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# House Bill 25-1252

1 message

**tanya regan** <tregan1980@gmail.com> Wed, Mar 5, 2025 at 4:06 PM
To: "committees.lcs.ga@coleg.gov" <committees.lcs.ga@coleg.gov>

Dear House Health and Human Services Committee:

I wanted to testify on House Bill 25-1252, "CONCERNING THE REGULATION OF MEDICAL FACILITIES THAT PERFORM INDUCED ABORTIONS AFTER THE FIRST TRIMESTER OF 103 PREGNANCY," but today the clock ran out. Notwithstanding, I am grateful to Representative Bottoms for bringing forth this incredibly important legislation. It disclosed two critical pieces of information to which I was not aware:

First, that Second and third-trimester abortion clinics are not currently 5 regulated by the Colorado department of public health and environment 6 (CDPHE); notwithstanding *all other facilities offering medical services are required to be licensed (including assisted living and hospice*) and

Second, *"that the risk of dying from an abortion increases 38% for each 10 week of gestation after 8 weeks. The risk of dying from a complication of an induced surgical abortion in the second and third trimester is greater than the risk of dying from procedures performed at ambulatory surgery centers in the United States and Canada, which centers in our state are regulated by CDPHE."*

The history and objectives of Planned Parenthood facilities, where the majority of abortions are performed, are notorious and purely satanical as evidenced by Margaret Sanger who founded the birth control movement and was largely influenced by the eugenics and Malthusian movements. The number of babies in the US aborted since the inception of ROE is 66.5 million – astoundingly, 30 percent were black babies! (Source: US Abortion Clock.org).

So how is it that while all other medical facilities must be licensed and must have oversight, the facility that so readily terminates the fetus' life, and puts the mother's life in a very precarious situation, has **no** regulatory oversight? That is legalized hacking of babies and mothers – the unmitigated gall to call it "health care" is twisted, a world of Marxist word manipulation. You can't legally murder babies so you call it "planned parenthood" and you can't legally prey upon pregnant young women and potentially murder them too. As Nora Clinton writes,

> *"The power of words has always mesmerized me. Growing up behind the Iron Curtain, I witnessed how every aspect of life was infused with politically correct jargon, while the wrong word, even in jest, could get people imprisoned or killed….totalitarian ideologues*

*have always been thieves of words. By "word theft" I mean deliberate appropriation of benign terms to manipulate language and thoughts. "Thieves of words" can be found today amid academics, policy makers, journalists, technocrats, corporate executives, and other public influencers. Even after the monumental collapse of communism in Eastern Europe, they continue to promote an anti-American and anti-Western worldview. Their effort to rewrite history and restructure society would fail without language control."*[1]

Representative Bottom's attempts to clarify and shed light on this dark and nefarious practice is critical to America moving forward as a leader in the free world. But we can't have freedom if those without voices are not defended. This bill is an important first step in illuminating and medieval butch shop practices that must be stopped. Please support Representative Bottoms and vote yes on this important piece of legislation.

Respectfully,

Tanya S Regan

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Tanya S. Regan
630 527 9403

HB25-1252
Regulation Abortion Facilities
Testimony

Thank you Mr. Chair and Members of the Committee for allowing me to testify.

I am Catherine Wheeler, a Board-Certified Ob/Gyn physician, and represent AAPLOG Action, asking you to vote in favor of this bill.

The joy of my career was caring for women, even more than delivering babies. I stand here today to advocate for women.

I believe all who testify today truly care about the woman, whether they authentically believe abortion helps women, or sincerely believe abortion harms women.

Please thoughtfully consider the evidence presented today, and ask yourself – where does the preponderance of the evidence lead?

The question before you is:

-Are the abortions done after the first trimester significantly more risky for women?
-And, If so, what is your duty to protect Colorado women, as in other healthcare?

