Approved: August 25, 2011
(Date)

MINUTES OF THE SENATE JUDICIARY COMMITTEE

The Chairman called the meeting to order at 9:38 A.M. on March 17, 2011, in Room 548-S of the Capitol.

All members were present, except Senator Donovan, who was excused

Committee staff present:
Lauren Douglass, Kansas Legislative Research Department
Robert Allison-Gallimore, Kansas Legislative Research Department
Jason Thompson, Office of Revisor of Statutes
Tamera Lawrence, Office of Revisor of Statutes
Jason Long, Office of Revisor of Statutes
Theresa Kiernan, Committee Assistant

Conferees appearing before the committee:
Senator Mark Taddiken
Kathy Ostrowski, Kansans for Life
Dr. Melissa Hague, M.D.
Sarah M. Gillooly, M.A., Planned Parenthood of Kansas and Mid-Missouri
Tiffany Campbell, KS NOW
Dr. Phil Wood, PhD., Trust Women PAC
Senator Marci Francisco

Others attending:
See attached list.

The Chairman opened the hearings on:

- **HB 2035 -- Amending statutes regulating late-term and partial birth abortion**
- **HB 2218 -- Abortion regulation based on capacity of unborn child to feel pain**
- **SB 146 -- Abortion; late-term and partial birth abortion**
- **SB 165 -- Licensure of abortion clinics**

The Chairman requested that conferees who desired to appear on more than one of the bills to express their comments and testimony in support of, or opposition to, the bills when first recognized.

Jason Long, Office of the Revisor of Statutes, reviewed the bills. In his review he noted that **HB 2035** and **SB 146** contain the same policy, except the House amended **HB 2035** to clarify an amendment to K.S.A. is not to be construed to limit the authority of the State Board of Arts to engage in a disciplinary action.

Robert Allison-Gallimore, Staff Researcher, reviewed the fiscal notes for the bills.

Senator Taddiken testified in support of **SB 146** (Attachment 1). He stated the bill contains many changes to statutes governing late-term and partial birth abortion. He added that he supports the amendments made to **HB 2035** by the House.

Senator Schodorf asked, "Would you object to adding a requirement that the father would be informed of the pregnancy and/or the abortion?"
Senator Taddiken responded, "No objection."

Senator Vratil asked, "Would attorneys fees be awarded to the prevailing side in a civil suit alleging violations of rights as provided by subsection (o) K.S.A. 65-6705?"
Senator Taddiken responded, "I don't know."

Senator Vratil asked, "**HB 2035** and **SB 146** would require the promulgation of rules and regulations. How could rules and regulations be adopted before the effective date of the bill?

Senator Taddiken responded, "The rules and regulations will not be adopted until the bill is in effect."

Kathy Ostrowski testified in support of **SB 146, SB 165, HB 2035** and **HB 2218** (Attachment 2). Ms. Ostrowski included suggested amendments in her testimony. She stated that **SB 146** and **HB 2035** would: Require more information and specificity in reports that must be filed by physicians; raise the evidentiary standard for judicial waiver of parental consent; grant the attorney general access to the reports that are required to be filed; give the attorney general standing to file civil suits; require consent of both parents, when possible, when a minor seeks an abortion; improve the process when a minor seeks to bypass her parents; and require a court to report suspected sexual abuse.

Ms. Ostrowski stated that **SB 165** would: Require the reporting of an abortion-related death within one business day of the occurrence; prevent webcam abortions; require all abortions to be performed by a physician; and impose requirements on locations where an abortion may be performed.

Dr. Melissa Hague, M.D. testified in support of **HB 2218** (Attachment 3). She stated that the bill imposes restrictions on abortions after the 22nd week of gestation due to pain experienced by the fetus during the procedure; an exception is provided if the life of the pregnant woman is threatened, but would require physicians to ensure certain standards are met prior to an abortion procedure. She stated that the reporting requirements of the bill would assist in providing better treatment and care of patients.

Written testimony in support of **SB 146** and **HB 2035** was submitted by Michael Schuttloffel, Executive Director, Kansas Catholic Conference (Attachment 4); and Judy Smith, State Director, Concerned Women for America of Kansas (Attachment 5).

Written testimony in support of **SB 165** was submitted by Michael Schuttloffel, Executive Director, Kansas Catholic Conference (Attachment 6).

Written testimony in support of **HB 2218** was submitted by Michael Schuttloffel, Executive Director, Kansas Catholic Conference (Attachment 7); and Judy Smith, State Director, Concerned Women for America of Kansas (Attachment 8).

Sarah M. Gillooly testified in opposition to **SB 146, 165, HB 2035** and **HB 2218** (Attachment 9). She stated **SB 146** and **HB 2035** would: Create an undue burden on access to abortion care and put women and minors in legal limbo during the period of time between the effective date of the bills and the effective date of rules and regulations adopted to implement the bills; severely limit, if not totally restrict, the ability of the most vulnerable women to access safe, legal health care; have a dramatic fiscal impact on the state; remove the civil immunity provided to physicians who comply with the informed consent requirements of K.S.A. 65-6709 and 65-6710; and place confidential medical information in the hands of elected politicians.

Ms. Gillooly stated that the provisions of **SB 165** were vague, unnecessary, burdensome and contrary to standard medical practice for physicians in Kansas (Attachment 10).

Ms. Gillooly stated that **HB 2218** is unconstitutional because it: Bans pre-viability abortions; fails to state a constitutionally recognized state interest; and fails to adequately protect a woman's health (Attachment 11).

MINUTES OF THE Senate Judiciary Committee at 9:38 A.M. on March 17, 2011, in Room 548-S of the Capitol.

Tiffany Campbell testified in opposition to **HB 2218** (Attachment 12).

She stated that if passed, women in Kansas, and their families, would be stripped of their right to make a private medical decision in consultation with their doctor and clergy.

Dr. Phil Wood, PhD. testified in opposition to **SB 146, HB 2035** and **HB 2218** (Attachment 13). He is concerned that the bill defines viability as a stage, which implies that viability is solely a function of gestational age. He stated that there is a difference between a fetus that is "nonviable" and a fetus that is dying.

Written testimony in opposition to **SB 146** and **HB 2035** was submitted by Virginia Phillips, Trust Women PAC (Attachment 14); and Amber Versola, Kansas NOW (Attachment 15).

Senator Marci Francisco testified as a neutral party to **SB 146, 165, HB 2035** and **HB 2218** (Attachment 16). She expressed concern with the definition of gestational age used in the bills. She also expressed concern the requirement that the physician inform the woman in writing "the abortion will terminate the life of a whole, separate unique, living human being.

Written testimony in opposition to **SB 165** was submitted by Virginia Phillips, Trust Women PAC (Attachment 17); Herbert Hodes, M.D., FACOG, Overland Park (Attachment 18).

Written testimony in opposition to **HB 2218** was submitted by Virginia Phillips, Trust Women PAC (Attachment 19); Amber Versola, Kansas NOW (Attachment 20); and Danielle Deaver (Attachment 21).

The Chairman closed the hearings on **SB 146, SB 165, HB 2035** and **HB 2218**.

The Chairman reminded the members of the committee that the meeting scheduled for March 18, 2011, would commence at 8:30 A.M.

Meeting adjourned at 10:29 A.M. The next meeting is scheduled for March 18, 2011.

PLEASE CONTINUE TO ROUTE TO NEXT GUEST

SENATE JUDICIARY COMMITTEE GUEST LIST

DATE: Thurs. March 17

NAME	REPRESENTING
Virginia Phillips	Trust Women PAC
Phillip Wood	Self
Amber Versola	KS NOW
Tiffany Campbell	self
Kari Ann Rinker	Kansas NOW
Meegan Brooks	Legislative Intern - Rep. Don Hill
Charles Moore	KDHE
Kevin Berone	Cap Leb. Group
marci francisco	KS Senator, 2nd District
Lidsey Douglas	KDOT
Dustin Bradley	KDOT
Magen Malbrough	Self
KRIS MORAN	self
Todd Kerig	Wichita Eagle
Rachel Whitten	Kansas Reporter
Robert Nolan	self
Neil Hague	self
Melissa Hague	self
Lou Zaeh	KDHE

PLEASE CONTINUE TO ROUTE TO NEXT GUEST

SENATE JUDICIARY COMMITTEE GUEST LIST

DATE: _____

NAME	REPRESENTING
Michael Schuttloffel	KS Catholic Conference
Jessica Daniel	Kansans for Life
Jeanne Gawdun	KFL
Cathy O'Sullivan	Kansans for Life
Sarah Gillooly	PPKM
Denise Cochran	CWA
Brenda Kohler	CWA
Barbara Sabatini	CWA
Donna Lippoldt	Kansas Family Policy Council
Bob Eberhardt	POH
Berend Koops	Hein Law Firm
~~JOHN FOSTER~~	KCWS
WILLIAM J. HEYDENREICH JR.	SELF
Susan Allen	Legis
Brenna Duffy	Intern
Patrick Vogelsberg	Kearney and Assoc.

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TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: AGRICULTURE
MEMBER: NATURAL RESOURCES
UTILITIES
WAYS & MEANS
FINANCIAL INSTITUTIONS AND
INSURANCE

Testimony on **Senate Bill 146**
to the
Senate Judiciary Committee
by Senator Mark Taddiken

March 17, 2011

Mr. Chairman and Committee Members,

Thank you for the opportunity to appear before you today in support of **SB 146.**

Senate Bill 146 contains a number of changes to statutes governing late term and partial birth abortions. Most of these changes should be familiar to you as they have passed the Senate before but have been vetoed.

1) Reports by abortion providers to KDHE would be required to include a specific medical diagnosis
2) Violations of K.S.A. 65-703 may be prosecuted by any district or county attorney as well as the attorney general
3) Changes the term fetus to unborn child to be consistent with other statutes
4) Changes the definition of the term viable
5) Creates a new definition of human being
6) Civil cause of action would be created regarding late term abortions and partial birth abortions

A new provision not previously considered by the Senate would delete current law requiring parental notification and would replace it with parental consent.

The bill requires the signature of both parents for consent, but ratchets down to one parent, guardian, or judicial bypass.

All the items included in this bill are current law somewhere in the United States.

I would ask for your favorable consideration of **SB 146**.

Senate Judiciary
3-17-11
Attachment 1

Kansans for Life
www.kfl.org

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PROPONENT, HB 146/HB 2035, SB 165/HB2337 and HB 2218

Chairman Owens and Senate Judiciary Committee,

I am Kathy Ostrowski, Kansans for Life Legislative Director since 2003.

Thank you for this opportunity to represent the 50 chapters of Kansans for Life across this state on this momentous day, presenting testimony in support of accurate abortion reporting, clinic licensure and the pain capability of the unborn.

SB 146 /HB 2035 will prevent abortionists from submitting reports with **"non-answers."** New KDHE Secretary Moser has announced that the straightforward reading of the 1998 law requires medical reasons, like insurance forms do. A short history of legislative attempts to address this problem is included, along with a sample KDHE report.

SB 146 /HB 2035 will also end the current absurd situation in which district attorneys can prosecute for illegal abortions but are denied access to state abortion reports while the Attorney General is granted specific access to those reports but is refused the ability to locally prosecute! Standing to sue civilly is included.

Parents have the right to protect their daughters from exploitation, abuse and physical and emotional trauma. In 2009, there were 1473 pregnant Kansas minor of which 18% obtained abortions. Requests for judicial bypass/parental waivers are remarkably few: 14 in 2008 and **10 in 2009**, indicating they are not often needed and /or minors don't seek them as they know they can intercept mailed abortion notices. SB 146 /HB 2035 creates **2 parent consent where possible** and improves the judicial process for bypassing parents at the minor's request.

SB 146 /HB 2035 will **raise the evidentiary standard** required for judicial waiver of the consent requirement from a preponderance of the evidence to clear and convincing evidence that the minor is mature enough to make the abortion decision on her own or that the consent of those required to give it would not be in her best interest. The bill lists factors to assist the court and requires the court to become a **mandatory reporter of suspected sexual abuse.**

SB 146 /HB 2035 Section 5 replaces fetus with "unborn child" consistent with the 2007 Alexa's Law and currently drafted bills and Section 6 inserts a medically factual sentence

that "abortion will terminate a separate, whole, unique, living human being." This sentence is law in 3 states and was upheld on appeal in the 8th circuit.

Section 7 replaces the 1998 **partial birth abortion statute with the federal language** upheld in the 2007 U.S. Supreme Court decision, Carhart v Gonzales.

Abortion clinic licensure is on firm constitutional ground. The courts have consistently held that **abortion clinics may rationally be regulated as a class while other clinics or medical practices are not.** Grisly details about unsanitary premises and unsafe practices at the Kansas Rajanna clinic (while under KMS "recommendations") and the Gosnell Philadelphia clinic, show there is no justification for delay. These clinics:

- re-used unsterilized instruments;
- stored fetal remains with food in a staff refrigerator;
- hired cheap, uneducated and incompetent staffers;
- broke state, federal and professional protocols on handling and injecting drugs;
- lacked required resuscitative equipment;
- had blocked emergency exits;
- targeted low-income, minority women who traditionally do not seek legal redress for malpractice or seek out governmental redress for medical abuse.

The U.S. Supreme Court ruled in 2007 that the government has an interest in **protecting the integrity and ethics of the medical profession and it may use its regulatory power to bar certain procedures and substitute others** in order to promote respect for life, including life of the unborn. 23 states regulate abortion facilities.

Last week a Kansas abortionist testified at the HB 2337 hearing that regulations are not needed, even though **5 women died in the past 5 years from Kansas abortions**. He did not tell whether they occurred at the PP /ASC clinic or the doctor office clinics, this year down to 2. The former is under no KDHE mandate about reporting abortion deaths, and the latter are governed by the Healing Arts Board, which already has a rule about reporting deaths within 2 weeks. The executive Director has no comment on the deaths, or the likelihood that they were reported.

So, an abortionist who came to oppose clinic licensure inadvertently gave us the very reason to pass this legislation! This begs the question if there were that many maternal abortion deaths, how many abortion injuries are occurring ?

SB 165 /HB 2337 section 9 will require deaths reported within 1 business day and injuries within 10 to KDHE AND appropriate professional boards.

The FATAL FLAW in Healing Arts rules is that -- beyond not covering ASCs-- they are not state statutes, and assurance that they are being followed depends on the willingness of the agency to be diligent in the face of political pressure, and budgetary limits. **The Board has conflicting goals, to retain doctors and protect the public**. Additionally, the rules do not authorize spot inspections, nor can they close a deficient facility to protect women. Aborted women and their families are reluctant to protesting shoddy treatment and unhygienic facilities-- for fear of exposing the abortion.

As shown in the green attachments, women and girls have been erroneously warned that they have signed away their legal rights.

SB 165 /HB 2337 section 10 will **prevent webcam abortions, without a physician onsite**, which is already law in Oklahoma. These are the "growth industry" and the percentage of abortions by pill grow every year, currently 20% in Kansas and nationwide. The national average price of abortion by pill is $500—the cost of licensure.

SB 165/HB 2337 changes Kansas law to require that **all abortions, not just those after 22 weeks gestation, be performed by a state-licensed physician**, and adds the requirement that the physician have **clinical privileges at a hospital located within 30 miles of the facility**, as is law in Missouri.

SB 165 specifies that **abortions after 22 weeks gestation take place in ASCs or hospitals**, and that the facility has **2 annual inspections, one unannounced**. Kansas veterinarians and restaurants only get spot checks.

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!

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 gestation (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 least five Supreme Court Justices admit the state has an interest in protecting pain-capable children. Hundreds of scientific articles in respected journals show that pre-viable unborn children are capable of feeling pain. They are anesthetized during intrauterine surgery because we know that they can feel pain.

The protocols of NICU units acknowledge the pain-sensitivity of post-20 week preemies is more acute than that of full term babies. **The physiology for the unborn to feel pain develops from week 7 through 20 and the structures to mediate or suppress pain do not develop until 26 weeks and do not mature until 40 weeks gestation or later!** Thus the unborn feels pain more excruciatingly that any child or adult with any disease will ever feel.

In 1998, Kansans chose to stop permitting abortion in the second half of pregnancy for unborn children suspected of having a disability. It is time in 2011 to realize that the unborn child feels pain excruciatingly and that, regardless of whether he or she will live a long life, it is barbaric to abort the unborn baby in the womb.

The binder has extensive sections from physician testimony and research about unborn pain and includes rebuttals to abortion supporters' flimsy objections.

We do want to have the committee make a few minor amendments:

1) in all abortion bills, use one definition for abortion, that of HB 2218:

> "Abortion" means the use or prescription of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant woman or her unborn child, and which causes the premature termination of the pregnancy.

