-1024]. another patient died[St Louis Circ Ct Div1#992-01174-settled by PP for $150,000.00 and taxi-ambulance service settled for $75,000.] waiting for ambulance; Crist faulted for CPR status & insufficient equipment by Missouri Dept. of Health
(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 within four weeks after the abortion, including a medical examination and a review of the results of all laboratory tests.	· whistleblower 1992: most Knarr patients never returned for follow up; whistleblower 2003: 75-80% Rajanna patients didn't return for follow up
(2) A urine pregnancy test is obtained at the time of the follow-up visit to rule out continuing pregnancy. If a continuing pregnancy is suspected, the patient shall be evaluated and a physician who performs abortions shall be consulted.	
(i) The secretary shall adopt rules and regulations to prescribe minimum abortion clinic incident reporting. At a minimum these rules and regulations shall require that:	
(1) The abortion clinic records each incident resulting in a patient's or viable fetus' serious injury occurring at an abortion clinic and shall report them in writing to the department within 10 days after the incident. For the purposes of this paragraph, " serious injury" means an injury that occurs at an abortion clinic and that creates a serious risk of substantial impairment of a major body organ.	· current BOHA OBS Guidelines suggest quarterly reports of injury and death to KMS committee · clinic watchers reported 5 ambulance runs in 13 months from Tiller Wichita clinic to Wesley hospital
(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.	· clinc watchers suspect 2 deaths from Tiller Wichita clinic, one confirmed
(3) Incident reports are filed with the department of health and environment and appropriate professional regulatory boards.	

(j)	
(1) The secretary shall adopt rules and regulations requiring each abortion to establish and maintain an internal risk management program which, at ...imum, shall consist of:	· KDHE cites Planned Parenthood for not teaching "risk management"May 2002; · whistleblower August 2003:Rajanna incident-reporting procedures unknown by staff
(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.	· the Medical Dierctor does some or all of the abortions at each 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.**	· 6 of 7 locations currently not inspected unless involved in full-blown investigation by BOHA; 7th site(PP) has voluntary ASC license · Planned Parenthood has deficient KDHE inspections, no penalties May 2002
(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.**	

15-7

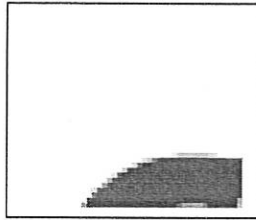
(m)		
	(1) No person shall operate an abortion clinic in this state unless such clinic holds a currently valid license as an abortion clinic under this act. Each such clinic shall be required annually to obtain a license from the department. The secretary shall adopt rules and regulations providing for 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.	·Federal Courts have ruled 5 times that this language ACCURATELY REFLECTS ABORTION STANDARDS. Extensive guidelines are already published by National Abortion Federation and Planned Parenthood. KDHE would not have to create content, just their application to existing state policies and practices; annual inspection of 7 locations requires modest time investment.
	(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.	· BOHA permits deficient providers (Knarr 1992-1994; Neuhaus 1999-2001, Rajanna 2005) to keep business open before corrrections achieved and while certification not achieved
(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. 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.**	
(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.**	

15-8

(p)

15-9

Provision	Evidence
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.	· Based on experience with nursing homes and hospitals,KDHE head Joe Kroll doubts that judge would do this to any deficient ASC abortion facility without this specific grant of power given here.
(1) Adequate private space that is specifically designated for interviewing, counseling and medical evaluations.	
(2) Dressing rooms for staff and patients.	· whistleblower August 2003: Rajanna lacks dressing rooms, patients just lower clothing or remove to chair near surgical table
(3) Appropriate lavatory areas.	
(4) Areas for preprocedure hand washing.	· whistleblower August 2003 photos show Rajanna without sink in procedure room & no sterile washroom with sink
(5) Private procedure rooms.	
(6) Adequate lighting and ventilation for abortion procedures.	· Law officer report against Rajanna 2004 says facility dark and musty
(7) Surgical or gynecologic examination tables and other fixed equipment.	· Insufficient resuscitative equipment found by Missouri Dept. of Health June 1997,after Crist abortion patient deaths [St.Louis Circ Ct Div.4-#002-1024; St Louis Circ Ct Div1 #992-01174]
(8) Postprocedure recovery rooms that are supervised, staffed and equipped to meet the patients' needs.	· whistleblower August 2003: Rajanna has unsterile, unsupervised and unmonitored "recovery"
(9) Emergency exits to accommodate a stretcher or gurney.	· whistleblower August 2003 photos show- Rajanna has blocked exit
(10) Areas for cleaning and sterilizing instruments.	· Law officer report against Rajanna 2004 says filthy with roaches on counters
	· whistleblower August 2003 photos show- Rajanna photos show unsterile environment with impermissibly uncovered sterile equipment, bleach used for sterilizing
(11) Adequate areas for the secure storage of medical records and necessary equipment and supplies.	· KDHE cited Planned Parenthood for keeping open boxes of records near copier accessible to patients and all staff May 2002;
	· whistleblower August 2003 photos show: Rajanna has improper storage, open records on floor in kitchen
(12) The display in the abortion clinic, in a place that is conspicuous to all patients, of the clinic's current license issued by the department.	· KDHE cited Planned Parenthood as missing required display of patient rights info May 2002;



March 15, 2005

Members of the Health and Human Services Committee:
Abortion: safe but rare. This statement reflects wishful thinking on the part of policy-makers and abortion proponents who 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. In light of the flurry of ambulance calls to the Tiller clinic in the past 12 months, including at least one death, it is imperative that an invasive surgical procedure such as an abortion be carefully monitored and regulated by an entity that can actually ensure the safety of women.

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 sometimes precipitated by shame or anxiety on the part of the woman. 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, 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. In light of the recent serious violations by a clinic in KCK invoking a "slap on the wrist" by the Board of Healing Arts *one year later*, and with the clinic operating for that time, it seems that the urgency for action has accelerated considerably. That is, it is urgent if we are sincere about protecting women. 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 or entrusting that regulation to a board that is appointed and appears to lack a sense of urgency in violations.

As a women's organization, we ask you to protect those women who choose abortion by requiring and enforcing 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
Marsha Strahm, Legislative Liaison

Senate Public Health & Welfare
3-22-05
Attachment #16

February 16, 2004
Testimony to the Kansas House of Representatives
House Federal and State Affairs Committee

Thank you for this opportunity to address you regarding HB 2751, clinic licensing and regulation.

I am Dr. Brendan Mitchell, a Board Certified Obstetrician/Gynecologist in practice ten years in the Johnson County area. I am part of a large single specialty group practice that performs a wide variety of surgical procedures in different settings. My patient population is diverse, covering a wide range of ages, educational levels and socioeconomic status. My colleagues and I are subject to quality assurance at every hospital and ambulatory surgery center where we practice, and rightly so.

It is the role of the state to protect the consumers of health care, and to insure that a mechanism is in place to monitor the quality of health care delivered. From my conversations with patients, I am gravely concerned about the quality of health care that women are receiving when they undergo abortion procedures, and the lack of quality oversight surrounding these practitioners and this procedure.

With over 12,000 abortions occurring annually in the state of Kansas, it is surprising to me that the abortion facilities are unregulated. Because of my experience treating women with miscarriage in the first and second trimesters, I understand that abortion is a procedure that is fraught with potential hazards, even in the most experienced hands. Women treated for miscarriage in the first and second trimester, and fetal death in the third trimester, are treated at hospitals and licensed ambulatory care facilities. These facilities are modern, clean, and secure, but most importantly, they are subject to independent quality assurance entities as a requirement for their operation.

Reasonably well-trained Ob-Gyns performing these surgical procedures for miscarriage would be expected to examine the patient prior to the procedure. They would perform basic laboratory analysis for anemia and Rh typing. They would be working with well-maintained equipment, and well trained and qualified staff. They would monitor the patient's condition during anesthesia, and in the postoperative period. Procedures to empty the uterus, after a pregnancy has been lost, are performed in a hospital or a licensed ambulatory care center. These facilities are regulated by the KDHE, and are subject to inspections to ensure minimum quality standards. Most physicians, myself included, would not want to perform these procedures, with their inherent risk of complications, in a substandard facility.

I have had personal experience with unexpected complications arising from this procedure. I was performing a D&C for first trimester miscarriage and encountered heavy unexpected hemorrhage. Despite the administration of numerous drugs to cause the uterus to contract, the patient continued to bleed and her condition deteriorated to the point of shock. It was necessary to perform an emergency hysterectomy to control the bleeding, and the patient required several units of blood and blood products. Because of the expert care delivered by a team that included an anesthesiologist and well-trained nurses, the patient survived. The hysterectomy specimen was sent to pathology as required, and an explanation was derived from examination of the specimen. The case was then reviewed by my peers. Had this D&C been performed in an area abortion clinic, the patient would not have survived.

For a variety of reasons, abortion is generally not performed in a regulated and licensed facility, and these reasons have nothing to do with the safety, complication rate or difficulty of the procedure. Abortions are generally

Senate Public Health & Welfare
3-22-05
Attachment #17

performed in an office or clinic setting, and they are not substantially different in risk from similar procedures performed in a hospital. There is currently no mechanism to regulate the quality of surgical and anesthesia care administered in an office or clinic performing abortions.

Abortion in this country has become less restricted since Roe vs. Wade. However, this does not abdicate lawmakers' responsibility to ensure the safety of patients undergoing surgical procedures in the state of Kansas. The public perceives that legal abortion is safe abortion. Indeed many of the proponents of abortion rights cite safe abortion as the main justification against laws restricting abortion. The public believes that the same standards that apply to other surgical procedures, apply to legal abortion. However, this is not the case. In the absence of quality standards, there is no evidence that abortion is safer now than before 1973.