**Gestational Age and Induced Abortion Morbidity and Mortality**

It is undisputed in the literature that induced abortion complications, their severity, and mortality are most associated with the gestational age of the pregnancy. In fact, the risk of a woman dying from induced abortion increases 38% per week after 8 weeks gestation, surpassing risk of death from live childbirth by 21 weeks.[1] The largest US study of second trimester dilation and evacuation procedures (D&E) revealed a 10% risk of complications, with 1.7% of women suffering life-threatening complications. [2] There is no significant data on risks of third trimester induced abortion. However, obstetricians are well aware of the risks of labor induction and preterm birth.

According to ACOG[3], the greatest immediate risk to the woman at delivery is hemorrhage, which is the cause of 11% of day of delivery deaths. 40% of women with hemorrhage have no risk factors, and thus every woman who is delivering should be considered at risk of hemorrhage. 54 to 93% of deaths from obstetric hemorrhage are considered preventable. The most important factors to prevent death are early identification of the hemorrhage, and rapid response and treatment. Despite the significant risk of hemorrhage, Colorado has no licensure,

regulation or oversight of abortion facilities that do abortions at gestational ages with greatest risk of hemorrhage, other complications, and mortality.

**Risks of Second Trimester Abortion (D&E)**

As a former second trimester abortionist, I can attest to the higher risks of abortions after the first trimester. When you sit down to begin a D&E, you better be focused and efficient, as well as well-trained and experienced, to decrease risk to the woman. The cervix is not meant to be dilated at this early gestation, but to be tightly closed. Thus, there is a risk of damage to the cervix from dilation, which may increase risk of future preterm births. It also leads to a risk of perforation through the uterine wall, and injury to other organs. Once the cervix is dilated, the membranes are ruptured to be able to access the baby and remove him or her in pieces from the uterine. Rupturing the membranes can cause an amniotic fluid embolus – amniotic fluid entering blood vessels, which can cause maternal death. Removing the baby with Sopher-Ovum forceps requires multiple passes of the instruments into the uterus, as the baby is removed piece by piece, each pass with a risk of the instrument going through the uterine wall, and instead of bringing out a baby part, bringing out bowel; or damaging the bladder, rectum, or major blood vessels. These are life-threatening emergent situations. Some of us do abortions under ultrasound guidance to decrease the risk of perforation and injury, and to try to be as sure as we can be that nothing is left in the uterus; but not all do. If there is a perforation identified during the abortion, laparotomy (open abdominal surgery) is required to fully assess for and repair life-threatening injury to other organs, especially the bowel. This requires transport to a hospital, delays in urgent care, increased risk of infection, and other complications. A different doctor typically assumes her care, increasing risks for communication and other errors, further increasing chance of complications.

The greatest immediate risk for the woman, however, is hemorrhage – just as it is in all deliveries. The uterine blood flow massively increases early in pregnancy to nurture and grow the developing baby. This is a low pressure, high volume vascular system. When the placenta is sheared off the uterine endometrial site in the induced abortion process, spiral arterioles are left wide open and bleeding. Uterine muscle contractions around these arterioles are primarily what decrease the bleeding, and allows clots to be begin to form. These contractions are not natural remote from term, and require the uterine cavity to be empty to be able to adequately contract around these arterioles. The increased blood flow to the uterus is well-established in the first trimester, and by the end of pregnancy receives 10% of her cardiac output, at 700 cc/ min. This is enough that she could exsanguinate in 10 minutes.[4]

Other risks include, cervical laceration; incomplete abortion (retained products) with risk of infection, sepsis, death, surgery to remove tissue, hysterectomy; embolus; anesthesia

complications, injury to endometrium with risk of future infertility or placenta accreta syndrome, transfusion, pelvic floor or vaginal trauma.