2) in HB 2218, correct an inadvertent omission of a few words in the legislative findings section, such that New section 1(b) reads

> "by eight weeks after fertilization, the unborn child reacts <u>to touch. After twenty (20) weeks after fertilization, the unborn child reacts to</u> stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling;

3) in Hb 2218, replace the word "would" to "she intends to" in two provisions:

> New Section 2 (e) ...No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which <u>she intends to</u> result in her death or in substantial and irreversible physical impairment of a major bodily function.
>
> New Section 3 (a) ...No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which <u>she intends to</u> result in her death or in substantial and irreversible physical impairment of a major bodily function.

I will leave you to hear from conferee Dr. Melissa Hague, maternal infant specialist, to testify that HB 2218 does not interfere with the medical management of high risk pregnancy.

I am available to answer committee questions today or at any future time. However, I urge this committee to pass these bills for the protection of Kansans and our moral integrity. Thank you.

Kansans for Life
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Proponent, HB 2218 **March 19, 2011**

I am Kathy Ostrowski, legislative Director for Kansans for Life, here to testify in support of HB 2218-- unique and sound legislation that says the state of Kansas has a compelling interest in protecting the unborn child at 20 weeks post-fertilization. The House passed this bill 91-30 on Feb. 24.

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 unborn child could only be asserted at "viability." At least five Supreme Court Justices admit the state has an interest in protecting pain-capable children. (see *Gonzales*)

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 U.S. Supreme 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.

HB 2218 significantly forces society to break out of arguing about competing legal rights between an adult and a 'fetus' and focuses the societal discussion on how much barbarism we will tolerate.

We urge the adoption of one amendment, correcting a few words that were accidentally dropped in section 2 of the legislative findings section., such that New section 1(b) reads

> "by eight weeks after fertilization, the unborn child reacts to touch. After twenty (20) weeks after fertilization, the unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling;

We also urge an amendment replacing the word "would" to "she intends to" so as to better clarify the nature of actions that are intended to cause harm, regardless of whether they would harm, such that

> New Section 2 (e) ...No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

> New Section 3 (a) ...No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

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**.

Kansans for Life urges committee members to pass the bill out favorably, when amended. Thank you, I stand for questions.

Attachments: Fetal Pain Capability -Bullet points

BLUE Divider, LEGAL ISSUES

Mary Spalding Balch 2 articles on Constitutionality of Unborn Pain
Teresa Stanton Collett on the Constitutionality of the Nebraska Bill

YELLOW Divider, PHYSICIAN TESTIMONY

Dr. Melissa Hague, Wichita Maternal-Fetal expert on Kansas bill 2218 (Senate conferee)
Dr. Julie A. Griffin, Parsons Internist/pediatric specialty, on Kansas bill 2218 (House conferee)
Dr. Michael Cotter, Topeka pediatrician, on Kansas bill 2218 (House conferee)
Dr. Anita Showalter, Washington Maternal-Fetal expert, on Nebraska bill (House conferee/phone)
Dr. William Polzin, Ohio Maternal-Fetal expert, on Kansas bill 2218 (written)
Dr. Sean P. Kennedy, Alaska Maternal-Fetal expert, on Nebraska bill (written)
Dr. Tom Grissom, Washington pain expert on Nebraska bill (written)
Dr. Ferdinand F. Salvacion, Illinois pain expert on Nebraska bill (written)

GREEN Divider, EXPLANATION OF PAIN CAPABILITY

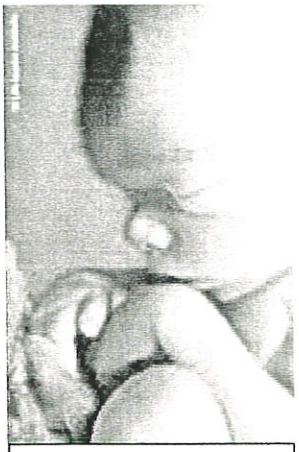
Chart of Pain development
Fetal Pain, 11 points of agreement (29 pages)

Unborn Pain analysis by Dr. Paul Ranalli, Toronto neurologist & brain physiology researcher
Dept. of Justice report on Pain of Unborn by preeminent pain expert, Dr. Kanwaljeet S. Anand

RED Divider ITEMS of CONTENTION

Letter to editor by Dr. Paul Ranalli rebuts ACOG objection
NRLC addresses conflicts in 2010 RCOG article
NRLC addresses HB 2218, Section 1 findings of fact
NRLC responses to 2005 JAMA article
Dr. Kennedy addresses recent Deaver infant death/Nebraska controversy,

PAIN CAPABILITY OF THE UNBORN CHILD



Unborn child at 20 weeks

The unborn baby at 20 weeks is already quite developmentally advanced

- The skeleton is complete and reflexes are present at 42 days.
- Electrical brain wave patterns can be recorded at 43 days. This is usually ample evidence that "thinking" is taking place in the brain.
- The fetus has complete fingers, toes, and ears at 49 days.
- All organs are functioning—stomach, liver, kidney, brain—and all systems are intact at 56 days.
- By 20 weeks, the fetus has hair and working vocal cords, sucks her thumb, grasps with her hands and kicks. They measure 12 inches.

With the advent of sonograms and live-action ultrasound images, neonatologists and nurses are able to see fetuses at 20 weeks gestation react physically to outside stimuli such as sound, light, and touch. The sense of touch is so acute that even a single human hair drawn across the fetus's palm causes them to make a fist.

Surgeons entering the womb to perform corrective procedures on tiny patients have seen them flinch, jerk and recoil from sharp objects and incisions.

"The neural pathways are present for pain to be experienced quite early by unborn babies," explains Steven Calvin, M.D., perinatologist, chair of the Program in Human Rights Medicine, University of Minnesota, where he teaches obstetrics.

Medical facts of fetal pain

Anatomical studies have documented that ***the body's pain network – the spino-thalamic pathway—is established by 20 weeks gestation.***

- "At 20 weeks, the fetal brain has the full complement of brain cells present in adulthood, ready and waiting to receive pain signals from the body, and their electrical activity can be recorded by standard electroencephalography (EEG)."— Dr. Paul Ranalli, neurologist, University of Toronto

- "An unborn baby at 20 weeks gestation "is fully capable of experiencing pain… Without question, [abortion] is a dreadfully painful experience for any infant subjected to such a surgical procedure." — Robert J. White, M.D., PhD., professor of neurosurgery, Case Western University

- Even before nerve tracts are fully established, the fetus may feel pain; studies show anencephalic infants, whose cortex is severely reduced if not altogether missing, may experience pain as long as other neurological structures are functioning. *[Van Assche, FA. "Anencephalics as Organ Donors."* Am J Obstet Gyn *163 (1990)]*

Fetal patients have heightened sensitivities

Fetuses at 20 weeks development may actually feel pain more intensely than adults. This is a "uniquely vulnerable time, since the ***pain system is fully established, yet the higher level pain-modifying system has barely begun to develop***," according to Dr. Ranalli.

"Having administered anesthesia for fetal surgery, I know that on occasion we need to administer the anesthesia directly to the fetus, because even at these early gestational ages the fetus moves away from the pain of the stimulation," stated David Birnbach, M.D., self-described as "pro-choice," in testimony before the U.S. Congress president of the Society for Obstetric Anesthesia and Perinatology.

Information excerpted from **www.doctorsonfetalpain.com**

Testimony of Melissa Hague, M.D.
HB 2218 - Fetal Pain Legislation
Kansas Senate Committee on Judiciary
March 17th 2011 9:30 am

Thank you for the opportunity to appear before your panel today. I am pleased to be able to discuss HB 2218 - the Fetal Pain Bill. My name is Melissa Hague.

I am an obstetrician-gynecologist practicing in Wichita. I grew up in Kansas, attending KU Medical School and completing my residency in Obstetrics and Gynecology at the KU program in Wichita in 2009. I am board certified by the American Board of Ob/Gyn and have certifications in advanced cardiac life support and advanced life support for obstetrics. Since medical school, whether it has been by coincidence or some other factor, I have provided care to many women experiencing high risk pregnancies – I have become known as a physician who is proficient and skilled in dealing with high risk pregnancies and their deliveries. I have dedicated myself to caring for women and their families and present this testimony today based on expertise I have gained through the study and practice of medicine. These statements represent my opinions and I do not represent any group or entity.

Pregnancies can either be high risk because of maternal health conditions and complications or because the fetus has a condition or anomaly requiring special treatment and monitoring. Maternal conditions can be relatively minor requiring only additional blood work or ultrasound (such as thyroid conditions) or life-threatening requiring early delivery and extensive monitoring (such as severe preeclampsia). Many high risk pregnancies require a team approach often including an obstetrician, perinatologist, neonatologist, and pediatric surgeons as needed. While some high risk pregnancies end in loss of the baby, we do our very best to maintain the pregnancy to at least 24 weeks so that resuscitation and postnatal care is possible. In most cases there are procedures, treatments, or medications that can help manage high risk situations and prolong the pregnancy to a time at which the baby would be viable if delivered. There are many new sophisticated tools at our disposal to preserve the pregnancy and enhance postnatal life with the help of experienced neonatology teams and facilities.

At this point, I should define what I mean when I say "gestational age". It is commonly accepted nomenclature to date a pregnancy in weeks, beginning with the last menstrual period (LMP). This would mean that if a woman's last period was 22 weeks ago, the fetus was actually conceived about 20 weeks ago. Therefore, "gestational age" hereafter refers to the age of the pregnancy counting from the first day of the last menstrual period.

Obviously, this date is not always known to the woman or provider. In my practice, if a patient presents with pregnancy and has an unknown LMP, I start with a physical exam to evaluate the approximate size of the uterus. This is a skill that is required of every physician providing obstetric and gynecologic care. Once I have estimated the uterine size, I will then perform an

ultrasound to determine the size of the embryo or fetus. In the first trimester, this is a simple measurement from the crown of the fetus to the rump that corresponds with a gestational age that is accurate to within approximately 4-7 days. Typically, if the dates differ by 5-7 days (depending on the individual provider this may vary) it is common to redate the pregnancy based on the ultrasound findings, using the estimated date of confinement (EDC) that is calculated based on the measurement.

After about 13 weeks through 20 weeks, ultrasound dating is considered accurate to within 7 days. In other words, if the measurement of the fetus (head, abdomen, and femur length are utilized) calculates an EDC that is more than 7 days different from the EDC based on the woman's LMP, the ultrasound dating is utilized. Second trimester ultrasounds do require more skill than first trimester ultrasounds, but these skills are acquired during an obstetrics and gynecology residency. If a provider is not well versed in ultrasound, he or she typically relies on ultrasonography performed by an outside facility and the interpretation of a radiologist or perinatologist. Ultrasound dating after 20 weeks is not as accurate. Error can be as high as 2-3 weeks after 32 weeks gestational age. As with many things in medicine, accuracy is a combination of factors including adequate equipment, position of the fetus, maternal habitus (i.e. obesity limits visualization), and skill of the person performing the ultrasound.

HB 2218 establishes restrictions on abortion after the 22nd week of gestation due to pain experienced by the fetus during the abortion procedure. The legislation accomplishes this goal by requiring the gestational age of any fetus be determined before any elective abortive procedure is allowed to go forward. If the fetus is determined to be 22 weeks or older, abortion procedures are not permitted. The legislation provides an exception that gives physicians and patients the ability to evaluate conditions of a high risk pregnancy in life-threatening situations that could result in necessitating an abortion even after 22 weeks gestational age.

This important exception is necessary because there are some conditions where it is abundantly clear that the life of the mother is in jeopardy and, regardless of the number of weeks of gestation and regardless of the mother's wish to keep her baby, an abortion becomes necessary. While these cases are indeed rare, circumstances often come down to a life or death decision. I practice in a tertiary care center where high risk patients from all over the state are referred. It would be very difficult to put a number on the patients that present between 22-24 weeks gestational age that require termination of the pregnancy to save the life of the mother. I deliver 30-40 babies a month, and approximately 30% of my practice would be considered high risk. I can only recall one case from the last year in which termination before viability (but after 22 weeks) was necessary to save the mother's life.

Cases in which termination would be required often involve massive hemorrhaging, life-threatening blood pressure abnormalities, or cardiac failure. They are serious enough that the pregnant mother would normally be admitted to a hospital so that proper monitoring can take place. Treatment of pregnancy related conditions that become life-threatening is not appropriate in a clinic or out-patient setting. If a woman presented to my office with life-threatening

complications, my first step would be to get her admitted to an appropriate facility for adequate monitoring of her condition. High risk pregnancies with life-threatening signs and symptoms can result in rapid deterioration if not monitored closely or treated appropriately - their severity would certainly preclude treatment on an out-patient basis. Cases in which the exceptions in HB 2218 apply would have no place in a clinic – the medical condition of a woman needing to obtain an abortion for life-threatening complications should be handled in a fully equipped medical center with specialists available to assist if necessary.

I believe HB 2218 properly addresses medical emergencies related to high risk pregnancies. While our goal is to monitor and preserve pregnancies through a delivery date of viability, it is sometimes the case that medical emergencies do occur in which there is very little time to consider options and the woman's health is quickly failing. HB 2218 makes adequate provisions to allow me as a physician to recommend to my patient whatever steps I believe prudent to preserve her life and her future health. HB 2218 requires that the gestational age of the fetus be determined before any abortive procedure is conducted due to fetal pain. As outlined above, the determination of gestational age can be performed rather rapidly to a good degree of accuracy. It should be noted that in HB 2218, the medical emergency exception will allow doctors to evaluate their patient's condition and proceed as best prescribed in whatever time frame they feel is appropriate. If HB 2218 is enacted into law, I would feel no compulsion to delay any lifesaving procedure (including abortion) for the purpose of determining the gestational age of a fetus if, in my medical opinion, the patient's condition warranted such action. However, it is almost always necessary for me to at least estimate the fetal age in order to determine the quickest and safest means by which to evacuate the uterus. I cannot imagine a situation in which I would not find it necessary to know an estimation of fetal age, even if this estimation was a simple physical exam of the patient. Ultrasound is also performed for many reasons, including the placental location. If a patient presents with life-threatening hemorrhage due to a placenta previa (placenta is the presenting part and covers the cervix), for example, an open surgical evacuation may be the safest way to stop the bleeding (i.e. hysterotomy). This bill does not propose any undue burden on physicians, and would not change my current practice of medicine.

I do not see how this legislation provides any unreasonable restriction of abortion or the practice of medicine. As a physician, I am subject to peer review of my management of patients at the facilities where I perform procedures and admit patients. Physicians realize that they must adhere to certain standards of care or subject themselves to disciplinary action by hospital or state boards or their professional associations. Requesting physicians to ensure certain standards are met prior to a procedure is not only reasonable, but is certainly a requirement in any other aspect of medicine. Requiring reporting of any deviation from the norm is also reasonable. It is this reporting that often assists us in our pursuit of better treatments and care of patients. This also serves to protect patients from physicians that do not adhere to established standards of care.

When I began, I told you I was an OB/GYN from Wichita who dealt with high risk pregnancies on a daily basis. I would be remiss if I did not tell you that I personally understand the

complications of a high risk pregnancy. In the spring of 2009, I became pregnant with my 3rd child. This pregnancy was quite different from my others, as I had never felt so ill. I told myself I was fine, that every pregnancy is different, and all the other things I may say to a patient. Over time, I realized there was something terribly wrong. I was in the midst of studying for board exams and preparing to start a new practice, but I could no longer ignore my feeling of unrest. At 14 weeks gestation, my uterus was measuring about what it should for a 30 week pregnancy. I had my ultrasound tech perform another sono (I had done several prior to this time that were fine), and I knew when I looked at the screen that things were about to change for me. I saw a normal appearing fetus in one sac, and a very abnormal mass of tissue in the other. The diagnosis was a very rare condition known as a molar pregnancy. Even more rare was the fact that there was a live fetus, as most of these do not involve a live fetus past the 9th or 10th week. I sought the expert opinion of both a perinatologist and a gynecologic oncologist, and was faced with the fact that termination was the only life-preserving option. Upon my admission to the hospital, it was discovered that my liver and kidneys were compromised and my blood pressure was dangerously elevated. Medications were started to prevent seizures and reduce my blood pressure and I was prepared for surgery. My condition was managed by two very experienced obstetricians and after two surgeries my health began improving. This was a very difficult time for me, as I was faced with the loss of a child and the very real threat of death. It is this circumstance that has helped me to understand and appreciate the need for protection for patients and their physicians in life-threatening circumstances.

From both my professional and personal experience with the life-threatening conditions that can occur during a pregnancy, I can offer a unique perspective. Regardless of an individual belief system either for or against abortion there are cases where it becomes necessary to terminate a pregnancy to preserve the life of the woman. This legislation places no restrictions on a physician and patient facing an emergent, life-threatening condition that would be best treated by termination.

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2. Gabbe, et al. Obstetrics: Normal and Problem Pregnancies. 5th edition. 2007. Churchill Livingstone Elsevier.