Obviously, there is a social stigma associated with abortion for many patients. Because of this, patients undergoing abortion are at great risk for substandard care or even abuse. Most abortion providers operate on a cash basis with no insurance coverage involved, eliminating quality assurance or facility standards that an insurance company would place on its participating providers. Many patients having abortions are given anesthetic agents producing amnesia for the experience, and are reluctant to report any perception of substandard care. They are not in a position to protect themselves.

I have had many patients with a history of abortion complain that they were given poor consent, that the ultrasound and other medical equipment appeared to be antiquated, and that the facility appeared unsanitary.

I have recently delivered a patient that was a former employee of an abortion clinic and reported poor training and appalling conditions. In my own practice it has become obvious to me that many patients undergoing the abortion procedure are not given adequate means to follow up in case of a complication. HB 2751 would establish a minimum set of standards of quality for offices and clinics where surgical abortion is taking place. It establishes regulations and standards that any reasonable consumer of health care would expect in a facility administering anesthesia and performing surgical procedures that carry a risk of infection or life threatening bleeding, and gives the ability to enforce these standards.

The standards proposed in this bill are the same standards set forth by the American College of Obstetrics and Gynecology, Planned Parenthood and the National Abortion Federation. These standards are basic and not restrictive, and are attainable by facilities practicing abortion.

The role of laws regulating the practice of the healing arts is to protect the public. Providers of health care are already subject to these laws. Unfortunately, however, the abortion industry has remained unfettered by the regulation designed to ensure safety and quality of care, and, because of the politically divisive nature of the abortion debate, it has managed to stay unregulated. This is bad for the consumer of abortion services. HB 2751 is good legislation. It will ensure that those who provide abortion in our state document to the people of Kansas that they are meeting the minimum standards promulgated by the abortion industry itself.

This is what the public expects of its elected officials and of its government.

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

(8)

CENTER FOR WOMEN'S HEALTH

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Members of the Health and Human Services Committee.

Thank you for the opportunity to speak to you in opposition to **HB 2503**. My name is Herbert Hodes, MD. I have been an abortion provider in Kansas for over 30 years. I am a board-certified Ob-Gyn; and, according to the Code of Ethics of the American College of Ob-Gyn, I am qualified to speak about this bill. The American College of Ob-Gyn is the accrediting organization of 45,000 specialists in women's health care. I have enclosed a copy of this Code of Ethics in which they admonish a physician for giving an expert opinion, or testimony, on something about which they have no real knowledge or experience.

The authors of **HB 2503**—lay people, have chosen to ignore the May, 2002 Guidelines for Office-Based Surgery passed by the Kansas Board of Healing Arts. A committee of over twenty physicians and surgeons, not lay-people, drew up these guidelines. These medical practitioners knew what was appropriate for ***all*** physicians who perform office-based surgery—not just abortion providers. These guidelines would apply to ***all*** physicians, dentists and oral surgeons.

The authors of **HB 2503** have assumed that abortion providers need additional rules to govern their practices. We already operate under the supervision of many medical organizations:

Kansas Board of Healing Arts	Insurance Companies (Payees)
Kansas Medical Society	County Medical Society
City Health Departments	Professional Liability Carriers
Kansas Bureau of Health and Education	ACOG
OSHA	HIPAA
Nat'l Abortion Federation	CLIA
Nat'l Coalition of Abortion Providers	AMA

I urge this committee to vote ***against*** **HB 2503**, and support the universal guidelines for ***all*** physicians and dentists proposed by the Kansas Board of Healing Arts in May, 2002.

I welcome any questions.

Sincerely,

Herbert C. Hodes, MD, FACOG

Senate Public Health & Welfare
3-22-05
Attachment #18

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.

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.

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 and revised: July 1997
Intact D & X statement: January 1997
Combined and reaffirmed: September 2000
Reaffirmed: July 2004

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)*.

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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

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services instituted. The physician should modify his or her practice until the diminished capacity has been restored to an acceptable standard to avoid harm to patients *(nonmaleficence)*. All physicians are obligated to respond to evidence of questionable conduct or unethical behavior by other physicians through appropriate procedures established by the relevant organization.

III. Avoiding conflicts of interest: Potential conflicts of interest are inherent in the practice of medicine. Physicians are expected to recognize such situations and deal with them through public disclosure. 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. The physician should be an advocate for the patient through public disclosure of conflicts of interest raised by health payer policies or hospital policies.

IV. Professional relations: The obstetrician–gynecologist should respect and cooperate with other physicians, nurses, and health care professionals.

V. Societal responsibilities: The obstetrician–gynecologist has a continuing responsibility to society as a whole and should support and participate in activities that enhance the community. As a member of society, the obstetrician–gynecologist should respect the laws of that society. As professionals and members of medical societies, physicians are required to uphold the dignity and honor of the profession.

Code of Conduct

I. Patient–Physician Relationship

1. The patient–physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments.
2. The obstetrician–gynecologist should serve as the patient's advocate and exercise all reasonable means to ensure that the most appropriate care is provided to the patient.
3. The patient–physician relationship has an ethical basis and is built on confidentiality, trust, and honesty. If no patient–physician relationship exists, a physician may refuse to provide care, except in emergencies (1). Once the patient–physician relationship exists, the obstetrician–gynecologist must adhere to all applicable legal or contractual constraints in dissolving the patient–physician relationship.
4. Sexual misconduct on the part of the obstetrician–gynecologist is an abuse of professional power and a violation of patient trust. Sexual contact or a romantic relationship between a physician and a current patient is always unethical (2).
5. The obstetrician–gynecologist has an obligation to obtain the informed consent of each patient (3). In obtaining informed consent for any course of medical or surgical treatment, the obstetrician–gynecologist must present to the patient, or to the person legally responsible for the patient, pertinent medical facts and recommendations consistent with good medical practice. Such information should be presented in reasonably understandable terms and include alternative modes of treatment and the

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objectives, risks, benefits, possible complications, and anticipated results of such treatment.

6. It is unethical to prescribe, provide, or seek compensation for therapies that are of no benefit to the patient.

7. The obstetrician–gynecologist must respect the rights and privacy of patients, colleagues, and others and safeguard patient information and confidences within the limits of the law. If during the process of providing information for consent it is known that results of a particular test or other information must be given to governmental authorities or other third parties, that must be explained to the patient (4).

8. The obstetrician–gynecologist must not discriminate against patients based on race, color, national origin, religion, or any other basis that would constitute illegal discrimination.

II. Physician Conduct and Practice

1. The obstetrician–gynecologist should recognize the boundaries of his or her particular competencies and expertise and must provide only those services and use only those techniques for which he or she is qualified by education, training, and experience.

2. The obstetrician–gynecologist should participate in continuing medical education activities to maintain current scientific and professional knowledge relevant to the medical services he or she renders. The obstetrician–gynecologist should provide medical care involving new therapies or techniques only after undertaking appropriate training and study.

3. In emerging areas of medical treatment where recognized medical guidelines do not exist, the obstetrician–gynecologist should exercise careful judgment and take appropriate precautions to protect patient welfare.

4. The obstetrician–gynecologist must not publicize or represent himself or herself in any untruthful, misleading, or deceptive manner to patients, colleagues, other health care professionals, or the public.

5. The obstetrician–gynecologist who has reason to believe that he or she is infected with the human immunodeficiency virus (HIV) or other serious infectious agents that might be communicated to patients should voluntarily be tested for the protection of his or her patients. In making decisions about patient-care activities, a physician infected with such an agent should adhere to the fundamental professional obligation to avoid harm to patients (5).

6. The obstetrician–gynecologist should not practice medicine while impaired by alcohol, drugs, or physical or mental disability. The obstetrician–gynecologist who experiences substance abuse problems or who is physically or emotionally impaired should seek appropriate assistance to address these problems and must limit his or her practice until the impairment no longer affects the quality of patient care.

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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

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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).

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Copyright © January 2004, The American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920. This document provides rules for ethical conduct for obstetricians and gynecologists.

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Expert Testimony

The American College of Obstetricians and Gynecologists (ACOG) recognizes that it is the duty of obstetricians and gynecologists who testify as expert witnesses on behalf of defendants, the government, or plaintiffs to do so solely in accordance with their judgment on the merits of the case. Furthermore, ACOG cannot condone the participation of physicians in legal actions where their testimony will impugn performance that falls within accepted standards of practice or, conversely, will support obviously deficient practice. Because the experts articulate the standards in a given case, care must be exercised to ensure that such standards do not narrowly reflect the experts' views to the exclusion of other choices deemed acceptable by the profession. The American College of Obstetricians and Gynecologists considers unethical any expert testimony that is misleading because the witness does not have appropriate knowledge of the standard of care for the particular condition at the relevant time or because the witness knowingly misrepresents the standard of care relevant to the case.

The Problem of Professional Liability—Reality and Perceptions

The American College of Obstetricians and Gynecologists recognizes its responsibility, and that of its Fellows, to continue efforts to improve health care for women through every available method of quality assurance. The American College of Obstetricians and Gynecologists also recognizes, however, that many claims of medical malpractice represent the response of a litigation-oriented society to a technologically advanced form of health care that has fostered unrealistic expectations. As technology continues to become more complex, both the benefits and risks also increase, making the complication-free practice of medicine less possible.

