Approved: 3/15/11
Date

MINUTES OF THE HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairman Steven Brunk at 1:30 p.m. on February 16, 2011, in Room 346-S of the Capitol.

All members were present except:
Representative Fund – excused
Representative Henderson – excused
Representative Kiegerl – excused
Representative O'Hara – excused
Representative Peterson – excused
Representative Seiwert – excused

Committee staff present:
Mike Heim, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Julian Efird, Kansas Legislative Research Department
Dennis Hodgins, Kansas Legislative Research Department
Stephen Bainum, Committee Assistant

Conferees appearing before the Committee:
Representative Lance Kinzer
Julie Ann Griffin, M.D.
Michael P. Cotter, M.D., FAAP
Anita Showalter, D.O.
Kathy Ostrowski, Kansans for Life

Others attending:
See attached list.

The Chairman opened the hearing on **HB 2218 Abortion regulation based on capacity of unborn child to feel pain**

Mike Heim gave the committee a synopsis of the changes to law in the bill.

Representative Knox asked who the penalties were against. Mike said they would be against the physicians who violate the act. They are the same penalties as under the late term abortion law.

Representative Kinzer presented testimony as a proponent of **HB 2218** (Attachment 1). He said that there are strong legal arguments for these changes. We know a lot more about fetal pain now than we did when Roe was decided. What we know now gives us every reason to believe that unborn children do experience pain at a particular point of their fetal development and that does create a legitimate state interest.

There may be some conflicting medical testimony on exactly the point in which unborn babies are able to feel pain. One of the things the court has ruled on is that the lack of medical certainty is not a basis for the court to overturn a restriction on abortion. The interest asserted in this legislation is not just one of diminishing or eliminating an unborn child's pain, the interest of the state is the unborn child's capacity to feel pain. It is akin to a born child to which specific rights attach.

Representative Knox voiced a concern about saying that because a child has reached a certain level of development he has value. Lance said that he believes there is no moral difference in the value of an unborn child from the moment of conception thru birth and natural death. We are trying to work within the practical realities of the judicial context.

Representative Holmes asked it were determined that there were irreversible bodily function damage that would justify an abortion, does this bill require that the baby be anesthetized before the abortion is performed? Lance said that it was not in the current text but the committee could insert it with an

amendment.

Representative Huebert asked if there was any information as to how this bill has impacted Nebraska? Lance was not aware the impact on Nebraska.

Representative Loganbill said that she had been doing research and it shows a lack of agreement as to when the fetus can feel pain. She said that we are early on this debate because the information is not one way or another. Some information says that it is 29 or 30 weeks before there is any kind of pain receptor that can feel pain and you are saying that it is 20 weeks. Lance said that the court cases are clear that the legislature is allowed to look at available medical evidence to make a policy judgment and implement it.

Representative Goico said that we have neonatal doctors who specialize in the care of very premature babies and you can see that they feel pain. Lance said that scientific knowledge and moral conviction are converging on the issue of the rights of the unborn.

Representative Rubin asked who the penalties would apply to. Lance said that the mother was protected from persecution. The penalties would apply to a person who performed an abortion on a baby past the point and time established in the act. The doctor would be the one subject to prosecution.

Representative Gatewood asked what are the further restrictions prescribed by this bill? Lance said the standard is moving from viability to a developmental stage of the child itself.

Julie Ann Griffin, M.D. gave testimony as a proponent of **HB 2228** (Attachment 2). She defined pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. The fetus develops nociceptors at 7 weeks around the mouth and face and cover the entire body by 20 weeks. However they do not have the ability to down regulate or inhibit the pain until late in gestation (36040 wga) so that the pain is much more intense and uncontrolled pain. Evidence of the fetus' ability to experience pain is seen by the production of stress hormone production. Moreover, fetal anesthesiology and fetal surgery are rapidly growing fields of medicine appearing in childrens hospitals across the nation.

Representative Patton said that you indicated that the fetus could feel pain more intensely. She said that the fetus could not make their own opiate until 36 weeks of development.

Representative Goico asked what the earliest age and weight was able to survive outside the womb. The American Academy of Pediatrics states that it is routine to resuscitate 24 week fetuses of 500 grams weight or higher. 500 grams is roughly 1 ½ pounts.

Michael Cotter, M.D. presented testimony as a proponent of **HB 2228** (Attachment 3). His testimony is based on his experience working in the Newborn Intensive Care Units of several hospitals. He testified that children past 22 weeks gestational age experience clear physical signs of discomfort and are very sensitive to painful stimulus. Pain is typically identified by observing certain physical signs which includes: crying, thrashing, painful appearing facial expressions, changes in vital signs and physical withdrawal from pain. Premature infants on ventilators are often kept on a continuous drip of an opioid pain medication and at times a sedative. Many Newborn Intensive Care Units utilize some type of scoring system to quantify the pain experience of preterm newborns.

Anita Showalter, D.O., presented testimony as a proponent of **HB 2228** (Attachment 4). She spoke of the determination of fetal gestational age. The methods used to determine gestational age include learning the patient's last menstrual period and ultrasound. She also described the medical complications of pregnancy requiring termination at or after 20 weeks. Medical conditions that could result in recommendation for abortion after 20 weeks and before 24 weeks could be things like cardiac conditions, or diagnoses of cancer requiring treatment.

Representative Patton asked at how many weeks pain receptors were developed. Dr. Showalter said that by 22 weeks from the last minstrel period.

Kathy Ostrowski presented testimony as a proponent of **HB 2228** (Attachment 5). She suggested two slight technical corrections. One is to add "or induced" after "performed" in line 24, pg 5/ section 2 (g) (1) to match the rest of the bill. The other was to replace "preserve the life of the pregnant woman' with

Minutes of the House Federal and State Affairs Committee at 1:30 p.m. on February 16, 2011, in Room 346-S of the Capitol.

"avert the death of the pregnant woman" everywhere it occurs. The charts she mentioned in her testimony are available from Kansans for Life.

The hearing was left open until tomorrow to hear the opponents of the bill.

Michael Schuttloffel, Catholic Conference provided written only testimony as a proponent of **HB 2228** (Attachment 6).

Judy Smith, Concerned Women for America presented written only testimony as a proponent of **HB 2228** (Attachment 7).

The next meeting is scheduled for February 17, 2011.

The meeting was adjourned at 3:08 p.m.

HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE

2.16.11

ROOM 346-S

NAME	REPRESENTING
Phillis Setchell	myself
Denise Cochran	CWA
Kathy Ostrowski	Kansans for Life
Jeanne Gawdun	KFL
Michael Cotter	myself
Michael Schuttloffel	Kansas Catholic Conference
Julie Griffin MD	Myself
JULIAN GRIMAN	SELF
TED HENRY	CB.
Jacob Greek	SELF
T.L. Cahill	Sen Dennis Pyle
Aimee Rosenow	Intern-O'Brien
Jennifer Weisbaar	myself
Virginia Phillips	Trust Women PAC
Martin Hawver	Hawver's Capitol Report
Brenda Elander	Self/intern
ERIC PAHLS	Self
Austin Harris	Self
Tim Stamper	gifted Students

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HOUSE OF REPRESENTATIVES

COMMITTEE ASSIGNMENTS

CHAIR: JUDICIARY

VICE CHAIR: CORRECTIONS & JUVENILE JUSTICE

MEMBER: JOINT COMMITTEE ON STATE-TRIBAL RELATIONS

RULES & JOURNAL

February 16, 2011

TESTIMONY REGARDING HB 2218

HB 2218 is very similar to a relatively new law passed in Nebraska last year. Its intent is to limit abortions in cases where the unborn child is capable of feeling pain to those situations where the mother's life is in peril or she faces a substantial and irreversible physical impairment of a major bodily function. The bill creates a presumption that an unborn child is "pain capable" at 22 weeks gestation. (The Nebraska law is 20 weeks from fertilization, the same as our proposed standard given the different scale of measurement). As of today the Nebraska law has not been subject to any constitutional challenge.

