

**THE ASSAULT ON WOMEN'S FREEDOMS:
HOW ABORTION BANS HAVE CREATED
A HEALTH CARE NIGHTMARE
ACROSS AMERICA**

HEARING
OF THE
**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS**
UNITED STATES SENATE
ONE HUNDRED EIGHTEENTH CONGRESS
SECOND SESSION
ON
EXAMINING WOMEN'S FREEDOMS, FOCUSING ON ACCESS TO
ABORTIONS ACROSS AMERICA

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JUNE 4, 2024
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**THE ASSAULT ON WOMEN'S FREEDOMS:
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A HEALTH CARE NIGHTMARE
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Tuesday, June 4, 2024

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., in room 216, Hart Senate Office Building, Hon. Bernie Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Murray, Casey, Baldwin, Murphy, Kaine, Hassan, Smith, Luján, Hickenlooper, Markey, Cassidy, Murkowski, Marshall, Tuberville, Mullin, and Budd.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. The Senate Committee on Health Education, Labor, and Pensions will come to order. Two years ago, six Supreme Court justices all nominated by Republican Presidents, decided to overturn *Roe v. Wade* abolish the constitutional right for women to have an abortion and to give politicians in state government the right to control the bodies of women in state after state.

This morning, we will be holding a hearing to take a hard look at how this Supreme Court decision, the *Dobbs* decision, has impacted women, physicians, and healthcare providers throughout our Country.

In a few minutes, I am going to be handing the gavel as Chair of the Committee to Senator Patty Murray, because given the subject matter, I think it's appropriate for a woman to Chair this important hearing. And this is an issue that Senator Murray has been deeply and passionately involved in for many, many years.

But before I hand the gavel over to Senator Murray, let me say a few words on a subject I feel very, very strongly about. It is no secret to anyone, that throughout our Country's history, women have had to fight for their basic human rights against all forms of patriarchy and sexism, no great secret.

Women had to struggle and some died in order to achieve the right to vote, something which they did not receive until 1920. Women had to struggle for the right to get the education that they wanted. All over America, women wanted to go to this school, wanted to do that, couldn't get into the door, because they were women.

Women had to struggle to get banks to lend them the money they needed to buy a car or start their own business. In fact, up to 1974, banks in America could legally refuse to issue a credit card to a woman simply because she was a woman.

Women struggled to get to choose the careers they wanted. In the 1950's, it was legal for employers to fire women for the crime of getting married, to get fired because she chose to get married. Up until 1964 it was legal for employers in America to reject a job applicant, simply because the applicant was a woman.

The struggle for equal pay, for equal work, continues to this day. In America today, women working full-time make just 84 cents on the dollar compared to men. And on and on it goes, women struggling with their basic human rights.

Then on January 22nd, 1973, after decades and decades of struggle, women in America finally won the right to control their own bodies, as a result of the Supreme Court decision in *Roe v. Wade*. No longer would state governments be able to tell women what they could or could not do with their own bodies.

When we talk about the history of how all of these happened, let's not ignore the lack of political representation that women had.

In 1987, not so many, many years ago, there were 2 women in the U.S. Senate and 98 men. Those are the folks all over this country who are making the decision. The truth is that men would not tolerate them being subject to government decisions regarding how they can control their own bodies.

I am not aware of any state in this country that has ever restricted the right of a man to get Viagra or any other medication prescribed by a doctor. I'm not aware of any state in this country that has prevented a man from getting a vasectomy or any other medical procedure that men choose to get that has been approved by a doctor.

We hear a lot of talk about freedom in this body, freedom to do what you want to do, and yet right now we are living at a time when half of our population or more has lost that freedom.

By the way, when I talk about the right of women to be able to control their own bodies, it's not just me talking, it's what the American people believe, in poll after poll, in state election, after state election.

People are saying, we may disagree politically, we may disagree on this or that issue, but very strongly, the American people believe it is women, not the government that has a right to control their own body.

Senator Murray, the gavel is yours.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. [Presiding.] Chairman Sanders, thank you so much for your statement, and thank you for letting me Chair today's hearing on a topic that is deeply important to me. And I want to thank all of our witnesses for joining us here today.

Today, we take a close accounting of the trauma Republicans are inflicting on women and families across our Country, and the dam-

age they are doing to basic reproductive healthcare through their horrific anti-abortion crusade. The issue here is simple and it cuts to the core of American values. Freedom.

Many women every day experience the joy of becoming pregnant and raising a family. They were able to make that decision for themselves, but no woman, no one should be dragged through a pregnancy against their will.

But right now, in America, more than a third of women of reproductive age live in states where they essentially do not have the choice to end a pregnancy if they need to.

Instead, Republicans have made the choice for them, with extreme abortion bans and cruel restrictions on access to care. With these policies, they have told women in no uncertain terms, you don't control your body, we do. That is horrifying. Think about what it means, what it really means to be told someone else can decide you have to stay pregnant no matter the circumstances.

Think about how little power that gives a woman over her own life and her own health. And think about how much power that gives, not just politicians, but any man who knows he can get a woman pregnant, force her to stay pregnant so he can have control over her or even get revenge for the rest of her life.

To every Republican who hopes this issue will go away or is hoping the post *Dobbs* reality will become settled, status quo. Listen, you never forget and you never just get used to someone else taking control of your body, your medical decisions, your plans for your family or your future.

You never forget a politician rescinding your right to make decisions about something as personal as your own pregnancy, and imposing his will instead, especially when you live with the consequences every day. And the consequences of the post *Dobbs* abortion bans are so much broader and so much more devastating than any one story or hearing can ever do justice.

There are stories that get a lot of attention that are shocking almost beyond belief. Stories of women denied care for a miscarriage because of abortion bans. Women turned away from hospitals because their doctor's hands were tied until they lost over half of their blood, until their husband found them unconscious, until the only option was an emergency hysterectomy or tragically until it was simply too late.

Or stories of children, who can't get abortion care after being raped. Some kids may be able to get across state lines to get the care they need. Other children have been forced into motherhood by Republican politicians. One teenager delivered a baby while clutching a teddy bear.

These nightmares are happening across our Country as a direct result of Republican abortion bans. And there are so many other stories that go untold.

Women who do not want to be pregnant for whatever reason, maybe they can't afford to have another child right now. Maybe they are in an abusive relationship, maybe they just don't want a kid right now, period. But they are told by politicians, they have no say in the matter, not unless they have the time and resources,

often thousands of dollars to travel in some cases, hundreds, and hundreds of miles.

It is harrowing to think that we live in a reality where forced pregnancy has become so widespread and so rampant that only the most dystopian stories get national attention. But the stories of all the other women who were confronted by these bans, their pain, their heartbreak, their anger, and fears are also horrific, valid and an important part of the conversation. A forced pregnancy does not have to make headlines to make someone's life a living hell.

Let's be clear about a few more things before we get started. Republican attacks are not only hurting people in the states where they banned abortion. They're not only hurting women who need an abortion, and their attacks on our rights are not stopping at an abortion.

When it comes to states like mine where abortion is legal, providers are being stretched beyond capacity by women in desperate need of abortion care they can no longer get at their home.

When it comes to women who aren't even seeking an abortion, bans are hollowing out healthcare for women in general, especially for those who already face some of the biggest challenges getting care.

Women of color, Indigenous women, those in rural communities, because in a surprise to no one, healthcare providers do not want to work in states where politicians get between a doctor and their patient and threaten providers with jail time, and the loss of their medical license if they dare to help patients get the care they need.

In states with extreme abortion bans, we are seeing healthcare providers closing their doors and shutting down their practices, new doctors staying away, and fewer options for patients to get a whole range of necessary healthcare services. The consequences extend far beyond abortion. And when it comes to what is next, well, Republicans have already made it painfully clear they want a national abortion plan.

No matter what they're saying now, we can just look at the record. Look at how many Republicans have co-sponsored national abortion bans. Look at the Life at Conception Act. That is a bill that is supported by more than half of the House Republican Conference that would enshrine fetal personhood nationwide.

Let's be clear what that would mean. Not just an abortion ban. It would mean that women and doctors will be charged with murder for an abortion making them eligible for the death penalty in their states. It would mean emergency contraception like Plan B, outlawed. And it would mean IVF ripped away from people who are trying to start a family.

This is not theoretical. We saw how much chaos this dangerously extreme ideology already caused for families in Alabama. And yet there are Republican states and Republican Members of Congress, including the Speaker of the House, who support making fetal personhood the law of the land. That is in the extreme, but in the face of all this horror, we've also seen an outcry from women and men who refuse to let Republicans keep dragging our Nation backward and stripping away our basic rights.

Every time abortion rights have been on the ballot, since *Dobbs*, every single time, abortion rights have won. People are standing up and they're speaking out and Democrats are proud to stand with them.