**Third Trimester Abortion Morbidity and Mortality**

Induced abortion after about 24 weeks is actually an induction of labor after first performing feticide (usually an injection by amniocentesis that ends the baby's life). It is a multi-day procedure, ending in delivery or extraction of the baby. I delivered thousands of babies in my career, including, unfortunately, babies who spontaneously died before birth. Deliveries before term have significantly increased risks to the woman, and induction increases those risks. Risks may include longer labors with attendant increases risks of infection and hemorrhage, the placenta not spontaneously separating (it is not designed to separate until near term) requiring manual or instrumented delivery, retained fragments of placenta, trauma to the cervix, and other risks. A living baby contributes to a normal delivery by rotating her head, shoulders and body as she descends through the woman's pelvis. A dead baby has no tone and does not contribute in this way, but rather tends to get into head and body positions that increase the difficulty of delivery and the risk of uterine and pelvic trauma to the woman. Additionally, abortion providers often use instruments to deliver or dismember the baby – much like forceps for live deliveries, which increase pelvic trauma and risk for the woman. Some of these instruments are used within the uterus, much like high forceps, which are no longer used in obstetrics due to their risk to both the woman and a living baby. Clearly, this is much higher risk than a first trimester suction curettage.

**What is being implemented in modern obstetrics to decrease maternal morbidity and mortality?**

In an effort to decrease maternal mortality, states have maternal mortality review committees[5], multidisciplinary teams that review cases of maternal mortality to determine root and preventable causes, and recommend improvements to systems to decrease maternal mortality.

By identifying the most common conditions leading to severe maternal morbidity, sentinel events (near misses), and maternal mortality, safety bundles have been developed and implemented to decrease maternal morbidity and mortality. For example,
the maternity safety bundle for hemorrhage, developed and copyrighted by the American College of Ob-Gyn (ACOG), revised in 2022, establishes the following guidelines:

**"Readiness - Every Unit**

- Develop processes for the management of patients with obstetric hemorrhage, including:

    - A designated rapid response team co-led by nursing, obstetrics, and anesthesia with membership appropriate to the facility's Level of Maternal Care;
    - A standardized, facility-wide, stage-based obstetric hemorrhage emergency management plan with checklists and escalation policy;
    - Emergency release and massive transfusion protocols to ensure immediate access to blood products;
    - A protocol, including education and consent practices, to collaborate with patients who decline blood products, but may accept alternative approaches; and
    - Review of policies to identify and address organizational root causes of racial and ethnic disparities in outcomes related to the diagnosis, management, and surveillance of obstetric hemorrhage.
- Maintain a hemorrhage cart or equivalent with supplies, checklists, and instruction cards for devices or procedures where antepartum, laboring, and postpartum patients are located.
- Ensure immediate access to first- and second-line hemorrhage medications in a kit or equivalent per the unit's obstetric hemorrhage emergency management plan.
- Conduct interprofessional and interdepartmental team-based drills with timely debriefs that include the use of simulated patients."

**Recognition & Prevention — Every Patient**

- Assess and communicate hemorrhage risk to all team members as clinical conditions change or high-risk conditions are identified; at a minimum, on admission to labor and delivery, during the peripartum period, and on transition to postpartum care.
- Measure and communicate cumulative blood loss to all team members, using quantitative approaches.
- Actively manage the third stage of labor per department-wide protocols.
- Provide ongoing education to all patients on obstetric hemorrhage risk and causes, early warning signs, and risk for postpartum complications.

**Response — Every Event**

- Utilize a standardized, facility-wide, stage-based, obstetric hemorrhage emergency management plan, with checklists and escalation policies for stage-based management of patients with obstetric hemorrhage, including:
- Advance preparations made based on hemorrhage risk (e.g. cell saver, blood bank notification, etc.)
- Evaluating patients for etiology of hemorrhage;
- Use of obstetric rapid response team;
- Evidence-based medication administration or use of nonpharmacological interventions;

- Appropriate activation of expanded care team and clinical resources as necessary.
- Provide trauma-informed support for patients, identified support network, and staff for all obstetric hemorrhages, including discussions regarding birth events, follow up care, resources, and appointments.