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Education

Resident in Obstetrics and Gynecology, Wesley Medical Center, July 2005-June 2009
University of Kansas School of Medicine, M.D., May 2005
Wichita State University, B.S. in Chemical Science, May 2001

Employment Experience

Physician, Heartland Women's Group at Wesley, August 2010-present
Physician, Heartland Women's Health, P.A., July 2009-August 2010
Resident Physician, Wichita Clinic Immediate Care, Wichita, Kansas, 2006-2009
Neonatal Resuscitation Contract Physician, Wesley Medical Center, Wichita, Kansas, 2006-2009
Locum Tenens Physician, Anthony Medical Center, Anthony Kansas, 2006-2007
Emergency Medical Technician, Via Christi St. Francis, Wichita, Kansas, 1998-2003

Certifications

Board Certified in Obstetrics and Gynecology by the American Board of Ob/Gyn
Advanced Cardiac Life Support
Neonatal Resuscitation
Advanced Life Support for Obstetrics

Hospital Affiliations and faculty appointments

Wesley Medical Center, 2009-present
Via Christi Medical Center, 2009-present
Obstetrics Faculty, University of Kansas School of Medicine, Department of Family Medicine, 2009-present
Clinical Instructor, University of Kansas School of Medicine, Department of Obstetrics and Gynecology, 2009-present

Leadership

Advisor, Ob/Gyn Student Group at KU, 2006-2009
Junior Fellow Chair, District VII, American College of Obstetrics and Gynecology, 2006-2009
President, University of Kansas School of Medicine-Wichita, class of 2005, 2003-2005

Honors and Awards

Jayhawker M.D. Resident Teaching Award, 2008
Co-author of winning paper - Region VII Resident's Trauma Research Paper Competition, 2003

Professional Society Memberships

American College of Obstetricians and Gynecologists, 2005-present
Medical Society of Sedgwick County and Kansas Medical Society, 2003- present
Christian Medical and Dental Association, 2010-present

Publications and Research

Frazier, L., O'Hara, M., Hague, M., et al. "Overcoming Barriers to Physical Activity During Pregnancy," Medicine & Science in Sports & Exercise: May 2010 - Volume 42 – Issue 5 - p 356.

Ponnuru K, Ponnuru S, Hague M, Dort JM, Smith RS. "Level II Trauma Activation: "Evaluation of Triage Criteria." Abstract presented at the Region VII, Committee on Trauma Resident Paper Competition as part of the 26th Annual Advances in Trauma Meeting, December 11, 2003 in Kansas City, Missouri.

Kansas Catholic Conference

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Testimony in Support of SB 146/HB 2035 – Late Term Abortion & Parental Consent
Michael Schuttloffel, Executive Director
Kansas Catholic Conference

Senate Committee on Judiciary
March 17, 2011
9:30 AM

Mr. Chairman and Members of the Committee:

The Kansas Catholic Conference strongly supports SB 146 and HB 2035.

In 1998, Kansas passed legislation restricting the cruel and barbaric practice of aborting fully viable unborn children to only those circumstances where the life or health of the mother was in grave danger. In time, it became clear that this law was being ignored, both by the abortion industry and by many of the executive branch officials charged with enforcing the law. Thus, in recent years, the Kansas Legislature attempted to clarify and strengthen its late-term abortion law, only to have those efforts vetoed repeatedly.

Those previously vetoed bills form the basis of SB 146 and HB 2035. Most of SB 146/HB 2035's provisions are not only not new to the Legislature, but are essentially extensions of existing law, written to close loopholes being exploited to thwart clear legislative intent.

For instance, SB 146 and HB 2035 will require an abortionist to report an actual medical diagnosis as to why a late-term abortion is necessary to preserve the life or health of the mother, and thus is legal in Kansas. We are pleased to see that the Secretary of the Kansas Department of Health & Environment has announced that this information will now be required of abortion providers. Until now, abortionists have been allowed to simply declare that there was a medical need for the abortion, without elaborating. That became the loophole by which Kansas became the late-term abortion capital of the Midwest. Such was never the will of the Legislature nor the people of Kansas.

The Catholic Church approaches the abortion issue from a moral perspective, as should all men and women of goodwill, for this is an issue that transcends party or partisan politics. The Church teaches clearly and unambiguously that the deliberate taking of an innocent, defenseless, human

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life is extraordinarily unjust and evil. This belief is shared by people of other faiths and of no faith. It is a position rooted both in the clear and indisputable scientific proof of the unborn child's humanity, and the timeless principles of human rights so eloquently immortalized in the Declaration of Independence:

> *We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.*

Life has pride of place in the Declaration, and should in our hearts as well. We believe that all people, from conception to natural death, have a right to life. We believe that all human life has dignity and value, regardless of age or disability. We also contend that public and private efforts should be made to assist women facing difficult pregnancies in accessing support systems that can help them understand that they are not alone, and we have tried to lead in this regard. The Catholic Church also offers counseling for post-abortive women; unsurprisingly, the decision to abort rarely brings the emotional comfort and relief that is promised by those who stand to gain from that particular decision.

The Catholic Church prays for an end to abortion, and we believe that just laws that reflect moral truths can help form the consciences of our people. To that end, we are strongly supportive of SB 146/HB 2035's language that abortion terminates "the life of a whole, separate, unique, living human being." We have heard from so many women who regret their abortions who tragically give the same account: they were told by their abortionist that there was no baby inside them, but just a piece of tissue. This crucial language will ensure that the medical facts of the matter are given a hearing as a woman considers her options, and not just the lies of the multi-billion dollar abortion industry.

We are also grateful for the fact that this legislation will strengthen parental rights by requiring parental consent before a minor has an abortion. So much about abortion would never be tolerated if it were any other medical procedure. In past years, the Legislature has had to debate whether a woman should be informed about the nature of the procedure she is about to undergo, and whether she should be allowed to see the sonogram image of her unborn baby or hear the heartbeat if she so requested. That such a debate could even take place would be inconceivable for any other procedure. Much the same, it is unimaginable that parents could be excluded from having a role in a major health decision involving their child. But today we actually have to debate whether a parent should be able to protect their child from a decision that will have grave physical, mental, and emotional ramifications for her, likely for the rest of her life. It is long past time to de-codify the proposition that the abortion industry has a right to overrule parents.

SB 146/HB 2035 is perhaps best understood as an attempt to restore respect not only for human life, but for the rule of law, for the will of the Legislature, and for the will of the people itself. The majority of Kansans are Pro-Life. It is time we begin to ensure that our laws, and the enforcement of those laws, reflect the character and wishes of this state's people.

CONCERNED WOMEN FOR AMERICA

Testimony in favor of HB 2035
Reporting accuracy and accountability of abortion providers is essential to protect women and minors

Chairman Owens and members of the Senate Judiciary Committee:

Concerned Women for America of Kansas is in support of HB 2035. We are the largest public policy women's organization, the largest in the nation and one of our core concerns is protecting women and young girls through effective public policy.

Recent revelations have shown that abortion providers have not been judicious in either their reporting or their advice to their potential clients who come to them for abortion services. Sting operations have revealed that they have readily agreed to cover up abuse of minors and have even helped pimps obtain judicial by-pass for minor girls. By law abortion providers are required to report sexual abuse, but apparently in some cases the profit motive trumps the law. The intent of this legislation is to make the abortion industry as accountable as other businesses that perform services for clients. The agencies tasked to enforce the law will be helped by accurate reporting and clarifications in judicial by-pass and parental consent.

Recent admissions by a practicing abortionist that five abortion-related deaths have occurred in Kansas in the past five years shows that abortion is not the safe procedure touted by those in favor of abortion rights. Recent horrific medical disclosures concerning the Gosnell facility in Pennsylvania demonstrate this industry needs regulatory boundaries so that women and minor girls are not harmed. Civil cause of action for patients and families is a reasonable safeguard for a blind invasive medical procedure that can cause serious complications.

Calling for a specific medical diagnosis in the case of the termination of a viable human baby is not too much to ask of an industry that claims to want abortion to be "safe and rare." Ending a human life should not be on the basis of the vague "mental health" exception which historically in Kansas has been based on episodic depression or inconvenience.

We urge that you pass HB 2035 out of committee; we also urge that you take the necessary steps to ensure that women and minor girls are protected not only by stringent reporting and judicial by-pass requirements but that you hold abortion providers accountable to the Kansas Department of Health and Environment both for reporting and licensing.

Judy Smith, State Director
Concerned Women for America of Kansas

Kansas Catholic Conference

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Testimony in Support of SB 165 – Clinic Licensure Legislation
Michael Schuttloffel, Executive Director
Kansas Catholic Conference

Senate Committee on Judiciary
March 17, 2011
9:30 AM

Mr. Chairman and Members of the Committee:

The Kansas Catholic Conference strongly supports SB 165, legislation that would apply common sense licensing requirements to facilities that perform abortion.

The Catholic Church opposes abortion because it is the killing of a human being -- an innocent, defenseless human being. One might therefore ask why we would seek to have the state license the practice of abortion. We do so because we believe that this is a necessary step if sanity is ever to be restored to our nation's approach to the issue of abortion. Supporters of abortion insist that it is just another health care procedure and should be treated as such. Yet they have nonetheless succeeded in ensuring that abortion is treated differently -- radically differently -- than any other procedure in health care. Indeed, there is no analogy in American life to the abortion industry and how it operates outside of the normal moral and legal universe inhabited by the rest of society.

For evidence of how it is that the normal rules do not seem to apply to abortion, look no further than the fact that veterinary clinics in Kansas are more strictly regulated than abortion clinics. No veterinarian, nor barber, nor short order cook could have escaped severe penalization had they maintained anything like the work environment found at the abortion-providing Affordable Medicine Clinic in Kansas City, Kansas in 2003. There, Kansas City Police discovered filthy facilities, infested with cockroaches, with dried blood on the floor. According to employees, Dr. Krishna Rajanna failed to properly sterilize equipment and even kept aborted fetuses in the refrigerator next to food. But because Dr. Rajanna killed unborn children for money, he was long exempt from penalty. Only after the application of sustained political pressure did he eventually lose his license.

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Remarkably, the stomach-churning details of that police report are surpassed by the 281 page grand jury report in the recent case of Pennsylvania abortionist Dr. Kermit Gosnell. According to the January 2011 report:

> [H]e regularly and illegally delivered live, viable, babies in the third trimester of pregnancy – and then murdered these newborns by severing their spinal cords with scissors. The medical practice by which he carried out this business was a filthy fraud in which he overdosed his patients with dangerous drugs, spread venereal disease among them with infected instruments, perforated their wombs and bowels – and, on at least two occasions, caused their deaths…The clinic reeked of animal urine, courtesy of the cats that were allowed to roam (and defecate) freely. Furniture and blankets were stained with blood. Instruments were not properly sterilized. Disposable medical supplies were not disposed of; they were reused, over and over again. Medical equipment – such as the defibrillator, the EKG, the pulse oximeter, the blood pressure cuff – was generally broken; even when it worked, it wasn't used. The emergency exit was padlocked shut. And scattered throughout, in cabinets, in the basement, in a freezer, in jars and bags and plastic jugs, were fetal remains. It was a baby charnel house.

As explained by Philadelphia District Attorney Seth Williams:

> What they discovered was horrific, out of one of the worst horror movies or horror novels that you could image…The interior of this clinic had blood stained walls, blood stained beds, unclean sheets, women walking around almost like zombies. They had been drugged to the state of being zombies, that the building itself was a maze of corridors and just unbelievable, just cat feces everywhere.

In what other industry would such a scenario even be possible? Where else is such madness allowed to go unscrutinized in our very midst? Perhaps most telling was the district attorney's comment that there was "more oversight of women's hair salons and nail salons" than there was of abortion facilities.

Two years ago, the Kansas Legislature debated legislation known as the Woman's Right to Know and See Act. Now law, it ensures that a woman about to undergo an abortion has the right to see the sonogram of her baby *if she chooses*. Some of those here today in opposition to SB 165 opposed that bill. They opposed the right of a woman to see the sonogram being performed on her. In a manner worthy of Orwell, they did this in the name of protecting women's rights.

It is impossible to imagine any other medical procedure where "women's rights" groups would fight tooth and nail against the right of a woman to have information about a medical procedure being performed on her. Most abortionists are male and few graduate summa cum laude from Harvard Medical School, yet we are told that these individuals must not be interfered with when underage girls are taken into their "care," must not be burdened with regulations for sterilized equipment, must not be subject to inspection, and must not be hindered by informed consent provisions that give women access to medical information. Imagine the accusations of

paternalism if in any other circumstance, we were told that women should not be emotionally burdened with medical information about the procedure they are about to undergo. Only with abortion, which functions in a parallel universe, is this even conceivable.

There is little hope that society's treatment of unborn human life will be brought into conformity with the natural law if the practice of abortion cannot even be made to conform to the standards of positive law. The fact that abortion clinics function outside even a minimal regulatory scheme is a symbol of the moral lawlessness of abortion itself, but it is more than mere metaphor. During the years that Kansas became the late-term abortion capital of America, abortion clinics existed as lacunae within Kansas' legal and regulatory framework, operating with veritable impunity, shielded by political benefactors, functioning beyond the reach of the law. Now, however, the state is reasserting the principle that its writ does in fact extend past the doors of abortions clinics. SB 165 is an announcement that abortion providers will now be subject to the rules like everybody else. The time has come for what has effectively served as legal immunity for the abortion industry to be revoked.

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Testimony in Support of HB 2218 – Fetal Pain Legislation
Michael Schuttloffel, Executive Director
Kansas Catholic Conference

Senate Committee on Judiciary
March 17, 2011
9:30 AM

Mr. Chairman 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? In a recent House hearing, 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.

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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.

CONCERNED WOMEN FOR AMERICA

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

Chairman Owens and members of the Senate Judiciary 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

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Planned Parenthood®
of Kansas and Mid-Missouri

March 17, 2011

TO: Members of the Senate Judiciary Committee
FR: Sarah Gillooly, Lobbyist, 913.334.8288
Planned Parenthood of Kansas & Mid-Missouri (PPKM)
RE: HB 2035 (Kinzer) & HB 146 (Taddiken) – Omnibus Abortion Restriction Bill

Today you are scheduled to hear the Omnibus Abortion Restriction Bills, HB 2035 (Kinzer) and SB 146 (Taddiken). HB 2035 and SB 146 are identical. These restrictive measures would put safe, legal abortion care virtually out of reach for some of Kansas' most vulnerable women. The legislation also intrudes in the doctor/patient relationship by usurping physicians' medical judgment and would put confidential medical information in the hands of elected politicians. This bill does nothing to prevent unintended pregnancy. Politics is the motivation for this legislation and not a concern for women.

While proponents of HB 2035/SB 146 claim it is "mostly a late-term bill," more than 25 of its approximately 36 substantive changes in statute relate to abortion at any point in pregnancy. HB 2035/SB 146 is not a "late-term" bill.

What's in HB 2035/SB 146:

- **Amends abortion reporting requirements**, the Woman's-Right-To-Know Act, and the post-viability abortion ban
- **Creates new prosecutorial authority and expands access to medical reports** to any district or county attorney in the state
- **Creates multiple new civil courses of action** against physicians
- **Repeals civil immunity** (65-6713) for physicians compliant with the Woman's-Right-To-Know Act
- **Requires notarized dual parent consent** for minors seeking abortion services
- **Revises the Judicial Bypass Waiver procedure** for minors petitioning the court to obtain abortion services including a mental health evaluation to determine how well the minor is informed about pregnancy, fetal development, abortion risks and consequences, and abortion alternatives
- **Requires the Department of Social and Rehabilitation Services to prepare and publish an annual report** on the number of reports of child sexual abuse received by the department from abortion providers
- **Requires the chief judge of each judicial district to file an annual report** with KDHE disclosing the number of minors seeking judicial bypass; the number of petitions granted; the reasons for grating such petitions; any subsequent action taken to protect the minor from domestic or predator abuse; each minor's state of residence, age and disability status; and the gestation of the minor's pregnancy
- **Redefines the term "human being"** as "an individual living member of the species of homo sapiens, including the unborn human being during the entire embryonic and fetal age from fertilization to full gestation," language that is not found elsewhere in Kansas statute, including Alexa's Law
- **Includes an emergency clause** which makes the act effective and in force from and after its publication in the Kansas register

Real Impact of HB 2035/SB 146:

If HB 2035/SB 146 becomes law, the legislation will:

- **Sec. 9, the enacting clause of this bill, would create an undue burden on access to abortion care and put women and minors in legal limbo during the interim between publication in the register and promulgation of rules by KDHE.** Since the legislation makes so many substantive changes to Kansas statute – including new promulgation of rules by KDHE and new rules and procedures for the judicial branch – the emergency clause in HB 2035/HB 146 is troubling. If KDHE, SRS and the Judicial Branch are unable to create rules and regulations by the time the new statute is published in the register, women seeking abortion services and clinics seeking to implement the law in good faith will be in legal limbo, potentially forcing the state into costly litigation. This concern is easily remedied by removing the emergency clause [Sec. 9].