Other conferees will discuss the science of this issue. My purpose is to briefly discuss the legal issues involved. First it is important o understand that this bill will create a question of first impression in the event it is litigated. The relevant question is whether the state has a compelling interest in protecting unborn children who are capable of experiencing pain from abortion– separate and apart from the previously recognized compelling state interest in viable unborn children.

In considering this question in is important to recognize the extent to which our knowledge and understanding of fetal development has changed since *Roe*. For example, 1981 marked the year of the world's first open fetal surgery, performed at the University of California. Once highly experimental, surgery on unborn children is now a frequent occurrence at several centers around the country (for example, to prevent twin blood transfer, to remove lung tumors and to clear blocked urinary tracts). Indeed, fetal surgery is likely to soon become standard care for some conditions such as spina bifida. Due to the ever-increasing resort to fetal surgery, physician observance of unborn children experiencing pain spurred the move to study the pain of the unborn child, and subsequently to regularly administer anaesthesia around 20 weeks gestation. Dr. K. J. S. Anand, professor of pediatrics, anesthesiology, pharmacology, neurobiology, and developmental sciences at the University of Arkansas College of Medicine told a Congressional sub-committee: "Studies have demonstrated that certain stress hormones . . . increased significantly in fetuses given blood transfusions through a needle place, under ultrasound guidance, in the intra-hepatic vein . . . , whereas no consistent responses occurred in the fetuses transfused via a needle placed at the insertion of the umbilical cord (which is not innervated). The magnitude of the stress hormone responses was correlated with the duration of the painful stimulation. In addition, these hormonal responses were reduced when ... a pain-relieving opiate drug ... was administered directly to the fetus."

House Fed & State Affairs
Date: 2.16.11

Attachment 1

While some dispute the capacity of the 20 week unborn child to experience pain, Justice Kennedy's opinion for the Court in *Gonzales* makes clear that medical unanimity is not required in order for legislatures to make and act on determinations of medical fact. Kennedy's majority opinion acknowledged that "There is documented medical disagreement whether the [Partial Birth Abortion Ban] Act's prohibition would ever impose significant health risks on women. ... The question becomes whether the Act can stand when this medical uncertainty persists. The Court's precedents instruct that the Act can survive this facial attack. The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty. [Citations omitted.] . . . The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community. . . . Medical uncertainly does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts."
Gonzales, 550 U.S. at 162-64.

Justice Anthony Kennedy has also written:

"[In *Casey*] We held it was inappropriate for the Judicial Branch to provide an exhaustive list of state interests implicated by abortion. 505 U.S. at 877. *Casey* is premised on the States having an important constitutional role in defining their interests in the abortion debate. It is only with this principle in mind that Nebraska's interests can be given proper weight. . . . States also have an interest in forbidding medical procedures which, in the State's reasonable determination, might cause the medical profession or society as a whole to become insensitive, even disdainful, to life, including life in the human fetus. . . . A State may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others."

With this in mind it is reasonable to conclude that recognizing a compelling state interest in the unborn child who is capable of pain would not require the Court to overturn, but merely to supplement, its prior recognition of a compelling state interest in a child after viability. The interest being asserted here is not just in diminishing the unborn child's pain. But rather in the fact that the very capacity to feel pain is a significant developmental milepost that should trigger a compelling state interest.

Justice Kennedy himself has described the gruesome nature of the most common abortion technique used in the second trimester, dilation and evacuation or D & E, in terms that make clear that it would be extremely painful: "[F]riction causes the fetus to tear apart. For example, a leg might be ripped off the fetus . . . ." *Gonzales v. Carhart, 550 U.S. 124, 135 (2007).* Justice Kennedy used even more graphic descriptions of D&E abortions in his dissent in Stenberg v. Carhart, 350 U.S. 914, 958-59 (Kennedy, J., dissenting), stating, "The fetus, in many cases, dies just as a human adult or child would: It bleeds to death as it is torn limb from limb."

In *Planned Parenthood of Southeastern Pennsylvania v Casey*, 505 U.S. 833, 869 (1992), the Joint Opinion by Justices O'Connor, Souter, and Kennedy, after acknowledging "a criticism that always inheres when the Court draws a specific rule from what in the Constitution is but a general standard" nevertheless concluded that "[l]iberty must not be extinguished for want of a line that is clear." After citing *stare decisis* in support of viability "so that before that time the woman has a right to choose to terminate her pregnancy" the opinion said "there is no line other than viability which is more workable." *Id.* at 870. "In some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child." *Id.*

The stage of development at which the unborn child is capable of experiencing pain – not presented as a potential basis for a compelling state interest in *Casey* or in any other Supreme Court case dealing with abortion – is at least as "clear" and arguably more "workable" in comparison with viability. While viability is predominately an extrinsic measurement of the capacity of medical science to sustain the life of a premature infant, the capacity to feel pain is an intrinsic, innate feature of the unborn child at a particular stage of development. Moreover, it may as equally be said of this stage as of viability that "a woman who fails to act before [it] has consented to the State's intervention on behalf of the developing child."

In his opinion for the majority of the Court in *Gonzales*, Justice Kennedy wrote:
" Respect for human life finds an ultimate expression in the bond of love the mother has for her child. . . . Whether to have an abortion requires a difficult and painful moral decision. . . .While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. ... Severe depression and loss of esteem can follow. In a decision so fraught with emotional consequence some doctors may prefer not to disclose precise details of the means that will be used, confining themselves to the required statement of risks the procedure entails. . . . It is, however, precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State. . . . It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form."

What Justice Kennedy stated to be true with regard to partial birth abortion, its impact on the mother, and the State's interest may equally be applied to those abortions performed when the unborn child is capable of experiencing, and does experience, pain from the abortion technique. "Anguished grief" and "profound sorrow" may well be the consequence when a mother learns after the event that "the way in which the fetus [was] killed" entailed substantial pain for "a child assuming the human form."

While no one can predict with absolute certainty how the Supreme Court might rule in a given case, given all of the above I can say that HB 2218 has been drafted carefully so as to maximize the likelihood of sustaining a Court challenge.

While some dispute the capacity of the 20 week unborn child to experience pain, Justice Kennedy's opinion for the Court in *Gonzales* makes clear that medical unanimity is not required in order for legislatures to make and act on determinations of medical fact. Kennedy's majority opinion acknowledged that "There is documented medical disagreement whether the [Partial Birth Abortion Ban] Act's prohibition would ever impose significant health risks on women. ... The question becomes whether the Act can stand when this medical uncertainty persists. The Court's precedents instruct that the Act can survive this facial attack. The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty. [Citations omitted.] . . . The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community. . . . Medical uncertainly does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts."
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With this in mind it is reasonable to conclude that recognizing a compelling state interest in the unborn child who is capable of pain would not require the Court to overturn, but merely to supplement, its prior recognition of a compelling state interest in a child after viability. The interest being asserted here is not just in diminishing the unborn child's pain. But rather in the fact that the very capacity to feel pain is a significant developmental milepost that should trigger a compelling state interest.

Testimony for the Kansas House of Representatives
Committee on Federal and State Affairs
Chairman Steve Brunk
16 February 2011, 1:30pm
Kansas State Capitol Building, Room 346

Julie Ann Griffin, MD
Hospitalist at Labette Health in Parsons, Kansas
Board Certified by the American Board of Internal Medicine
and the American Board of Pediatrics
Licensed by the Kansas State Board of Healing Arts

Introduction

- Recognition of the Committee for consideration of House Bill No. 2218
- Appreciation of the Committee's time and attention
- Discussion of personal background and qualifications
- Topics to be discussed: definition of pain, description of the anatomy and physiology of pain, examination of fetus' developmental abilities with respect to pain, evidence of the fetus' ability to experience pain, and reviewing the response of the medical community in light of fetal pain and viability research

Definition of Pain

- International Association for the Study of Pain defines pain as "an unpleasant *sensory* and *emotional* experience associated with actual or potential tissue *damage*, or described in terms of such damage."
    - "The inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment."
    - "It is unquestionably a *sensation* in a part or parts of the body, but it is also always *unpleasant* and therefore also an *emotional* experience." (emphasis added)
- Being incapable of verbal expression, the human fetus expresses pain through surrogate markers, including anatomical, functional, physiological and behavioral indicators.
    - These markers are correlated with the same markers in children and adults.