**Reporting and Systems Learning — Every Unit**

- Establish a culture of multidisciplinary planning, huddles, and post-event debriefs for every obstetric hemorrhage, which identify successes, opportunities for improvement, and action planning for future events.
- Perform multidisciplinary reviews of serious complications per established facility criteria to identify system issues.
- Monitor outcomes and process measures related to obstetric hemorrhage, with disaggregation by race and ethnicity due to known racial and ethnic disparities in obstetric hemorrhage outcomes.
- Establish processes for data reporting and the sharing of data with the obstetric rapid response team, care providers, and facility stakeholders to inform care and change care systems, as necessary.

**Respectful, Equitable, and Supportive Care — Every Unit/Provider/Team Member**

- Include each patient that experienced an obstetric hemorrhage and their identified support network as respected members of and contributors to the multidisciplinary care team and as participants in patient-centered huddles and debriefs.
- Engage in open, transparent, and empathetic communication with pregnant and postpartum people and their identified support network to understand diagnoses, options, and treatment plans, including consent regarding blood products and blood product alternatives."[6]

Due to the high risk of hemorrhage in all deliveries and induced abortions, these safety bundles are implemented in every licensed and regulated site of delivery – except second and third trimester abortion facilities.

**How does licensure, inspection and regulation improve patient safety?**

In 1999, the Institute of Medicine published its report, "To Err is Human: Building a Safer Healthcare System."[7] They found that more people die from medical error in hospitals than from traffic accidents and breast cancer. They found that more than individual errors, "more commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them." Thus, mistakes can best be prevented by designing the health system at all levels to make it safer--to make it harder for people to do something wrong and easier for them to do it right." The four tiers of their approach to build safer healthcare systems are:

1. "Establishing a national focus to create leadership, research, tools, and protocols to enhance the knowledge base about safety"
2. "Identifying and learning from errors by developing a nationwide public mandatory reporting system and by encouraging health care organizations and practitioners to develop and participate in voluntary reporting systems. "
3. "Raising performance standards and expectations for improvements in safety through the actions of oversight organizations, professional groups, and group purchasers of health care."
4. "Implementing safety systems in health care organizations to ensure safe practices at the delivery level"

Developing safer systems, and developing a culture and commitment patient safety are critical to preventing complications, which are highest in ICU, operating, and emergency settings[8] (which would include the acuity of delivery.

**What Regulations does Colorado Require of Other Health Facilities?**

The regulations and oversight Colorado requires in other healthcare facilities where these D&C, D&E, inductions of labor, and delivery occur are commonsense and exactly what we all expect from safe healthcare for ourselves.

- Birthing Centers[9] which are licensed and regulated, only serve low risk pregnant women, and exclude cervical ripening and induction of labor. CDPHE regulations include defining the scope of practice, credentialing of providers, patient records, developing policies and procedures with regular review, transfer policies, personnel, quality management programs, infection control programs, emergency preparedness and staff drills, assessment of quality of care, assessment of patient risk and appropriateness for this center, data collection including outcomes, staff job descriptions and assessment of skills, discharge planning, policies for physical facilities, lab facilities, food services, pharmaceutical services, anesthesia services, inspection and availability of emergency supplies, proper storage of medications and supplies, patient care policies and procedures, housekeeping policies, laundry and linen procedures, waste storage and disposal.
- Ambulatory Surgery Centers[10] are licensed and regulated. Surgeries are typically limited to:
    1. "those in which the combined operating and recovery time does not exceed 24 hours from the time of admission; and
    2. those that do not generally result in extensive blood loss; require major or prolonged invasion of body cavities; directly involve major blood vessels; or constitute an emergency or life threatening procedure."

    Regulations in addition to ones listed under Birthing Centers include more specific regulations for transfer requirements and preparation, radiology, anesthesia services, data collection of procedures and complications, operating rooms, equipment, ventilation, scrub areas, sterilization protocols, separation of sterile areas and

equipment, lighting, recovery area and procedures/ protocols, patient care areas, incineration, pest control, compliance with fire guidelines,

- Hospital Labor and Delivery Units are considered high acuity units, such as Emergency and ICU. Thus oversight, regulation and inspection or more rigorous, including inspections by the Joint Commission and CMS (Center for Medicaid and Medicare Services).