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- **Severely limit, if not totally restrict, the ability of Kansas' most vulnerable women to access safe, legal health care, whether they are facing medically difficult pregnancies or are minors in unhealthy families.** Sec. 4 changes current parental notification of abortion for minors to two parent consent. Parents rightfully want to be involved in their teen's lives. We want our daughters to come to us if they become pregnant, and most do. However, some teens can't or won't go to their parents for legitimate reasons. Tragically, some live in dangerous homes. HB 2035 would put vulnerable teens in those families in jeopardy. No matter what, the most vulnerable women in Kansas need professional medical care and counseling without delay. **A Judicial Bypass Waiver is not guaranteed for minors who seek remedy through the court, and the requirement for a public reporting detailing the number and nature of judicial bypass waivers sought and granted further interferes with the independence of the judiciary.**

- **Have a dramatic fiscal impact of hundreds of thousands of dollars**. The note for HB 2035 from KDHE is $70,380. The Office of the Attorney General estimates an additional fiscal impact of $220,000 from the State General Fund. However, no fiscal note has been requested from SRS or the Judicial System, both of which must implement new procedures and public reporting, including mental health exams for minors seeking judicial bypass. Neither agency has reported the estimated cost to implement HB2035, adding additional untold costs to the $290,380 already estimated. The Women's Right to Know Act (WRTKA) of 2009 carried a fiscal note of over $100,000 as well; however, the funding to implement WRTKA was never provided. During difficult economic times, including a half-billion dollar budget shortfall, passing unfunded mandates or expensive reporting requirements, that do nothing to reduce the number of abortions in Kansas, doesn't make sense.

- **Repeal KSA 65-6713 and therefore remove civil immunity for physicians who are compliant** with the informed consent process included in the Woman's Right To Know Act (65-6709, 65-9710). The current civil immunity statute does NOT give physicians immunity from medical malpractice or other civil complaints. The civil immunity statute (65-6713) applies only to the Woman's-Right-To-Know Act. Repeal of civil immunity would likely result in an increase in baseless lawsuits against physicians and have a chilling effect on physicians who do provide or are considering providing abortion care in Kansas.

- **Would place confidential medical information in the hands of elected politicians** by expanding prosecutorial authority and access to original ITOP reports, to all district and county attorneys.

HB 2035/SB 146 seeks to put certain political and moral beliefs before a physician's best medical judgment and does nothing to prevent unintended pregnancy or reduce the number of abortions in Kansas. The Legislature must stop wasting time playing political ping-pong with women's health and focus on solution-focused measures that move Kansas forward in a positive direction and expand access to preventive health care.

Planned Parenthood®
of Kansas and Mid-Missouri

Testimony of Sarah M. Gillooly, M.A.
Kansas Public Affairs Manager of
Planned Parenthood of Kansas & Mid-Missouri,
in opposition to SB 146/HB 2035
before the
Senate Judiciary Committee
of the Kansas Legislature
March 17, 2011

Good afternoon. My name is Sarah M. Gillooly and I am the Kansas Public Affairs Manager for Planned Parenthood of Kansas and Mid-Missouri. Thank you for this opportunity to present testimony on our opposition to SB 146/HB 2035. In Kansas, Planned Parenthood maintains family planning health and education centers in Wichita, Hays, Lawrence and Overland Park. One of our most important goals is to help men and women make responsible choices that prevent unintended pregnancies. More than ninety percent of our patients come to our agency for family planning and other preventive health services. At our Comprehensive Health facility in Overland Park, we also provide safe and legal abortion care for women in their first and

Proponents of SB 146/HB 2035 have claimed the bill is "mostly a late term bill," when in fact at least 25 of the approximately 36 proposed substantive changes to statute apply to abortion at any point in pregnancy. However, this legislation is a direct attack on women facing the most difficult circumstances – whether they are women facing medically difficult pregnancies or minors in untenable family circumstances. Although Planned Parenthood opposes this bill in its entirety, I will highlight how these proposed changes put the lives of Kansas' most vulnerable women in serious jeopardy.

Section 4 of SB 146/HB 2035 might be aimed at strengthening protections already in place for minors, but in practice it will make it more difficult for minors to obtain abortion services and place Kansas' most vulnerable young women and families at considerable risk. Let me first explain the current parental notification procedures. When a minor seeks abortion care at our Comprehensive Health facility, written notification is given, and that notification must be returned to our physician with a parent's notarized signature, tantamount to consent. The number of minors who have abortions is low, only 2 percent nationwide, and the vast majority of these young women, over 90 percent, do consult their parents and other family members when making such a significant life decision. At Planned Parenthood our counselors always encourage parental involvement. Parents rightfully want to be involved in their teen's lives. We want our daughters to come to us if they become pregnant, and most do. In fact, of the small number of minors we serve, most of them bring at least one parent, if not two, to the health center. However, some teens can't or won't go to their parents for very legitimate reasons. Tragically, some live in dangerous homes. SB 146/HB 2035 may sound good, but in the real would it would have terrible consequences. We - Planned Parenthood, this legislative body, and all Kansans - cannot ignore the fact that not all families are perfect and no law can mandate family communication and functionality.

SB 146/HB 2035 would change the current requirement from parental notification signed and notarized by one parent to notarized consent of both parents. Of the three alternatives to the two parent consent requirement, none take into account parents who are legally separated or domestic violence in the home where parents are living together. The first alternative in SB 146/HB 2035 acknowledges parents who are divorced or unmarried. It does not acknowledge parents who have entered into a legal separation agreement. In Kansas, legal separation may be granted on the same grounds as divorce, and may contain provisions detailing how matters will be handled during the separation, including provisions relating to a parenting plan. The exclusion from this exemption of parents who are legally separated is

troubl ımilarly, there is no one parent consent alternative for a situation where the minor's mother is currently with the minor's father and would risk her and/or her daughters safety by seeking the notarized consent of the minor's father. This is deeply troubling as it may pose serious risk to the minor and/or her mother in circumstances of domestic violence. In addition, there is no alternative for a minor whose parents disagree between themselves on a course of action for their daughter. In this situation, who prevails? These three missing alternatives, among others, demonstrate the inability of the state to know the complexity of each teen's situation, and the failure of this bill to provide adequate options for young women in vulnerable and troubled families.

In some rare circumstances, it is not only appropriate but safest for the minor to obtain safe, legal abortion care without parental involvement. The sad reality, that this legislature must acknowledge, is that desperate teens will do desperate things. In the real world, SB 146/HB 2035 can't force teens to talk to their parents, but may force them to seek illegal, unsafe abortions or even consider suicide. No matter what, our daughters need professional medical care and counseling without delay. Their safety must remain the priority. Judicial bypass, an alternative to parental notification or consent, is a constitutionally protected way to protect the safety of young women who are unable to seek parental involvement in their decision to terminate a pregnancy.

The changes in SB 146/HB 2035 to the judicial bypass process are unnecessary and only provide additional hurdles for vulnerable teens in difficult circumstances. In Kansas, these provisions are fixing a problem that does not exist. At Planned Parenthood, the instance of minors seeking abortion care who must use the judicial bypass process is extremely rare. There is no evidence to suggest the bypass waiver is abused or that judges don't make serious consideration when granting the waivers. We believe judicial decisions are best left to judges, and not to elected politicians who cannot begin to enumerate all the possible circumstances faced by teens and families in our state. To believe that young women may be misusing or abusing the judicial bypass process is absurd. A scared pregnant teen who cannot tell her parents isn't going to navigate a crowded court system and reveal intimate details about her life to an unfamiliar judge in an impersonal courtroom without first exploring all of her options.

In addition to our real and serious concerns about this bill placing vulnerable teens in even more precarious situations, we oppose SB 146/HB 2035 because of the numerous other provisions which will reduce access to abortion care for all women, especially those facing medically challenging pregnancies, including: amending all the abortion statutes to contain medically inaccurate, and in some cases, misleading information; amendments to the reporting requirements which are unnecessary given the extremely low number of abortions later in pregnancy that may be occurring in Kansas since the murder of Dr. Tiller; expansion of prosecutorial authority and access to confidential medical information, which given the legacy of Phil Kline, is especially troubling; and the creation of new civil courses of action, which will have a chilling effect on abortion providers.

In closing, Planned Parenthood asks this Committee to oppose SB 146/HB 2035 as it seeks only to place more unnecessary burdens on abortion providers and women seeking abortion care. SB 146/HB 2035 does not, and cannot, consider the complexity of each woman's circumstance and may put minors in considerable danger. The cruel irony of HB 2035 is that teens who need help the most will be the least likely to get it. SB 146/HB 2035 does nothing to reduce the need for or number of abortions in Kansas, but we know what does work. The real answer to reducing the abortion rate for all women is access to affordable birth control and comprehensive sex education.

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Planned Parenthood®
of Kansas and Mid-Missouri

March 17, 2011

TO: Members of the Senate Judiciary Committee
FR: Sarah Gillooly, Lobbyist, Planned Parenthood of Kansas & Mid-Missouri (PPKM)
RE: SB 165 – Targeted Regulation of Abortion Providers (Pilcher-Cook)

Today you are scheduled to hear the Targeted Regulation of Abortion Providers bill (Pilcher-Cook). This restrictive measure would put safe, legal abortion care virtually out of reach for most Kansas women. Abortion in Kansas is safer than many other surgical procedures, as well as childbirth. Proponents of SB 165 will claim abortion is dangerous and clinics are unsanitary. However, in the last 35 years only 2 abortion related deaths have occurred in Kansas. The graphic images provided by proponents of SB 165 come from a physician who is no longer licensed in the state of Kansas. Comprehensive Health of Planned Parenthood of Kansas and Mid-Missouri (CompHealth of PPKM) is an inspected and licensed ambulatory surgical center. Patient health and safety is our guiding philosophy.

Many of the provisions in SB 165 are vague, unnecessary, burdensome and contrary to standard medical practice for physicians in Kansas. SB 165 seeks to put certain political and moral beliefs before a physician's best medical judgment and does nothing to prevent unintended pregnancy or reduce the number of abortions in Kansas.

What's in SB 165:

- **Creates 433 lines of new licensure requirements and regulations of abortion providers** –regulations that are not required of any other office-based surgical procedure in Kansas. In the last 35 years, 2 Kansas deaths were attributed to abortions, while between 1990 and 2003, 152 deaths were attributed to other office-based surgical procedures.
- **Requires abortion providers to apply, and pay $500, for a license from KDHE**
- **Prohibits new facilities from having a name the same as or similar to any other licensed facility**
- **Creates three new classes of violations.** Class I violations will result in fines between $200 and $5,000. Class II violations will result in fines between $100 and $5,000. Class III violations will result in fines between $0 and $5,000. A violation of any class allows the Secretary of KDHE to deny, suspend, or revoke the license of a facility.
- **Requires physicians who provide medical abortion to have clinical privileges within 30 miles of the facility and physicians who provide surgical abortion to have admitting privileges within 30 miles of the facility.**
- **Mandates volunteer training pursuant to the rules and regulations adopted by KDHE**
- **New Sec. 10 mandates that no diagnostic or therapeutic services involving an abortion procedure shall occur outside the physical presence of a physician and that any drug used for the purpose of inducing an abortion must be administered by or in the physical presence of the physician**

While there are many problems with SB 146/HB 2035, here are a few examples:

- **Sec. 10 (a) states that "no diagnostic or therapeutic professional service involving an abortion procedures shall occur outside the physical presence of a physician..."** Sec. 10 (a) is vague and potentially impossible to implement. For example, must the physician draw blood him/herself to determine a patients Rh factor, a diagnostic service currently provided by licensed professional medical staff?
- **Sec. 10 (b) states that "When RU-486 (mifepristone) or any drug is used for the purpose of inducing an abortion, the drug must be administered by or in the same room and in the physical presence of the physician..."** Sec. 10 (b) completely ignores recommended best medical practice. While it appears the intent of this section is to prohibit "tele-medicine abortions" in Kansas, a procedure not offered by any abortion provider in the state, the real effect will jeopardize the health and safety of medication abortion patients. Medication abortion, only available within the first 9 weeks of a pregnancy, contains two doses of medication, and the protocol is outlined by the American College of Obstetricians and Gynecologists. Mifepristone, which terminates the pregnancy, is administered by the physician in person. Misoprostol, which causes the uterus to cramp and shed its tissue, is administered 24-hours later, at home, by the woman. Misoprostol takes effect in as soon as 30 minutes. Sec. 10 (b) is in direct conflict with the American College of Obstetrician and Gynecologist recommended procedures for the administration of medication abortion and jeopardizes women's health.

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- **New Sec. 8 (b) requires any physician who provides a medication abortion to have clinical privileg[illegible] hospital located within 30 miles. New Sec. 9 (d)(3) requires any physician who provides a surgical abortion to have admitting privileges at a hospital within 30 miles.** These unnecessary and burdensome provisions single out physicians who provide abortions from all other physicians in Kansas. "Locum tenens" is standard medical practice in which a physician obtains backup coverage when attending Continuing Medical Education Credit Classes or taking personal days. Doctors who do office procedures do not have this "30 mile" requirement – anyone who needs to be hospitalized will. Physicians who provide office based surgery routinely have a back up arrangement with other physicians to follow and admit a patient to the hospital when a patient experiences complications.

- **SB 165 has a dramatic fiscal impact of $1,300,000**. The note for HB 2337, the House companion bill to SB 165, from KDHE is $1,300,000. The Women's Right to Know Act (WRTKA) of 2009 carried a fiscal note of over $100,000 as well; however, the funding to implement WRTKA was never provided. During difficult economic times, including a half-billion dollar budget shortfall, passing unfunded mandates, that do nothing to reduce the number of abortions in Kansas, doesn't make sense.

- **Sec. 13, the enacting clause of this bill, would create an undue burden on access to abortion care and put women and clinics in legal limbo during the interim between publication in the statute book and promulgation of rules by KDHE.** If KDHE is unable to promulgate rules and regulations by the time the new statute is published in the statute book, women seeking abortion services and clinics seeking to implement the law in good faith will be in legal limbo, potentially forcing the state into costly litigation. This concern is easily remedied by amending the enacting clause to state that the act shall take effect and be in force from and after *180 days after promulgation of rules by KDHE*. Designating a period in which abortion providers must implement the new regulation after the promulgation of rules by KDHE will ensure high-quality implementation of the regulations as intended.

SB 165 creates vague, unnecessary, burdensome regulations that are, in some cases, contrary to recommended medical practice. SB 165 singles about physicians who provide abortion services while ignoring the hundreds of more dangerous office-based surgical procedures. If the legislature and proponents of SB 165 are serious about protecting women's health and lives, they would focus on the 152 Kansas non-abortion related deaths attributed to office-based surgical procedures and the 35 Kansas deaths attributed to pregnancy and childbirth.

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Planned Parenthood®
of Kansas and Mid-Missouri

Testimony of Sarah M. Gillooly, M.A.
Kansas Public Affairs Manager of
Planned Parenthood of Kansas & Mid-Missouri,
in opposition to Senate Bill No. 165 before the
Senate Judiciary Committee
of the Kansas Legislature
March 17, 2011

Good afternoon. My name is Sarah M. Gillooly and I am the Kansas Public Affairs Manager for Planned Parenthood of Kansas and Mid-Missouri. Thank you for this opportunity to present testimony in opposition to HB 165. In Kansas, Planned Parenthood maintains family planning health and education centers in Wichita, Hays and Overland Park. Our most important goal is to help men and women make responsible choices that prevent unintended pregnancies and sexually transmitted infections. More than ninety percent of our patients come to our agency for family planning and other preventive health services. At our Comprehensive Health facility in Overland Park, we also provide safe and legal abortion care.

SB 165 seeks only to unnecessarily restrict access to abortion, not protect women's health.

First, medicine, not politics, should determine appropriate settings for patient care. Although there are risks associated with all office-based surgical procedures, including Lasik eye surgery, vasectomy, wisdom tooth extraction, incision of the eardrum, and D &C for reasons other than abortion, SB 165 singles out surgical abortions for extra regulation. With no credible medical justification for this distinction, this bill is clearly motivated by politics, not concern for women's health. In fact, women account for more than 60% of all office-based surgery patients, and many common procedures, such as eye surgery and wisdom tooth extraction, have higher risks of complication than abortion. If proponents of SB 165 are truly concerned about women's health, why not regulate all surgical procedures performed on women? According to prominent pro-life/anti-choice activist Mark Crutcher, the goal of laws like SB 165 is to create "an America where abortion may indeed be perfectly legal, but no one can get one." Despite the claims of proponents, SB 165 seeks to restrict access to abortion, not protect women's health. Abortion in Kansas is safer than many other surgical procedures and is considerably safer than childbirth.

According to KDHE, between 1990 and 2003, there were 152 deaths caused by surgical and medical care. None of these deaths were attributed to abortion services. In the same period, there were 35 maternal deaths attributed to pregnancy or deliver-related complications. In 2009 alone, 13 Kansas women died as a result of complications from pregnancy and childbirth. Between 1990 and 2005, there were only 2 deaths attributed to legal abortions, and less than 0.5% of women obtaining abortions experience any complication.