Democrats are going to make sure women's voices are heard in our Nation's capital, including at hearings like this one. And we're going to keep fighting to pass the Women's Health Protection Act and restore the basic and fundamental right of women to control their own bodies.

While former President Trump continues to brag about how he overturned *Roe*, and makes clear he will go even farther to restrict and ban abortion if given the chance, Democrats have been clear. With a pro-choice majority in the House and Senate and Joe Biden in the White House, we will restore and protect abortion rights for every woman in America. Thank you.

With that I look forward to hearing from all of our witnesses, but first, I will turn it over to Senator Cassidy for his opening statement.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Senator Murray.

Let's table-set. It's an election year in which a Democratic incumbent President is running behind. So, a decision has been made to raise abortion to a high profile to change the setting, to invite a lot of folks to put us on TV. It's partisan politics being played out in a Committee hearing, but let me point out as well, it's not entirely partisan.

Louisiana's pro-life law was written by a female Democratic State Senator and written and signed into law by a Democratic Governor. And that female Democratic state senator was reelected with wide margins. So, there is a breadth across the political spectrum of people who have a different way of framing this.

My Democratic colleagues want you to think that Republicans believe terrible things, they'll attempt to normalize a decision to abort a child. But a Republican would say that you can't normalize a procedure, at least this Republican, in which the intent is to end a life. Don't be misled. This is a life. This is a life because can anyone say that child is not a life. How could you not?

I'm a doctor. I see that you have to take care of that mama. You have to take care of that mama, but you have to recognize that there is another life there as well. This is not just a collection of cells. This is a child that if delivered will live, and maybe this one too, and that one as well. So, let's have a national dialog. Let's actually explore this as opposed to exploit it for political advantage.

In medical school, I was taught, to care for every patient who walks in the door, and to recognize that when a woman is pregnant, there are two patients there.

The second that baby gets there, it doesn't matter how small and how vulnerable, how unsustainable, how weak. The doctors, the nurses, the institution does everything they can to save their life. And by golly, don't you want them to do that? Don't you want the people who are entrusted with the healthcare to have that ethic?

I believe that the responsibility to protect and say the child shouldn't be determined by the arbitrary difference of being inside or outside the womb. I'm unapologetically pro-life. Scientifically and morally, there's no difference in the value of a child, whether she is in her mother's arms or whether she is in her mother's womb.

The science is clear. This is just not a clump of cells and this is a difficult poster to look at. I can tell you it's difficult. The reason it's difficult is because you recognize, that by their policies, it should be legal to abort that child. It is difficult, but let's frame it for what it is. How can we dehumanize this? And yet this is what it's an attempt to do. At what point do my Democratic colleagues believe that a child deserves to live?

It does a disservice to the mother to dehumanize the unborn child and discuss this issue as only the right to abort or not to abort. This is one of the most significant decisions a woman will ever make. We should not trivialize.

Now I understand and accept the need for exceptions, the laws that regulate abortion under certain circumstances. But unlike some of our testimony here, terminating life does not spare a woman from potential grief. This should never be an easy decision, if so, we've lost our moral compass.

I just want people to read the entire testimony of Dr. Francis in which she refutes a lot of what was said, kind of blithely, and she actually puts scientific data behind it.

As a physician, fear mongering, I find it infuriating. A woman experiencing, the emotionally and physically painful experience of miscarriage or an ectopic pregnancy is already grappling with a loss of our unborn child, and yet this Committee hearing would take this vulnerable moment of that woman's life and misrepresented, and use it for political gain.

There is no law in any state preventing a doctor from treating a patient going through a miscarriage or an ectopic pregnancy or from preventing the saving of the life of a mother. That is called healthcare. That is not an abortion.

One of the most inspirational medical professors said, that in healthcare and medicine, our highest calling is truth. And frankly, that's why I find it frustrating that fellow physicians are misleading on these facts and corrupting truth for political viewpoint.

While it's disappointing that my colleagues would say things that are not true, deceiving Americans about Republicans stand on the issue is also reprehensible that they mislead Americans on the Democrats own extreme views.

Now, Democrats will say that they want to codify *Roe v. Wade*. That's not true. The truth is, is that the democratic policies go beyond *Roe*. Their marquee legislation will legalize late term abortion and every state aborting this child, ban states that prevent coerced abortion, allow strangers to convince an underage child to get an abortion without notifying the parents that she is pregnant.

Perhaps that pregnancy was due to abuse, shouldn't the parents know? Why should the parents' rights be obligated and eviscerate the conscience rights of healthcare professionals who have moral or

religious objections to abortion? Speak about driving people out of the healthcare field.

Now, Senator Kaine has a bill that explicitly codifies *Roe* into law. The only Democrats willing to co-sponsor are Senator Sinema and Manchin, neither one of whom call themselves Democrats by now. So, it begs the question, why does Senator Kaine bill to codify *Roe* not have more Democratic support? Well, it makes a good rallying cry, the policy of codifying *Roe* is too conservative for the fringes that now define the debate in the Democratic party.

There are nine states plus Washington DC, whose laws right now allow, allow for abortion up to parturition. The child can be ready to go through the birth canal and abortion is legalized. Not because of the life of the mother, just to legalize it. That is where the Democratic party has gone. That should give us all a moral pause.

Now I ask my Democratic colleagues, can you designate a point at which a pregnancy should not be terminated unless for the life of the mother or instead of some extenuating circumstances? Can you tell me if it's here or here or here? I think that's a fair question. I invite everybody to be a doctor who's trying to balance the needs of the unborn child with that of the mom.

My Democratic colleagues may also claim that abortions are low risk procedures, claiming that they're so safe, they can be done without medical supervision. Not entirely accurate, minimizing the potential complications. But that's the way you can kind of feel better about this. And again, I refer people once more to Dr. Francis' complete testimony, not just the 5-minutes she'll give today.

Now, demagoguing and fear mongering on access to treatment for miscarriages and ectopic pregnancies, cast in a decision to abort or not to abort as an easy one, is a tremendous disservice. I have supported postpartum coverage for women in Medicaid. I've worked on serious legislation to advance maternal health like the Connected Moms Act with Senator Maggie Hassen, which lets physicians remotely monitor pregnant women for potential complications.

From my practice in Louisiana, a woman who's eight and a half months pregnant, using public transportation in August in Louisiana, you can empathize for her and understand that if you can remotely monitor her, her life is so much better. Senator Bob Casey and I led legislation now law to ensure that pregnant women are entitled to reasonable accommodations in the workforce.

There is much more we can do to support the woman who's pregnant, but we should debate and advance legislation so that we are not leaving them without solutions when they're faced with a very difficult, traumatic, and complex question.

We want women, moms to be healthy, successful, and prosperous. And the human life inside a woman triggers the double line—the human life, do a pregnancy test, those double lines come up. Those double lines should not represent a burden as the other side would like to cast. It should represent a gift, but there's things that we can do to make her life easier.

I'm open to the tough conversations. I think we should all be, but we shouldn't minimize by dehumanizing. And it must be with re-

spect for both the mother and the defenseless and voiceless unborn child that are participating in that debate. This is too personal for too many Americans.

With that I yield.

Senator MURRAY. We will now introduce today's witnesses and move to testimony. Today, we'll be hearing from Madysyn Anderson. She's a young woman from Texas who was forced to leave her state and travel hundreds of miles to get the abortion care she needed after Texas passed its draconian abortion ban.

Dr. Nisha Verma, an OB-GYN, an abortion provider in Georgia, and a fellow with Physicians for Reproductive Health. Destiny Lopez, acting CEO of the Guttmacher Institute. And Dr. Allison Linton, Chief Medical Officer of Planned Parenthood of Wisconsin. She's also an OB-GYN, an abortion provider, and a fellow with Physicians for Reproductive Health. I will turn it over to Ranking Member Cassidy to introduce his witnesses.

Senator CASSIDY. Yes, I introduce Dr. Christina Francis. She is a board-certified OB-GYN, working as OB-GYN hospitalist, treating women with both high and low risk pregnancies who are hospitalized. She is a board member of Indiana Right to Life. And she is the CEO of the American Association of Pro-Life Obstetricians and Gynecologists.

I'll also introduce Ms. Melissa Ohden. I have that right, Ohden? Yes, who was the founder and Chief Executive Officer of the Abortion Survivors Network. Melissa will tell us of her story about surviving a failed saline infusion abortion in 1977 that was intended to end her life. We're fortunate that Melissa has made this her life's work and runs the Abortion Survivors Network, a group providing support to other abortion survivors and mothers who have experienced a failed abortion. I look forward to hearing from you today, Melissa, and thank you for sharing your powerful story.