Anatomy and Physiology of Pain

- Four processes in the sequence of events with respect to pain perception: transduction, transmission, modulation, and perception.
- *Transduction* of pain starts with a noxious stimulus to the skin or viscera (internal organs). The primary afferent nociceptors (a receptor preferentially sensitive to such stimuli) are activated.
    - Nociceptors are specialized to receive energy in various forms: mechanical, chemical, electrical, or thermal.

- *Transmission* occurs when this information is electrically conducted through the nervous system via three major pathways.
    - The information travels through peripheral nerves to interneurons in the spinal cord. The spinal neurons send projections to the brainstem and diencephalon (part of the forebrain that contains important structures such as the thalamus, hypothalamus, posterior portion of the pituitary gland, and pineal gland). Neurons from the brainstem and diencephalon then transmit these signals to the cortex structures, the highest areas of the brain.
- *Modulation* is the process involving the descending pathways that downregulate this information by the expression of inhibitory neurotransmitters and endogenous opioids, biologically making the stimulus more tolerable.
- *Perception* is the "feeling" of pain, the subjective sensation thereof, presumably resulting from the concerted activation of the various cortical structures of the brain.

Development of the Fetus' Ability to Experience Pain

- Nociceptors are present by 7 weeks around the mouth and face and cover the entire body by 20 weeks, and they are more densely configured per square inch than on an adult.
- Second order neurons in the spinal cord appear from 10 to 30 weeks gestational age (wga), increasing in anatomical complexity and functional maturation throughout fetal life.
- The neuronal cell types in the fetal brainstem and diencephalon organize and differentiate from the first and into the second trimester; these functional receptors, chemical transmitters, and enzymes are those expressed in the adult human brain.
- The cerebral cortex starts to form at 8-10 wga, and by the 15th wga, the fibers from the pathways below have penetrated into the cortex.
- The modulation or inhibitory pathway does not develop until late gestation (36-40 wga) so that pain signals are unfiltered, and essentially, uncontrolled, in the human fetus.

Evidence of the Fetus' Ability to Experience Pain

- Studies demonstrate that fetuses given transfusions through a needle placed through the fetal abdominal wall and into the liver results in significantly increased stress hormone production (plasma cortisol, catecholamines, and β-endorphin) by the fetus, and this response was correlated with the duration of the painful stimulation.
- No consistent response was elicited when the non-innervated umbilical cord was used.
- These hormonal responses were reduced when narcotic analgesia was administered directly to the fetus.
- Blood flow to the middle cerebral artery of the brain decreases within seventy seconds after painful stimulation (caused by invasive procedures such as fetal blood sampling, body cavity aspirations, and insertional of feto-amniotic shunts) in fetuses as young as 16 wga.
- Ultrasonographic findings have captured specific fetal movements in response to punctures *in utero*.

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Response of the Medical Community in Light of Fetal Pain and Viability Research

- Maternal anesthesia requires doses toxic to the mother in order to ensure sufficient doses of pain relief to the fetus during a surgical procedure.
- The fields of pediatric anesthesiology and surgery have gone from withholding any analgesia to neonates undergoing major surgery in the 1980s to recognized subspecialties requiring their own certifications by national organizations due to the complexities of providing anesthesia and surgical treatment to neonates.
- Moreover, fetal anesthesiology and fetal surgery are rapidly growing fields of medicine appearing throughout children's hospitals across the nation with the goal of providing pain- and stress- free environments for fetuses undergoing invasive procedures.
- The pediatric subspecialty of neonatology has been able to lower the limits of viability of a preterm neonate from twenty-eight weeks gestation age in 1973 (year of the *Roe v Wade* decision) to twenty-three weeks gestational age today.
- Neonatologists now use well-researched and validated tools to measure and adequately treat pain for infants in neonatal intensive care units.

Conclusion

- Pain is both a sensory and emotional experience
- Four major pathways are involved in order to perceive pain
- The human fetus develops aspects of pain architecture as early as 6-7 wga, and these features constitute a developed and coordinated pain response to noxious stimuli by twenty to twenty-two weeks gestational age
- The human fetus is unable to modulate or inhibit these responses until late in gestation
- Human fetuses produce significantly increased stress hormone responses, experience changes in direction of blood-flow to the brain, and exhibit specific movements away from pain, while undergoing invasive medical procedures as early as 16 wga.
- Physicians and other researchers in the fields of medicine and surgery have made considerable strides in their understanding of fetal pain in the last thirty years.
- Appreciation for both the mother and the fetus as two separate human beings capable of feeling pain and for whom I provide medical care calls me to support HB No. 2218.

2-3

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House Federal & State Affairs Committee
Proponent, HB 2218

Feb.16, 2011

Chairman Brunk and members of the committee,

My name is Dr. Michael Cotter. I have been asked to provide expert medical testimony regarding the subject of fetal pain in unborn human beings older than 22 weeks gestational age. Before starting I wish to provide the Committee with my educational and work background. I graduated Summa Cum Laude from the University of Notre Dame in 1994. I graduated Alpha Omega Alpha with a Degree in Medicine from the Albert Einstein College of Medicine in New York City in 2000. I did my Pediatric residency training with the Boston Combined Residency Program in Pediatrics. This program combined training in a major metropolitan tertiary care Pediatric hospital, Children's Hospital Boston, as well as the pediatric service of a major metropolitan general hospital, Boston Medical Center. I held teaching appointments at the medical schools with which these hospitals were affiliated, namely Harvard Medical School and Boston University School of Medicine. After finishing my residency training in 2003, I chose a career in primary care Pediatric medicine where greater than 90% of my clinical time is spent in direct patient care in the office setting with less than 10% of my clinical time doing hospital based medicine. I worked in private practice in Maryland until 2006 when my wife, a native Kansan brought me to Topeka. Since that time I have been in private practice as a general Pediatrician in a group practice owned by Stormont-Vail Hospital.

My testimony is primarily based on my experience as a medical resident, providing direct medical care for preterm infants while they were cared for in the Newborn Intensive Care Unit or NICU. During my training, I spent several months working in both the NICU at Brigham and Women's Hospital (affiliated with Harvard Medical School) and the NICU at Boston Medical Center (affiliated with Boston University School of Medicine). During my tenure, I was routinely involved with the care of babies born as 23 weeks gestational age (roughly the limit of viability). That is equivalent to 21 weeks post fertilization. I do recall caring for one child born between 22 to 23 weeks gestation (or 20-21 weeks post fertilization). As I'm sure most members of this committee are aware, viability is the point in pregnancy when an unborn human being can survive outside of it's mother's womb (albeit with medical support). As I mentioned, the youngest child I have cared for was born between 22 and 23 weeks of gestation which is just a couple weeks past the halfway point of a pregnant mother's second trimester.

I can testify that children past 22 weeks gestational age experience clear physical signs of discomfort and are very sensitive to painful stimulus. At somewhere around 18 to 24 months of age, most children develop the ability to communicate that they are experiencing pain with words. Prior to that, pain is typically identified by observing certain physical signs, a list of which includes, but is not necessarily limited to: crying, thrashing, painful appearing facial expressions or grimacing, changes in vital signs (heart rate, respiratory rate and blood pressure) and physical withdrawal from painful stimulus (for example, pulling a body part away from a needle when the skin is poked). I can

testify that in my experience, children past 22 weeks gestation, without exception, experience these physical findings which even a non-medical professional would be able to identify as pain.