It therefore becomes important to distinguish between medical "maloccurrence" and medical malpractice. Medical maloccurrence is defined as a bad outcome that is unrelated to the quality of care provided. Certain medical or surgical complications can be anticipated and represent unavoidable risks of appropriate medical care. Other complications arise unpredictably and are similarly unavoidable. Still others occur as a result of decisions that have been made carefully by patients and physicians with fully informed consent but appear, in retrospect, to have been a less appropriate choice among several options. Each of these situations represents a type of maloccurrence, rather than an example of malpractice, and is the result of the uncertainty inherent in all of medicine. Malpractice requires a demonstration of negligence (ie, substandard practice that causes harm). The potential for personal, professional, and financial rewards from expert testimony may encourage testimony that undermines the distinction between unavoidable maloccurrence and actual medical malpractice. It is unethical to distort or to represent a maloccurrence as an example of medical malpractice, or the converse.

The American College of Obstetricians and Gynecologists supports the concept of appropriate and prompt compensation to patients for medically related injuries. Any such response, however, also should reflect the distinction between medical maloccurrence, for which all of society should perhaps bear financial responsibility, and medical malpractice, for which health care providers should be held responsible.

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Responsibility of Individual Physicians

The moral and legal duty of physicians who testify before a court of law is to do so in accordance with their expertise. This duty implies adherence to the strictest personal and professional ethics. Truthfulness is essential. Misrepresentation of one's personal clinical opinion as absolute right or wrong may be harmful to individual parties and to the profession at large. The obstetrician–gynecologist who is an expert witness must limit testimony to his or her sphere of medical expertise and must be prepared adequately. Witnesses who testify as experts must have knowledge and experience that are relevant to obstetric and gynecologic practice at the time of the occurrence and to the specific areas of clinical medicine they are discussing. The acceptance of fees that are greatly disproportionate to those customary for professional services can be construed as influencing testimony given by the witness. It is unethical for a physician to accept compensation that is contingent on the outcome of litigation (1, 2).

The American College of Obstetricians and Gynecologists encourages the development of policies and standards for expert testimony. Such policies should address safeguards to promote truth-telling and to encourage openness of the testimony to peer review. These policies also would encourage testimony that does not assume an advocacy or partisan role in the legal proceeding.

The following principles are offered as guidelines for the physician who assumes the role of an expert witness:

1. The physician must have experience and knowledge in the areas of clinical medicine that enable him or her to testify about the standards of care that applied at the time of the occurrence that is the subject of the legal action.
2. The physician's review of medical facts must be thorough, fair, and impartial and must not exclude any relevant information. It must not be biased to create a view favoring the plaintiff, the government, or the defendant. The goal of a physician testifying in any judicial proceeding should be to provide testimony that is complete, objective, and helpful to a just resolution of the proceeding.
3. The physician's testimony must reflect an evaluation of performance 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. Medical decisions often must be made in the absence of diagnostic and prognostic certainty.
4. The physician must make a clear distinction between medical malpractice and medical maloccurrence.
5. The physician must make every effort to assess the relationship of the alleged substandard practice to the outcome, because deviation from a practice standard is not always substandard care or causally related to a bad outcome.
6. The physician must be prepared to have testimony given in any judicial proceeding subjected to peer review by an institution or professional organization to which he or she belongs.

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1. American Medical Association. Medical testimony. In: Code of medical ethics: current opinions with annotations. Chicago (IL): AMA; 2002. p. 259–61.
2. American Bar Association. Rule 3.4 Fairness to opposing party and counsel. Annotated model rules of professional conduct. 5th ed. Chicago (IL): ABA; 2003. p. 347–58.

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Office-Based Surgery Task Force

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Guidelines for Office-Based Surgery and Special Procedures

(Approved by KMS House of Delegates May 5, 2002)

Statement of Intent and Goals

The following are clinical guidelines for surgical and special procedures performed in physician offices and other clinical locations not otherwise regulated by the Kansas Department of Health and Environment (i.e. hospitals and ambulatory surgical centers licensed pursuant to ***K.S.A. 65-425***). The purpose of these guidelines is to promote patient safety in the non-hospital setting, and to provide guidance to physicians who perform surgery and other special procedures which require anesthesia, analgesia or sedation in such settings. Included are recommendations for qualifications of physicians and staff, equipment, facilities, quality assurance, and policies and procedures for patient assessment and monitoring. These guidelines are not intended to establish a standard of care, and variation from these guidelines does not establish that a required standard of care was not met. Unless otherwise indicated, the terms in these guidelines have the meanings as they are defined in **Appendix A.**

These guidelines are applicable to any surgical or special procedure involving anesthesia levels which are greater than minimal sedation, local anesthesia in quantities greater than the manufacturer's recommended dose, adjusted for weight, or tumescent local anesthesia exceeding 7 mg/kg of lidocaine. These guidelines are not applicable to minor surgery. Any physician performing office-based surgery, regardless of the level of anesthesia required, should have the necessary equipment and personnel to be able to handle emergencies resulting from the procedure and/or anesthesia.

I. Personnel

a. All health care personnel should have appropriate licensure or certification and necessary training, skills and supervision to deliver the services provided by the facility.
b. Appropriate policies and procedures for oversight and supervision of non-physician personnel should be in place.
c. At least one person should have training in advanced resuscitative techniques (e.g. *ACLS* or *PALS*, as appropriate), and should be immediately available to the patient and in the facility at all times until the patient is discharged from anesthesia care.

II. Facility and Safety

a. Locations at which office-based surgery and special procedures are performed should comply with all applicable federal, state and local laws and regulations pertaining to fire prevention, building construction and occupancy, accommodations for the disabled, occupational safety and health, and disposal of medical waste and hazardous waste.
b. Policies and procedures should comply with applicable laws and regulations pertaining to controlled drugs supply, storage, security and administration.
c. Premises should be neat and clean. Sterilization of operating materials should be adequate.

III. Patient and Procedure Selection

a. Procedures to be undertaken should be within the scope of practice of the health care personnel and within the capabilities of the location.
b. The procedure should only be of a duration and complexity that can be safely undertaken, and which can reasonably be expected to be completed and patient discharged during normal operational hours.
c. The condition of the patient, specific morbidities that complicate operative and anesthetic management, the specific intrinsic risks involved, and the invasiveness of the planned procedure or combination of procedures should be considered in evaluating a patient for office-based surgery.
d. Nothing relieves the surgeon or physician of the responsibility to make a medical determination of the proper surgical setting or forum, and particular care should be exercised in the evaluation of patients that are considered high risk.

IV. Perioperative Care

a. Anesthesia services should be provided consistent with the **"Essentials for Office-Based Anesthesia"** as incorporated herein.
b. The anesthesia provider should be physically present during the intraoperative period and should be available until the patient has been discharged from anesthesia care.
c. Patients should be discharged only after meeting clinically appropriate criteria which includes the following factors: stable vital signs, responsiveness and orientation, ability to move voluntarily, reasonably controlled pain, and minimal nausea and vomiting.

V. Monitoring and Equipment

a. All locations to which these guidelines apply should have a defibrillator, a positive pressure ventilation device, a reliable source of O2, suction, resuscitation equipment, emergency drugs; and emergency air-way equipment including appropriate sized oral airways, endotracheal tubes, laryngoscopes and masks.
b. Locations that provide general anesthesia should have medications and equipment available to treat malignant hyperthermia when triggering agents are used. At a minimum, such locations should maintain a supply of ***dantrolene sodium*** adequate to treat a patient until the patient's transfer to a hospital or other emergency facility can be effected. Such locations should maintain tracheostomy and chest tube kits.
c. There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to the patient, anesthesia machine and all monitoring equipment.
d. All equipment should be maintained, tested and inspected according to the manufacturer's specs.
e. An appropriate back up energy source should be in place to ensure patient protection in the event of an emergency.
f. In any location where anesthesia is administered, there should be appropriate anesthesia apparatus and equipment which allow monitoring in accordance with the criteria set forth **in "Essentials for Office-Based Anesthesia"** as incorporated herein.

:mergencies and Transfers

a. At a minimum, the location should have written protocols addressing emergency situations such as medical emergencies and internal and external disasters such as fire or power failures. Personnel should be appropriately trained in and regularly review all emergency protocols.
b. The location should have written protocols in place for the timely and safe transfer to a pre-specified alternate care facility within a reasonable proximity when extended or emergency services are needed. The location should have a plan for transfer or a transfer agreement with a reasonably convenient hospital, or all physicians performing surgery in the location should have admitting privileges at such a hospital.

VII. Accreditation or licensure

a. Accreditation by a nationally recognized accrediting agency is encouraged.
b. Any location at which surgical or other special procedures requiring general anesthesia are performed is strongly encouraged either to be licensed as an ambulatory surgical center under K.S.A. 65-425, or accredited by a nationally recognized accrediting agency.

VIII. Quality Assurance and Peer Review

All locations at which surgical or special procedures subject to these guidelines are performed should establish an internal quality assurance/peer review committee (*pursuant to K.S.A. 65-4915*) for the purpose of evaluating and improving quality of care. The physician in charge of such location should report to the Kansas Medical Society Office Based Surgery Review Committee, on a quarterly basis, any incidents related to the performance of office-based surgery, special procedures or anesthesia which is a reportable incident or which results in the following quality indicators:
a. death of the patient during the surgical or special procedure, or within 72 hours thereafter;
b. transport of the patient to a hospital emergency department;
c. unscheduled admission of the patient to a hospital within 72 hours of discharge, when such admission is related to the office-based surgery or special procedure;
d. unplanned extension of the surgery or special procedure more than four (4) hours beyond the planned duration of the procedure being performed;
e. an unplanned procedure to remove a foreign object remaining in the patient from a prior surgical or special procedure in that location;
f. performance of wrong surgery, surgery on the wrong site, or surgery on the wrong patient; or
g. unanticipated loss of function of a body part or sensory organ.