Senator MURRAY. Again, thank you to all of our witnesses. We will begin with Ms. Anderson.

**STATEMENT OF MADYSYN ANDERSON, ABORTION PATIENT,
HOUSTON, TX**

Ms. ANDERSON. Thank you, Senator Chair Sanders, Senator Murray, Ranking Member Cassidy, and Members of the Committee. My name is Madysyn Anderson, and I live in Houston, Texas.

Two years ago, during my senior year at the University of Houston, I had just come out of a 2-year long relationship. After a couple weeks of nausea, not sleeping or eating, I took a pregnancy test. I called a friend to bring me more tests because I was in disbelief. At one point, I had five tests in front of me and there was no disputing I was pregnant.

This was just 2 weeks after the Texas abortion ban, known as S.B 8, went into effect banning abortion after 6 weeks. I knew almost immediately that abortion was the right choice for me. I called and got an appointment at the local Planned Parenthood just 5 minutes away from me for later that week. I thought I was early enough to be able to get my abortion that week, but at my appointment, my pregnancy measured 11 weeks.

I was shocked, I couldn't get an abortion in Texas. I called 20 different clinics after my first visit. Yes, 20 I called surrounding states and even as far as the Dakotas, no one could see me right away. The earliest I could be seen was 2 weeks later at Jackson Women's Health Organization in Mississippi. This was before the *Dobbs v. Jackson Women's Health* decision that would take away the Federal constitutional right for abortion, and before 20 more states would ban abortion, and before wait times and states that didn't have bans would stretch longer and longer.

My dad took off work, and we drove a total of 720 miles round-trip, and spent 13 hours on the road. We spent 5 hours in a hotel trying to sleep before my first appointment just to turn right around and go back home.

Here's the thing. Because of unnecessary restrictions on abortion care in Mississippi, I would have to make the trip all over again. The state essentially puts patients in a timeout because they don't trust people to know what is best for their health or lives. When I got this news, I was angry, and sleep deprived, and starving, and never more certain of my decision. That certainty never faltered.

The following week, my mom was able to find us affordable tickets, and we flew out to Jackson. The start of our day was at 7am to make it to my 1.30pm appointment. After my procedure, I went in the recovery room for about 20 minutes before having to hop in the car and make my flight back home.

I want to talk for a minute about money. As a college student who took out multiple student loans and was counting every penny I had to pay for my first appointment in Houston, my first appointment in Mississippi, and the abortion itself. Then gas and a hotel for the first trip. And then flights for the second trip. I missed 20 hours each of work and a mandatory internship for my school, a total \$2,850.

There is no dollar value I can put on the stress of managing everything. The despair of having to go to such lengths for basic healthcare that was legal just weeks before I needed it.

The gut-wrenching reality of having to disclose something so personal to my boss, professors, and anyone in a position of authority for fear of losing my job, of failing every class that semester due to all of the class time and assignments that I was forced to miss.

I felt so much anger that the politicians in Austin thought that they had the right to make this decision for me. I'm one of thousands of people that have now gone through this. Every day that we go without the right for abortion, there will be more of us. More savings accounts drained, more classes and shifts missed, more choices on which bills to skip paying.

If I had found out I was pregnant last year or last month, Jackson Women's Health would not have been there for me. The people who cared for me that day cannot care for abortion patients today. I have to go to New Mexico, Kansas, or as far as Illinois to make that decision.

Today, we talk about abortion and it is easy to get stuck in theoreticals, but I am a real person. The lives of abortion patients are not theoretical. People will continue to get pregnant when

they're not ready or just simply don't want to be. We will always need abortions. This is simply no place for a politician to decide for us. Thank you for inviting me here today and letting me share my story with you.

[The prepared statement of Ms. Anderson follows.]

PREPARED STATEMENT OF MADYSYN ANDERSON

Chair Sanders, Senator Murray, Ranking Member Cassidy, Members of the Committee:

My name is Mady Anderson, and I live in Houston, Texas.

Two years ago, during my senior year at the University of Houston, I had just come out of a 2-year relationship. After a couple weeks of nausea and not sleeping or eating, I took a pregnancy test.

I called my friends to bring me more tests because I was in disbelief. At one point I had five positive tests in front of me.

I was pregnant.

This was just 2 weeks after Texas's abortion ban, known as S.B. 8, went into effect, banning abortion after 6 weeks.

I knew almost immediately that abortion was the right decision for me.

I called and got an appointment for the following week at my local Planned Parenthood, 5 minutes away. I thought I was early enough to be able to get my abortion that week. But at my appointment my pregnancy measured at 11 weeks.

I was shocked. I couldn't get an abortion in Texas.

I called 20 different clinics after that first visit. Yes, you heard correct. 20.

I called surrounding states and even as far as the Dakotas; no one could see me right away. The earliest I could be seen was 2 weeks later, at Jackson Women's Health Organization in Mississippi.

This was before the *Dobbs v. Jackson Women's Health* decision that would take away the Federal constitutional right to abortion. Before 20 more states would ban abortion. Before wait times in states without bans grew longer and longer.

My dad took off from work, and we drove a total of 720 miles roundtrip, and spent 13 hours on the road. We spent 5 hours in a hotel trying to sleep, before going to my first appointment—just to turn right around and head back home.

Here's the thing: Because of medically unnecessary restrictions on abortion care in Mississippi, I would have to make the trip all over again. The state, essentially, put patients in a time-out because they don't trust people to know what is best for our own health and lives. When I got this news, I was angry, sleep-deprived, and starving—and as certain as I ever was that I wanted an abortion. That certainty never faltered.

The following week my mom was able to find us affordable tickets, and we flew back to Jackson. We started our day at 7 a.m. for my 1:30 p.m. appointment. After my procedure, I waited in the recovery room for about 20 minutes, before hopping in a car to make my flight back home.

I want to talk for a moment about money. As a college student who took out multiple student loans, I was counting every penny.

- I had to pay for the appointment in Houston.
- Then gas and hotel for the first trip to Mississippi.
- Then the first appointment in Mississippi.
- Then plane tickets for the second trip to Mississippi.
- Then the abortion itself.
- Then I missed 20 hours of work.
- And 20 hours of my mandatory internship program.
- The total? \$2,850.

There is no dollar value I can put on the stress of managing all of this. The despair of having to go to such lengths for basic, safe health care that was legal just weeks before I needed it. The gut-wrenching reality of having to disclose this deeply personal thing that should be private to professors, my boss, and anyone else in a position of authority over me for fear of not only losing my job but also failing out of all my classes due to all the classes and assignments I missed.

I felt so much anger that politicians in Austin thought they had the right to make this decision for me.

I am one of thousands of people who have now gone through this. Every day, every month we go without a Federal right to abortion, there will be more of us. More savings accounts drained, more classes and shifts missed, more choices about which bill to skip paying.

If I had found out I was pregnant last year or last month, Jackson Women's Health wouldn't have been there for me. The people who cared for me that day cannot care for abortion patients in Mississippi. I would have had to go to New Mexico, Kansas, or as far as Illinois.

When we talk about abortion, it's easy to get stuck talking in theoreticals.

But I am a real person.

The lives of abortion patients are not theoretical. People will continue to get pregnant when we don't want to be. We will always need abortions.

There is simply no place for politicians to decide for us.

Thank you for inviting me here today and letting me share my story.

[SUMMARY STATEMENT OF MADYSYN ANDERSON]

My name is Mady Anderson, and I live in Houston, Texas. Two years ago, during my senior year at the University of Houston, I had just come out of a 2-year relationship. After a couple weeks of nausea and not sleeping or eating, I took a pregnancy test. I was pregnant.

This was just 2 weeks after Texas's abortion ban, known as S.B. 8, went into effect, banning abortion after 6 weeks.

I knew almost immediately that abortion was the right decision for me. I called and got an appointment for the following week at my local Planned Parenthood, 5 minutes away. I thought I was early enough to be able to get my abortion that week. But at my appointment my pregnancy measured at 11 weeks. I couldn't get an abortion in Texas.

The earliest I could be seen was 2 weeks later, at Jackson Women's Health Organization in Mississippi. This was before the *Dobbs v. Jackson Women's Health* decision that would take away the Federal constitutional right to abortion. Before 20 more states would ban abortion.

My dad took off from work, and we drove a total of 720 miles roundtrip, and spent 13 hours on the road. Because of medically unnecessary restrictions on abortion care in Mississippi, I would have to make the trip all over again.

The following week my mom was able to find us affordable tickets, and we flew back to Jackson. We started our day at 7 a.m. for my 1:30 p.m. appointment. After my procedure, I waited in the recovery room for about 20 minutes, before hopping in a car to make my flight back home.