Infants at this age commonly experience agitation and discomfort from the sensation of having an endotracheal tube in place for mechanical ventilation. (This is a "breathing tube" that is passed through the mouth, down past the vocal cords and into the trachea to mechanically breathe for a baby). Premature infants on ventilators are often kept on a continuous drip of an opioid pain medication (examples include fentanyl or morphine) and at times a sedative (examples include Versed or Ativan). Without these medications, they frequently show physical signs of discomfort or cardio-respiratory decompensation. Painful procedures (which can include but are not limited to chest tube placements, wound dressing changes, replacement of the endotrachial tube and placement of PICC lines- which are essentially long IV lines) are routinely performed with opioid and on occasion sedative medications on board. The absence of such pre-medications can often cause considerable signs of pain as well as transient respiratory and cardiovascular decompensation. Routine, less invasive, interventions like blood draws and IV placement cause clear signs of pain in premature newborns as well.

It can be argued that premature infants in fact experience more pain than their older counterparts. The more premature a newborn is, the less "state control" they have. State control can be understood as a child's ability to shut out stimuli. The cause of this is a lack of neurologic "coordination" in a young infant's nervous system. Parents of full term newborns notice that even non-noxious stimuli (for example sudden sounds or a cold diaper wipe) can cause them to startle and then enter a crying fit that takes a bit of time from which to recover. That lack of state control is even more pronounced in preterm infants. Non painful stimuli in preterm infants often cause agitation, fussiness, apnea (prolonged pauses in breathing), drops or elevations in heart rate and color changes. Newer newborn intensive care units, like the one at Stormont Vail, are physically designed to minimize external stimuli. Babies are in individual rooms with low lighting and tight temperature regulation. Ambient noise sensors cause lights to go off in the NICU to warn the staff they are making too much noise or talking too loudly. All of this is designed to limit non-noxious stimuli that can significantly agitate a preterm baby. Painful stimuli in my experience cause more intense responses than non-painful stimuli.

It is worth noting that many (if not all) Newborn Intensive Care Units utilize some type of scoring system to quantify the pain experienced by preterm newborns. Stormont-Vail uses what is called the Premature Infant Pain Profile. Patients receive points on the scale for changes in heart rate, changes in oxygen saturation, furrowing of the brow, eye squeezing or nasolabial furrowing (deepening of the fold that runs from the nostril to the corner of the mouth). Furthermore, the earlier the gestational age (23 weeks for example), the higher score they receive. These are all industry accepted, standardized, and objective measures that are used by neonatal health care providers to rate a preterm infant's pain.

Human beings past 22 weeks gestational age have a similar response to painful stimulus whether they are born or not yet born. Babies are not born with an "on / off switch" that is pushed to activate their central and peripheral nervous system after they are delivered. The only difference is that the response to these noxious stimuli are not as easily observable when the fetus is in utero. Recent medical advances in fetal surgery now allow for surgery to be performed on a fetus while still in its mother's womb. Our current knowledge of fetal development and the development of the fetal nervous system has prompted anesthesiologists to provide anesthesia to fetuses during these procedures. While I feel competent to testify as to the evidence of pain felt by 23 week gestational age newborns based on my direct clinical experience, I lack the basic science expertise to testify as to the exact minimum age of gestation where a fetus can feel pain. Nevertheless, it is reasonable, from my understanding of general Embryology to assume that pain is perceived well before 22 weeks of gestation. Requisite elements of the fetal nervous system are in place well before then. Furthermore, the process of organ system development in a fetus is a gradual process. The perception of pain is probably best thought of as a gradually increasing capability, much like the gradual turning on of a light with a dimmer. In my clinical experience, all I can say is that the light appears clearly on at 22-23 weeks.

My training is in Pediatric medicine. I have not been directly trained in abortion procedures and as such am not well versed in the specifics of the various procedures used to abort pregnancies at different stages of fetal development. I do know that early term abortions involve evacuating the contents of the uterus with a sharp instrument. Arms and legs of the fetus are re-assembled on a sterile operating room table like a jig-saw puzzle to make sure that the fetus has been completely removed to decrease the risk of medical complications for the mother. This procedure cannot be performed, to the best of my knowledge, on later term abortions because of the size of the fetus's head. Dilation and Extraction, a procedure used in late term abortions, involves manually turning the fetus foot first and manually extracting the fetus into the birth canal. In order to get the head of the fetus to pass through the cervix, an incision is made at the base of the skull through which part of the fetal brain is suctioned out to facilitate passage of the fetus in it's entirety. I understand that some abortion providers inject solutions directly into heart of a fetus to terminate the fetus's life prior to extraction. This would be done via a needle that penetrates the chest wall. After experiencing how 23 week preterm infants respond to something as simple as a routine blood draw, it does not take much for me to imagine the level of discomfort produced by these procedures.

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Education / Training

1990 - 1994	**University of Notre Dame,** Notre Dame, IN B.A., Philosophy; Concentration, Pre-Medicine. Graduated Summa Cum Laude.
1995 - 2000	**Albert Einstein College of Medicine,** Bronx, NY M.D. with Distinction in Research.
2000 - 2003	**Boston Combined Residency Program in Pediatrics,** Boston, MA Boston Children's Hospital & Boston Medical Center.

Licensure / Professional Associations

2003 - Present	**American Board of Pediatrics,** Board Certified
2003 - Present	**American Academy of Pediatrics** Candidate Fellow since 2003, Member Fellow since 2004
2006 - Present	**Kansas Board of Healing Arts,** Full medical license in Kansas

Academic Appointments

2000 - 2003	**Harvard Medical School,** Boston, MA Teaching Fellow
2000 - 2003	**Boston University School of Medicine,** Boston, MA Teaching Fellow

Honors and Awards

1994	**Phi Beta Kappa,** University of Notre Dame

1999 **Alpha Omega Alpha,** Albert Einstein College of Medicine

2003 **Best House Officer Teacher Award**
Boston University School of Medicine, Awarded yearly to one pediatric resident based upon the evaluation of medical students and faculty

Language

Spanish. Proficient in medical Spanish. Able to conduct patient encounters with Spanish speaking families without the aid of an interpreter.

Clinical Experience

Jan - April 2000 **Hospital Ramón y Cajál,** Madrid, Spain
Clinical rotations in Pediatric Radiology and Dermatology

2003 – 2004 **Child and Teen Wellness Center (Daniel J Levy, MD PA)**
Owings Mills,MD- Community based pediatric clinic

2004 - 2006 **the Pediatric Group,** Davidsonville, MD
Community based pediatric clinic

2006 – Present **PediatricCare,** Topeka, KS
Community based pediatric clinic

Hospital Affiliations / Privileges

2006-Present **Stormont-Vail Regional Health Center,** Topeka, KS

Research Experience

1994 - 1995 **Data Manager**
Elkhart General Hospital, Elkhart, IN
Joseph Bufill, M.D., Identified individuals at risk for familial cancer syndromes, arranged for genetic screening and genetic counseling for relevant family members, enrolled families into studies at academic medical centers, and collaborated to publish our data.

1996 - 1997 **Research Assistant**
Albert Einstein College of Medicine, Bronx, NY
Robert Burk, M.D., Designed a clinical study of prostate cancer patients to determine patterns of heredity, to compare modes of presentation, and to select kindreds for genetic analysis.

3-5

2009-present Sub-Investigator

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Principal Investigator: An observational prospective study to assess respiratory syncytial virus (RSV) Respiratory Events Among Premature Infants (32 to 35 week gestational age) - Outcomes and Risk Tracking Study (The REPORT study), 2010.

Sub-Investigator: A Phase 3b, Randomized, Open-Label, Multi-Center Study to Evaluate the Safety and Immunogenicity of 2 or 3 Doses of investigational product Conjugate Vaccine in Healthy Infants and the Effects of a Booster Dose of investigational product Administered in the Second Year of Life, 2010.