Kansas Medical Society Guidelines for Office-Based Surgery and Special Procedures

(Approved by KMS House of Delegates May 5, 2002)

ESSENTIALS FOR OFFICE-BASED ANESTHESIA

These criteria and guidelines apply to any administration of anesthesia, including general, spinal, and managed intravenous anesthetics (i.e., local standby, monitored anesthesia or conscious sedation), administered in designated anesthetizing locations and any location where conscious sedation is performed. In emergency circumstances in any situation, appropriate life-support measures take precedence and can be started with attention returning to these monitoring criteria as soon as possible and practical.

These guidelines are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. In certain circumstances some of these monitoring methods may be clinically impractical, and appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual monitoring may be unavoidable. Under extenuating circumstances the physician may waive these criteria, and in such circumstances it should be so stated (including the reasons) in a note in the patient's medical record. These guidelines are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

1. An orderly preoperative anesthetic risk evaluation should be done by the responsible physician and recorded on the chart in all elective cases, and in urgent emergency cases, the anesthetic evaluations should be recorded as soon as feasible.
2. Every patient receiving general anesthesia, spinal anesthesia, or managed intravenous anesthesia (i.e., local standby, monitored anesthesia or conscious sedation), should have arterial blood pressure and heart rate measured and recorded at least every five minutes where not clinically impractical, in which case the responsible physician may waive this requirement stating the clinical circumstances and reasons in writing in the patient's chart.
3. Every patient should have the electrocardiogram continuously displayed from the induction and during maintenance of general anesthesia. In patients receiving managed intravenous anesthesia, electrocardiographic monitoring should be used in patients with significant cardiovascular disease as well as during procedures where dysrhythmias are anticipated.
4. During all anesthetics, other than local anesthesia and/or minimal sedation (anxiolysis), patient oxygenation should be continuously monitored with a pulse oximeter, and, whenever an endotracheal tube or Laryngeal Mask Airway (LMA) is inserted, correct positioning in the trachea and function should be monitored by end-tidal CO2 analysis (capnography) throughout the time of placement.

a. Additional monitoring for ventilation should include palpation or observation of the reservoir breathing bag, and auscultation of breath sounds.

b. Additional monitoring for circulation should include at least one of the following: Palpation of the pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, pulse plethsymography, or ultrasound peripheral pulse monitoring.

nen ventilation is controlled by an automatic mechanical ventilator, there should be in continuous use a device that is cap of detecting disconnection of any component of the breathing system. The device should give an audible signal when its alarm threshold is exceeded.

6. During every administration of anesthesia using an anesthesia machine, the concentration of oxygen in the patient's breathing system should be measured by a functioning oxygen analyzer with low concentration audible limit alarm in use.

7. During every administration of general anesthesia, there should be readily available a means to measure the patient's temperature.

8. Qualified trained personnel dedicated solely to patient monitoring should be available.

Kansas Medical Society Guidelines for Office-Based Surgery and Special Procedures and Essentials for Office-Based Anesthesia

(Approved by KMS House of Delegates May 5, 2002)

APPENDIX A

Definitions:

"Conscious sedation" means a minimally depressed level of consciousness that retains the patient's ability to maintain adequate cardiorespiratory function and the ability to independently and continuously maintain an open airway, a regular breathing pattern, protective reflexes and respond purposefully and rationally to tactile stimulation and verbal command. This does **not** include oral preoperative medications or nitrous oxide analgesia.

"General anesthesia" means the administration of a drug or drugs which results in a controlled state of unconsciousness accompanied by a loss of protective reflexes including loss of ability to independently and continuously maintain patent airway and a regular breathing pattern. There is also an inability to respond purposefully to verbal command and/or tactile stimulation.

"Local anesthesia" means the administration of an anesthetic agent into a localized part of the human body by topical application or local infiltration in close proximity to a nerve, which produces a transient and reversible loss of sensation.

"Minimal sedation (anxiolysis)" means the administration of oral sedative or oral analgesic drugs in doses appropriate for the unsupervised treatment of insomnia, anxiety or pain.

"Minor surgery" means surgery which can be safely and comfortably performed on a patient who has received local or topical anesthesia, without more than minimal sedation and where the likelihood of complications requiring hospitalization is remote.

"Office-based surgery" means any surgical or other special procedure requiring anesthesia, analgesia or sedation which is performed by a physician in a clinical location other than a hospital or ambulatory surgical center licensed by the Kansas Department of Health and Environment, and which results in a patient stay of less than 24 hours.

"Physician" means a person licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Kansas.

"Reportable incident" means an act by a physician or other health care provider which is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient, or may be grounds for disciplinary action by the appropriate licensing agency.

"Special procedure" means a patient care service which requires contact with the human body with or without instruments in a potentially painful manner, for a diagnostic or therapeutic procedure requiring anesthesia services (i.e., diagnostic or therapeutic endoscopy; invasive radiologic procedures; manipulation under anesthesia, or endoscopic examination).

"Surgery" means a manual or operative procedure which involves the excision or resection, partial or complete, destruction, incision or other structural alteration of human tissue by any means, including the use of lasers, performed upon the human body for the purpose of preserving health, diagnosing or treating disease, repairing injury, correcting deformity or defects, prolonging life or relieving suffering, or for aesthetic, reconstructive or cosmetic purposes. Surgery includes, but is not limited to incision or curettage of tissue or an organ, suture or other repair of tissue or an organ, a closed or open reduction of a fracture, or extraction of tissue from the uterus, and insertion of natural or artificial implants.

"Topical anesthesia" means an anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

"Tumescent local anesthesia" means the induction of local anesthesia through the administration of large volumes of highly dilute lidocaine (not to exceed 55mg/kg), epinephrine(not to exceed 1.5 mg/liter), and sodium bicarbonate (not to exceed 10-15 meq/liter) in sterile saline solution by slow infiltration into subcutaneous fat. It does not include the concomitant administration of any sedatives, analgesics and/or hypnotic drugs at dosages that possess significant risk of impairing the patient's ability to maintain adequate cardiorespiratory function and the ability to independently and continuously maintain an open airway, a regular breathing pattern, protective reflexes and respond purposefully to tactile stimulation and verbal command.

Directory of Resource Organizations

I. Accrediting Organizations for Office-Based Surgery:

American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
1202 Allanson Rd.
Mundelein, IL 60060
Phone: 888.545.5222
www.aaaasf.org

Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
3201 Old Glenview Rd., Suite 300
Wilmette, IL 60091.2992
Phone: 847.853.6060
info@aaahc.org

American Osteopathic Association Healthcare Facilities Accreditation Program
142 East Ontario St.
Chicago, IL 60611
Phone: 800.621.1773
www.aoa-net.org

Institute for Medical Quality (IMQ)
221 Main Street, Suite 210
San Francisco, CA 94105
Phone: 415.882.5151
www.imq.org

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Phone: 630.792.5000
www.jcaho.org

II. Other Resource Organizations

American Academy of Dermatology
930 N. Meacham Road
Schaumberg, IL 60168
Phone 847.330.0230
www.aad.org

American Academy of Facial Plastic and Reconstructive Surgery
310 S. Henry Street
Alexandria, VA 22314
Phone 703.299.9291
www.facial-plastic-surgery.org

American Academy of Otolaryngology-Head and Neck Surgery
One Prince St.
Alexandria, VA 32314
Phone 703.836.4444
www.entnet.org

American Association of Nurse Anesthetists
222 South Prospect Ave.
Park Ridge, IL 60068
Phone 847.692.7050
www.aana.com

American College of Surgeons
633 North Saint Clair St.
Chicago, IL 60611
Phone 312.202.5000
www.facs.org

American Society of Anesthesiologists
520 N. Northwest Highway
Park Ridge, IL 60068
Phone 847.825.5586
www.ASAHQ.org

American Soc./Aesthetic Plastic Surgery, Inc.
36 West 44th Street, Suite 630
New York, NY 10036
Phone 212.921.0500
www.surgery.org

American Society for Dermatologic Surgery
930 North Meacham Road
Schaumburg, IL 60173
Phone: 847.330.9830
www.asds-net.org

American Society of Plastic Surgeons
444 East Algonquin Road
Arlington, Heights, IL 60005
Phone 847.228.9900
www.plasticsurgery.org

American Gastroenterological Association
7910 Woodmont Ave., 7th Floor
Bethesda, MD 20814
Phone 301.654.2055
www.gastro.org

Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039
Phone 817.868.4000
www.fsmb.org

My name is Sarah London. I am the Kansas Public Policy Manager for Planned Parenthood of Kansas & Mid-Missouri. Thank you, Chairman Barnett and members of this committee, for giving me the opportunity to discuss HB 2503 and our 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 2004, Planned Parenthood provided family planning and related care to over 30,000 women and men; comprehensive health provided abortion care to 4,000 women.

Today I would like to clear up some possible misconceptions about healthcare regulations, in order to demonstrate how unfair and unprecedented HB 2503 truly is. I would also like to draw some distinction between Planned Parenthood's medical guidelines and the restrictions presented in HB 2503. Finally, I would like to suggest better ways to protect women's health through preventing unwanted pregnancies, rather than making abortion services more expensive and less accessible.

This bill singles out abortion for extra regulation without credible justification.
Let's put this into context. The Kansas Department of Health and Environment governs hospitals and ambulatory surgical centers. KDHE issues licenses to both types of facilities and conducts periodic inspections to ensure compliance. No doctors are required to license their facilities to perform outpatient surgery. According to KDHE, the most common reason for obtaining a state license is to qualify for third–party reimbursement. Furthermore, there are currently no medical procedures, including outpatient surgeries that must be governed by KDHE.