As a college student who took out multiple student loans, I was counting every penny. I had to pay for the appointment in Houston. Then gas and hotel for the first trip to Mississippi. Then the first appointment in Mississippi. Then plane tickets for the second trip to Mississippi. Then the abortion itself. Then I missed 20 hours of work. And 20 hours of my mandatory internship program. The total? \$2,850. There is no dollar value I can put on the stress of managing all of this.

I am one of thousands of people who have now gone through this. Every day, every month we go without a Federal right to abortion, there will be more of us. More savings accounts drained, more classes and shifts missed, more choices about which bill to skip paying. The lives of abortion patients are not theoretical. People will continue to get pregnant when we don't want to be. We will always need abortions. There is simply no place for politicians to decide for us.

Senator MURRAY. Thank you very much.

Dr. Verma.

**STATEMENT OF NISHA VERMA, M.D., MPH, FELLOW,
PHYSICIANS FOR REPRODUCTIVE HEALTH, ATLANTA, GA**

Dr. VERMA. Good morning, Chair Sanders, Senator Murray, Ranking Member Cassidy, and distinguished Members of the Sen-

ate HELP Committee. My name is Dr. Nisha Verma, and I'm a board-certified, fellowship-trained obstetrician and gynecologist, providing full spectrum reproductive healthcare. I'm a fellow with Physicians for Reproductive Health, and I'm also a proud Southerner.

I was born and raised in North Carolina. I currently provide care in Georgia, and I've lived in the southeast for most of my life. I made a commitment when I became a doctor to care for people without judgment throughout their lives. For me, that commitment holds whether I'm talking a young person through a first pap smear, delivering a couple's highly anticipated third child, or supporting a patient and her family as they decide to continue or end a pregnancy.

However, after the Supreme Court's *Dobbs* decision, with Georgia enacting a law that bans most abortions in our state very early in pregnancy, I struggle every day to provide necessary lifesaving medical care. I've seen young moms with worsening medical conditions that make their pregnancies very high risk, and couples whose deeply desired pregnancies are in the process of miscarrying, be turned away or forced to leave their communities to access needed healthcare.

As a doctor, I have the immense privilege of sitting with patients and learning about their lives. For me, these patient stories are a powerful reminder that abortion is not an isolated political issue, and today I want to provide a glimpse of what access to abortion care means for real people.

Shortly after Georgia's 6-week abortion ban went into effect in 2022, I saw a young woman who had just started her junior year of high school, and despite using her birth control correctly, realized after missing her period that she might be pregnant.

She called to make a clinic appointment for an abortion right away, but when she came to see me, she unfortunately was just a couple days past George's arbitrary cutoff, which bans most abortions after just 2 weeks from the first missed period.

I had to tell her that even though I have the skills to help her, I can no longer perform her abortion in our state. She returned to rural Georgia where she lives and I didn't see her again until a few weeks ago. At our most recent visit, she told me that she was unable to find the resources and support to get out of state for abortion care.

She also couldn't find a doctor in her part of the state that took her insurance Medicaid for many months, and so even though she was forced to continue her pregnancy against her will, she couldn't get prenatal care. After delivering her baby, she struggled with postpartum depression and had to move out of her home, drop out of school and work a minimum wage job to try to make ends meet.

She told me that she loves her son, but this is not the life she wanted or planned for herself. I have thought about this patient every day since she came back to my clinic. I know it was Georgia's laws that prevented me from providing her with the medical care she needed and deserved, but I still feel like as her doctor, I failed her.

This patient's story, while heartbreaking, is not unique. We know that bans and restrictions have forced many people to stay pregnant, and we know the harm that people experience when they're unable to get this care. They're more likely to face long-lasting economic hardship, to stay in contact with a violent partner and to develop serious health problems.

Mental health conditions like the postpartum depression that my patient experienced, are the leading cause of pregnancy related deaths in this country.

We also know that abortion care is incredibly safe. In fact, in 2022, over 75 major professional societies representing the overwhelming consensus of the science-based medical community came together to reaffirm that abortion is safe, essential healthcare.

As patients face a growing wave of abortion restrictions, many describe feeling betrayed by a government and healthcare system that is supposed to serve and protect them. Doctors too feel betrayed by our government. Many of my colleagues are overwhelmed by laws that threaten to make us criminals for providing evidence-based, life-saving care to our patients, and are leaving their states. And places like Georgia, where already over 50 percent of counties have no OB-GYNs, these worsening workforce shortages are devastating for all aspects of reproductive healthcare.

I understand that abortion care can be a complicated issue for many people, just like so many aspects of healthcare and life can be. I also know that abortion is necessary compassionate essential healthcare, and that patients are capable of making complex, thoughtful decisions about their health and lives. No law should prevent them from doing so.

I urge you to listen to the stories of people who provide and access abortion care. I hope these stories help you to see how profoundly restrictions on abortion access harm all of our communities. Thank you for having me today and I look forward to your questions.

[The prepared statement of Dr. Verma follows.]

PREPARED STATEMENT OF NISHA VERMA

Good morning Chair Sanders, Senator Murray, Ranking Member Cassidy, and distinguished Members of the Senate HELP Committee. My name is Dr. Nisha Verma, I use she/her pronouns, and I am a board-certified, fellowship trained, obstetrician and gynecologist providing full-spectrum reproductive health care. I am a fellow with Physicians for Reproductive Health, and I am also a proud Southerner—I was born and raised in North Carolina, I currently provide care in Georgia, and I have lived in the Southeast for most of my life.

I made a commitment when I became a doctor to care for people, without judgment, throughout their lives. For me, that commitment holds whether I am talking a young person through a first pap smear, delivering a couple's highly anticipated third child, or supporting a patient and her family as they decide to continue or end a pregnancy. However, after the Supreme Court's *Dobbs* decision, with Georgia enacting a law that bans most abortions in our state very early in pregnancy, I struggle every day to provide necessary, life-saving medical care. I've seen young moms with worsening medical conditions that make their pregnancies very high risk and couples whose deeply desired pregnancies are in the process of miscarrying, be turned away or forced to leave their communities to access needed health care.

As a doctor, I have the immense privilege of sitting with patients and learning about their lives. For me, these patients' stories are a powerful reminder that abortion is not an isolated political issue, and today, I want to provide a glimpse of what access to abortion care means for real people.

Shortly after Georgia's 6-week abortion ban went into effect in 2022, I saw a young woman who had just started her junior year of high school, and despite using her birth control correctly, realized after missing her period that she might be pregnant. She called to make a clinic appointment for an abortion right away, but when she came to see me, she unfortunately was just a couple days past Georgia's arbitrary cutoff, which bans most abortions after just 2 weeks from the first missed period. I had to tell her that, even though I have the skills to help her, I could no longer perform her abortion in our state. She returned to rural Georgia, where she lives, and I didn't see her again until a few weeks ago. At our most recent visit, she told me that she was unable to find the resources and support to get out of state for abortion care. She also couldn't find a doctor in her part of the state that took her insurance, Medicaid, for many months, and so even though she was forced to continue her pregnancy against her will, she couldn't get prenatal care. After delivering her baby, she struggled with postpartum depression and had to move-out of her home, drop out of school, and work a minimum wage job to try to make ends meet. She told me that she loves her son, but this is not the life she wanted or planned for herself.

I have thought about this patient every day since she came back to my clinic. I know it was Georgia's laws that prevented me from providing her with the medical care she needed and deserved, but I still feel like, as her doctor, I failed her.

This patient's story, while heartbreaking, is not unique. We know that bans and restrictions have forced many people to stay pregnant.¹ And we know the harm that people experience when they are unable to get this care—they are more likely to face long-lasting economic hardship, to stay in contact with a violent partner, and to develop serious health problems.² Mental health conditions, like the postpartum depression my patient experienced, are the leading cause of pregnancy-related deaths in this country. We also know that abortion care is incredibly safe—in fact, in 2022, over 75 major professional societies representing the overwhelming consensus of the science-based medical community, came together to reaffirm that abortion is safe, essential health care.³

As patients face a growing wave of abortion restrictions, many describe feeling betrayed by a government and health care system that is supposed to serve and protect them. Doctors, too, feel betrayed by our government. Many of my colleagues, overwhelmed by laws that threaten to make us criminals for providing evidence-based, life-saving care to our patients, are leaving their states. In places like Georgia, where already over 50 percent of counties have no OB/GYNs, these worsening workforce shortages are devastating for all aspects of reproductive health care.⁴

I understand that abortion care can be a complicated issue for many people, just like so many aspects of health care and life can be. I also know that abortion is necessary, compassionate, essential health care, and that patients are capable of making complex, thoughtful decisions about their health and lives—no law should prevent them from doing so.