Abor emains one of the safest surgical procedures for women. Abortion is far safer than other types outpatient surgery, none of which will face the undue regulations proposed in SB 165. Legal abortion in the first trimester is 10 times safer than childbirth, and nearly 90% of women obtain abortion during the first trimester, when it is safest. The American College of Obstetricians and Gynecologists has determined that such abortions may be performed safely and appropriately in a physician's office. In the last 20 years, the maternal mortality rate in the United States has not declined, despite the significant advances in obstetric care. If proponents of SB 165 were serious about protecting women's health, and not just intent on ending abortion, they would work to decrease the number of pregnancy and childbirth related deaths in Kansas.

SB 165 and its unnecessary provisions will come at significant cost to Kansas during a fiscal crisis.
HB 2035, the Omnibus Abortion Restriction bill, previously passed by the House carries a fiscal note of over $290,000. The Department of Health and Environment indicated the passage of the bill would increase expenditures by $70,380 from all funding sources, including $20,380 from the State General Fund and $50,000 from agency special revenue funds. The Office of the Attorney General estimated increased expenditures of $220,000 from the State General Fund. The Department of Health and Environment has yet to provide a fiscal note for HB 2218, the PreViability Abortion Ban, previously passed by the House. However, the serious constitutional issues contained in HB 2218 alone are likely to result in prolonged and expensive litigation.

The initial fiscal note for HB 2337, the House companion bill to SB 165, is $1,300,000. The Woman's Right to Know Act (WRTKA) of 2009 carried a fiscal note of over $100,000 as well; however, the funding to implement WRTKA was never provided. During difficult economic times, when all state agencies including KDHE are working at reduced capacity, passing unfunded mandates or expensive licensure requirements does nothing to protect women's health or reduce the number of abortions in Kansas.

In closing, Planned Parenthood asks this Committee to oppose SB 165 as it seeks only to place more unnecessary burdens on abortion providers and women seeking abortion care and does nothing to protect women's health. Nor does SB 165 do anything to reduce the need for or number of abortions in Kansas, but we know what does work. The real answer to reducing the abortion rate for all women is access to affordable birth control and comprehensive sex education.

Planned Parenthood®
of Kansas and Mid-Missouri

TO: Members of the Senate Judiciary Committee
FR: Sarah Gillooly, Lobbyist, 913.334.8288
Planned Parenthood of Kansas & Mid-Missouri (PPKM)
RE: HB 2218 (Kinzer, et al) – Pre-Viability Abortion Ban

Today, March 17, 2011, the Pre-Viability Abortion Ban, HB 2218 (Kinzer, et al) will be heard in Senate Judiciary. This bill seeks to 1) ban all abortion procedures taking place at or after 22 weeks gestation with narrow exceptions for a woman's life and physical health, and 2) eliminate the health exception that allows abortion procedures to take place later in pregnancy in cases of fetal indication. Abortion opponents base this type of legislation on the belief that a fetus can begin to feel pain at 22 weeks gestation. We urge you to oppose HB 2218 due to the following concerns:

This legislation jeopardizes a woman's health.

- While rare, an abortion that takes place after 22 weeks into a pregnancy is often necessary because of a serious medical condition that endangers the life or health of the mother.[i]
- The health exception is an essential component of any public policy and needs to remain fully intact. It ensures that women will continue to have the opportunity to make the best decision for herself and her family when a pregnancy threatens her health.

The decision to get an abortion after 22 weeks if often made in rare and extreme circumstances.

- While the 2010 KDHE Vital Statistics Data is not yet available, since the murder of Dr. Tiller, no physician in Kansas is regularly providing abortions at 22 weeks and later in pregnancy.
- A woman may decide to end her pregnancy after 22 weeks because severe fetal indication that prohibits a wanted pregnancy from ever becoming viable. In addition, in tragic circumstances such as Twin to Twin Transfusion Syndrome, a woman may decide to selectively reduce a multiple pregnancy to save the life of the other multiple.

HB 2218 is unconstitutional, as placing a pre-viability time restriction on abortion procedures is unconstitutional.

- The U.S. Constitution prohibits a state from enacting a law that bans abortion prior to the point in pregnancy when a fetus is viable, which is consistently considered to be 24 weeks gestation. [ii]
    - The Supreme Court has specifically rejected as unconstitutional laws that provide a fixed gestational limit for determining when abortions can be performed. ***See attached narrative memo for further constitutional concerns.***
- Further, the Supreme Court has held that the "determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician."[iii]
- The Supreme Court has long held that after viability, a state may prohibit abortion, but that prohibition must make exception for where abortion "is necessary, in appropriate medical judgment, for the preservation of the life or health" of the woman.[iv]
- As an attorney, the bill sponsor is certainly aware of the law, and thus it can only be assumed this legislation has been introduced to intentionally draw a court challenge, which will come at a hefty price tag for Kansas taxpayers.
- The similar Nebraska law has not yet been challenged in court because no abortion currently provider exists in the state with legal standing to challenge the law.

Medical experts agree that the concept of fetal pain is based on speculation and not evidence.

- A 2010 review of evidence concluded that a fetus cannot experience pain in any sense prior to 26 weeks gestation. [v]
- The world's leading medical institutions that establish standards for reproductive health, including the highly respected and trusted American College of Obstetricians and Gynecologists as well as the Royal College of Obstetricians and Gynaecologists, agree that before 26 weeks of gestation, the fetus does not possess the structural and functional neurological capacity to experience pain.[vi]

[i] Center for Disease Control and Prevention, 2006. "Abortion Surveillance – United States, 2006," Table 7. Accessed at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5808a1.htm#tab1
[ii] See, *e.g., Planned Parenthood v. Casey,* 505 U.S. 833, 859 (1992) ("[V]iability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions.")
[iii] See *Planned Parenthood of* Central *Missouri v. Danforth* 428 U.S. 52 (1976).
[iv] See *Roe v Wade,* U.S. 113 (1973); *Casey, 505 U.S. at 879.*
[v] Royal College of Obstetricians and Gynaecologists, March 2010. "Fetal Awareness – Review of Research and Recommendations for Practice." Accessed at http://www.rcog.org.uk/fetal-awareness-review-research-and-recommendations-practice
[vi] Lee, Susan, et al., 2005. "Fetal Pain: A Multidisciplinary Review of the Evidence," The Journal of American Medical Association, 294 (8), 947-954. Accessed at http://jama.ama-assn.org/content/294/8/947.short

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Planned Parenthood®
of Kansas and Mid-Missouri

Testimony of Sarah M. Gillooly, M.A.
Kansas Public Affairs Manager of
Planned Parenthood of Kansas & Mid-Missouri,
in opposition to House Bill No. 2218 before the
Senate Judiciary Committee
of the Kansas Legislature
March 17, 2011

Good afternoon. My name is Sarah M. Gillooly and I am the Kansas Public Affairs Manager for Planned Parenthood of Kansas and Mid-Missouri. Thank you for this opportunity to present testimony in opposition to HB 2218. In Kansas, Planned Parenthood maintains family planning health and education centers in Wichita, Hays and Overland Park. Our most important goal is to help men and women make responsible choices that prevent unintended pregnancies and sexually transmitted infections. More than ninety percent of our patients come to our agency for family planning and other preventive health services. At our Comprehensive Health facility in Overland Park, we also provide safe and legal abortion care. We do not provide abortions after 21 weeks gestational age, which is the timeframe contemplated in this bill. Also attached to my written testimony is a memo from Former Acting Solicitor General Walter Dellinger regarding the constitutionality of Nebraska LB 1103, on which KS HB2218 is modeled.

I am here today to explain why Planned Parenthood of Kansas and Mid-Missouri opposes HB 2218. First and foremost, we oppose HB 2218 because it is unconstitutional as written in 3 separate ways: (1) it bans pre-viability abortions, (2) it fails to state a constitutionally recognized state interest, and (3) it fails to adequately protect a woman's health.

On the first point, according to *Planned Parenthood v. Casey* (1992), the U.S. Constitution prohibits a state from enacting a law that bans abortion prior to the point in the pregnancy when a fetus is viable. Furthermore, in PP of Central *Missouri v. Danforth* (1976), the Supreme Court held that the "determination of whether a fetus is viable is, and must be, a matter for the judgment of the responsible attending physician."

Also in *Danforth*, the Court specifically rejected as unconstitutional laws which provide for a fixed gestational limit on when abortions can be performed. The court reasoned: "Because viability may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability – be it weeks of gestation or fetal weight or any other single factor – as the determinant of when the State has a compelling interest in the life or health of the fetus." So, because this bill sets a gestational age when abortions are to be banned, and does not permit the responsible attending physician to determine whether or not the fetus is viable – HB 2218 is unconstitutional.

Secondly, the bill fails to state a constitutionally recognized state interest. To date, the U.S. Supreme Court has only ever recognized two state interests that are sufficient to override a woman's ultimate decision to terminate a pregnancy. Those two state interests are either (1) the preservation of the potential life represented by a viable fetus, or (2) regulation necessary to protect the health of the women undergoing the medical procedure. The interest asserted by the State of Kansas in this bill is neither of these.

And third, HB 2218 is unconstitutional because it fails to adequately protect a woman's health with an appropriate exception. The Supreme Court has long held that even after viability, when a state may prohibit abortion, the prohibition must make exceptions for where the abortion "is necessary, in the appropriate medical judgment, for the preservation of the life or health" of the woman. The exception in HB 2218 only applies when a continuation of the pregnancy will cause a substantial and irreversible physical impairment of a major bodily function." This exception language is too narrow to pass constitutional muster and threatens the health and safety of pregnant women in Kansas.

There is, of course, one outlier in the discussion of health exceptions, and that is the 2007 decision of *Gonzalez v. Carhart*. It is imperative to recognize, however, that in holding that a health exception was not required in that federal legislation, the Court ruled that to be true only because they were banning a particular method of performing an abortion, and not making abortion unavailable. There were other methods of an abortion available to the woman – which would not be true in the instance of HB 2218.

To repeat – this bill is unconstitutional for 3 reasons: (1) it bans pre-viability abortions, (2) it fails to state a constitutionally recognized state interest, and (3) it fails to adequately protect a woman's health.

In addition to the unconstitutionality of HB 2218, Planned Parenthood of Kansas and Mid-Missouri opposes this legislation because it is an attack on pregnant women and their families. Women facing medically complex pregnancies, such as those with severe fetal indication, often have no knowledge of the complications with their pregnancies until 18 to 20 weeks gestation. Under HB 2218, women would be forced, and to some extent coerced, by the state to make rushed decisions whether to continue their pregnancies or not in the face of fetal anomalies incompatible with life or fetal indications that jeopardize the life of one or more multiples, such as Twin to Twin Transfusion Syndrome. If the Kansas legislature is truly concerned with the health of pregnant women, you will reject HB 2218.

In closing, Planned Parenthood asks this Committee to oppose HB 2218 because it is clearly unconstitutional, potentially embroiling the state in years of expensive litigation, and jeopardizes the health and safety of pregnant women. HB 2218 does not, and cannot, take into account the complex realities of each individual pregnancy. The cruel irony of HB 2218 is that women who need help the most will be the least likely to get it. HB 2218 does nothing to reduce the need for or number of abortions in Kansas, but instead places women in peril.

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February 24, 2010

Judiciary Committee
Nebraska Legislature
Room 1103, State Capitol
Lincoln, Nebraska 68509

Re: Constitutionality of LB 1103

Dear Judiciary Committee Members,

This letter explains why, based on the most current precedent of the United States Supreme Court, it is my opinion that LB 1103, the Abortion Pain Prevention Act, is unconstitutional both because it impermissibly bans abortions prior to fetal viability and because it fails to protect women's health adequately.*

I. A Woman's Constitutional Right to Choose

For more than thirty-five years, the U.S. Supreme Court has recognized that the constitutional rights to liberty and privacy extend to the decision of a woman to terminate her pregnancy. The Court first reached this conclusion in the landmark decision of *Roe v. Wade*, 410 U.S. 113 (1973), where the Court specifically held that: (1) a state may not ban abortion prior to fetal viability; and (2) a state may ban abortion after viability so long as there are exceptions to protect the woman's health and life. *Id.* at 163-64 ("If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother."). The Court explained in *Roe* that viability was that point in pregnancy when the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid." *Id.* at 160.

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), the Supreme Court reaffirmed these central tenets of *Roe*. *Id.* at 878-79. The plurality opinion, joined by Justice Anthony Kennedy, specifically held that "viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions." *Id.* at 860; *see also id.* at 870 ("We conclude the line should be drawn

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* I am the Douglas B. Maggs Professor Emeritus at Duke Law School, where I am now on leave, and a Visiting Professor of Law at Harvard University. I am also currently practicing law in Washington, DC. From 1993 to 1996, I served as Assistant Attorney General and head of the Office of Legal Counsel (OLC) at the United States Department of Justice. During the 1996-1997 term of the U.S. Supreme Court, I was acting Solicitor General. I continue to practice and argue cases before the U.S. Supreme Court. For example, in the 2007-2008 term of the Court, I argued *Morgan Stanley v. Public Utility District*, *Exxon v. Baker*, and *Heller v. District of Columbia*. In all of these capacities, it has been my job to consider and argue the constitutionality of a wide variety of issues that impact our national policy. I have also published articles on constitutional issues for scholarly journals including the *Harvard Law Review*, the *Yale Law Journal*, and the *Duke Law Journal*, and have written for the *New York Times*, the *Washington Post*, *Newsweek*, the *New Republic*, and the *London Times*. I have testified more than twenty-five times before committees of the United States Congress, many times on constitutional issues.

at viability, so that before that time the woman has a right to choose to terminate her pregnancy.").

The constitutional protection for a woman's decision to end her pregnancy derives from the Due Process Clause of the Fourteenth Amendment to the Constitution. The Supreme Court has consistently ruled that the Due Process Clause protects the right to "substantive liberties," including the right to "a realm of personal liberty which the government may not enter." *Casey*, 505 U.S. at 847. Because of the inherently private nature of the "decision whether to bear or beget a child," the Supreme Court has recognized that individuals have the right to "be free from unwarranted governmental intrusion" when deciding whether to continue or terminate a pre-viability pregnancy. *Casey*, 505 U.S. at 851. This right to choose a pre-viability abortion without undue interference from the government applies *regardless of why* the woman has chosen to end her pregnancy and regardless of why the state might seek to restrict that choice.

LB 1103 violates these principles, as explained in more detail below, both because it bans *pre-viability* abortions and because even if it applied only *post-viability*, the narrow exceptions to the ban fail to adequately protect a woman's health.

II. LB 1103 is Unconstitutional Because It Bans Pre-Viability Abortions

In the years following *Roe*, the Supreme Court had numerous opportunities to reconsider its decision both that states may not ban abortion prior to viability and what viability in this context means. It has never wavered. For example, three years after *Roe*, in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976), the Court upheld a definition of "viability" in a Missouri statute because it allowed for the necessary "flexibility of the term." *Id.* at 64. The *Danforth* Court specifically rejected the "contention that a specified number of weeks in pregnancy must be fixed by statute as the point of viability." *Id.* at 65. The Court explained:

> [I]t is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician.

Id. at 64.

Three years after *Danforth*, in *Colautti v. Franklin*, 439 U.S. 379 (1979), the Court considered a Pennsylvania law regulating post-viability abortion and reaffirmed both that viability was the earliest point at which the state could ban abortion and that the determination of viability must not be fixed in weeks, but rather is a matter to be left to the physician's judgment. The Court explained:

> [T]his Court has stressed viability, has declared its determination to be a matter for medical judgment, and has recognized that differing legal consequences ensue upon the near and far sides of that point in the human gestation period. We

> reaffirm these principles. Viability is reached when, in the judgment of the attending physician on the particular facts of the case before him, there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support. Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability – be it weeks of gestation or fetal weight or any other single factor – as the determinant of when the State has a compelling interest in the life or health of the fetus. Viability is the critical point.

Id. at 388-89.

A decade later, in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), the Court reiterated its holdings in *Danforth* and *Colautti* that the determination of viability is a matter for the judgment of the attending physician. *See id.* at 516-17 (plurality); *id.* at 526-27 (O'Connor, J., concurring); *id.* at 545 n.6 (Blackmun, J., joined by Brennan, J., and Marshall, J., concurring and dissenting). And, as noted above, in *Casey*, the Court once again concluded that "the line should be drawn at viability, so that before that time the woman has a right to choose to terminate her pregnancy." 505 U.S. at 870.

LB 1103 is in clear violation of these principles. It does not draw its line at viability – it draws the line at 20 weeks after fertilization. As explained above, the Supreme Court has specifically – and repeatedly – rejected the notion that abortion may be banned at a specific point in pregnancy.[1] Instead, it has always held that viability is the earliest point at which a ban may apply – and that the determination of when viability is reached must be left to the physician.