**Later Abortion in Colorado Must be licensed and regulated for women's protection and safety**

Colorado has no licensure, inspection, regulation, or enforced data collection of second and third trimester abortion facilities, including number and type of abortions, gestational ages, complications, transfers to hospitals for complications, or adverse outcomes. The Colorado Department of Health and Education mingles deaths from induced abortion into overall maternal deaths. Thus, no one really knows the outcomes of later abortions in Colorado.

How will the state know if, say, a woman is transferred from an abortion facility for hemorrhage and dies at the local hospital? Or if a woman suffers a uterine perforation and is transferred to the local hospital for major surgery. Or even if there is a pattern of major complications. How will the state know and be able to protect other women? My experience caring for women with complications from second trimester abortion from the local abortion clinic was that there was no reporting mechanism, and the hospital did not report the complications, either. We know from Kermitt Gosnell's complications that the local hospitals who cared for these patients knew, and also did not report. Many women suffered unnecessarily as a result. Medicine is notoriously poor at policing its own without oversight and regulation.

If Colorado legislators genuinely care about women's health and safety, they will protect them by licensure, regulation and oversight, as with other healthcare. Or do you not want to know?

[1] Bartlett LA, et.al., Risk factors for legal induced abortion-related mortality in the United States. Obstet Gynecol 2004; 103(4): 729-737

[2] Lederle L., et.al., Obesity as a Risk Factor for Complication after Second-Trimester Abortion by Dilation and Evacuation. Obstet Gynecol 2015; 126(3): 585-592.

[3] Quantitative blood loss in obstetric hemorrhage. ACOG Committee Opinion 794, Dec 2019. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/12/quantitative-blood-loss-in-obstetric-hemorrhage

[4] Buskmiller, C. Previable Induction of Labor for Life-Threatening Maternal Disease without Placental Pathology National Catholic Bioethics Quarterly 21.2 (Summer 20201)

[5] About Maternal Mortality Review Committees, CDC, May 15, 2024. https://www.cdc.gov/maternal-mortality/php/mmrc/index.html

[6] Obstetric Hemorrhage Patient Safety Bundle, Alliance for Innovation on Maternal Health (AIM), Rev. 2022, copyrighted by ACOG. https://saferbirth.org/psbs/obstetric-hemorrhage/

[7] To Err Is Human: Building a safer healthcare system. Institute of Medicine, Nov 1999. https://nap.nationalacademies.org/resource/9728/To-Err-is-Human-1999--report-brief.pdf

[8] Ibid.

[9] Colorado Regulations for Birthing Centers https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7258&fileName=6%20CCR%201011-1%20Chap%2022

[10] Colorado Regulations for Ambulatory Surgery Centers https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=5318

HB25-1252
Regulation Abortion Facilities
Testimony

Thank you Mr. Chair and Members of the Committee for allowing me to testify.

I am Catherine Wheeler, a Board-Certified Ob/Gyn physician, and represent AAPLOG Action, asking you to vote in favor of this bill.

The joy of my career was caring for women, even more than delivering babies. I stand here today to advocate for women.

I believe all who testify today truly care about the woman, regardless of their beliefs about abortion.

I ask you to thoughtfully consider the evidence presented today.

The question before you is:

-Are the abortions done after the first trimester significantly more risky for women?
-If so, what is your duty to protect Colorado women, like other healthcare?