I am unwavering in my commitment to support people in my home in the South. It shouldn't have to be this way. I urge you to listen to the stories of people who provide and access abortion care. I hope these stories help you to see how profoundly restrictions on abortion access harm all of our communities.

Thank you for having me today, I look forward to your questions.

Senator MURRAY. Thank you.

¹ See #WeCount Report, SOC. OF FAM. PLANNING (May 14, 2024), <https://societyfp.org/wp-content/uploads/2024/05/WeCount-report-6-May-2024-Dec-2023-data-Final.pdf>.

² See Diana Greene Foster, *Turnaway Study: Ten Years, A Thousand Women, and the Consequences of Having or Being Denied an Abortion*, ANSIRH (2020), <https://www.ansirh.org/research/turnaway-study>.

³ *More than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference*, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (July 7, 2022), <https://www.acog.org/news/news-releases/2022/07/more-than-75-health-care-organizations-release-joint-statement-in-opposition-to-legislative-interference>.

⁴ See Stephanie Colombini, *Turning Away Patients Every Day: Georgia OB-GYN on the Effects of Abortion Bans*, HEALTH NEWS FL (May 16, 2024), <https://health.wusf.usf.edu/health-news-florida/20240516/turning-away-patients-every-day-georgia-ob-gyn-on-the-effects-of-abortion-bans>; Adrienne D. Zertuche, *Georgia's Obstetric Crisis: Origins, Consequences, and Potential Solutions*, GA. SENATE STUDY CMTE ON WOMEN'S ADEQUATE HEALTHCARE (Oct. 26, 2015), <https://www.senate.ga.gov/committees/Documents/Oct%2026%20Ga%20Maternal%20Health%20%20Infant%20Research%20Group%20-%20Dr%20Zertuche.pdf>.

Ms. Lopez.

**STATEMENT OF DESTINY LOPEZ, MPA, ACTING CO-CEO
GUTTMACHER INSTITUTE, WASHINGTON, DC**

Ms. LOPEZ. Thank you, Chair Sanders, Ranking Member Cassidy, Senator Murray, and the distinguished Members of the Committee for the opportunity to highlight the clear and growing evidence that the *Dobbs* decision is harming reproductive health and freedom.

My name is Destiny Lopez, and I am the acting co-CEO of the Guttmacher Institute, a leading research and policy organization committed to advancing sexual and reproductive health and rights worldwide.

For decades following the 1973 *Roe v. Wade* decision, anti-abortion advocates worked strategically to make abortion harder to get and highly stigmatized. Public support for abortion's legality has remained high and consistent. But the sheer number of state-level abortion restrictions ensured that abortion became inaccessible for many, even with *Roe* in place.

The *Dobbs v. Jackson Women's Health Organization* decision was an inflection point, unleashing chaos and fear across the Nation. Our experts are constantly assessing this changing landscape and the increasingly robust body of evidence that illustrates the harms caused and exacerbated by *Dobbs* decision.

Two years after the decision, here is what we know: Access to abortion care is severely restricted in many parts of the country. 14 states are now enforcing total abortion bans with very limited exceptions, and many more have other new restrictions in place. The total number of brick-and-mortar clinics providing abortion care in the U.S. declined by more than 40 between 2020 and early 2024.

Banning abortion does not stop the need for abortion access. Which is why many people seeking abortions post-*Dobbs* must overcome huge financial and logistical barriers to get care, especially those in states with total or early gestational bans.

The number of Americans traveling out of state for abortions doubled from 81,000 in 2020 to more than 170,000 in 2023. States that border states with total abortion bans saw the sharpest increases in out-of-state patients.

No one should have to travel to another state to access basic healthcare. And in fact, those who can't overcome the burdens of traveling for care, which for some might mean crossing multiple state lines, may be forced to stay pregnant against their will. Others may decide to self-manage their abortion.

Decades of research have documented that the majority of people obtaining abortions have few financial resources, are people of color, and are already parenting. They are the ones most harshly impacted by bans and restrictions.

We also know that providers are resilient and adapting to meet patient needs. While brick-and-mortar facilities provide more than three-quarters of all abortions, online clinics are expanding care options by offering medication abortion services via telehealth. Re-

search by the Society for Family Planning shows that virtual-only telehealth abortions accounted for almost one in five abortions from October to December 2023.

There are many other important ways *Dobbs* is interfering with reproductive health care across the Nation that I don't have time to discuss in detail today, from current and future OB-GYNs not wanting to practice in ban states to impacts on maternal health and people facing obstetric emergencies.

What does all this mean? Overturning *Roe* did not resolve the debates on abortion that have characterized U.S. politics for the past 50 years. Instead, it enabled policies that have significantly worsened the harms faced by individuals who are most marginalized in our health care system.

Still, despite these immense hardships and many people being denied care, there were more than one million clinician-provided abortions in 2023, a 10 percent increase from 2020. This is a testament to the heroic efforts of providers, abortion funds and other support networks, to the resilience and determination of people seeking care, and to the centrality of abortion in peoples' lives. And it explains why the anti-abortion movement and their political allies are doubling down on even more repressive policies.

For instance, this year, four states introduced legislation and one passed a law criminalizing adults who support adolescents seeking abortion care in another state. Earlier in the year, the Alabama Supreme Court's decision to classify frozen embryos as "children", wreaked havoc on fertility treatment services while advancing the anti-abortion movement's long-term goal to enshrine fetal personhood in both law and policy.

These attacks on bodily autonomy, coupled with two major abortion cases currently before the Supreme Court, signal that the policy and legal landscape will continue to shift.

The full damage caused by *Dobbs* will not be clear for years to come, but the evidence suggests it will not be easy to repair. That's why it is imperative that policymakers at all levels of government champion a bold vision of abortion care that goes beyond what *Roe* promised.

Only policies rooted in evidence and human rights will guarantee that all people have meaningful access to high-quality, affordable abortion care where they live and via the method they choose. Thank you.

[The prepared statement of Ms. Lopez follows.]

PREPARED STATEMENT OF DESTINY LOPEZ

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Banning abortion does not stop the need for abortion access. Which is why many people seeking abortions post-*Dobbs* must overcome huge financial and logistical barriers to get care, especially those in states with total or early gestational bans. The number of Americans traveling out of state for abortions doubled from 81,000 in 2020 to more than 170,000 in 2023. States that border states with total abortion bans saw the sharpest increases in out-of-state patients.

No one should have to travel to another state to access basic healthcare. And in fact, those who can't overcome the burdens of traveling for care, which for some might mean crossing multiple state lines, may be forced to stay pregnant against their will. Others may decide to self-manage their abortion. Decades of research have documented that the majority of people obtaining abortions have few financial resources, are people of color, and are already parenting. They are the ones most harshly impacted by bans and restrictions.

We also know that providers are resilient and adapting to meet patient needs. While brick-and-mortar facilities provide more than three-quarters of all abortions, online clinics are expanding care options by offering medication abortion services via telehealth. Research by the Society for Family Planning shows that virtual-only telehealth abortions accounted for almost one in five abortions from October to December 2023.

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Still, despite these immense hardships and many people being denied care, there were more than one million clinician-provided abortions in 2023—a 10 percent increase from 2020. This is a testament to the heroic efforts of providers, abortion funds and other support networks, to the resilience and determination of people seeking care, and to the centrality of abortion in peoples' lives. And it explains why the anti-abortion movement and their political allies are doubling down on even more repressive policies.

For instance, this year four states introduced legislation—and one passed a law—criminalizing adults who support adolescents seeking abortion care in another state. Earlier in the year, the Alabama Supreme Court's decision to classify frozen embryos as "children" wreaked havoc on fertility treatment services while advancing the anti-abortion movement's long-term goal to enshrine fetal personhood in both law and policy. These attacks on bodily autonomy, coupled with two major abortion cases currently before the Supreme Court, signal that the policy and legal landscape will continue to shift.

The full damage caused by *Dobbs* will not be clear for years to come, but the evidence suggests it will not be easy to repair. That's why it is imperative that policymakers at all levels of government champion a bold vision of abortion care that goes beyond what *Roe* promised.

Only policies rooted in evidence and human rights will guarantee that all people have meaningful access to high-quality, affordable abortion care where they live and via the method they choose.

Thank you.

¹ Information throughout this testimony is referenced here: Baden K, Dreweke J and Gibson C. Clear and Growing Evidence That *Dobbs* Is Harming Reproductive Health and Freedom. Guttmacher Institute, 2024, <https://www.guttmacher.org/2024/05/clear-and-growing-evidence-dobbs-harming-reproductive-health-and-freedom>.