The Board of Healing Arts governs all doctors. They have the authority to revoke or suspend licenses, as well as impose limitations when professional standards of conduct are not met. BHA governs gynecologists, podiatrists, general practitioners and many other specialties. BHA recently adopted the KMS guidelines for outpatient surgery, which apply equally to all procedures.

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

A few very important points to consider:

1. No medical procedures in Kansas have regulations similar to 2503. These rules are prejudicial and unjustified.
2. Doctors choose to obtain a state license, usually for third-party reimbursement. There is no requirement for any type of outpatient procedure to be performed in a state-licensed facility. HB 2503 sets a new precedent of state micromanagement for one procedure.
3. Doctors adhere to professional standards of care, national and state guidelines, and federal regulations. Any more regulation should encompass all outpatient surgeries equally.

Senate Public Health & Welfare
3-22-05
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If proponents of HB 2503 are interested in protecting women's health, why aren't we regulating all office-based surgeries that women get?

Planned Parenthood guidelines vs. HB 2503

I want to dispel the fiction that HB 2503 simply reflects Planned Parenthood's standards. We have compared HB 2503 with our *Manual of Medical Standards and Guidelines*. While some of the standards are similar, there are many substantial differences. HB 2503 is modeled after legislation passed in Arizona in 1999. Our manual is revised at least annually and usually more often. The current version was updated in January 2005. The "standards" in HB 2503 are thus already six years out of date. HB 2503 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. Second, medical standards are revised constantly because medical practice and technology change constantly. Third, medical standards advise practicing physicians on standards of practice while respecting a doctor's judgment to do right by their patient.

Planned Parenthood's national medical committee, comprised of forty distinguished physicians, nurses and other leading health professionals establishes Planned Parenthood's standards. HB 2503, in contrast, was developed by medical laypeople for purely political reasons

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 standard of care has and will continue to change. How quickly will the Kansas Legislature convene to change HB 2503 when magnetic resonance or computerized tomography techniques evolve to replace gynecologic sonography? Will you even know when that change is needed?

The American College of Obstetricians and Gynecologists has written *Guidelines 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…" Unfortunately, HB 2503 mandates standards that do not respect the physician's professional judgment.

Planned Parenthood of Kansas and Mid-Missouri dutifully meets all protocols. We aim to provide the highest quality medical services to our clients. We strongly oppose HB 2503 because their intent is not safety, but politics. We do not want to divert our limited resources toward medically unnecessary measures, including new lighting fixtures or expanding doorway widths.

Prevent unwanted pregnancies to protect women's health.

In addition to abortion care, Planned Parenthood is committed to help men and women with family planning. Through community and peer educators, we strive to give teens and parents information about reproductive health and sexuality and to help them make informed and decisions about relationships and sexual behavior. Our experts keep up to date on the best strategies to prevent unwanted pregnancies—the best way to protect women's health.

All outpatient surgical procedures carry risk. Ideally, women would not have to seek abortions in the first place. As Senator Hillary Clinton recently said, it is a sad and tragic choice for many women. If this committee would like truly reduce the number of abortions in Kansas, we have several suggestions:

First, we could enforce our state law that requires comprehensive sex education so that our young people will have facts about protecting themselves.

Second, we could enact "contraceptive equity," which would require insurance companies to cover birth control if they cover other prescription drugs.

Third, we could provide more information about and access to emergency birth control, or EC. If taken up to 72 hours after unprotected sex, EC can prevent an unwanted pregnancy.

All three of these measures could prevent unwanted pregnancies in Kansas and reduce the number of abortions in our state. All of these measures would do more to protect women's health than HB 2503. I would be happy to work with the committee to move forward on these critical health issues.

You heard testimony from advocates with a single agenda—to close clinics providing abortion in Kansas. 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, CDC and the Healthcare stabilization fund point to the safety of abortion care in Kansas—above all other surgical care.

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 2503. It is part of the effort by opponents of abortion to make abortion more expensive and less available.

HB 2503 is deceptive and prejudicial. It is bad public policy and does not deserve your support.

(2)

Dr. Irene Bettinger
Testimony in opposition of HB 2503
Tuesday, March 22, 2005

Good afternoon. Thank you Chairman Barnett and members of this committee for allowing me to express my opposition to HB 2503. I am a Kansas resident and a Kansas licensed physician, actively practicing Neurology in the Greater Kansas City area.

I graduated from medical school 39 years ago. My post-graduate training included emergency room and Obstetrics-Gynecology. Of course, this was before the *Roe v. Wade* decision. I dealt with large numbers of patients dealing with complications due to illegal abortions. I have to tell you that these women were under great duress. I observed women who had induced abortion with coat hangers and Permanganate solution.

Thankfully, over 30 years ago, abortion was legalized. With great pride, I will remind the committee that Kansas was a leader in the movement to ensure that women have access to a safe and legal abortion. As a result, the complications associated with abortion plummeted, and it has truly become one of the safest outpatient procedures done in this country today.

Given this background, I must question what HB 2503 is meant to accomplish, and where it is heading.

There are numerous surgical procedures being performed in doctor's offices and outpatient clinics throughout Kansas. For example, Colonoscopy, a scope looking at the lower bowels, and EGD, looking with a scope into the stomach, are both performed under conscious sedation in doctor's offices. Cystoscopy, or looking in the bladder, which is commonly done in men, is frequently performed safely and efficiently as an outpatient procedure.

Increasingly, surgical procedures are being performed in doctor's offices. Are we going to develop rules and regulations separately for each of these procedures? Does the legislature plan to tell an urologist how to perform a cystoscopy? If so, it will certainly inhibit delivery, but in no way improve safety.

Even if the legislature wishes to focus only on abortion, these rules and regulations will not improve safety, they will serve only to block access to services. Complications from abortion are very rare in Kansas. It is one of the safest surgical procedures. There is no way that HB 2503 can improve upon the outstanding safety record of abortion in Kansas.

Given that HB 2503 seeks to place rules and regulations only on doctors who perform abortions, and that abortion in Kansas is safer than most any other outpatient procedure, I must conclude that this is not an effort aimed at women's safety, but truly intended to decrease the number of doctors performing legal abortions in Kansas. I feel that this is entirely inappropriate action by the legislature, and I urge you to vote NO on HB 2503.

Senate Public Health & Welfare
3-22-05
Attachment #20

P.O. Box 1061
Lawrence, KS 66044

National Organization for Women
Jana Mackey - Lobbyist

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lobbyist@kansasnow.org

Oppose HB 2503. It will hurt women, not help them.

The National Organization for Women's purpose is to take action to bring women into full participation in the mainstream of American society now, exercising all privileges and responsibilities thereof in truly equal partnership with men. Kansas NOW has 760 active members, distributed throughout the state. Those members have agreed upon an agenda that includes increased access to comprehensive healthcare and feel that the passage of HB 2503 would interfere with that goal.

It may seem contradictory for NOW to oppose legislation that claims to make a medical procedure safer for women. After all, we as an organization are very concerned about the quality of care available to women in Kansas. This apparent inconsistency, however, is resolved when one takes a closer look at the intent of HB 2503 and the consequences it would have for women.

In the first place, it must be noted that no other medical procedure is regulated in the way that HB 2503 proposes. The special treatment of abortion may lead us to believe that abortion is a very dangerous type of surgery. Supporters of this type of legislation often refer to the idea that abortion is a unique procedure and therefore requires unique oversight. I would argue that childbirth is also a very distinctive process. Interestingly, women are ten times more likely to die as a result of carrying a pregnancy to term than they are to die as a result of complications associated with abortion, according to the Center for Disease Control. Other routine procedures have fatality rates that even further outweigh the risk of death associated with abortion – it entails half the risk of death involved in a tonsillectomy and one-hundredth the risk of death involved in an appendectomy.

In light of these facts, we must question the urgency of regulating abortion clinics alone. A possible argument would be that abortions are more dangerous in Kansas than in the rest of the country, but the facts do not support this assertion, either. According to the KDHE, there were 152 deaths due to "medical misadventure" between 1990 and 2003. Not one of these deaths were related to abortion services.

Considering that the fatality rate related to abortion procedures has seen an overall decline since abortion was legalized in 1973, and considering that abortions performed in Kansas are no exception to this trend, the goal of HB 2503 is very clear: to place an unnecessary and, in many cases, detrimental burden on abortion clinics. If these restrictions are signed into law, the cost of compliance will be very high for the clinics. In order to cover these costs, they will have to increase the prices of their services, placing them out of reach of many women, arguably the women who most desperately need them. If this is not sufficient, clinics will be forced to close down, leaving women with fewer options.

Increasing the cost of abortions and closing down the clinics that perform them would not protect women's health. In fact, by interfering with women's ability to access and afford reproductive healthcare, HB 2503 would place them in more danger. The most important thing a woman can do to avoid abortion complications is to have the procedure as soon as possible – the earlier the abortion, the safer it is.

This bill, if passed, would work in a number of ways to delay women's abortions and consequentially make them more dangerous. By forcing unnecessary responsibilities and restrictions upon doctors, it would interfere with their ability to work efficiently and provide timely care to patients. By adding to the cost of abortions, it would add to the time it takes many

Senate Public Health & Welfare
3-22-05
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National Organization for Women

Jana Mackey - Lobbyist

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women to procure the resources necessary to afford this already-expensive procedure. Also, by forcing some clinics out of business, it would make it more difficult and time-consuming to locate and travel to a provider.