Publications

Cotter M, Bufill J, Hartmann-Adams H, Artz S, Halling K, Thibodeau S. Familial medullary thyroid cancer (abstract). Program/Proceedings of the American Society of Clinical Oncology 1995; 14:A324.

Halling KC, Bufill JA, **Cotter M**, Artz SA, Carpenter AB, Schaid D, Hartman-Adams H, Chang H, Boustany MM, Fithian L, Jhiang SM, Thibodeau SN. Age-related disease penetrance in a large medullary thyroid cancer family with a codon 609 RET gene mutation. Molecular Diagnosis 1997; 2(4):277-286.

Cotter MP. Gern RW. Ho GY. Chang RY. Burk RD. Role of family history and ethnicity on the mode and age of prostate cancer presentation. *Prostate. 50(4):216-21, 2002 Mar 1.*

Personal and Professional References

Furnished on request.

TESTIMONY OF ANITA SHOWALTER, D.O
HEAD, DIVISION OF OBSTETRICS AND GYNECOLOGY
ASSOCIATE PROFESSOR OF WOMEN'S HEALTH
PACIFIC NORTHWEST UNIVERSITY OF HEALTH SCIENCES
Before the Nebraska Senate Judiciary Committee
February 25, 2010

Background

I am a physician specializing in obstetrics and gynecology. I head the Division of Obstetrics and Gynecology at the Pacific Northwest University of Health Sciences College of Osteopathic Medicine. I also have an active clinical practice with Yakima Valley Farm Workers Clinic, a federally qualified health center. I currently serve on the Board of Trustees of the American College of Osteopathic Obstetricians and Gynecologists and have been active in their educational programs. I have been a proponent of safe, compassionate health care for women. I offer my own opinions today and do not represent any group.

Determination of Fetal Gestational Age

The provisions of Section 4 of LB 1103, the Abortion Pain Prevention Act, which provides that before an abortion is performed the referring physician or the physician inducing the abortion make a determination of the probable gestational age of the unborn child, with a medical emergency exception, are medically reasonable, accord with standard medical practice, and place no undue burden on the physician or the woman upon whom the abortion is to be performed. The Section 2 (8) definition of "probable gestational age" as "what, in reasonable medical judgment, will with reasonable probability be the gestational age of the unborn child at the time the abortion is planned to be performed" gives adequate room for physicians to estimate gestational age in accordance with accepted standards of medical practice.

The methods used to determine gestational age include learning the patient's last menstrual period and ultrasound. Fertilization occurs approximately two weeks after the last menstrual period, so the gestational age by the last menstrual period is two weeks less than dating by the last menstrual period.

When a patient has had regular periods and she has been tracking the dates of those periods, dating by the last menstrual period is usually accurate. If her cycles are irregular or if she has not been carefully documenting her menses, this may not be accurate. A first trimester ultrasound can be performed. Since ultrasounds are inexpensive and readily available, many physicians perform a first trimester dating ultrasound routinely.

A first trimester ultrasound measures the fetal length from the crown to the rump and is accurate in determining dating of the pregnancy within 4.7-7 days. [1,2] When the date

from the last menstrual period and the ultrasound dates agree, this is highly accurate for dating. When there is a discrepancy of greater than one week between the ultrasound date and the patient's last menstrual period the ultrasound date is considered the most accurate.

During the second trimester, from 13 weeks to 20 weeks from the last menstrual period, an ultrasound is considered accurate within 7 days. [3] When the ultrasound and last menstrual period dates agree this is also considered very accurate. When there is a discrepancy between the last menstrual period and the ultrasound date, the ultrasound date is most accurate. The ultrasound date during the second trimester is usually obtained by taking composite measurements of the fetal head, the fetal abdomen, and the length of the femur. Composite measurements increase accuracy.[4,5] Training to do these basic biometric measurements occurs in obstetrics and gynecology residencies and is a skill that is considered basic to modern obstetrical care. Ultrasound units are found on most labor and delivery floors for rapid evaluation of patients.

It is agreed that pregnancy dating is accurate within seven days employing these methods at or earlier than 20 weeks. The greater the gestational age, the less accurate ultrasound is for dating, however employing serial measurements increases its accuracy. After 20 weeks from the last menstrual period, the error progressively increases to about 1.5 weeks. After 32 weeks the error can be as high as 2.5 weeks. [6]

When the patient presents with a pregnancy and a medical complication, dating of the pregnancy is determined in the following manner: If the patient has prenatal records the established estimated date of confinement is used to determine her gestational age. If records are not available a bedside ultrasound or ultrasound in the radiology department may be performed and gestational age estimated based on the fetal measurements.

In cases of significant immediate medical emergency there may not be sufficient time to accurately assess fetal age. However, even in the most extreme circumstances, there is usually available time to quickly scan with ultrasound to get an idea of fetal size, position, and position of the placenta while an IV is being placed, blood is being typed and crossed, and the patient is being prepared for a procedure. This information is necessary to determine the safest procedure for the circumstances and so is usually performed in even the most grave of situations. An example of this may be a patient that presents with life threatening hemorrhaging from the uterus. If the cervix is open the uterus may be evacuated as quickly as possible. If not, or if there is placenta previa (placenta presents first) a cesarean delivery would be performed. If the fetus is determined to be pre-viable, the focus would be to evacuate the uterus quickly as possible by the safest means possible without concern of an intact fetus. If there is possibility of viability, care would be taken to deliver the fetus intact. With massive bleeding, if a procedure is not performed quickly the fetus is not likely to survive and the prudent physician would work to save the mother. Other medical emergencies may be life-threatening but would present with more time to reevaluate the situation and discuss treatment options with the patient.

The medical emergency exception from the requirement to determine probable medical age adequately covers these circumstances. The definition of "medical emergency" in Section 2 (5) is "a condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function." The circumstances in which it might be necessary to perform a pregnancy termination without fully determining gestational age, such as those I have described, all clearly fall within this definition.

Medical Complications of Pregnancy Requiring Termination at or After 20 Weeks

Section 5 of the bill permits the induction of an abortion upon a woman when gestational age is 20 or more weeks if "in reasonable medical judgment, she has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function." This language is fully adequate to cover circumstances in which termination of a pregnancy is truly medically necessary.

Medical conditions that could result in a recommendation for abortion after 20 weeks and before 24 weeks could be things like cardiac conditions, renal conditions, or diagnoses of cancer requiring treatment that may adversely affect the pregnancy. In these situations there is adequate time to assess fetal age, maternal condition, and the best procedure under the circumstances to evacuate the uterus.

Most women with significant cardiac conditions are aware of their diagnoses before pregnancy. If the diagnosis is not compatible with a safe pregnancy the patient is advised to use adequate contraception or sterilization to avoid pregnancy which could be life-threatening to her. Some cardiac conditions can be adequately treated prior to pregnancy with good results and the patient may conceive with careful follow up. Occasionally a cardiac condition is not diagnosed until after her pregnancy has occurred, and occasionally the patient conceives purposefully against medical advice. Starting in the first trimester the cardiac output increases and peaks at about 20 weeks, adding increased stress to the heart.[7] If significant stress to the heart occurs so that the patient's life is threatened and if the patient's condition worsens despite treatment, an abortion may be recommended to save her life. In this situation the method for abortion would need to be carefully chosen to provide the least stress on the patient's heart. Even so, any procedure could also be life threatening, and the risks/benefits would have to be carefully weighed taking the patient's wishes into account.

Moderate to severe renal disease can progress more rapidly during pregnancy. Even so, because of the advances in care for women with significant renal disease, some will choose to conceive anyway. We do not have reliable predictors of which women will

experience a decline in their function. Furthermore, once rapid decline in function ensues, terminating the pregnancy does not necessarily reverse the renal deterioration.[8]

Cancers do not pose an immediate threat of mortality, yet delaying treatment may substantially affect the patient's outcome. For this reason, a multidisciplinary approach is recommended to discuss the timing and type of therapy, maternal effects, fetal effects, timing and route of delivery or termination, and overall prognosis. [9] Some types of disorders may be adequately treated without adversely affecting the pregnancy such as Hodgkins and Non-Hodgkins lymphomas. [10,11] The statement in Section 5 of the bill, "in reasonable medical judgment, she has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function," would give the physician and patient the liberty to treat a cancer in the manner that seemed most appropriate.