[SUMMARY STATEMENT OF DESTINY LOPEZ]

Destiny Lopez is the acting co-CEO of the Guttmacher Institute. Her testimony will focus on what the research tells us about the impact of *Dobbs*, 2 years after *Roe* was overturned. Ms. Lopez will share the state policy landscape as it relates to abortion access, including that 14 states are now enforcing total abortion bans. Her testimony will include data about people traveling out of state for abortion care and why the lack of abortion access in communities exacerbates inequities and falls hardest on certain groups. Ms. Lopez’s testimony emphasizes the resilience of providers, support networks and patients in finding ways to provide and access care—including the increased use of telehealth to access medication abortion, but makes clear that the landscape is fraught with chaos, hardships and many people being denied abortion care. She also notes that the policy and legal landscape continue to shift—with attacks on IVF and two abortion-related cases before the Supreme Court—as the anti-abortion movement doubles down on more repressive policies.

Senator MURRAY. Dr. Linton.

STATEMENT OF ALLISON LINTON, M.D., MPH, CHIEF MEDICAL OFFICER, PLANNED PARENTHOOD OF WISCONSIN, FELLOW, PHYSICIANS FOR REPRODUCTIVE HEALTH, MILWAUKEE, WI

Dr. LINTON. Chair Sanders, Senator Murray, Ranking Member Cassidy, Members of the Committee, my name is Dr. Allison Linton. I’m a board-certified obstetrician and gynecologist as well as a board-certified complex family planning specialist.

I completed my medical school training, a residency in obstetrics and gynecology, a complex Family Planning fellowship and a master’s of public health at Northwestern University. I’m now an assistant professor of Obstetrics and Gynecology in Milwaukee, as well as Chief Medical Officer of Planned Parenthood in Wisconsin and a fellow at Physicians for Reproductive Health.

I have spent my life learning how to provide the highest standard of care possible to my patients, but because of decisions made by people in power in rooms similar to this in Washington and across the country, my colleagues and I can no longer provide the care we know our patients need.

For the past 711 days since the Supreme Court took away the constitutional right to abortion, my patients and my colleagues have been existing in a state of chaos, confusion, and fear.

In my home State of Wisconsin, a statute from 1849 remained on our books that seemed to ban abortion from the moment of conception. A law written before the Civil War in the abolition of slavery, before women had the right to vote, before the discovery of penicillin.

We had questions about the enforceability of the law, but without Federal protections, the penalties a \$10,000 fine and 6 years in prison were too severe to risk.

All providers in Wisconsin stopped providing abortions immediately after the *Dobbs* decision, with the exception of if an abortion “is necessary” or is advised by two other physicians is necessary to save the life of the mother per the statute.

For those who have no understanding of the complexities of the human body or the perils of pregnancy, this exception might seem self-explanatory. I’m here to inform you Members of the Committee that it is not.

On one hand, we risk medical malpractice and harming a patient if we don't act soon enough. And on the other, we risk criminal prosecution, if a prosecutor feels that we acted too early. What about a patient with a newly diagnosed breast cancer at 8 weeks of pregnancy, who cannot start chemotherapy or radiation while she is pregnant. Is delaying her treatment until after delivery a risk to her life?

What about a patient with a blood clotting disorder where pregnancy will further increase their risk of a pulmonary embolism or stroke. Is the risk of a blood clot enough or do I have to wait until the actual stroke occurs? What about a 13-year-old who's the victim of incest. Is the psychological and physical trauma of carrying a child in her barely pubescent body enough to justify ending her pregnancy?

What about a mother of three who cannot emotionally or financially support another child? She is making a loving decision for the children she already has. Shouldn't she have just as much right to and control over her body and future as any other person who needs an abortion?

Regardless of the reason, these are not rhetorical questions. These are real patients that I encountered and tried to care for in Wisconsin. In reality, any law that tries to delineate when an abortion is or is not permitted will never be able to fully account for the complexities of our patient's health and our patient's lives.

Each patient's situation is unique and regardless of their reason for needing an abortion, they deserve healthcare. Since June 24th, 2022, pregnancy in the United States is far more dangerous for patients with medical complexities, yes, but also for people with abusive partners, for people who may not understand what is happening to their bodies.

For Black women who die from pregnancy and childbirth, three times as often as white women. And it will only get more dangerous. The fear of not being able to provide care for patients as leading practitioners, to move away from states with abortion bans and restrictions, or to stop treating pregnant patients.

It's made recruiting providers more difficult. I have had students request transfer to another state to finish their training. This means that there is less sexual and reproductive healthcare where it is most desperately needed.

After a ruling from a state judge on our 1849 law, we started providing abortion again in Wisconsin in late 2023, but we still work under medically unnecessary restrictions. These restrictions include a 24-hour waiting period, a same provider requirement and a ban on telemedicine abortion. They do nothing but make it harder for patients to get the care they need, especially those that live in rural areas of the state.

Abortion bans mean that there is no longer a standard of care for pregnant patients. They are getting the care based on the state that they live in, in the wealthiest country in the world, this is what we're subjecting pregnant people to: chaos, confusion and fear. My patients deserve so much better. Thank you.

[The prepared statement of Dr. Linton follows.]

PREPARED STATEMENT OF ALLISON LINTON

Chair Sanders, Senator Murray, Ranking Member Cassidy, Members of the Committee:

My name is Dr. Allison Linton. I am a board certified obstetrician and gynecologist as well as a board certified complex family planning specialist.

I completed my medical school training, a residency in obstetrics and gynecology, and Complex Family Planning fellowship and Masters of Public Health at Northwestern University in Chicago, Illinois. I subsequently moved to Milwaukee, Wisconsin, where I am an Assistant Professor of obstetrics in gynecology, as well as the Chief Medical Officer of Planned Parenthood of Wisconsin, and Fellow at Physicians for Reproductive Health.

I have had the opportunity to teach dozens of ob-gyn residents and hundreds of medical students over the past 7 years. I have had the opportunity to work with community partners, expanding access to contraception and sexually transmitted infection testing and treatment in multiple Milwaukee health departments. I have given lectures and trainings across the Midwest in both academic and community settings.

But most of all, I have been honored to take care of patients. I see them annually for Pap tests and breast cancer screening exams, catching up on their new jobs, where their kids are going to college, or what vacation they have coming up. I see them as adolescents when they have questions about how their body is changing. I see them for STI testing, discussions of birth control, irregular periods, and chronic pain symptoms. I sit with them for hours on labor and delivery as they push to bring a new baby into the world. And I cry with them when something changes in their life or a new diagnosis is made and they are forced to make decisions they never thought they would have to.

Sometimes they come alone. Sometimes with a partner or a friend. But we are always with them. Their doctors, their nurses, their health care teams—we support them in every situation, giving them all the information we can, and trusting them to make the decision that is best for them.

Unfortunately, our ability to do our job changed 2 years ago. On June 24, 2022 at 9:10 a.m. Central Time, the *Dobbs v. Jackson Women's Health Organization* ruling sent reproductive health care into a tailspin. For the past 711 days, my patients and my colleagues have been existing in a state of chaos, confusion and fear.

In my home state of Wisconsin, a statute from 1849 remained on our books, which seemed to ban abortion from the moment of conception. A law written before the Civil War and the abolition of slavery, before women had the right to vote, before the discovery of penicillin. While there were certainly questions about the enforceability of this law, due to the harsh penalties associated with violating it—\$10,000 fine and 6 years in prison—all abortions in the state were immediately ceased. There was only a narrow exception for an abortion that “is necessary, or is advised by 2 other physicians as necessary, to save the life of the mother.” No exceptions for rape or incest. No further language to help clarify. Just that one sentence.

For those who have no understanding of the complexities of the human body or the perils of pregnancy, this exception may seem self-explanatory. I have heard some say that physicians should know which cases meet this exception and which don't. That it is up to our best medical judgment and it's the physician's fault if a patient suffers from not receiving appropriate care.

As a practicing physician, I can tell you this is NOT self explanatory. Deciding whether something is or is not necessary to “save the life of the mother” is not clear. Phrases like “threat to maternal life” are not a medical diagnosis, and adding phrases like “imminent death” or “direct threat” do not help to clarify. Medicine is complex and rapidly changing. It is an art where physicians must take all the information presented and try to predict a prognosis or outcome. And we are not infallible. Our tools are not infallible. Telling a physician to “do our best” under threat of felony charges if someone doesn't agree with our best medical judgment is not fair and it is not appropriate.

As physicians, we are trained to make decisions based on the medical evidence in front of us. We are taught to minimize risk to our patients, discuss all medically appropriate options, including their relevant risks and benefits, and honor patient autonomy when they choose the treatment that is best for them. As of June 24, 2022 at 9:10 a.m. Central, we were no longer able to do this.

When would an abortion be necessary “to save the life of the mother”?