All in all, HB 2503 is nothing more than an effort to place abortion out of women's reach. One needs only look, however, to the number of abortions performed before Roe v. Wade (that is, more than at any time since) to realize that women will do whatever they need to do to stay in control over their bodies. Quite simply, women will find ways to have abortions no matter how difficult any legislature may try to make it. For this legislature to callously disregard the health and well-being of these women by delaying their abortions and making them more dangerous would be an insult and a threat to Kansans.

NOW shares the goal of reducing the number of abortions that women must undergo. We, however, believe that there are more effective and less harmful ways to set about this goal. The fact is that the only way to prevent abortions is to prevent unwanted pregnancies. There are a number of proven ways to achieve this goal that, interestingly are not being discussed by the Health and Human Service Committee nor elsewhere in the Kansas Legislature.

- 80% of teen pregnancies are unplanned. Comprehensive sexuality education, unlike abstinence education, has been proven effective in reducing unwanted pregnancy. It would be in the state's best interest to find ways to encourage the implantation of such a curriculum in all of its schools.
- Emergency Contraception, often confused wrongly with medical abortion, is a safe and effective way to reduce the risk of pregnancy for up to five days after intercourse during which protection was either not used or failed. The state should invest in efforts to promote EC and guarantee women's access to it.
- According to the Allan Guttmacher Institute, 308,670 Kansas women are in need of contraceptive services and supplies, and 157,410 need public support to get them. The state should work to see that these women have what they need to prevent pregnancies. A good starting point would be requiring insurance companies that cover other prescriptions to cover prescription contraceptives. (Currently, even state employees are not covered for contraception.)

These are just a few of the many ways in which the goal of reducing abortions could be reached while helping – not hurting – women. As for the supposed goal of this legislation, there are a surely ways that all surgical procedures could be made more safe for Kansas women. Targeting abortion clinics alone is not the way to go about making surgery safer.

NOW opposes HB 2503 and any legislation that is prejudicial toward women.

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PROKANDO

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316.691.8267 (Fax)
866.327.6663 (Toll Free)

Julie Burkhart – *Chair* Joan Armentrout – *Treasurer*

72

Senator Jim Barnett
300 SE 10th Ave. #401S
Topeka, KS 66612

Dear Senator Barnett:

My name is Julie Burkhart and I am the executive director of ProKanDo, which is a pro-woman, reproductive rights organization. Thank you for affording me to opportunity to address the committee regarding HB 2503.

This bill, "Targeted Regulations Against Abortion Providers," has appeared, in a variety of forms around the United States for the past several years. This is the third year in which I have testified against this particular bill and the fourth year it has appeared before the legislature. HB 2503 originated in Arizona and was subsequently passed in 1999; however, it was enjoined shortly thereafter and as a result, has never been enacted. I want to address this for a moment because the issue of enactment was raised in the House Committee. I have provided documents for you from the United States District Court for the District of Arizona, Tucson Division, in which it clearly shows that the statute has not been enacted due to court proceedings. I have been informed, and I have included this correspondence for you, that the 9th Circuit Court has kicked the case back to the District Court for trial; therefore, the non-enforcement stipulation order remains in effect. I wanted to be clear about this and point this out because, in the State of Kansas, we are facing the same scenario that Arizonians have faced: the potential to spend thousands of dollars on litigation in defense of a prejudicial bill.

For those who are unsure about the origin and intent of this bill, please make no mistake, the sole purpose of this bill is to further limit the number of abortion providers, thus restricting health care services to women, with punitive, detrimental measures that increase costs and restrict surgical healthcare options. Simply, the facts do not substantiate the necessity for this bill.

For example, the Health Care Stabilization Fund reports that payout between fiscal years 2000-2004 for medical malpractice, specifically relating to abortion, was 1.35%. The total malpractice payout for other medical procedures during those years was $91,550,800.22. Turning to the State Board of Healing Arts, between 1999-2004, 925 complaints were filed against M.D.'s and D.O.'s. Out of those complaints, abortion physicians represent 0.76% of all complaints. Additionally, if the public health and welfare are threatened because abortion clinics are not operating under these proposed prejudicial guidelines, why then is

Senate Public Health & Welfare
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Julie Burkhart – *Chair* Joan Armentrout – *Treasurer*

there not an outcry about the public health and welfare for those who receive other office-based surgical procedures such as breast augmentation and reduction, liposuction, hernia repairs and knee arthroscopies – just to name a few? In fact, the American Society of Anesthesiologists states that, "By the year 2005, an estimated 10 million procedures will be performed annually in doctors' offices…"

The fact about abortion is that it entails half the risk of death involved in a tonsillectomy, one-hundredth the risk of death involved in an appendectomy and one-tenth the risk of death associated with childbirth. Of women who have first trimester abortions, 97% report no complications, 2.5% have minor complications and less than 0.5% require additional surgical procedure or hospitalization.

I want to talk a little bit about the case involving Dr. Rajanna. I want to remind you that when the House was hearing TRAP at one point last session, proponents of this bill came into a committee hearing with so-called incriminating photos of Dr. Rajanna's clinic. Additionally, I know that those photos were distributed to senate members as well. I would like to remind the committee that the photos you viewed were taken in August of 2003 – at least six to eight months before this so-called public health crisis was brought to light. I ask you – why did proponents of this bill wait so long to bring a complaint to the Board of Healing Arts if there was a bona fide public health crisis? I would also like to remind the committee that it was the proponents who filed a complaint with BOHA – there was never a complaint filed by a patient from the clinic. Essentially, I question the motives of those who have campaigned so tenaciously for this bill – is it persistence due to true concern for women or is it political opportunism?

As a society, if we're really concerned about reducing the number of abortions, then the legislature should seriously consider a bill that would allow marketing Emergency Contraception (EC) as an over the counter drug and to provide educational materials so that the broader population has knowledge of EC. For those of you who are unfamiliar with medication, if it is within 72 hours of unprotected sex, an unintended pregnancy can be avoided, thus, lowering the need for abortion services. Additionally, we can also work to provide contraceptive equity so that women will not have to bear the brunt of the cost for contraception. We can also work to make sure that girls and women receive comprehensive sex education so they will be able to make the best decisions for themselves, which will be line with their moral convictions. These are just a few things that the legislature could do if the intent is to reduce the number of abortions performed each year.

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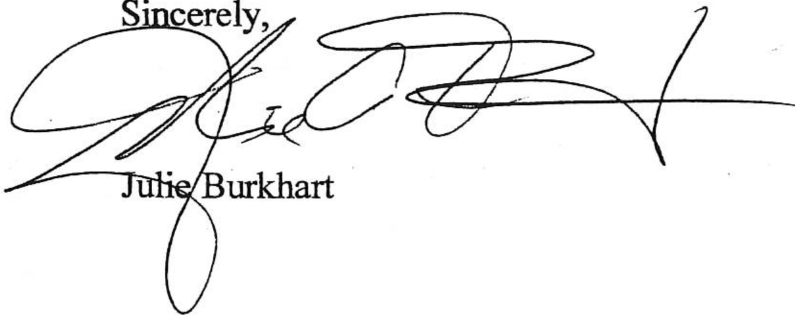
The American College of Obstetricians and Gynecologists has publicly stated that, "Abortion is a confidential, medical matter that should be protected between the physician and their patient. The intervention of legislative bodies into medical decision-making is inappropriate, ill advised, and dangerous. Women who wish to obtain an abortion should be unencumbered by obstacles such as: …stricter facility regulations for abortion than for other surgical procedures of similar risk."

In conclusion, this bill is bad for women and is bad for the "smaller" abortion providers. Quite clearly, this legislative measure is intended to restrict abortion even further by eliminating several small practitioners who safely do abortion procedures in their office-based practices. I urge you to oppose this bill, as it is purely political and does not respect the intellect of women in this state to decide what is best for themselves and their families.

Sincerely,



Julie Burkhart

FORMERLY THE CENTER FOR REPRODUCTIVE LAW AND POLICY

CENTER FOR REPRODUCTIVE RIGHTS

FAX

To:	Julie Burhart.	**From:**	Janet Crepps
Fax:		**Pages:**	5
Phone:		**Date:**	3/18/2005
Re:	Arizona documents	**CC:**	

• **Comments:** Julie – attached are the Arizona documents showing that the State has agreed not to enforce the regulations until 45 days after the litigation is complete, including all appeals. Since the 9th Circuit sent the case back to the District Court for a trial, the case is not over, and the stipulation is still in effect. Let me know if you need anything else on this.

2106 BETHEL ROAD | SIMPSONVILLE, SC 29681 | TEL 864 962 8519 | FAX 864 962 5926 | WWW.REPRODUCTIVERIGHTS.ORG

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22-4

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CLERK U.S. DISTRICT COURT DISTRICT OF ARIZONA
BY

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA
TUCSON DIVISION

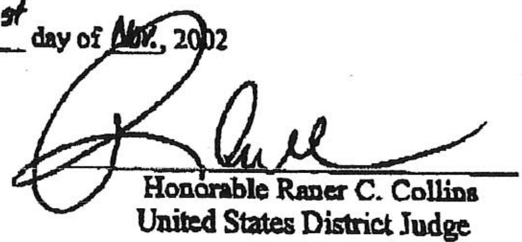
Nov. 6, 2002

TUCSON WOMAN'S CLINIC, et al. Plaintiffs, vs. CATHERINE EDEN, et al. Defendants.	Civil No. CIV 00-141 TUC RCC **Order**

Pursuant to a Stipulation of the parties, and good cause appearing therefor,

IT IS HEREBY ORDERED that for purposes of this Court's order dated October 16, 2002, "the conclusion of all appeals" means the latest of: (1) the expiration of the parties' time to file notices of appeal with the United States Court of Appeals for the Ninth Circuit; (2) if one or more of the parties appeals to the United States Court of Appeals for the Ninth Circuit, the expiration of the parties' time to file petitions for certiorari to the United States Supreme Court following a final decision by the Ninth Circuit; (3) the denial of all filed petitions for certiorari by the United States Supreme Court; or (4) the granting of all filed petitions for certiorari and disposition of this case by the United States Supreme Court.