As a former second trimester abortionist, I can attest to the higher risks of abortions after the first trimester, which exponentially increases with each week. Studies of D&E show a 10% complication risk, with 1.7% life-threatening. When you sit down to begin a D&E, you better be well-trained, focused and efficient. The cervix is not meant to be dilated at this early gestation. Even with pre-dilation, metal dilators are usually required, and can damage the cervix and perforate the lower uterine wall, injuring the rectum or bladder. Rupturing the membranes to gain access to the baby can cause an amniotic fluid embolus, which is highly fatal. Removing the baby requires multiple passes of instruments, with a risk of perforating the very soft uterus each time, risking damage to bowel, major blood vessels or the bladder, necessitating transfer to a hospital for major surgery..

The greatest immediate risk for the woman, however, is hemorrhage,– just as it is in all deliveries. In studies of D&E, hemorrhage ranges from 4-37%, attesting to the wide variation in skill and experience of providers. With no licensure or regulation, facilities are not required to credential their providers to assure their competence.

It is dangerous reckless for abortions after the first trimester to be allowed in unregulated, unlicensed, uninspected facilities.

Regulation and oversight would ascertain whether there are management plans and an escalation policy for hemorrhage, hemorrhage and emergency carts, policies and immediate access to hemorrhage medications, staff training and emergency drills, and other appropriate policies and preparedness.

**House Health & Human Services**

**03/11/2025 Upon Adjournment**

**HB25-1252 CDPHE Regulation of Abortion Clinics**

**Typed Text of Testimony Submitted**

| Name, Position, Representing | Typed Text of Testimony |
|---|---|
| Tom Jensen<br>For<br>themself | Dear Members of the House Health and Human Services Committee,<br>I strongly urge you to pass through committee The Abortion Clinics Regulation Bill (HB25-1253). Abortion risk for complications increase with passing weeks and although most are done prior to 21 weeks, over 10% of abortions performed in Colorado are done past this mark when the risk of death rises to 8.9/100,000 which is likely an underestimation given lack of reporting of abortion and reliance on death certificates that do not include that information. A recent 2017 meta-analysis found risk of death following pregnancy termination twice as likely than after childbirth in 1 year follow up time frame (SAGE Open Med. 2017 Nov DOI: 10.1177/2050312117740490). Therefore, if we regulate facilities than are labor and delivery wards, we should have similar regulations for these facilities that provide 2nd and 3rd Trimester abortions. Even the UN has stated in 2020 series on Reproductive Health states "[t]he Committee on Economic, Social and Cultural Rights has established that the right<br>to sexual and reproductive health requires health facilities, goods, information and<br>services, including safe abortion and post-abortion services, which are available,<br>accessible, acceptable and of good quality." Therefore we should demand these facilities be regulated like other healthcare facilities in our state by the CDPHE and allow for improved documentation of safety then what we currently have in this state.<br>Regards,<br>Dr. Jensen |
| Robin Robinson<br>For<br>themself | To Committee Members,<br>I am writing in support of this bill.It seems<br>only right and reasonable to protect patients by |

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| | regulations and inspection of onsite surgical clinics. As we know even women who choose the abortion pills can often have issues and need help even though it is not from a surgical abortion. None of you go to an unispected , regulate and clean healthcare facillity. I ask you to actually care for women not in word only but in deed and truth. |
| Lloyd Benes<br>For<br>themself | HB25-1252, CDPHE regulation of abortion clinics:<br>I'm Lloyd Benes, representing myself, asking for YES on this bill HB25-1252.<br>In Colorado, second- and third-trimester abortion clinics should be regulated like other ambulatory surgical centers to ensure patient safety, & medical accountability. Dr. Warren Hern's scientific publication reveals that 70% are performed on healthy women with healthy babies (source=tinyurl.com/yc8a2uzk). The Colorado CDPHE reports about 500 babies are aborted annually after 21 weeks. That is the age of viability when babies can survive if born prematurely. 22-week babies are being saved at UC Health University of Colorado Hospital (source=tinyurl.com/t76jayzw).<br>Other outpatient surgical centers performing similarly invasive procedures are required to meet strict standards, including proper sterilization, adequate staffing, emergency preparedness, staff certifications, facility cleanliness, annual health inspections and requiring informed consent so women know what are the risks of 2nd/3rd trimester abortions. Abortion clinics should not be absolved from these basic medical regulations.<br>Exempting abortion clinics from high standards prioritizes abortion ideology over women's safety, leading to poor outcomes like the Nebraska couple's lawsuit against Dr. Warren Hern. Hern performed an abortion on Jennifer DeBuhr, near the end of her second trimester, resulting in complications, including a skull fragment lodged in her uterus. She was not informed of the risks, leading to the removal of her uterus and the loss of her ability to have children—no informed consent—source=tinyurl.com/yw8dhsbw.<br>The Feb 6, 2025, death in Ft Collins is not the only case of abortion ideology taking priority over women's safety in Colorado |