What about a patient who presents with heavy bleeding in the first trimester, but there is still fetal cardiac activity on ultrasound—can I remove the pregnancy to stop her bleeding? Do I have to wait for a certain amount of blood loss? Do I have to wait for her vital signs to change, or until she needs a blood transfusion, or until she bleeds so much that she can no longer clot her own blood?

What about a pregnancy affected by a lethal fetal diagnosis such as anencephaly where the top of the fetal head fails to develop or renal agenesis where the fetus's lungs cannot develop. Continuation of pregnancy will never lead to a live child, so is the risk of pregnancy without any potential benefit enough to justify an abortion?

What about when the bag of water breaks before the fetus can survive outside the womb? Or a pregnant patient with unresolved congestive heart failure from her last pregnancy that puts her at a higher risk of dying in this pregnancy—what percent chance of death does she need?

What about a patient with newly diagnosed breast cancer at 8 weeks of pregnancy who cannot start chemotherapy or radiation while she is pregnant? Is delaying her treatment until after delivery a risk to her life?

What about a patient with a blood clotting disorder where pregnancy will further increase their risk of a pulmonary embolism or stroke? Is the risk of a blood clot enough, or do I have to wait until the actual stroke occurs?

What about a 13 year old who is the victim of incest? Is the psychological and physical trauma of carrying a child in her barely pubescent body enough to justify ending the pregnancy?

What about a mother of three who cannot emotionally or financially support another child? She is making a loving decision for the children she already has. She should have just as much control over her body and future as any other person who needs an abortion, for any reason.

These are not rhetorical questions. They are real patients that my colleagues and I have encountered and tried to care for in Wisconsin.

In reality, any law that tries to delineate when an abortion is or is not permitted will never be able to fully account for the complexities of our patients' health and their lives. Each patient's situation is unique, and regardless of their reason for needing an abortion, they deserve health care. These decisions are deeply personal, and my job is to make sure my patients have all the information they need to make the best decision for themselves, their families, and their futures.

Under the 1849 law, instead of being able to follow the medicine—offering patients all their options and letting them choose—we would call additional colleagues asking their opinions, we would discuss cases with our hospital's lawyers. And far too often, we would have to look our patients in the eye and tell them that despite having the medical training to help them and knowing that an abortion was a safe and medically appropriate option, we couldn't help them in their home state due to a law written over 170 years ago by legislators who likely had no medical training and certainly had no understanding of modern medicine.

The consequences of this confusion and fear went beyond what many would typically consider abortion-related. I received calls from colleagues asking if they could provide care for a patient who had experienced a miscarriage. I received calls from colleagues in Illinois and Minnesota who were seeing patients with ectopic pregnancies who had been told they could not receive care in Wisconsin.

Of course my first thought was frustration and concern for patients that were not receiving the standard of care due to fear and misunderstanding. But you must remember we are physicians—not lawyers. These physicians were afraid, trying to interpret an archaic, non-medical law through a modern medical lens. They feared a threat of prosecution, loss of their medical license, loss of their livelihood and career. You cannot blame physicians for being afraid when you have forced them to go against the core tenants of their medical training.

Shortly after the *Dobbs* decision, my partners and I discussed our concerns of covering labor and delivery due to fear of what clinical scenarios may present. We feared being forced to go against our medical training of providing the standard of care OR providing the standard of care and putting ourselves at risk of criminal prosecution. I had similar discussions with my colleagues in the Emergency Department and institutions across the state. We all felt we were left with an impossible choice—risk of malpractice and harming a patient or risk of criminal prosecution?

Since June 24, 2022, pregnancy in the United States is far more dangerous. For patients with medical complications, yes, but also for people with abusive partners. For people who may not understand what is happening to their bodies. For Black

women, who die from pregnancy and childbirth three times as often as white women.

It will only get more dangerous: The fear of not being able to adequately care for patients has led some practitioners to choose to move out of their home states or to stop caring for pregnant patients. It has also made it more difficult to recruit new providers to move into states where they may face criminal prosecution for providing the standard of care. In many areas of the country with maternity care deserts, including Wisconsin, this difficulty retaining and recruiting providers will only worsen our maternal health crisis. There is less sexual and reproductive health care where it is most desperately needed.

In the wake of *Dobbs*, I learned of several residents and medical students inquiring about transferring to another state for the remainder of their training. Speaking to one student, they voiced concerns not just about not being able to receive adequate training to provide comprehensive care to their patients after graduation, but given that they too were of reproductive age, they worried about their health if they or their partner were to experience a medical complication during pregnancy.

Unfortunately, confusion and fear was not isolated to physicians and health care providers. While Wisconsin's 1849 law only threatened prosecution of the person who performed an abortion and not the patient themselves, patients were still afraid. I met with patients who told me they were afraid to come to the emergency room when they were experiencing medical complications in early pregnancy, concerned they would be denied care or accused of doing something to themselves to harm the pregnancy. I spoke with a patient who told me she thought she wasn't allowed to discuss her thoughts about terminating her pregnancy with her own family, being under the impression that they could be charged with a crime if they knew what she was considering. Despite trying our best as a medical community to reassure patients that they could trust their health care team and should feel safe seeking help, I have no doubt that many patients did not receive the care they deserved due to confusion and fear stopping them from disclosing information to their providers.

After a ruling from a state judge on our 1849 law, we started providing abortion again in Wisconsin in late 2023. Now, the lower court's ruling is making its way through the appeals process. Because we don't have any affirmative state-wide protection, there is uncertainty about the future of abortion access in Wisconsin. And we still work under medically unnecessary restrictions. These restrictions, including a mandatory 24-hour waiting period, with a same-provider requirement for medication abortion, and a ban on telemedicine abortion, do nothing but make it harder for patients to get the care they need—especially those who live in rural areas of the state.

I'm glad to see the Senate taking action, from Senator Baldwin's legislation to help restore the Federal right to abortion, to moving to pass the Right to Contraception Act and ensuring the right to IVF. All of this will not fix what has been broken by the *Dobbs* decision, but it is a step in the right direction.

Abortion bans mean there is no longer a standard of care for pregnant patients—they're getting care based on the state they live in. In the wealthiest country in the world, this is what we're subjecting pregnant people to: chaos, confusion, and fear.

My patients deserve so much better.

[SUMMARY STATEMENT OF ALLISON LINTON]

My name is Dr. Allison Linton. I am a board certified obstetrician and gynecologist as well as a board certified complex family planning specialist.

I completed my medical school training, a residency in obstetrics and gynecology, and Complex Family Planning fellowship and Masters of Public Health at Northwestern University in Chicago, Illinois. I subsequently moved to Milwaukee, Wisconsin, where I am an Assistant Professor of obstetrics in gynecology, as well as the Chief Medical Officer of Planned Parenthood of Wisconsin and Fellow at Physicians for Reproductive Health.

As physicians, we are trained to make decisions based on the medical evidence in front of us. We are taught to minimize risk to our patients, discuss all medically appropriate options, including their relevant risks and benefits, and honor patient autonomy when they choose the treatment that is best for them. As of June 24, 2022 at 9:10 a.m., we were no longer able to do this. For the past 711 days, my patients and my colleagues have been existing in a state of chaos, confusion and fear.

In my home state of Wisconsin, a statute from 1849 remained on our books, which seemed to ban abortion from the moment of conception. A law written before the Civil War and the abolition of slavery, before women had the right to vote, before the discovery of penicillin. While there were certainly questions about the enforceability of this law, due to the harsh penalties associated with violating it—\$10,000 fine and 6 years in prison—all abortions in the state were immediately ceased with the exception of if an abortion “is necessary, or is advised by 2 other physicians as necessary, to save the life of the mother.”

For those who have no understanding of the complexities of the human body or the perils of pregnancy, this exception may seem self-explanatory. As a practicing physician, I can tell you this is NOT self explanatory. Telling a physician to “do our best” under threat of felony charges if someone doesn’t agree with our best medical judgment is not fair and it is not appropriate.

In reality, any law that tries to delineate when an abortion is or is not permitted will never be able to fully account for the complexities of our patients’ health and their lives. Each patient’s situation is unique, and regardless of their reason for needing an abortion, they deserve health care. These decisions are deeply personal, and my job is to make sure my patients have all the information they need to make the best decision for themselves, their families, and their futures.

After a ruling from a state judge on our 1849 law, we started providing abortion again in Wisconsin in late 2023. But we still work under medically unnecessary restrictions, and we don’t have any affirmative state-wide protection.

Abortion bans mean there is no longer a standard of care for pregnant patients—they’re getting care based on the state they live in. In the wealthiest country in the world, this is what we’re subjecting pregnant people to: chaos, confusion, and fear.

Senator MURRAY. Dr. Francis.