DATED this 1st day of Nov., 2002



Honorable Raner C. Collins
United States District Judge

1 appeals

242

Bonnie Scott Jones*
The Center for Reproductive
Law & Policy
120 Wall Street, 14th Fl.
New York, New York 10005
Facsimile (917) 637-3666
Telephone (917) 637-3600

*Application for pro hac vice admission granted

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA
TUCSON DIVISION

TUCSON WOMAN'S CLINIC, et al. Plaintiffs, vs. Catherine Eden., et al. Defendants.	Civil No. CIV 00-141 TUC RCC

STIPULATION NOT TO ENFORCE OR IMPLEMENT THE AMENDED REGULATORY SCHEME

Plaintiffs and defendant Janet Napolitano, in her capacity as Arizona Attorney General, and defendant Catherine Eden, in her capacity as Director of the Arizona Department of Health Services, (collectively "state defendants") stipulate to the following:

1. In this lawsuit, Plaintiffs challenge Arizona Revised Statutes §§ 36-402, 36-449, 36-449.01, 36-449.02, and 36-449.03 and 36-2301.02, as revised by Arizona House Bill 2706 and Arizona House Bill 2647 to require the licensing and regulation of medical facilities that provide abortions; and Arizona Regulation

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Title 9, Chapter 10, Article 15, as amended (collectively, "the amended regulatory scheme");

2. Pursuant to stipulations between the parties, the amended regulatory scheme has not yet been implemented or enforced;

3. On October 1, 2002, this Court entered final judgment in this case, granting summary judgment to plaintiffs in part and to defendants in part;

4. Plaintiffs plan to appeal this Court's ruling to the extent that it grants judgment to Defendants in part;

5. Plaintiffs and the state defendants have agreed, in the interests of preserving the time and resources of the parties and the Court, that the state defendants shall not implement or enforce the amended regulatory scheme until all appeals in this case have been concluded.

6. Accordingly, plaintiffs and the state defendants stipulate that the state defendants shall not implement or enforce the amended regulatory scheme until at least 45 days after the conclusion of all appeals in this case.

7. Pursuant to this agreement, private abortion clinics of health care providers licensed under Title 32 of the Arizona Code shall not be required to become licensed as health care institutions until such time, if any, as the state defendants begin enforcement of the challenged regulatory scheme.

8. For purposes of this stipulation, "the conclusion of all appeals" means the latest of: (1) the expiration of the parties' time to file notices of appeal with the United States Court of Appeals for the Ninth Circuit; (2) if one or more of the parties appeals to the United States Court of Appeals for the Ninth Circuit, the

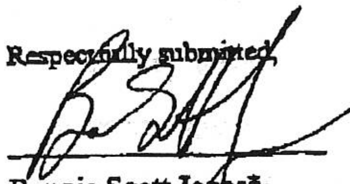
22-7

expiration of the parties' time to file petitions for certiorari to the United States Supreme Court following a final decision by the Ninth Circuit; (3) the denial of all filed petitions for certiorari by the United States Supreme Court; or (4) the granting of all filed petitions for certiorari and disposition of this case by the United States Supreme Court.

9. Plaintiffs and the state defendants respectfully request that the Court issue an order in accordance with this agreement. A proposed form of order is attached hereto.

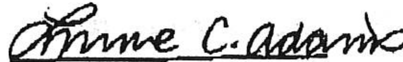
Dated: October 23, 2000.

Respectfully submitted,



Bonnie Scott Jones*
The Center for Reproductive
Law & Policy

Attorneys for Plaintiffs



Lynne C. Adams
Kevin D. Ray
Timothy Miller
Assistant Attorneys General

Attorneys for Defendants
Catherine Eden, Director of ADHS and
Attorney General Janet Napolitano

*Application for pro hac vice granted

22-8

HB2503 Opponent, Mark Pederson, Manager, and Zaremski, MD, Medical Director
Capitol Bldg., Rm 526-S, 15March2005, 1:30pm, Human & Health Services Cmte.

Aid For Women, abortion clinic, 720 Central Avenue, Kansas City, KS 66101, 913.321.3350
National Abortion Federation (NAF) member

This is at least the fourth attempt to get abortion health restrictions in place[1] which presumes abortions are unsafe, and for the fourth time, "Where are those facts about abortion risks? I will agree that 2nd trimester abortions are slightly riskier than 1st trimester, but those mortalities are still better than childbirth[2,3], and yet birthing can still be done at home. Driving to the clinic is riskier than either of these.[4]

Proponents will not be appeased until abortion is eliminated. This bill is not about women's health care otherwise they would not have forbid abortions at ambulatory KU Medical Center in 1998.[5] Don't believe these proponents who claim to want to make abortion safer, **unless safer means none**. Are there plans to regulate births which are ten times more dangerous? Nope, even though there have been 37 birth-related deaths since 1990.

What regulations would prevent abortion clinic deaths, specifically please? Which causes of deaths have there been and how will these regulations prevent them? In my opinion it won't prevent any deaths. Proponents will use the loaded word 'botched,' the real word being 'incomplete' which isn't life-threatening and preferable over 'perforation,' and still has more to do with doctor skill (curettaging too lightly or heavily) and patient's circumstances (lying about medical history). This bill doesn't fix doctor skill or patient mistakes. That's why we go to annual NAF meetings for continuing medical education. ProLifer's also bandy the phrase 'vulnerable women' who won't talk when wronged, but our patients are not vulnerable if they have crossed through the proLife gauntlet picket line.

Why have proponents not enabled the Board of Healing Arts with more power? Proponents claim that BOHA is 'toothless,' 'impotent,' and 'reactive, not pro-active' to fix poor abortion clinics.[6] We've had our problems, and BOHA has dealt us Corrections. BOHA doesn't seem so toothless, but I am open to broadly based increases in BOHA's power. By the way, if this bill is supposedly pro-active, pro-active implies before problems have happened. Is that an accidental admission?

Proponents have claimed abortion deaths are being hidden by coroners out of respect, collusion by the CDC et cetera, and therefore proponents couldn't get needed proof of risks. We've been told that ambulances have arrived at our clinic silently, proof of city collusion to hide problems.[7] Conspiracies abound. A coroner told me that they have no problem declaring embarrassing Cause-of-Death statements such as AIDS, accidental auto-erotic hangings, drug overdoses, and suicides. In Wyandotte county a death outside of a hospital is required to be sent to the coroner. Part of proponent's mis-impression comes from the fact that there must be a direct or indirect causal relationship to abortion to be listed as an "abortion death"[8]. An anesthesia-related death during an otherwise uneventful abortion shouldn't be an abortion death. Also, deaths in another state attributable to a Kansas abortion provider don't count unless the state's other numbers are included. Keep it simple.

The 1997 CDC mortality rate for legal abortions is 0.6 per 100K abortions[9], and abortion is done exclusively in outpatient clinics. The mortality for birthing ranges from 6.0 per 100K births for white women and up to 24.9 for black women, the national average being 8.9.[10] Most deliveries are in hospitals. Car accidents kill 16 people/100K people annually, while suicide consumes 11 people per 100K people annually. Remove the mote from thine own eye first.

Ambulatory rules under SB155 require local hospital privileges or transfer agreements with a local hospital[11] and rules under HB2503 require hospital privileges in state[12]. Will there be legal remedy provided for the abortion provider when the hospital discriminates by refusing to make transfer agreements by use of the Conscience Clause that same proponents have pushed for? Providence Medical Center would never make a tacit transfer agreement with any

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abortion clinic. KU Medical Center cannot make a transfer agreement for fear of losing their State funding. Those are MY local hospitals. To get ONE abortion done at any other secular ambulatory surgery center requires a committee meeting, much less ten thousand KS abortions annually. HB2503 requires an RN or LPN, but our 3 female CPR-trained CMA's will not suffice. An LPN would be an over-qualification for dressing patients, making bottle labels, taking Histories, Vitals, and discussing birth control. Our female surgery nurse of 35 years experience doesn't qualify to provide post-operative monitoring under these rules. Under SB155, ambulatory regulations require 5' wide hallways.[13] I have a 43" wide corridor. Ambulatory regulations require a 360 sqft surgery room minimum[14] and I have a 9'9" x 11' surgery room. Regulations require an X-ray illuminator in each surgery room.[14] I have one hallway X-ray illuminator and have never used it for abortions. I worry about what the regulations under HB 2503 would become.

Proponents claim that these are minimum requirements BASED ON national standards, implying national acceptance. The phrase "based on" is a lie as HB2503 goes beyond NAF standards, and therefore IS NOT a minimum. Where in the minimum NAF Clinical Policy Guidelines will one find the hospital privileges requirement, or the requirement for LPN's or RN's that exclude CMA's? You will find the current online 2005 NAF Clinical Policy Guidelines at http://www.guidelines.gov/summary/summary.aspx?doc_id=6518&nbr=4087. Proponent Ostrowski claim these regulations are derivative of NAF's 2000 Clinical Guidelines, page 94 or something, yet current NAF Guidelines only go to page 51! Where can these supposed NAF regulations be? The current NAF members annually sign a promise to follow these standards and we follow them because we want to be better than the proLifer's think.