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|---|---|
| | Additionally, over 700 whistleblowers have left the abortion industry.—source=www.abortionworker.com) This is dangerous for women, these former abortion workers provide a well-documented history of unhygienic and unsafe practices (sources=tinyurl.com/2hsy7sur, tinyurl.com/2e9mt4du, tinyurl.com/yckfp5sr).<br><br>In conclusion, regulating second- and third-trimester abortion clinics like other ambulatory centers is essential to avoid outcomes like Jennifer DeBuhr. Please Vote Yes on HB25-1252. |

Please vote yes on the important bills.

Thank you,
Barbara Rice
Colorado Springs, CO

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It is appalling that this bill is needed, that we need to ensure that medical or mental health services are not provided to a minor without written or verbal consent from that minors parent. I understand Colorado has progressively lowered the age at which minors can access certain healthcare services without parental involvement, reflecting a policy focus on access over parental oversight. I believe this undermining of the parental relationship actively harms children and that this drive to provide access to drugs and surgeries to kids is abhorrent, driven by pure ideology not supported by good science.

I wanted to point out a concept in support of the bill - the concept of **iatrogenesis** - that a healer can cause unintended harm in the course of treatment and that this harm should be considered in whether or not the treatment is pursued. These harms are not considered when determining if a child should undergo therapy and certainly are not taken into account by the child him/herself given the immaturity and naive of the child. This is the idea that you shouldn't take medicine unless you really need it due to hidden risks and side effects. **The same concept of hidden risks, iatrogenesis, needs to be applied to therapy.** There are harms of therapy, therapy should not be applied to children willy nilly, in all cases, as if it were a risk free net positive endeavor. Therapy can intensify bad feelings, it can induce rumination, and worse, indicate to the child that there is something wrong with them, a stance of victimhood they take with them for life. There is a power imbalance inherent in a child-adult therapy relationship.

Can a child truly give informed consent in this dynamic?? **Can a child give informed consent to medical and mental health treatments driven by adults with an ideological agenda?**

**Children need their parents. Health professionals should not enable kids who are having difficulties with their gender and/or with their parents by placing them in the drivers seat of their care when they are having emotional problems. This is when they need clear eyed guidance of their parents the most.**

**Sending a signal to a kid that they NEED a therapist and that a therapist KNOWS BETTER than their parent is DANGEROUS. This undermining of the parent relationship HURTS KIDS and opens them up to predation by dangerous individuals.. STOP ENABLING TROUBLED KIDS TO DECIDE THEIR OWN CARE. This is crazy and wrong! This is bad government pretending to parent! Leave the kids alone!**

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Hello,
I am emailing as a Colorado voter who is very concerned about the lack of appropriate environmental regulations and protection of minors in regards to abortion clinics in our state. It is critical that Colorado Health and Human Services supports these new bills to ensure that parents retain their rights to consent to medical procedures for minors and that abortion clinics are held responsible for the environmental damage they may cause by unsafely disposing of dangerous chemicals. It is also critical that Colorado does everything possible to ensure that we have "safe haven" laws so that parents are able to surrender an infant that they are unable to care for. None of these new proposals in bill HB25 should be controversial or partisan. Safe Haven laws, protecting parental rights, and requiring abortion clinics to uphold a basic standard of environmental care is not too much to ask and it is disappointing that these kinds of laws are not already on the books in Colorado. These new bills are a necessary step in making Colorado a cleaner, healthier and safer place for all.