Of perhaps particular note, Utah enacted an abortion statute similar to LB 1103 in 1991. *See Jane L. v. Bangerter*, 102 F.3d 1112, 1114 (10th Cir. 1996) (considering statute that banned most abortions after "20 weeks gestational age, measured from the date of conception"). The Tenth Circuit struck down the law, ruling that Utah's attempt to legislate the viability determination, rather than permit physicians to exercise their judgment about viability, "is directly contrary to the Supreme Court authority." *Id.* at 1115. The Tenth Circuit explained:

> [T]he State made a deliberate decision to disregard controlling Supreme Court precedent set out in *Roe*, *Danforth*, *Colautti*, and *Webster*, and to ignore the Supreme Court's repeated directive that viability is a matter for an attending physician to determine. In our view, the State's determination to define viability in a manner specifically and repeatedly condemned by the Court evinces an intent to prevent a woman from exercising her right to choose [a previability] abortion . . . and it therefore imposes an unconstitutional undue burden on her right to choose.

Id. at 1116-17 (footnote omitted).

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[1] The point of viability cannot be legislated with a number of weeks because it may differ with each pregnancy. Nonetheless, a fetus is not "generally understood to have achieved viability – meaning that there exists a realistic potential for long-term survival outside the uterus [until] twenty-four weeks lmp or later." *Planned Parenthood Fed'n of Am. v. Gonzales*, 435 F.3d 1163, 1166 n.1 (9th Cir. 2006).

A court looking at LB 1103 would have no choice but to reach the same conclusion as the Tenth Circuit did – LB 1103 is in deliberate disregard of the Supreme Court's longstanding precedent, and therefore, unconstitutional.

III. LB 1103 is Unconstitutional Because it Threatens Women's Health

The only exception to LB 1103's prohibition on performing an abortion after 20 weeks from fertilization is if the woman "has a condition which so complicates her medical condition as to necessitate the abortion . . . to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function."

As is explained above, the Supreme Court has long held that after viability, a state may prohibit abortion, but that prohibition must make exception for where abortion "is necessary, in appropriate medical judgment, for the preservation of the life *or health*" of the woman. *Casey*, 505 U.S. at 879 (emphasis added); *see also Roe*, 410 U.S. at 165.

While the Supreme Court has said that language similar to LB 1103's exception is an adequate *medical emergency* exception for restrictions that delay abortions such as a 24-hour waiting period or a parental consent requirement, *Casey*, 505 U.S. at 880, the Court has never upheld similarly narrow language as an adequate health exception for a complete abortion *ban* such as LB 1103. Furthermore, the medical emergency exception that the Supreme Court upheld in *Casey* was not limited to "physical" health as LB 1103 is.

In fact, the Court has rejected the notion that the protection afforded to women's health by an abortion restriction may be so limited. *See Doe v. Bolton*, 410 U.S. 179, 192 (1973) ("[T]he medical judgment may be exercised in the light of all factors – physical, emotional, psychological, familial, and the woman's age – relevant to the well-being of the patient. All these factors may relate to health."); *cf. Casey*, 505 U.S. at 882 ("It cannot be questioned that psychological well-being is a facet of health."); *Thornburgh v. ACOG*, 476 U.S. 747, 768-69 (1986) (invalidating *post-viability* abortion restriction because it placed pregnant women at medical risk by failing to require maternal health to be the "physician's paramount consideration"); *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1080-81 (S.D. Ohio 1995) (holding post-viability abortion restriction unconstitutional because "a state may not constitutionally limit the provision of abortions only to those situations in which a pregnant woman's *physical health* is threatened, because this impermissibly limits the physician's discretion to determine what measures are necessary to preserve her health") (emphasis added), *aff'd on other grounds*, 130 F.3d 187 (6th Cir. 1997).

Because LB 1103 allows abortions only if necessary "to avert serious risk of substantial and irreversible physical impairment of a major bodily function," it would be unconstitutional even if it applied only *post-viability* (which it does not), because it does not allow all abortions that may be necessary for the preservation of the health of the woman.

IV. The Supreme Court's Decision in *Gonzales v. Carhart* Does Not Alter this Result

I understand that some proponents of LB 1103 believe that the case law I have discussed above is in doubt following the Supreme Court's 2007 decision in *Gonzales v. Carhart*, 550 U.S. 124 (2007) ("*Carhart II*"), which upheld the federal ban on "partial-birth abortion." For the following reasons, I do not believe that to be so.

First and foremost, the Court in *Carhart II* did not overrule any of its previous precedent. Indeed, the Court went to great lengths to explain why its decision to uphold the federal ban was fully consistent with both *Casey* and its earlier ruling in *Stenberg v. Carhart*, 530 U.S. 914 (2000) ("*Carhart I*"), which struck down a similar Nebraska law. *See, e.g.*, *Carhart II*, 550 U.S. at 146 (stating that the Court was "apply[ing]" the standard set forth in *Casey*); *id.* at 151-52 (differentiating the federal ban from the Nebraska ban upheld in *Carhart I*).

Moreover, while it is true that the federal partial-birth abortion ban does not contain an exception to protect women's health, the Court was clear in *Carhart II* that it could uphold that law only because it reached just *one method* of abortion. Central to the Court's holding was the fact that other methods of abortion remained available in all instances, and especially if a woman needed an abortion to protect her health. The Court explained that Congress could ban one method of abortion without a health exception "given the availability of other abortion procedures that are considered to be safe alternatives." 550 U.S. at 167; *see also id.* at 164 ("Alternatives are available to the prohibited procedure."); *id.* at 165 ("Here the Act allows, among other means, a commonly used and generally accepted method, so it does not construct a substantial obstacle to the abortion right.").

In contrast, LB 1103 bans *all* abortions after 20 weeks after fertilization – not just one method. Therefore, if a woman needs an abortion to protect her health that does not meet the bill's narrow exception, she would not have a safe alternative to end her pregnancy, as Supreme Court precedent – including *Carhart II* – has required for more than thirty-five years.

The *Carhart II* Court's treatment of the interests that a state may assert in order to justify an abortion restriction has garnered much debate. However, that discussion does not alter LB 1103's unconstitutionality. There is nothing in *Carhart II* that suggests that a state can ban all abortions at any point prior to viability – regardless of the interest it asserts in doing so. Nor did the Court hold that a state could put forth an interest that would overcome the constitutional protection required for women's health.[2]

Finally, contrary to some suggestions, nothing in the recent changes to the composition of the Court alters my conclusion. The decisions in both *Carhart I* and *Carhart II* were decided by a vote of 5 to 4. In both cases, Justice Kennedy voted to uphold the ban on partial-birth abortion. Therefore, *Carhart II* was consistent with his prior vote dissenting in *Carhart I*. However, as I mentioned earlier, Justice Kennedy is also one of the members of the Court who joined the plurality opinion in *Casey*, which LB 1103 clearly violates. Therefore, in order for the U.S. Supreme Court to uphold LB 1103, Justice Kennedy would have to disavow his prior opinion in

[2] While there is nothing contrary to these principles in Justice Ginsburg's dissent in *Carhart II*, the analysis would be the same even if there were – it is axiomatic that dissenting opinions have no precedential force.

Casey, something that I believe that he is unlikely to do, especially given the strong endorsement of *Casey* in the majority opinion in *Lawrence v. Texas*, 539 U.S. 558 (2003) which Justice Kennedy authored. *See* 539 U.S. at 573-74.

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For all of these reasons, it is my opinion that the most recent and controlling precedent of the United States Supreme Court leads to only one conclusion – LB 1103 is an unconstitutional restriction on a woman's right to choose, and would be found so by the federal courts.

Sincerely yours,

Walter Dellinger

Walter Dellinger
Former Acting Solicitor General

2/16/11

TO: Kansas Senate Judiciary Committee

FR: Tiffany Campbell

RE: HB 2218 OPPONENT

Good afternoon committee members. My name is Tiffany Campbell, and I'm a mother of three, **former Olathe resident, testifying in opposition to HB 2218.** My husband Chris and I, in consultation with our doctors, made the difficult decision to have an abortion in 2006. We did it so we could bring our youngest son into this world rather than burying two babies. Here's what happened.

Chris and I were happily married with two children and looking to add to our family when we became pregnant. We were thrilled. Then, I landed in the hospital with a severe kidney infection and received my first ultrasound. We were overjoyed to see we were expecting identical twin boys.

But then we learned that our sons were suffering from a severe case of Twin-to-Twin Transfusion Syndrome, a condition where twins unequally share blood circulation. One boy was receiving too much blood resulting in a strained heart and acute risk of heart failure. Meanwhile, his brother was clinging to life, but his blood supply was insufficient to sustain normal development. This is an affliction where if one twin dies, the other faces significant risk of death. In fact, severe TTTS has a 60-100% fetal, or neonatal mortality rate.

My husband and I were sent to one of the premier fetal care centers in the country and told our only hope for saving this pregnancy was to have a selective termination on the one of the babies, and hope the other twin would survive.

So we were faced with an awful situation that forced us to examine our most fundamental moral and spiritual beliefs. At first we just didn't want to believe the doctors' prognosis. We wanted so badly for our boys to win the fight. But we couldn't stay on the sidelines forever: against all of our hopes and prayers, our twins' conditions continued to deteriorate quickly.

This was the most difficult decision of our lives. We could let nature run its course and pray that by the grace of God our boys would miraculously survive, or we could abort the sicker of the two, giving his brother a legitimate shot at life.

We decided to abort one of our sons at 18 weeks. Our decision was predicated on consultation with experts in the field of fetal medicine, our personal beliefs, prayer, and a mother's intuition.

This was an excruciating decision for us to make. But, it would have been unimaginably worse if our decision had been criminalized. Under Kansas HB 2218, a woman who may not find out about a condition such as mine until her 21st gestational week would have no time to contemplate this most difficult of decisions, for she would be working against a clock that would deem her a criminal at 22 weeks.

Under HB 2218, a woman at 22 weeks with my condition would be forced to go against her better judgment and against the sound medical advice of her physicians -- facing the probability that she would bury two babies.

If HB 2218 is passed, Kansas women and their families will be stripped of their right to make this private medical decision in consultation with their doctor and clergy. Instead, the government would be dictating a family's personal choices.

Today we have a **healthy four-year-old boy** who is the treasure of his older brother and sister. He's the family jester, the optimist, the one with a quick smile and a contagious giggle. It's like he made a pact with his twin brother to live passionately -- to live for both of them in honor of the spirit of his fallen brother.

Everyday our youngest son's contagious giggle reminds us that we made the right decision for our family. Let God be our judge. Please vote no on HB 2218.

Thank you for hearing my family's story.

Phil Wood

The Honorable Tim Owens, Chairman
Senate Committee on Judiciary
Statehouse, Room 548-S
Topeka, Kansas 66612

Dear Chairman Owens and Committee Members:

Thank you for the opportunity to address you about my concerns about this proposed legislation. I have decided to speak to your committee today in hope that some of the experiences of my family would be informative to you as you consider the issue of **pre-viability abortion and later termination of pregnancy.** My wife and I were faced with the difficult experience of having to abort our much-wanted twin sons at 22 weeks gestation. While I can claim to special insights into the very complicated issue which faces the committee by virtue of these experiences, I do feel that our experiences may help shed light on the complex medical and personal issues involved in the termination of such pregnancies. Our experience especially highlights many considerations involved in determining risk to the health of the mother. To summarize major points I wish to emphasize in the proposed legislation, I would like to note:

A. That there is a difference between a fetus which is "nonviable" and one which is "dying." I am particularly disturbed by the language in the committee which defines viability as a "stage" implying that viability is a sole function of gestational age.
B. That the children involved in our last pregnancy were genetically healthy, but, nonetheless "nonviable."
C. That in some cases a pregnancy can cause a health risk to the mother which may prevent the possibility of future pregnancies. Further, decisions regarding whether to continue a pregnancy and the evaluation of the risk to the mother are complex. Our experiences provided us with no "clear bright line" test which may be applied across all pregnancies. Our decision was made on the best medical information we had from the several doctors we consulted during this time and, more importantly, changed in dramatic ways over the course of the pregnancy.
D. In many ways my family was "lucky" in that we were able to save up enough money to end this pregnancy in a way which did everything we could to preserve the health of my wife. Had we not made it a regular practice to save a substantial portion of my paycheck, or if I had made less money than I do, our situation would have been much more difficult.

That many of the hardships which we encountered were due to the fact that no medical facilities were available in the State of Missouri to perform the abortion which was necessary.

<u>A short personal description</u>

Before describing our experiences, it is perhaps helpful to tell you a bit about myself. I teach at the University of Missouri in the Psychology Department. My wife and I both enjoy being active in the

community. I am an active member of St. Andrew's Lutheran Church in Columbia. My wife and I are fortunate in having an adorable daughter, Julie, who is now a senior in high school and a son, Justin, age 11, who we adopted from China. I could be like any of your neighbors or constituents.

Our Pregnancy

Let me begin by first telling you that this pregnancy was very, very much wanted. Three years earlier, my wife had an ectopic pregnancy. Although we do not know if the ectopic pregnancy was to blame, we were not successful in our attempts to become pregnant again after that. After that, we began to work with a fertility clinic. We decided to have a GIFT procedure done, a surgical procedure which involved harvesting eggs from my wife, mixing them with my sperm, and returning them to her fallopian tubes. It is worthwhile to note that our use of the fertility clinic was in no way related to the medical difficulties which followed.

My wife and I were overjoyed to learn that this last procedure had been successful and that she was now pregnant. We soon learned that she was pregnant with twins. Our twins were, however, diagnosed as having two amnions, but a shared placenta. We did not discover the implications of this facet of the pregnancy until the 16th week of her pregnancy.

Identical Twins

Identical twins are quite rare, relative to fraternal twins. It is estimated by the Twin Twin Transfusion Syndrome Foundation (http://www.ttsfoundation.org/index.html) that up to about 15% of all identical twin pregnancies involve some degree of twin-twin transfusion syndrome if two amnions and one placenta are present. In twin-twin transfusion syndrome of the blood vessels of the fetus fails to return to it and instead crosses over to the circulatory system of the other twin. This transfusion poses great problems for both twins: The donor twin does not get all of the nourishment it needs because it doesn't have enough blood. The recipient twin suffers as well, because fetal blood is thick and pumping it places a burden on the heart of the fetus, causing the walls of the heart to thicken. It is difficult to know how many identical twins actually have this, given that such transfusion goes undiagnosed. I hasten to add that the twins involved are genetically and, apart from the difficulties posed by the transfusion "healthy." Twin-twin transfusion syndrome is a disease of the placenta.

The Problems

We first because aware of the problems with my wife's condition at 16 weeks, when we went to have an amniocentesis. Twin-Twin transfusion syndrome was diagnosed. The degree of transfusion was pronounced: One twin being a "stuck twin" meaning that it had little or no amniotic fluid around it, while the other twin had a surplus of fluid. We learned at this time that this condition is a disease of the placenta and that this condition put one or both of our twins at significant risk for cerebral palsy, mental retardation, and/or serious heart problems. The "donor" twin, who is giving blood to the other, can have stunted development while the recipient twin, who received the blood from the other, can have heart strain due to the effort of pumping the thick neonatal blood from his twin.

What follows is an annotated chronology of what happened next, which I've reconstructed from medical records and our best recollection. I apologize that some of the medical details are rather graphic, but I believe you need to know what we knew and when we knew it, and how the available medical details we had informed our private health care decisions at the time. I believe you will also understand that we did not choose to terminate this pregnancy at the first hint of potential problems.

Week of Gestation	Event
16	Twin-Twin Transfusion diagnosed. Serial amniodrainage was done. This involved taking a large needle and draining about a liter of amniotic fluid off. It wwas hoped that resolving this fluid imbalance would help the transfusion syndrome to spontaneously resolve.
17	We learned the donor twin was diagnosed with club foot- presumable due to the fact that he had little or no amniotic fluid. It appeared that fluid had not re-accumulated around the larger twin. a physician we consulted with advised an additional ultrasound with high resolution in order to determine if there were additional problems with the twins.
18	Standard ultrasound revealed that the second twin had two club feet.
19	High resolution ultrasound reveals that, in addition, the transfusion problem appears to have interfered with the generation of kidneys in the smaller twin (although this is not certain at this point). This baby has no kidneys, no renal artery, and no bladder. In addition, the amniodrainage which was done has resulted in free-floating amniotic bands between the twins. These bands, which can wrap around the head, fingers, arms, feet and hands of the fetus, can result in amputations. In addition, these bands, if swallowed, can result in cleft palate and/or throat. Banding is described as "severe." My wife is now on bed rest. I care for my wife and daughter as best I can and juggle my work week accordingly. Doctors conclude that one twin poses a present clear risk to the life of the other and recommend a procedure in which the umbilical cord of one twin is tied off, causing it to die, and thereby prevent excess blood going to the other twin. such surgery is unavailable in Columbia, and we are referred to a specialist in Florida for the procedure.
20	Amniotic fluid is increasing in my wife, but no further drainages can be done because these bands float toward the needle and prevent the withdrawal of further fluid. My wife now looks as if she is nine months pregnant.
21	It is not possible to fly to Florida- no airline will fly a high risk pregnancy. I borrow my parent's van and we drive to Tampa, with my wife in the back of the van on a cot. It takes us two and a half days. My wife is very uncomfortable. The doctor in Florida informs us based on his ultrasound that surgery is impossible because the larger twin is now in heart failure, the amniotic banding is too severe, and his instruments need intact membranes to push against in order to do the surgery. He tells us that both twins will die, with or without surgery. He tells us that we should get an abortion if we ever plan to have another pregnancy, because of the risk of rupture to the uterus. There is some risk of amniotic embolism for my wife as well. His hospital, a Catholic institution, cannot perform such a procedure and he tells us to go home and find an abortion clinic. No doctors at this hospital or in Missouri told us that the pregnancy posed a risk to my wife's life; I would like to point out. I drive back to Missouri with my wife in the back of the van on the cot.