Proponents claim that veterinary clinics are more regulated than abortion clinics, that a woman would be better off at a veterinarian clinic than an abortion clinic. That is misleading. Veterinary standards at the statute-level are general. At the regulation-level directed by the Board of Veterinary Examiners, they are quite proscriptive. But then again, veterinarians aren't required to have malpractice insurance, something all physicians must have, and veterinarians are unlikely to get sued and have no death reporting requirement. Specific proscriptive laws are usually implemented by regulation not statute.[15]

Anti-abortion proponent Mark Crutcher of Life Dynamics, Inc. 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."[16] Until KU Medical Center starts performing abortions again, the State helps finance important public health renovations at abortion clinics, and make annual licensing fees the same as ambulatory facilities (free), proponent's safety motives shouldn't be believed.

KDHE KIC statistics[17]

Mortalities 1990-2003:		Hospital diagnoses (not deaths) 1995-2002:	
11,351	Pneumonia	25,173	Complications of surgical procedures or medical care
6,825	Motor vehicle accidents	21,367	Scepticemia
4,442	Suicides	9,658	Aspiration pneumonitis, food/vomitus
3,034	Septicemia	1,815	Ectopic pregnancies
2,078	Homocides	1,083	Miscarriages-spontaneous abortion
1,799	Pneumonitis (throwing up during anesthesia)	154	Post-abortion complications (abortion, ectopic, and molar)
348	Complications of medical & surgical care	123	Induced abortion
302	Influenza		
37	Pregnancy complications		
0	Legal abortion		

FOOTNOTES

[1] Senate Bill 155 (2005) full ambulatory restrictions, House Bill 2751 (2004 3rd incarnation) partial ambulatory with $49,000 per clinic annual registration fee (6 clinics), House Bill 2176 (2003 2nd incarnation) partial ambulatory with $32,000 per clinic annual regisration fee, and HB2819 (2002 1st incarnation) partial ambulatory and claims to follow our own national standards.
[2] "The risk of death associated with abortion increases with the length of pregnancy, from 1 death for every 500,000 abortions at 8 or fewer weeks to 1 per 27,000 at 16-20 weeks and 1 per 8,000 at 21 or more weeks." New York: Allan Guttmacher Institute, http://www.agi-usa.org/pubs/fb_induced_abortion.html and made reference to previously published report titled "AGI, Abortion and Women's Health: A Turning Point for America?" New York: AGI, 1990, p. 30.
[3] Pearlman et al, *Obstetric & Gynecologic Emergencies: Diagnosis and Management*, (ISBN 0-07-145740-2), Chapter 6, Stubblefield P & Borgatta L, Complications of Induced Abortion, McGraw-Hill Companies, Inc., p. 65, c. 2004.
[4] http://www.cdc.gov/nchs/data/hus/hus04.pdf, Annual deaths from Vehicular Accidents, p. 190, 15.7 per 100K people; annual Suicides, p. 197, 11.0 per 100K people, 2002, all ages crude rate.
[5] KSA 76-3308(i)
[6] Kline news conference last April 28, 2004 regarding poor cleanliness of Dr. Rajanna's clinic. Mason: Was this discussed with BOHA? Rep Long: Larry Buenig [BOHA] was notified 4 weeks ago, and is finally up for review. Mason: They are powerless without new laws. But HB 2741 would enable BOHA to do something. Kline: No clear jurisdiction. Det. Howard to Tomasic: Inability to do anything. A restuarant health inspector has more power. Kline: BOHA is broken. During House Federal & State Affairs, HB 2751 2004 Proponent Mary Kay Kulp of Kansas Right To Life: Complaints [to BOHA] don't do anything. No standard of care. BOHA reacts but doesn't prevent.
[7] Mary Kay Kulp complained that they had seen ambulances at KCK clinic but ambulance was quiet, that there was collusion with the city to hide problems. We had an 8-month pregnant woman wearing over-alls, dropped off at our clinic without appointment by boyfriend who screeched his tires while leaving, and she demanded that we get this pregnancy out of her NOW because she was going to get arrested if she went to the hospital... [assumed drug use]. Her water broke while talking with us, and she went into labor with contractions about 5-minutes apart. We called 911, explained the situation, they arrived quietly, and they gurneyed her out the back door. Ignorant anti-abortion Eugene Frye from across the street was taking pictures like crazy, assuming we had just butchered an abortion patient. Why bother to tell him? Another time it was a minor who had a seizure and we sent her to the hospital via ambulance also. Later we were told at the hospital that she had faked the seizure to scare her mother who had pushed her into having the abortion! This is the kind of insanity we deal with every year, including this bill. Thus far in 12 years, we've only had one serious ambulance case and it was safely resolved.
[8] http://www.cdc.gov/mmwr/PDF/ss/ss5309.pdf, Morbidity and Mortality Weekly Report, November 26, 2004, Vol. 53, No. SS-9, US Department of Health and Human Services, Centers for Disease Control and Prevention, Abortion Surveillance - United States, 2001, p. 3, "An abortion death was defined as a death resulting from 1) a direct complication of an abortion, 2) an indirect complication caused by the chain of events initiated by an abortion, or 3) aggravation of a pre-existing condition by the physiologic or psychologic effects of an abortion (1,2)"
[9] Ibid., p. 32, Table 19, Number of deaths and case-fatality rate for abortion-related deaths reported to CDC, by type of abortion - United States, 1972 - 2000.
[10] http://www.cdc.gov/nchs/data/hus/hus04.pdf, p. 189. Crude rates were used. Maternal mortality of complications of pregnancy, childbirth, and the puerperium, according to race,

Hispanic origin, and age: United States, selected years 1950-2002. Typically these results are for deaths up to 42 days after childbirth. Other reputable studies include all deaths up to 1 year after childbirth.

[11] K.A.R. 28-34-52b. Assessment and care of patients **(g) The ambulatory surgical center shall have a written transfer agreement with the local hospital for the immediate transfer of any patient** requiring medical care beyond the capability of the ambulatory surgical center, **or each physician** performing surgery at the ambulatory surgical center **shall have admitting privileges with a local hospital**.

[12] HB2503(d) "The Secretary shall adopt rules and regulations relating to abortion clinic personnel. At a minimum these rules shall require that: (3) A physician with admitting privileges at an accredited hospital in this state is available."

[13] KAR 28-34-62a Construction Standards. (a) General provisions. All ambulatory surgical center construction, including new buildings and additions or alterations to existing buildings, shall be in accordance with standards set forth in sections 1,2,3,4,5,6, **and subsections** 9.1, **9.2,** 9.5, 9.9, 9.10, and 9.32 in the American Institute of Architects Academy of Architecture for Health, publication number ISBN 1-55835-151-5, entitled **"1996-1997 Guidelines for Design and Construction of Hospital and Health Care Facilities,"** copyrighted in 1996, and hereby adopted by reference.

> **9.2)** Common Elements of Outpatient Facilities, **H1.** Details shall comply with the following standards: **(a) "Minimum public corridor width shall be 5 feet (1.52 meters)."**

[14] Ibid., Section **9.2)** Common Elements of Outpatient Facilities, **B3.** Treatment rooms(s). **Rooms for minor surgical** and cast procedures (if provided) **shall have a minimum floor area of 120 square feet** (11.15 square meters), excluding vestibule, toilet, and closets. Or more strictly, under Section **9.5)** Outpatient Surgical Facility, **F2. Each operating room shall have a minimum clear area of 360 square feet** (33.48 square meters), exclusive of cabinets and shelves,... **There shall be at least one X-ray film illuminator in each room.**

[15] Kansas Board of Veterinary Examiners, http://www.accesskansas.org/veterinary/policies.html
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.kssbeo.com/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;

[16] Targeted Regulations of Abortion Providers (TRAP), The Center for Reproductive Law and Policy, New York, NY, May 1999 handout.

[17] http://kic.kdhe.state.ks.us/kic/, Kansas Department of Health and Environment, Kansas Information for Communities (KIC).

hb2503c.wpd

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Chairman Jim Barnett
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March 22, 2005

Dear Chairman Barnett and Committee Members:

I want to thank you for allowing Sylvie Rueff to testify on my behalf today, as I have surgery scheduled and cannot get away on such short notice. However, I felt compelled to submit written testimony on a bill that provides a slippery slope for the practice of medicine in the State of Kansas. I write this testimony with the hope of pointing out the pitfalls that exist with HB 2503 and the reason this is not needed in the State of Kansas.

I am a medical doctor and specialize in the field of Plastic & Reconstructive Surgery. I have been a practicing, board-certified physician for 20 years with an office located in Overland Park, Kansas. I have attached a copy of my curriculum vitae for your review.

Upon reviewing this bill, I am concerned that it was written, not by medical professionals, but by politicians who do not recognize the constant and rapid changing face of medical technology. I note that this bill has garnered no support from the Kansas Nursing Association, the Hospital Association, the Kansas Medical Society or any other professional medical group. I also note that those who have been supportive of this bill have little to no medical training, which would qualify them to develop or administer health care policy.

Physicians are regulated by multiple organizations; however, the language from these regulating bodies is not as prescriptive as the bill that we have before us today. In the practice of medicine, there will always be new discoveries by which a physician will then practice so as to deliver the highest quality health care.

In the practice of medicine, CLIA, HIPPA, BOHA, KMS, OSHA and the AMA already regulate all physicians. In addition, physicians are regulated by the parent organization under which they practice, such as the family medicine association, the cardiology association, the dermatology association, etc…

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