-Sincerely,
Colleen Longua, Colorado citizen

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Please pass these Bills to provide a safe environment for the most vulnerable.
Thank you!
Ellen Bonner
Sent from my iPhone

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We must make sure of oversight of abortion clinics, just as we do for the nearby birthing centers. The desperate women, often taken to abortion clinics by men, under force of one type or another, deserve a regulated facility. Susan Bosold, RN, PhD

To: Members of the House Health and Human Services Committee
From: Khoa Nguyen | Young Invincibles | MD/MBA Candidate at the University of Colorado
Re: HB25-1252 - CDPHE Regulation of Abortion Clinics

Mr. Chair, and members of the committee,

Thank you for the opportunity to share my testimony with you. My name is Khoa Nguyen. I am representing Young Invincibles as one of their Youth Advocates. For my background, I am currently completing my MD at the University of Colorado School of Medicine and my MBA at the University of Colorado Denver Business School. Short of applying to residency and obtaining my MD, I have fulfilled all curricular and licensure requirements expected thus far for the MD. **I urge a 'no' vote on HB25-1252.**

Federally, all medical facilities providing abortion services are subject to OSHA, CLIA (Clinical Laboratory Improvement Amendment), and HIPAA standards [1-3]. Likewise, all medical facilities in Colorado are subject to general health and safety regulations enforced by the Colorado Department of Public Health and Environment (CDPHE) [4]. These regulations ensure that all healthcare providers, including those offering abortion services, adhere to established standards of care to protect patient safety and well-being. For state licensing, healthcare providers, including those that provide abortion services, must adhere to standards set by the Colorado Medical Board [5]. It is clear already that abortion providers in Colorado operate under existing stringent standards designed to protect patient health and maintain quality medical care. This poses the question: why do we need more regulations in an already comprehensively regulated environment?

This bill will restrict access to crucial reproductive healthcare services. Additional licensing requirements on top of our existing standards may be redundant and impose further administrative burdens. Where is the evidence that additional regulations will guarantee improved patient outcomes? Likewise, implementing further regulations could lead to the closure of clinics unable to meet new standards, thereby reducing the availability of safe abortion services. This reduction in access may force individuals to seek unsafe alternatives or travel long distances, disproportionately affecting marginalized communities.

As a future physician, I often tell my patients, "What happens in your care or what you choose to do for your care is between you, me, the rest of your care team, and whichever god you pray to." For my reproductive patients, this is especially important as they face complex decision-making regarding their reproductive health. Every patient's healthcare decisions are deeply personal and a one size fits all approach does not work. At the end of the day, it is paramount that my patients have access to safe, timely, and compassionate care. Adding further state-specific regulations may interfere with medical autonomy and detrimentally impact the patient-provider relationship.

Healthcare providers are best positioned through years of schooling, experience, and rigorous attention to medical ethics to determine appropriate standards of care based on current medical evidence and what OUR patients need; not state legislators. I urge the committee to **reject** HB25-1252. Thank you for your time and consideration. I am happy to answer any questions.

To: Members of the House Health and Human Services Committee
From: Khoa Nguyen | Young Invincibles | MD/MBA Candidate at the University of Colorado
Re: HB25-1252 - CDPHE Regulation of Abortion Clinics

Sincerely,
Khoa Nguyen | MD/MBA Candidate
University of Colorado School of Medicine | University of Colorado Denver Business School
Youth Advocate | Young Invincibles
Junior Fellow | Global Council on Science and the Environment

**References**


1. https://www.osha.gov/complianceassistance/quickstarts/health-care
2. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.151
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4. https://codes.findlaw.com/co/title-25-health/co-rev-st-sect-25-1-5-103/
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