22	We attempt to get an abortion in St. Louis. They refuse to do this after evaluation because they say that the head of the larger twin is too large. The give us a sheet of paper with the addresses of three clinics- one in Atlanta, one in Houston, and one in Wichita. After consulting with our physicians, we choose Wichita. We set up an appointment at the clinic at the next available time, which is three days later.

I hope that the above chronology gives you a flavor of the many changing considerations which faced us during this time.

The Abortions

I probably do not need to tell you all the details concerning our visit to the clinic. I would like to give a general flavor, though, in mentioning the abortion protesters, their uninformed, but impassioned emotional harassment outside the clinic, especially at the sight of my wife, which appeared to outward appearances as if she was nine months pregnant due to fluid buildup**. Inside, the laws of the state of Kansas require us to fill out forms describing the developmental progression of our boys, focusing on their ability to feel pain, how human they look, and basic descriptions of brain development.** Although I feel the document was clearly designed to put more of an emotional burden on us, I found myself wondering what quality of life my boys would have if we continued the pregnancy further. "Surely they cannot feel very good in utero being as sick as they are," I thought.

The doctor, George Tiller, M.D., was especially caring and helped us to go through this ordeal together. (This was obviously prior to Dr. Tiller's murder while serving as an usher in Reformation Lutheran church for performing abortions such as the one I describe.) I was also present when the lifeless bodies of my sons were delivered. The doctor took care to allow both of us to see our boys, and I participated in a baptism for them which, while very sad, meant very much to me. I was gratified when, weeks later, a package arrived in the mail containing photographs of our boys which someone at the clinic had taken.

My observations and conclusions

- Later termination of pregnancy is not as available as the general public believes.

At the clinic, we met and got to know other couples who were going through similar problems from New York City, Chicago, and Texas. Although they didn't have twins, they all had similar cases where a genetically healthy child had something bad happen in utero (e.g., a disruption of food supply to the fetus, viral infections in the uterus, heart failure).

- What if we had waited or if the situation had become even more serious?

I have no idea, of course, what medical course would have been indicated if my wife had presented to the clinic in great distress with little time to preserve her health In such situations, there is often no clear bright line which details exactly when the life and not only the health of the mother is at risk. If such would have been the case for us, I feel I can speak for both my wife and myself in saying we would not hesitate to have such a procedure done that would have preserved her life.I do not know if my daughter and son would have a mother if we had not had this procedure or, if she did, what our lives would now be like. I shudder to think what would have happened to us if we had not

saved the resources necessary to pay for the medical care we required. Individuals without such means are in dire straits indeed.

- Was our experience typical?

You may think that the situation I describe must be quite rare. I cannot present, by virtue of experiencing our loss, that I can know anything about the incidence rates of other problems. As a scientist, I can only suggest that carefully controlled information be gathered if you feel it necessary to know this. Our experiences, however, represent the issues which parents face when the unexpected happens and the only ones genuinely qualified to make these health care decision are our physicians and ourselves.

- A final note of thanks.

I have much gratitude to the physicians who helped us during this time. I would like to argue that the most competent and intelligent decisions regarding the care of my wife and the children from this last pregnancy were made in consultation with the physicians who helped care for us. To our surprise, many of the physicians had not even heard of the conditions I have described. The experience of this pregnancy, which began with such promise was, I believe, at times difficult for the physicians who cared for us as well. Sometimes, however, the right decision is one which involves great difficulty.

P1

The Honorable Tim Owens, Chairman
Senate Committee on Judiciary
Statehouse, Room 548-S
Topeka, Kansas 66612

Dear Chairman Owens:

Thank you Chairman Owens and Members of the Committee for allowing me to provide this testimony in opposition to HB 2035 and its Senate version, SB 146. My name is Virginia Phillips and I work with Trust Women, a reproductive health and justice organization.

HB 2035 and SB 146, though, on the surface, may seem benign, present a direct attack on pregnant women—women facing difficult pregnancies and/or minors in unstable living situations. These bills attempt to create legislation that does not take into consideration the multitude of situations pregnant women may find themselves in.

The provision of two-parent parental consent may sound good in theory, but, unfortunately, not all young women in Kansas live in stable home situations that would allow for safe compliance should HB 2035 become the law. The minors in Kansas most in need of help would face a considerable burden and those living in dangerous homes would be placed in jeopardy.

Further legislation regarding the judicial bypass process is the equivalent of fixing something that is not broken. By tampering with the process, the Legislature will only hurt the young women who are living in difficult and dangerous home environments. Since 2008, the numbers have not only decreased, they have also been sparse regarding teens who have sought judicial bypass. According to the Office of Judicial Administration, there were 20 requests for judicial bypass in 2008, 15 in 2009 and 10 in 2010. Young women are clearly not abusing the judicial bypass procedure.

The Department of Health and Environment (KDHE) indicates that passage of SB 146 would increase one-time expenditures of $34,000 from agency fee funds in FY 2011 to make updates to the Vital Statistics System, consult with medical professionals in order to prepare rules and regulations, and to modify forms and instructions for staff members and providers. Conversely, KDHE indicates that passage of HB 2035 would increase expenditures by $70,380 from all funding sources, including $20,380 from the State General Fund and $50,000 from agency special revenue funds. Spending anywhere from $34,000 to $74,380 on a bill that does nothing to reduce the occurrence of unintended pregnancy or increase Kansas women's access to health care is far from fiscally sound.

Furthermore, most women seeking abortions are already mothers. This law would risk the privacy of Kansas women and their families by extending access to KDHE abortion records to county and district prosecutors. Kansas saw what happened the last time an elected official with an ax to grind did in order to gain access to the private medical files of Kansas women. The Attorney General's office currently has standing to ask for records, but we don't need to turn all of the county and district attorneys loose to conduct their own inquisitions.

Abortions past 22 and later in pregnancy are not regularly performed in Kansas. Spending valuable time passing restrictions that further police pregnant women is not in the best interest of Kansas women and families, nor is it fiscally sound.

This bill opens the door to civil litigation of physicians providing abortions, creating yet another obstacle for doctors who provide gynecological care. Not only the Attorney General, but also all county and

district prosecutors would have the ability to pry into the private lives of Kansas women and their families. HB 2035 would allow for all types of people to file suits on the woman's behalf, wreaking havoc on the judicial system and compromising medical privacy by permitting too many prosecutors access to sensitive medical records.

Neither HB 2035 nor SB 146 provide any furtherance of public health, safety and welfare. The ultimate goal of proponents of these bills is to make abortion illegal. I urge you to oppose HB 2035 and SB 146.

Thank you for your consideration.

Sincerely,

Virginia Phillips
Trust Women PAC

STATE OF KANSAS

MARCI FRANCISCO
SENATOR, 2ND DISTRICT

DURING SESSION
STATE CAPITOL — 134-E
TOPEKA, KANSAS 66612
(785) 296-7364
HOT LINE 1-800-432-3924
TTY 1-785-296-8430
FAX: 785-368-6365

marci.francisco@senate.ks.gov

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER
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NATURAL RESOURCES
MEMBER
UTILITIES
WAYS & MEANS
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ARTS AND CULTURAL RESOURCES
ENERGY & ENVIRONMENTAL POLICY
INFORMATION TECHNOLOGY
LEGISLATIVE EDUCATIONAL PLANNING
STATE BUILDING CONSTRUCTION

Senate Committee on Judiciary
Neutral Testimony on SB 146, SB 165, HB 2035, HB 2218
March 17, 2011

Chairman Owens and Members of the Committee:

I appreciate this opportunity to address a concern I have with the definition of gestational age that is in our statutes and included in all four bills you are hearing today. Although I have raised my concerns previously on the floor in the Senate and in a conference committee, those opportunities only allowed for an "up or down" vote on the bill or report.

The definition in our current statutes is: "Gestational age" means the time that has elapsed since the first day of the woman's last menstrual period". This creates awkward situations in which physicians are asked to report on evaluations that would not be included under the definition:

SB 146, page 5, lines 11 through 15, and **HB 2035**, page 5, lines 15 through 19 *"The medical basis for the determination of the gestational age of the unborn child shall also be reported by the physician as part of the written report made by the physician to the secretary of health and environment under K.S.A. 65-445, and amendments thereto"* ; in **SB 165**, page 7, lines 28 through 34, *"that the physician is responsible for estimating the gestational age of the unborn child 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"* **HB 2218**, page 4, lines 20 through 27, *"In making such a determination, the physician shall make such inquiries of the woman and perform or cause to be performed such medical examinations and tests as a reasonably prudent physician, knowledgeable about the case and medical conditions involved, would consider necessary to perform in making an accurate diagnosis with respect to gestational age".*

I suggest that you consider adopting a new definition of gestational age such as: "Gestational age" means an estimate of the age of the fetus based on a physician's evaluation of a woman's report of the first day of her last menstrual period and additional information from physical examinations and ultrasound imaging. With such a definition, we could rely on a physician to make a determination and give us a report on the procedures used to make that determination. I recognize that this would be just the beginning, and there remains work to do to make our statutes read cohesively using this definition.

Senate Judiciary
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Attachment 15

One other request I will make on behalf of women who are facing very difficult situations: please consider not requiring that a physician inform a woman in writing that "the abortion will terminate the life of a whole, separate, unique, living human being" (SB 146, page 13, lines 28 and 29) or include that in printed materials (SB 146, page 16, lines 36 through 38) in those cases where the fetus is incomplete or has died in utero.

I understand you will be receiving other good testimony and appreciate your consideration of these issues among those others you will be considering.

marci francisco

Senator Marci Francisco

Kansas NOW
Amber Versola, Lobbyist
Phone (785) 979-1733
lobbyist@ksnow.org

PO BOX 1860
Wichita, KS 67201

3/13/2011

TO: Senate Judiciary Committee

FR: Amber Versola, Lobbyist – Kansas NOW

RE: Opposition to HB 2035 – Written Only

Kansas NOW respectfully opposes HB 2035 due to the overwhelming negative consequences that it would have for some of the most vulnerable Kansas women. This attempt to legislate morality interferes with the legal right of women to seek a legitimate health care procedure.

- Section 2(k) redefines "viable" as *"that stage of fetal development when it is the physician's judgment according to accepted obstetrical or neonatal standards of care and practice applied by physicians in the same or similar circumstances that there is a reasonable probability that the* ***life of the child can be continued indefinitely outside the mother's womb with natural or artificial life-supportive measures****."* This may force a woman to give birth to a baby with a fetal anomaly - an anomaly that leaves her child with a dismal quality of life, and no chance of survival without artificial life support.

- Page 9 of the bill (lines 12 through 29) mandates dual parental consent for young women who seek an abortion. Section 4 does allow exceptions for some situations (such as incest), but does not account for other matters (such as domestic violence).The stated exceptions rely on a dangerous assumption of transparency. This creates justifiable concern for young women who live in the horrifying reality of domestic violence.

  Various circumstances prevent such victims of domestic violence from disclosing their situation. It is possible that a teens' mother would consent to the medical care, but could potentially put either herself or her daughter (or both of them) at risk of getting hurt by asking an abusive father to also consent to the medical procedure. It is also possible that the perpetrator of abuse could use his required signature on the form as a source of control over his wife or daughter.

- Page 13 (lines 32 through 36) makes judges mandated reporters for young women who are granted judicial bypass. Conceivably, this eliminates any guarantee of privacy that a minor would have in the process.

- Section 7(a) repeals the mental health exception. Not only does this ignore the commonly accepted definition of health ("Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." –World Health Organization); but it also presents what could be a costly constitutional challenge.

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- Page 21 of HB 2035 (lines 17 through 28) allow a woman's parents or husband to sue her doctor without her consent. This presents a clear violation of privacy in regard to her personal medical information.

HB 2035 is an expensive piece of legislation that limits access to a legal medical procedure, yet does nothing to reduce the need for that procedure. The price tag for this legislation is placed on the backs of our state's most vulnerable women and children. It is my hope that we can count on this legislative body to consider the impact this bill would have on a woman's life and on our state financially.

Thank you for your time and thoughtful consideration of this matter.

Sincerely,

Amber Versola
Lobbyist, Kansas NOW

P1

The Honorable Tim Owens, Chairman
Senate Committee on Judiciary
Statehouse, Room 548-S
Topeka, Kansas 66612

Dear Chairman Owens:

My name is Virginia Phillips and I work with Trust Women, which is a reproductive health and rights organization. Thank you for affording me to opportunity to provide this written testimony to the committee regarding SB 165.

This bill, "Targeted Regulations Against Abortion Providers," has appeared, in a variety of forms before this committee and around the United States for the past several years. According to SB 165's fiscal note, provided by the Director of the Budget, the Department of Health and Environment indicates that passage of the bill would increase State General Fund expenditures by $1,259,481 and require the addition of 12.50 FTE positions. At a time when Title X Family Planning Funding is under attack and thousands of Kansans who depend on these services to prevent unintended pregnancy may not be able to afford contraception, it hardly seems effective to use over a million dollars of the Kansas budget to fix something that isn't broken. If the goal is to protect women and keep Kansans safe and healthy, then valuable time this session should instead be spent helping women and their families' access safe, quality healthcare and preventive services.

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. According to the Kansas Department of Health and Environment, there has been only 1 maternal death resulting from an abortion procedure in Kansas in the last decade.

Additionally, if the public health and welfare are threatened because abortion clinics are not operating under these proposed prejudicial guidelines, why then is 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. According to the Institute for Safety in Office-Based Surgery, over 10 million office-based procedures were performed last year in the United States. If this bill is absolutely necessary, all office-based surgery centers ought to be evaluated and held to the same standards.

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.

As a society, if we're really concerned about reducing the number of abortions, we should 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 in 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.

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 Kansas women and their families and is bad for independent abortion providers. Quite clearly, this legislative measure is intended to restrict abortion even further by eliminating small practitioners who safely do abortion procedures in their office-based practices. I urge you to oppose this bill, as it is not necessitated by factual evidence, does nothing to enhance the public health and welfare of Kansans and does not respect the intellect of women in this state to decide what is best for themselves and their families.

Sincerely,

Virginia Phillips
Trust Women PAC

CENTER FOR
WOMEN'S HEALTH
HODES NAUSER

Herbert Hodes, M.D. FACOG
Center for Women's Health
4840 College Boulevard
Overland Park, Kansas 66211

March 17, 2011

Members of the Senate Judiciary Committee:

Thank you for the opportunity to speak to you in opposition to SB 165/HB 2337. 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 Obstetricians and Gynecologists, I am qualified to speak about this bill. The American College of Obstetricians and Gynecologists is the accrediting organization of 45,000 specialists in women's health care across the country.

The authors of SB 165/HB 2337 – lay people, have once again 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 politicians and lay-people, drew up these guidelines. These medical practitioners knew what was appropriate for ***all*** physicians who perform office-based surgery – those who provide abortions as well as those who perform the dozens of other office-based surgeries offered in Kansas. These guidelines apply to ***all*** physicians, dentists, and oral surgeons.

The authors of SB 165/HB 2337 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
Kansas Medical Society
City/County Health Departments
Kansas Department of Health & Environment
OSHA
Nat'l Abortion Federation
Abortion Care Network
Insurance Companies (Payees)
County Medical Societies
Professional Liability Carriers
ACOG
HIPAA
CLIA
AMA

I urge this committee to vote against SB 165/HB 2337, and support the universal guidelines for all physicians and dentists as approved by the Kansas Board of Healing Arts in May 2002.

Sincerely,

Herbert C. Hodes, MD, FACOG

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3-17-11
Attachment 18

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.

Emergencies 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 CO_2 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.

5. ı ventilation is controlled by an automatic mechanical ventilator, there should be in continuous use a device that is capa 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.