Other types of medical conditions that might be life threatening to the mother that would require termination of the pregnancy for successful treatment would be massively rare. Most medical conditions of the mother can be treated adequately despite the pregnancy.

Section 5 requires that at or after 20 weeks, "the physician shall terminate the pregnancy in the manner which, in reasonable medical judgment, provides the best opportunity for the unborn child to survive, unless, in reasonable medical judgment, termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function of the woman than would other available methods." In a limited number of cardiac conditions, according to some experts, delivery of the fetus by dilation and evacuation may improve outcomes over other methods. The language of the bill allows for the physician to make that judgment although it may not result in an intact fetus.

The procedure to save a woman's life after 24 weeks gestation is called a delivery, not an abortion. Dilation and evacuation, which may not result in a living child, is reserved for fetuses of earlier gestation. It is not necessary to end the life of the viable fetus to deliver it and the methods that are used at this gestational age do not require the death of the fetus to successfully terminate the pregnancy. Therefore an expectation of intact delivery of a viable fetus with intent to treat its prematurity is not unreasonable.

Appendix A describes different medical conditions of pregnancy and their treatment, demonstrating that there is no need for an abortion to respond to complications in circumstances other than those for which Section 5 makes provision.

4-4

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1. Gabbe, et al. Obstetrics Normal and Problem Pregnancies. p 217. 5th edition. 2007. Churchill Livingstone Elsevier.
2. Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 321. 5th edition. 2004. Saunders.
3. Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 321. 5th edition. 2004. Saunders.
4. Gabbe, et al. Obstetrics Normal and Problem Pregnancies. p 217. 5th edition. 2007. Churchill Livingstone Elsevier.
5. Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 322. 5th edition. 2004. Saunders.
6. Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 322. 5th edition. 2004. Saunders.
7. Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 817. 5th edition. 2004. Saunders.
8. Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 905. 5th edition. 2004. Saunders.
9. Creasy, et al. Maternal Fetal Medicine Principles and Practice. pp 1213-1214. 5th edition. 2004. Saunders.
10. James, et al. High Risk Pregnancy Management Options. pp. 1999. Saunders.
11. Creasy, et al. Maternal Fetal Medicine Principles and Practice. pp. 768-769 5th edition. 2004. Saunders.
12. Creasy, et al. Maternal Fetal Medicine Principles and Practice. pp 990-991. 5th edition. 2004. Saunders.
13. Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 816. 5th edition. 2004. Saunders.

APPENDIX A

Chronic Renal Disease and Pregnancy

Medical Condition	Effects	Abortion
Chronic Glomerulonephritis	Increase hypertension in late pregnancy. Usually no adverse effect.	No
IgA nephropathy	May have sudden deterioration. Most note good outcomes.	May not stop deterioration of renal function once deterioration has started
Chronic Pyelonephritis	Bacteriuria in pregnancy may lead to exacerbation	No
Reflux neuropathy	Results satisfactory when preconception function is only mildly affected	No
Urolithiasis	May be adequately treated in pregnancy	No
Polycystic kidney disease	Usually minimal	No
Diabetic Neuropathy	No adverse effects on the kidneys	No
Systemic Lupus erythematosis	Prognosis favorable if disease is in remission before conception	No
Periarteritis nodosa	Fetal prognosis poor Associated with maternal death	Consider termination, risks and benefits
Previous urologic surgery	Urinary tract infections are more common May need Cesarean delivery	No
After nephrectomy	Pregnancy is well tolerated	No

Adapted from Table 44-7 Chronic Renal Disease in Pregnancy, Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 908. 5th edition. 2004. Saunders.

4-6

Cardiac Disease and Pregnancy

Cardiac Condition	Effects and Treatment	Abortion
Pulmonary Hypertension	Maternal mortality 50-80% Attention to adequate blood volumes is necessary for adequate pulmonary flow	Minimal risk with termination 1st trimester Later abortions carry increased risk
Eisenmenger Syndrome	Maternal mortality 30-70% Need to maintain adequate pulmonary blood flow Deliver with invasive cardiac monitoring	Minimal risk with termination 1st trimester Later abortions carry increased risk
Dilated Cardiomyopathy	Maternal mortality 15-60% Watch fluid balance Deliver with invasive cardiac monitoring	Minimal risk with termination 1st trimester Later abortions carry increased risk
Marfan Syndrome with aortic root dilation	Maternal mortality 25-50% Risk is dissection of the aortic root. Prophylactic repair may be done.	Minimal risk with termination 1st trimester Later abortions carry increased risk
Aortic Stenosis	Maternal mortality 10-20% Maintain adequate blood pressure	Discuss treatment options, risks and benefits
Mitral Valve Stenosis with Atrial Fibrillation	Maternal mortality 14-17% Monitor fluid status	Discuss treatment options, risks and benefits
Tetrology of Fallot	Maternal Mortality 12% in untreated disease, risk minimal after correction	Discuss treatment options, risks and benefits
Coarctation of the aorta	Maternal mortality 5% in untreated disease Correct prior to pregnancy	Discuss treatment options, risks and benefits
Ventricular septal defect	Minimal effect or so severe as to be fatal Correct prior to pregnancy	Depends on severity of disease
Pulmonary stenosis	Pregnancy contraindicated in severe stenosis Mild to moderate has little affect on pregnancy	Severe: consider termination Mild-moderate: not indicated

Creasy, et al. Maternal Fetal Medicine Principles and Practice. p 815-843. 5th edition. 2004. Saunders. The statistics are compiled from different studies, therefore must be considered approximations.

4-7

MANAGEMENT OF CARDIAC DISEASE AND PREGNANCY FOR IMPROVED OUTCOMES

Prepregnancy

- Obstetrician and cardiologist in collaboration
- Discussion of maternal/fetal risks
- Discussion of effective/safe contraception
- Obtain update on cardiac status
- Optimize medical and surgical management
- Advise against pregnancy with certain conditions

Prenatal

- Assess functional class of heart disease
- Termination is an option with a few conditions
- Joint management with cardiologist
- Avoid/minimize aggravating factors
- Anticoagulation for certain conditions
- Prophylactic antibiotics for certain conditions
- Fetal surveillance

Labor/Delivery

- Elective induction may be necessary for maternal or fetal conditions
- Prophylactic antibiotics for certain conditions
- Avoid mental and physical stress
- Labor in left lateral or upright positions
- Monitor electrocardiogram, invasive monitoring with some conditions
- Administer extra oxygen with certain conditions
- Full resuscitation facilities available
- Continuous fetal heart rate monitoring
- Assisted second stage with certain conditions
- Avoid ergotamine for third stage

Postnatal

- Vigilance for cardiac failure
- Avoid fluid overload
- Continued high-dependency care
- Discuss safe/effective birth control

Adapted from table on page 689. James, et al. High Risk Pregnancy Management Options. 1999. Saunders.

4-8

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Medical License – State of Washington #OP00002278

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EDUCATION

1975-1976 Goshen College Goshen, IN

1987-1989 Indiana University at South Bend South Bend, IN
- B.S., Biological Sciences
- Graduated with High Distinction

1989-1993 Ohio University College of Osteopathic Medicine Athens, OH
- D.O., Doctor of Osteopathic Medicine

1993-1994 Doctors Hospital of Stark County Massillon, OH
- Specialty Track Internship in Obstetrics and Gynecology

1994-1997 Cuyahoga Falls General Hospital Cuyahoga Falls, OH
- Residency in Obstetrics and Gynecology

AWARDS

Freshman Chemistry Award, Indiana University at South Bend, 1988

Ciba-Geigy Community Service Award, OU-COM, 1991

Outstanding Osteopathic Mentor, Ohio University College of Osteopathic Medicine, 1999-2000

Community Faculty Clinical Teaching Award, Des Moines University Osteopathic Medical Center College of Osteopathic Medicine and Surgery, June 2003

Distinguished Fellow - American College of Osteopathic Obstetricians and Gynecologists, March 2007

AOA Osteopathic Mentor Hall of Fame, 2007

MEDICAL STAFF PRIVILEGES

Yakima Valley Memorial Hospital, Yakima, Washington

4-9

TEACHING APPOINTMENTS AND EMPLOYMENT

Clinical Assistant Professor OU-COM CORE, 2003-2006

Clinical Assistant Professor Kirskville COM, 2003

Assistant Professor, Oklahoma State University Center for Health Sciences, February 2007 to December, 2007

Self Employed as a Private Physician 1997-2007

Employed with Yakima Valley Farm Workers Clinic as a staff OB/GYN, October 2007 to present

Associate Professor of Women's Health, Head of the Division of Obstetrics and Gynecology, Pacific Northwest University of Health Sciences, April 2008 to present

PROFESSIONAL MEMBERSHIPS AND POSITIONS

American Academy of Osteopathy

American College of Osteopathic Obstetricians and Gynecologists

- Board of Trustees,
- Co-Chair Annual Conference 2006
- Continuing Medical Education Committee
- Committee for Women's Rights in Childbirth Choices
- Chair: Committee for Osteopathic Curriculum Development
- Philanthropy Committee
- Membership and Promotions Committee

American Osteopathic Association

Christian Medical and Dental Association

Sigma Sigma Phi

LECTURES, PUBLICATIONS AND PRESENTATIONS

Poster Presentation: Osteopathic Manipulation in Obstetrics: A Historical Perspective
- Presented at the ACOOG Annual Convention, La Jolla, CA 1997

Poster Presentation: Postpartum Pelvic Dysfunction: A Case Report
- Presented at the ACOOG Annual Convention, La Jolla, CA 1997

"Exercise in Pregnancy"
- Dunlap Memorial Hospital Health Fair – 1998

"When the Hormones Swing, I Duck!"

- Dunlap Memorial Hospital Community Awareness Lecture –1999
- Aultman Hospital Community Service Lecture - 1999

"OMM in a Specialty Practice"

- OU-COM Specialty Emphasis Week 1999

"OMM in Obstetrics and Gynecology"

- OU-COM UAAO presentation and hands-on workshop, 1999

"Getting the Delivery You Want"

- International Cesarean Awareness Network Conference, Workshop, Cleveland, Ohio, April 2000

"Osteopathic Manipulation in Obstetrics and Gynecology"

- Visiting Professor Program, ACOOG 2004-2006
- Lecture and lab for second year students at OSU-COM, 2000-2007
- Lecture and lab for CORE OB/GYN residents, May 2002
- Lecture and lab for ACOOG Midyear Conference, October 2002
- Lecture for ACOOG Annual Conference, March 2003, March 2005
- OMM Workshop table trainer ACOOG Annual Conference March 2006
- Lecture and lab Kansas City University of Medicine and Biosciences, March 2004, March 2005, March 2006, March 2007
- Lecture and lab, Touro College of Osteopathic Medicine, February 2006, January 2007, March 2009
- OMM Workshop, ACOOG Fall Conference, September 2006
- OMM Workshop, ACOOG Spring Conference, March 2007
- "Osteopathic Practice and Principles for the Female Patient" Lecture and Workshop, ACOOG Fall Conference, September, 2007
- Osteopathic Practices and Principles for the Female Patient, Workshop Michigan OPTI OB/GYN Residents, November, 2007; September, 2009
- AOBOG Board Review lecture, April 2007, April 2009
- Lecture, Washington Osteopathic Medical Association Spring Conference, March 2009

"Osteopathic Philosophy in OB/GYN"
Lecture and Lab AOA Unity Conference, October 2005

"The Holistic Woman"

- Lecture for Women's Health Update: A Look to the Future, Doctors Hospital, Columbus, Ohio, May 2006

"HRT Today"

- WOMA Fall Conference, Pacific Northwest University of Health Sciences, September, 2008

"Cervical Cancer Screening Update"

- Yakima Valley Memorial Hospital Family Practice Conference, October, 2008

Complementary and Alternative Medicine use in the Amish

- V.E. von Gruenigen, A.L.Showalter, K.M. Gill, H.E. Frasure. M.P. Hopkins, E.L. Jennison, Comprehensive Therapies in Medicine (2001) p.232-233.

Anita Showalter, D.O. is Head of the Division of Obstetrics and Gynecology at Pacific Northwest University of Health Sciences in Yakima, Washington. Her clinical practice is with Yakima Valley Farm Workers Clinic, a federally qualified health care center with a mission to the underserved in Washington and Oregon. She attended medical school at Ohio University College of Osteopathic Medicine, and did her residency training at Cuyahoga Falls Community Hospital in Cuyahoga Falls, Ohio. Her special interests include the use of osteopathic manipulation in female care, particularly improving outcomes in obstetric patients and treating chronic pain syndromes. She is a Distinguished Fellow in the American College of Osteopathic Obstetricians and Gynecologists, currently serves on the Board of Trustees, and frequently lectures at their conferences.

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Proponent, HB 2218 **Feb. 16, 2011**

Good afternoon Chairman Brunk and members of the Federal & State Affairs committee,

Today I am honored to stand with medical professionals and other conferees who recognize the historic importance of this bill. HB 2218 is nearly identical to the Nebraska **"pain-capable unborn child protection act"** that has been in effect since October 2010 without legal challenge.

According to a May 2010 briefing by the pro-abortion Guttmacher Institute, 1.5% of the estimated more than 1.2 million elective abortions performed annually in the United States are on unborn children at 21 weeks LMP (19 weeks post-fertilization) or older.

This translates to roughly 18,000 abortions annually – a substantial number of which probably occur at 20 weeks after fertilization, which is past the point that substantial medical evidence indicates that the unborn child is capable of feeling pain.

At the time of the Roe v Wade ruling, our understanding of pain was so primitive that newborns undergoing surgery did so without anesthesia, receiving only a paralytic to keep them immobile!

We now have scientific information that wasn't available to the Roe v Wade Court when they recognized a state's interest in the viable child could only be asserted at "viability." At least five Supreme Court Justices admit the state has an interest in protecting pain-capable children.

We can show that pre-viable unborn children who are capable of feeling pain are now treated as patients and can undergo surgery for corrective procedures. They are anesthetized during the surgery because we know that they can feel pain. This is all new information that has never been presented to the Court.

HB 2218 strictly defines a maternal medical emergency to be of a physical "bodily" nature that excludes threats of self-harm or suicide. No longer should Kansas tolerate a law with a loophole big enough to drive a truck through.

But the larger picture is that HB 2218 significantly forces the discussion to break out of the old trap of arguing about competing legal rights between an adult and a 'fetus' and question, instead, how much barbarism we will tolerate.

Decades ago, a movie made about abortion by reformed abortionist, Bernard Nathanson, was entitled The Silent Scream. Medical investigation has only proven how apropos that title was -- that abortion inflects horrible, unimaginable torture on tiny humans.

At least seven states already include the pain capability of the unborn child as part of their abortion informed consent provisions.

House Fed & State Affairs
Date: 2.16.11
Attachment 5

Kansans for Life suggests two slight technical corrections:

1) add "or induced" after "performed" in line 24, pg 5/ Section 2 (g) (1) to match the rest of the bill, and

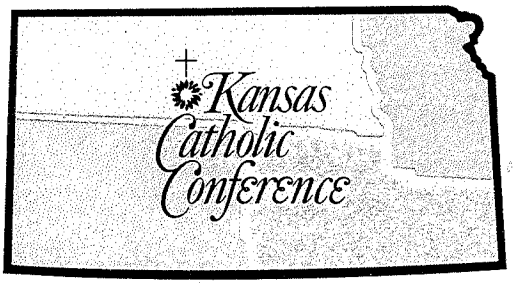
2) replace "preserve the life of the pregnant woman" with "avert the death of the pregnant woman" everywhere it occurs.