APPENDIX B

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

Office-Based Surgery Task Force

Roger Warren, MD	Hanover, (General Surgery), Chairman
Larry Anderson, MD	Wellington, (Family Practice)
Gary Baker, MD	Kansas City, (Plastic Surgery)
Howard Ellis, MD	Shawnee Mission, (Ob-Gyn), KS Board of Healing Arts
Thomas Faerber, MD	Shawnee Mission, (Maxillofacial Surgery)
Robert Gibbons, MD	Shawnee Mission, (Anesthesiology)
Jimmie Gleason, MD	Topeka, (Ob-Gyn), KaMMCO
James Hamilton, MD	Topeka, (General Surgery)
David Hedrick, MD	Salina, (Otolaryngology)
Kevin Hoppock, MD	Wichita, (Family Practice)
Michael Hutchinson, MD	Kansas City, KUMC, (Anesthesiology)
Frank Koranda, MD	Shawnee Mission, (Otolaryngology)
Alan Kruckemeyer, MD	Salina, (Orthopedic Surgery)
Ron Marek, DO	Family Practice, KS Assoc. of Osteopathic Medicine
Mark McCune, MD	Shawnee Mission, (Dermatology), KS Board of Healing Arts
Christopher Moeller, MD	Wichita, (Dermatology)
Katie Rhoads, MD	Olathe, (General Surgery
Robert Ricci, MD	Topeka, (Gastroenterology)
David Ross, MD	Arkansas City, (Family Practice), KaMMCO
Hari Strump, MD	Hays, (General Surgery)
Kim Templeton, MD	Kansas City, KUMC, (Orthopedic Surgery)

The Honorable Tim Owens, Chairman
Senate Committee on Judiciary
Statehouse, Room 548-S
Topeka, Kansas 66612

Dear Chairman Owens:

Thank you Chairman Owens and members of the Committee for allowing me to provide this testimony in opposition to HB 2218. My name is Virginia Phillips and I work with Trust Women, a reproductive health and justice organization.

Below, I will relay to you excerpts of the experiences of eight brave pregnant women who were willing to share their difficult, private, family decisions in defense of Kansas women and their families' right to decide what is best for them. The stories of these women were provided to Trust Women PAC in written form for the use in this testimony opposing HB 2218.

These eight women could be our friends, sisters, mothers, wives,--our children's pre-school teacher, a nurse in our doctor's office, the young mother seated next to us in church. Each woman, in consultation with her physician—often in consultation with several physicians for the purpose of multiple opinions—chose to end her pregnancy past 22 weeks. Each of these pregnancies was a wanted pregnancy and each woman also found out that her baby was diagnosed with a severe fetal anomaly- including severe hydrocephalus, Turner 's syndrome, severe heart failure and abnormal formation of organs, congenital diaphragmatic hernia (CDH), Heterotaxy Syndrome and hypoplastic left heart syndrome. These may not all be familiar terms, but in each instance, these diagnoses meant that physicians were surprised the baby was still alive at all and that it would either die before full term or die almost immediately after birth.

Of the women - Mindy, Miriam, Melissa, Christie, Susan, Michelle, Carmin and Melissa - most were scared of their future reproductive abilities due to complications of pregnancy; they wanted to have another baby and were worried that without terminating, they would risk their fertility. Each described the decision as heart-wrenching in her own words, but also noted that this was the unselfish decision - a decision they all made as parents. *As Susan put it, they "loved their babies as much as any other parent. We did not want them to suffer..."*

"I want to have more children. I want several children. I want to have a full, happy home. But at this point, all I could think was that I would probably lose my uterus--and all in vain. If it was for a baby that might live, it might be worth it...but it wasn't," explained Mindy of her fear and frustration with the situation.

"If we did nothing, we would be on a "death watch," merely waiting for our baby to die, and that was totally unacceptable to us...I was prepared to go anywhere, at any expense, and at medical risk, to end our anguish. We loved our baby too much to suffer the misery of waking up every morning awaiting his impending death. We had been told that even if our baby had been born alive, he would face certain organ failure and would be put through painful surgeries and interventions for months and months--and then still would die. And given that our baby was going to die anyway, we didn't want him to suffer,"

wrote Miriam.

"Termination for medical reasons is a horrible choice no parent wants to make, but it should not be limited," asserted Melissa, a nurse.

"Over the years since her passing, I have often contemplated what life would have been like had I not been given the option to end her suffering early. The remaining four months of my pregnancy would have been torturous--not only in having to deal with questions from others about the pregnancy and the baby's arrival, but in having to prepare my 2-year-old for the death of her little sister. Being forced to carry a doomed pregnancy to term would have devastated my family greatly, not only emotionally, but financially and spiritually as well," said Christie of her thoughts since ending her pregnancy, the pregnancy of a wanted, loved child.

"Being Catholic, this decision was wrought with the added guilt that I would be surely going straight to hell. I sought out the priest who married us and asked for his guidance prior to the termination. He gave me great comfort and assurance that our baby boy was in a better place and that our decision was based on our deep love for him as it was in his best interest," told Michelle of her consideration of her Catholic faith during her decision.

I ask that, on behalf of the health and safety of Kansas women - our mothers, sisters, wives, daughters, friends and community members - that you do not support HB 2218. This bill removes the ability of pregnant women and families to make critical decisions about pregnancy in consultation with their physicians. The bill puts lawmakers in the position of health care administrator and decision-maker and bans safe, legal procedures. This is nothing more than political interference in a pregnant woman's most personal, private medical decisions.

The women who will be adversely affected by HB 2218 are women whose pregnancies went horribly, irreversibly wrong. HB 2218 may, in some cases, take away a woman's ability to have children in the future by refusing her needed medical care. I don't believe that the legislature intends for women's fertility to be sacrificed for political gain. This is why we must be mindful of the fact that pregnancy is not a "one-size-fits-all" situation - each woman is different, with different medical needs, and each pregnancy is different as well. We must honor the differences in each woman and the physicians - OBGYN's, Family Physicians, Perinatologist, Maternal/Fetal Medicine Specialists - who strive to provide sound care and counsel to the women who present before them.

I urge the Committee to allow women and their families, in consultation with their physicians, to make the decisions that are best for them. I urge the Committee to carefully weigh the consequences that women will face and be forced to endure if they are not allowed to make medically sound and reasonable decisions about their pregnancies. I urge the Committee to consider the pregnant women and their partners who have to walk through these life decisions - as parents.

Thank you for the opportunity to share this testimony and the stories of the eight brave women opposing HB 2218.

Sincerely,
Virginia L. Phillips

Kansas NOW
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PO BOX 1860
Wichita, KS 67201

3/15/2011

TO: Senate Judiciary Committee

FR: Amber Versola, Lobbyist – Kansas NOW

RE: Opposition to HB 2218 – Written Only

Kansas NOW respectfully requests that this committee reject HB 2218 as it is a blatantly unconstitutional pre-viability ban on abortion. This bill fails to consider that women, their families, and circumstances are all unique – and consequently, it mandates government intrusion into personal medical decisions.

- Section 1 consists of legislative findings that are based on highly disputed medical theories. These findings ignore the established precedence of viability that was set by the Supreme Court, and were inserted as a foundation for anticipated court challenges.

- The medical theories described in section 1 should not be construed as fact. They are based on studies that are not accepted by any reputable medical professional association. The American College of Obstetricians and Gynecologists has stated that it knows of no legitimate evidence that fetuses experience pain at this stage. The Journal of American Medicine has stated that it is unlikely that a fetus will feel pain until the third trimester. According to the British Medical Journal, it is unlikely that a fetus will feel pain until 26 weeks, if at all.

- Section 3 makes exceptions to "preserve the life of the pregnant woman" and for cases when "continuation of the pregnancy will cause a substantial and irreversible physical impairment of a major bodily function of the pregnant woman." There are no exceptions for mental health or fetal anomalies. The lack of such exceptions is unconstitutional, and also serves to compound the anguish and suffering of women and their children.

  This bill will force women to continue with their pregnancy, knowing that their much wanted child will never be able to sustain life on its' own – and what life it does experience will be filled with pain.

- **Dr. Anand, the physician whose study this legislation is largely based upon has gone on record as stating that even *"he does not oppose abortion in all circumstances but says decisions should be made on a case-by-case basis."*[1]**

Kansas NOW contends that HB 2218 is legally unsound, and its' inclusion of flawed medical findings does not constitute good public policy. We trust women, and know that women are capable of making

[1] Annie Murphy Paul, "The First Ache," *New York Times*, February 10, 2008, http://www.nytimes.com/2008/02/10/magazine/10Fetal-t.html?pagewanted=1&_r=1 (accessed February 16, 2010).

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important, personal medical decisions without government intervention. It's in good faith that we count on you to share such trust by rejecting HB 2218.

Sincerely,

Amber Versola

Lobbyist, Kansas NOW

To: Senate Judiciary Committee

FR: Danielle Deaver

RE: Opposition to HB 2218 Written and DVD

My name is Danielle Deaver. My husband, Robb, and I are telling our story today because we do not want any other woman or couple, ever, to have to go through the agony we endured when we started to lose our baby, Elizabeth, when I was 22 weeks pregnant ,and our doctors' hands were tied by an unjust and cruel new law.

Robb and I were married in 2003 in the Methodist Church in St. Paul, Nebraska. Because I was then 26 years old and Robb was 32, and we knew we wanted a family, we start trying to get pregnant immediately after we were married.

It took some time for me to get pregnant the first time, but I eventually did. I lost that first pregnancy in September 2005, when I was just seven weeks along.

Shortly after that miscarriage I got pregnant again, but in May of 2006 I had a second-trimester miscarriage. We lost our baby, who we named Jonathan, when I was 16 weeks along. It was especially hard losing that pregnancy, because we'd thought that since we'd made it past the first trimester, I would be able to carry the pregnancy to term.

Even though I'd lost two pregnancies, we kept trying. I became pregnant again in 2007, but lost the baby at 10 weeks. I cannot begin to tell you how disheartened we were, and how nervous I was to try again. Still, we did, and on May 18, 2008, I delivered our beautiful, healthy son, Alex. Alex will be three this May. He is our world. He's wonderful. He's perfect, he's funny, and he keeps me sane. Before his birth I knew that I would love him. What I didn't realize, though, was how much I would LIKE him! Robb and I thank God for him, every single day.

Robb and I wanted to have two children, and we wanted to do it within a couple years of Alex's birth, so he would have a sister or brother fairly close in age. Because I now knew it was possible for me to carry a baby to term, we started trying to get pregnant again when he turned two. When we learned I was pregnant in August 2010, we were over the moon.

With this pregnancy, everything went perfectly. I felt great. I was comfortable, I only had a little morning sickness, and most of all, I wasn't scared every single day. I was happy. I wasn't worried like I'd been during my earlier pregnancies. I thought that my body had healed itself, and that, because I'd had so much trouble maintaining pregnancies before, we were careful about announcing this one. But I relaxed after the first trimester, and started telling people close to us. We told Robb's parents by taking a photograph of Alex holding a sign that said "Future Big Brother."

Everything went beautifully until we were putting Alex to bed on the Saturday after Thanksgiving. It was Saturday, November 27, 2010. I felt something weird and looked down, and I realized my water had broken. It wasn't real bad at first, but by the time Robb made arrangements for someone to stay with

Alex and we left for the hospital, it was more than a little. When I got to the emergency room at Mary Lanning Hospital, which is where I work as a registered nurse in the progressive care unit, my shoes were filled with fluid. I was 22 weeks and one day along in my pregnancy.

I was admitted and the on call doctor came in and told us this happens sometimes, but it could get better. She said it sometimes works out that if the baby's head is in the down position, it helps plug the rupture enough so that it seals and your body can produce more amniotic fluid to continue the pregnancy. So, of course, we grabbed onto that hope and prayed that would happen for me, and that I could maintain the pregnancy. We had an ultrasound the next morning and we were told that there was still very little fluid around the baby, but that it could still seal. We were told to go home and stay on bed rest, and that my doctor's office would call us the next day with arrangements to see the perinatologist. My OB/GYN told us that I needed to see a specialist and he would help make a referral. I was released from the hospital and went home. I stayed flat on the couch all day, doing everything I could possibly do to maintain my pregnancy. That was Sunday, November 28.

The next day, Monday, November 29th, my doctor's office called and told me we had an appointment on Tuesday, November 30th to see a perinatologist at the University of Nebraska Medical Center in Omaha. They said it was OK for me to travel by car.

When we got to the Med Center, they did another ultrasound. Then the perinatologist came in to see us in the room where we had the ultrasound. The first words out of her mouth were, "You can get pregnant again." She started talking about future pregnancies, not this one, so we knew the news wasn't good – that this pregnancy wasn't viable.

We asked her about this pregnancy, though, since the baby still had a heartbeat, was alive, and we were not ready to give up so soon. So the doctor sat down and started telling us what it meant for the fetus to have little or no amniotic fluid cushioning it. She said that even if I was able to maintain the pregnancy until after viability, it was extremely likely that the baby's lungs would not develop past 22 weeks, one day, which is when my water broke. Without that fluid around the baby, without the lubrication there, the baby couldn't move its arms and legs, so she would be born with contractures. She said the uterine wall would push on the baby and because at that point its skull isn't completely formed, she would have facial deformities. So, assuming I could continue the pregnancy, the baby would have facial deformities, limb contractures so it couldn't move, and because its lungs wouldn't develop, it couldn't breathe on its own, but maybe she could live on a ventilator. And those were the GOOD options.

Robb and I asked so many questions. How do we make it stop? How do we make it OK? Then I asked her, "At what point do we go from being good parents and doing everything we can to save our baby, to being selfish and putting our baby through what is essentially torture when she was born, if she couldn't move and couldn't breathe? What were the odds of even bringing home a baby with a heartbeat, and what were the chances of bringing home one who had any kind of quality of life at all?"

She told us there was a less than 10 percent chance that we would bring a baby home with a heartbeat and able to breathe. The doctor didn't tell us to not have hope or tell us it was impossible. She just answered all of our questions, and then she gave us some time to think.

When she came back into the room, I asked her if she could just induce labor, so that nature could take its course now, rather than waiting. Because, we thought, what was the point of trying to maintain a pregnancy that was going to end badly?

The perinatologist said that she couldn't do that because of this law that was passed in Nebraska. She said she could go to jail if she induced labor while the baby had a heartbeat, and that she could lose her license to practice medicine. She said the only way they could induce labor was if the baby was dead or if I was sick enough that they were concerned about my health. Because she was fairly new to Nebraska, she said she would look into it, to see if there was anything at all she could do to help us. Meanwhile, the only thing we could do was go home and wait. She told us to watch for signs of infection or placental abruption, such as fever and chills, or for signs of labor, like pain, bleeding or a lot of discharge. Again, this was all on Tuesday, December 1st.

So, we went home and waited. And waited, and waited. I couldn't work, of course. All I could do was wait – wait for the baby to die, wait for me to get really sick, or wait for me to go into labor. It was awful. It was horrifying. And I hope to God that neither I nor anyone else ever has to go through this again.

I cried all the time. And because Alex was just two, he didn't really understand what was wrong. But every time he saw me cry he said to me, "Mommy's water broke?"

Finally, on Tuesday, December 7th, I started feeling some pain and thought I might be in early labor. I went to Mary Lanning Hospital, where my OB/GYN confirmed that it was early labor, and then he suggested that we go home to wait some more because it was too early. I begged him to admit me to the hospital. I just couldn't face going home and waiting again. So, he admitted me to the hospital. That day, Robb and I walked and walked around the hospital, because sometimes walking helps speed up labor. I think we walked miles, hoping that the labor would progress.

Nothing more really happened, though, until the next morning, which was Wednesday, December 8th, when I went into full labor. Because my full labor had progressed enough, the doctor was able to administer Pitosin to speed things along. I delivered our baby, who we named Elizabeth after Robb's grandmother, at 3:00 p.m. She was perfect. I was actually hoping for some sort of deformity – that there would be something wrong with her – so that I would know there was a reason for all of this. But she was tiny, and she was perfect. Robb and I held her until she expired 15 minutes later – at 3:15 p.m.

One of the nurses I work with arranged for her pastor to come and baptize our baby. After Elizabeth had been gone for about an hour, he came and prayed over her and prayed with us. Several of the staff that day had told us about a program called "Now I lay me down to sleep," which is a service provided by local photographers who volunteer their time to take pictures of infants who have died. They came and took pictures of Elizabeth so we have a reminder of our beautiful, perfect baby girl. We went home the next day. After we were home for a few hours, the funeral director called so that we could meet with him. We met with him on Friday, December 10th, to make arrangements for our daughter's cremation and pick out an urn. We keep her photo and urn in a special area of our house, so she remains present in our lives every day.

I would urge all lawmakers to slow down when they are considering laws that restrict the private medical decisions made by a woman and her doctor. Please, take the time to think about and fully understand all of the ramifications of laws like LB 1103, the law that was passed in Nebraska last year that prevented our doctors from inducing labor even when there was no hope for a good outcome.

These kinds of laws can, and do, have lasting, negative impacts on real people. Robb and I are proof of that. Losing a wanted pregnancy is hard enough. What we had to live through because of a law, was excruciating, and the pain we endured for 10 days between the time my water broke and the time Elizabeth was born was entirely unnecessary. There ought to be room, even in a conservative state like Nebraska, for a private decision between a mother and her doctor.