HB 2218 is unique and sound legislation that says the state of Kansas has a compelling interest in protecting the unborn child at 20 weeks post-fertilization.

Kansans for Life urges committee members to pass the bill out favorably with suggested amendments.

Kathy Ostrowski
State Legislative Director of Kansans for Life

ATTACHMENTS:
Mary Spalding Balch, 2 articles about Constitutionality of Unborn Pain bills
Teresa Stanton Collett on the constitutionality of the Nebraska Bill
Yellow divider
Analysis of HB 2218 by Maternal-Fetal expert William Polzin, M.D.
Comments on Nebraska bill by Maternal-Fetal expert Sean Patrick Kenney, M.D.
Green divider
Chart of pain vulnerability
Analysis of unborn pain by Paul Ranalli, M.D.
Pain expert Tom Grissom, M.D. on the Nebraska bill
Pain expert Ferdinand F. Salvacion, M.D. on the Nebraska bill
Key article on unborn pain by premiere pain expert Kanwaljeet (Sunny) Anand
Red divider
Letter to editor/rebuttal to ACOG objection by Ranalli
NRLC responses to objections
NRLC evaluation of findings in Section 1 of HB 2218



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Testimony in Support of HB 2218
Michael Schuttloffel
Executive Director, Kansas Catholic Conference

House Federal and State Affairs Committee
February 16, 2011
1:30 PM

Chairman Brunk and Members of the Committee:

America's failure to extend constitutional protection to the unborn is the preeminent human rights issue – the preeminent human rights failure – of our time. In the thirty-eight years since *Roe v. Wade* took the abortion issue out of the hands of the democratic process, advancements in medical technology have proven that what grows inside the mother's womb is not a clump of tissue, but a human being.

Today in America, it is perfectly legal to kill a defenseless human being – a human being with arms and legs, a heartbeat, brainwaves, his or her own blood, and his or her own distinct human DNA. Advancements in medical technology also tell us that many of these innocent human beings feel pain. And so it is that we are not only killing our children, but we are torturing them as well. The agony, confusion, and terror that such a little, defenseless life experiences as it is torn limb from limb is beyond anything any of us will ever experience. These are stark terms, but the time has come for our country to have a frank conversation about what abortion actually is. We believe that this bill will facilitate that conversation.

For too long, advocates of legal abortion have hid behind euphemisms like "choice" and "health" without daring to engage the central question at stake: what is it that is being destroyed inside the womb? Just recently, as this committee considered HB 2035, abortion advocates refused to answer legislators' questions about what an abortion is, and what it destroys. Abortion advocates dismissed such questions as matters of personal philosophy, but this is not a philosophical question. It is a medical question. It is a scientific question. It demands an answer.

What does it say about our society that we send people to jail for cruelty to animals, but we write them a check for dismembering an unborn child? Perhaps the magnitude of this madness is so great as to make it difficult for people to believe that such evil could in fact be occurring within our midst. But it is. And we will bear history's harsh judgment, just as we judge those who could somehow have been so wrong as to treat human beings as less than human 150 years ago.

The Kansas Catholic Conference's support for this bill must be understood within the context of the restrictions placed on lawmakers by the courts. The ability to feel pain does not endow one with humanity, nor does the inability to feel pain make one less human. However, the legal, moral, and constitutional catastrophe that was the 1973 *Roe v. Wade* decision still limits what is possible for abortion legislation. HB 2218, like all Pro-Life bills that we encourage legislators to support, is imperfect. Innocent human beings who deserve the right to live fall outside the scope of its protections.

Under the Supreme Court decisions that control abortion jurisprudence, states acquire a compelling interest in the protection of unborn life at the point of viability. This is of course an arbitrary, and essentially absurd, standard, because viability is more a measure of the state of medical technology than anything else. Viability in 1973 is not viability today, nor will viability be the same in another 38 years. Nor is the point of viability in Johnson County the same as it is in Somalia. As a measure of humanity, it is fundamentally unserious.

If the Court will not recognize the right to life of all human beings born and unborn, if it will only bestow constitutional protection upon the unborn once they have passed a certain milepost of fetal development, then perhaps that milepost should be a measure of some intrinsic condition of the unborn human being, like its capacity to feel pain, and not a measure of a particular hospital's neonatal facilities.

We reject the Supreme Court's entire project of distinguishing between which unborn humans are constitutionally protected and which are not. Nonetheless, if imperfect legislation can reduce abortion, raise public awareness of its brutal realities, and move public opinion towards greater compassion for the plight of the unborn, then we will support it.

Thank you for your consideration.

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CONCERNED WOMEN FOR AMERICA

WHEN A WOMAN'S CHOICE IS NOT ENOUGH
Choosing to care about unborn children's pain

Chairman Brunk and members of the House Federal and State Affairs Committee:

Concerned Women for America of Kansas, the largest public policy women's organization in the United States strongly supports House Bill 2218, a bill that regulates abortion based upon the unborn child's ability to feel pain.

Almost three years ago, my premature twin grand-daughters were born, and as a result of their early arrival they spent some time in the NICU (neonatal intensive care unit). As I visited them, I looked around at other babies in the unit, and even though my grand-daughters were tiny according to my standards, some of the other babies were small enough to fit into my hand. As I watched the nurses tenderly take care of these tiny humans, I realized they were reacting to the nurse's touch with flinches, grimaces and a pulling away from the source of stimuli. I also noticed when their mom was there, they were strangely calmer. My own grand-daughters reacted to us and especially to mommy in a way that clearly reflected awareness.

Scientific advances have given us "a window" into the womb via sonograms; fetal surgery is now commonplace. In fact a recent news story stated that babies with *spina bifida* do better if they get surgery to correct the open spine *before* birth. Testimonies given before Congress in 2005 by expert witnesses Jean A. Wright, M.D., MBA and Dr. K.J.S. Anand stated that an unborn child can feel pain at 20 weeks if not much sooner. They both stated that the child has "all the prerequisite anatomy, physiology, hormones, neurotransmitters, and electrical current to close the loop and create the conditions needed to perceive pain." Dr. Anand, presently a Professor of Pediatrics, Anesthesiology & Neurology at the University of Tennessee, further stated that "a human fetus possesses the ability to experience pain from 20 weeks of gestation, if not earlier, and that the pain perceived by a fetus is possibly more intense than that perceived by newborns or older children." He testified that in surgeries on unborn infants performed without anesthesia the infants demonstrated an increase in the "fight or flight" hormones indicating an intense response to the pain, resulting in a poorer outcome for those infants. Studies have shown that pain in an unborn child or premature infant is not modulated by higher cerebral functions until 36-40 weeks gestation. In other words, these young infants feel pain more acutely. Studies have also shown that the hormonal responses elicited by painful stimuli were relieved by the administration of opiates and other pain-relieving medications causing pediatric surgeons to start administering anesthetics to the child.

A single study by the Royal College of Obstetricians and Gynecologists (RCOG) refuting the current science used a faulty mechanism for defining pain. In fact they never even consulted with experts in fetal pain development. They completely ignored the fact that unborn children have the highest number of pain receptors per square inch that they will ever have. This leaves one to wonder if the facts of what is happening to an unborn child and its perception of pain during an operation or abortion are just too awful to contemplate.

My grand-daughters had the opportunity to catch up from their early arrival but many infants whose life depends upon a "choice" will not have that opportunity. In fact, they will experience a painful death that we would abhor administering to a convicted serial killer.

We urge you to pass this bill.

Judy Smith, State Director
Concerned Women for America of Kansas
February 16, 2011

House Fed & State Affairs
Date: 2.16.11
Attachment 7