STATEMENT OF CHRISTINA FRANCIS, M.D., CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS, FORT WAYNE, IN

Dr. FRANCIS. Thank you. Chairman Sanders, Ranking Member Cassidy, and Senator Murray, and Members of the Committee. Thank you so much for the opportunity to speak to you today. As a board-certified OB-GYN hospitalist, who manages both high and low risk pregnancies and has delivered thousands of babies, I really do have the best job in the world.

Not only do I have the distinct honor and privilege to be with women and their families during the most exciting, challenging, and sometimes heartbreaking times of their lives. Not only do I get to help usher little lives into the outside world for the first time, but I also serve as an advocate for both my maternal and fetal patients.

One of the reasons those of us at this table likely chose the specialty of obstetrics was because of the challenge of taking care of two patients at once. Induced abortion, which intentionally ends the life of one of those patients is not healthcare. It is not performed by the vast majority of OB-GYNs and it actively harms our patients.

Thankfully, in most circumstances, the lives of our two patients benefit one another and our mantra of healthy mom, healthy baby, is a reality. There are, however, still situations in which a pregnancy complication can endanger the mother’s life. While these most often occur after the point of fetal viability, currently approximately 22 weeks of pregnancy, they can occur before this point.

The decision to intervene in these situations is extremely difficult, and not one that any of us take lightly. I have sat on the

edge of my patient's bed crying with her as we discussed why we couldn't wait even one or two more weeks when her baby might survive to deliver her. In these discussions, we recognize that our intent in intervening is to save the mother's life, with the unintended consequence of our fetal patient losing his or her life.

An induced abortion occurs when the goal is to end our fetal patient's life. In my nearly two decades of practice, I have never performed an induced abortion, and have also seen most of my colleagues provide excellent care to women even in difficult circumstances without abortion as well.

There's been a lot of false information being spread that laws limiting abortion will prevent these lifesaving treatments. But honestly, this is absurd. Not only do no state laws prohibit these treatments, but even state laws restricting abortion before *Roe* allowed for them.

There are more than 7,000 members of AAPLOG, along with the remainder of the 93 percent of OB-GYNs who do not perform abortions, know that induced abortion does not need to be legal in order to ensure we can provide our patients with excellent healthcare. Women deserve fully informed consent and ongoing medical care. This is yet another point of agreement we should have at this table.

However, the same abortion advocates who are positing that women will die from ectopic pregnancies if states restrict abortion, are the people who have for the last several years, been advocating for women to receive abortion drugs without first being seen by a physician. Which is critical to ensure they do not have an ectopic pregnancy, which occur in one in 50 pregnancies and are the leading cause of maternal mortality in the first trimester.

This is not good medical care and women seeking abortions deserve the same level of healthcare as any other woman. Induced abortion has no health benefits to our patients. It ends the life of one and often causes significant harm to the other.

For example, there are more than 160 studies that show an increased risk of preterm birth in future pregnancies after surgical abortions. Having sat with a patient during the loss of her fifth child, due to extreme prematurity after having surgical abortions with her first two pregnancies, I can tell you that this is devastating for women and their families.

Abortion also leads to a significant increased risk of adverse mental health outcomes. The vast majority of the literature on this issue shows long lasting mental health effects from abortion, including depression, anxiety, drug abuse, and suicide for at least 20 to 30 percent of women.

When our Country is already facing a mental health crisis, we should be minimizing things that contribute to this, not encouraging them. As OB-GYNs, we love caring for both our patients. We all desire for women to have the best possible healthcare and for them and their children to have the best chance to pursue their goals and dreams.

Pro-life laws have not created a women's healthcare nightmare. The idea that induced abortion is the only way women can be suc-

cessful or healthy has. We now have the opportunity to change course.

I invite my colleagues at the table, the thousands of OB-GYNs across this country and you Senators, to lead the way as we empower women with accurate information as exceptional healthcare and better solutions for our maternal patients than ending the lives of their own children.

[The prepared statement of Dr. Francis follows.]

PREPARED STATEMENT OF CHRISTINA FRANCIS



Written testimony of Christina Francis, MD for the Senate HELP Committee hearing on “The Assault on Women’s Freedoms: How Abortion Bans Have Created a Health Care Nightmare Across America”

June 4, 2024

Chairman Sanders, Ranking Member Dr. Cassidy and Members of the Committee,

Thank you for the opportunity to submit testimony on behalf of myself, as a board-certified OB/GYN, and on behalf of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), a professional medical organization with more than 7,000 members across the country and internationally, for which I serve as CEO. I thank you for the chance to offer my expert analysis on the impact of laws protecting life on the healthcare of my patients.

Our country is divided over the issue of abortion, but I do think that there is common ground to be found. However, in order to work together to improve the health and lives of American women, we must ensure that women and physicians are receiving accurate information – beginning with not making women feel that the Supreme Court’s *Dobbs* decision has led to a nightmare for their healthcare. One thing we should all be able to agree upon is that women deserve excellent healthcare and to be empowered with accurate information to inform that healthcare. Prior to the *Dobbs* decision in 2022, we had nearly unfettered access to abortion for 49 years and yet we had one of the worst maternal mortality rates¹ in the developed world, along with the worst preterm birth rate.² My patients deserve better and it is time for us to look for real solutions to the root causes of these problems.

As OB/GYN physicians, we care for two patients during pregnancy. Abortion guarantees the ending of the life of one of our patients – and can severely threaten the life and health of the other. Science is clear that a new, distinct, and living human being comes into existence at the moment of fertilization. Dr. Ward Kischer, the author of one of my medical school textbooks, said this: “Every human embryologist in the world knows that the life of the new individual human being begins at fertilization... It is a scientific fact.”³ A 2018 survey showed that 95% of more than 5000 human biologists were in agreement that life begins at fertilization⁴. This is not a matter of opinion or political persuasion – it is a matter of science. Notably, this held true regardless of the biologist’s position on abortion or political affiliation.

¹ Tikkanen, R., Gunja, M. Z., FitzGerald, M., & Zephyrin, L. (2020, November 18). *Maternal mortality and maternity care in the United States compared to 10 other developed countries*. Maternal Mortality Maternity Care US Compared 10 Other Countries | Commonwealth Fund. Retrieved July 16, 2022, from <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries#:~:text=In%202018%2C%20there%20were%2017,%2C%20Norway%2C%20and%20New%20Zealand>

² March of the Dimes. (n.d.). *Born too soon global map*. Global Map. Retrieved July 16, 2022, from <https://www.marchofthedimes.org/intmission/global-preterm.aspx>

³ Kischer, C. W. (2020, July 17). *When Does Human Life Begin? The Final Answer*. American Life League. <https://www.all.org/learn/item:gdls-when-does-human-life-begin-the-final-answer>

⁴ Jacobs, Steven and Jacobs, Steven. Biologists’ Consensus on “When Life Begins” (July 25, 2018). Available at SSRN: <https://ssrn.com/abstract=3211703> or <http://dx.doi.org/10.2119/ssrn.3211703>



As a practicing OB/GYN Hospitalist, I manage both low- and high-risk pregnancies. I have sat with my patients during the best and worst times of their lives – including when facing a potentially life-threatening complication of a very wanted pregnancy. The decision to intervene in these situations, especially preterm, is extremely difficult and not one that I take lightly. I have sat on the edge of my patient’s bed, crying with her, as we discussed why we couldn’t wait even one or two more weeks, when her baby might survive, to deliver her. After doing everything possible to maximize both her and her baby’s health, sometimes we have to intervene, even knowing it’s too early for her baby to survive. But in all these discussions, we don’t talk about doing an abortion – because our intent in intervening is not to end the life of her child. Even in those situations where we deliver before the baby can survive, we do so in a way that respects the dignity of the lives of both the mother and her child. This is how I’ve practiced for nearly two decades and I’ve always been able not only to provide excellent care to my patients but also to intervene at the first sign of a potentially life-threatening complication.

Abortive procedures aren’t detrimental only to the life of the preborn child; they are also dangerous to the mother both in the short and long-term. Pregnancy is not a disease and induced abortion is not healthcare. Despite what proponents of abortion may claim, induced abortion carries no maternal health benefit and ends the life of a separate human being. As demonstrated by hundreds of studies over nearly five decades, abortive procedures carry several deleterious effects for women, including increasing the risk of preterm birth and mental health problems. These problems have a statistically greater impact on minority populations.

The effects of induced abortions impact women throughout their lifespans, and as board-certified physicians, we believe that our patients’ health will be improved if they receive actual healthcare – not the devastation and false promises of abortion. In fact, induced abortion exists to solve a social problem, not a medical one.

Since the *Dobbs* decision overturned *Roe* and *Casey*, there have been repeated claims that restricting abortion will lead to women dying and that by increasing access to abortion we can decrease maternal mortality rates. These statements, meant to instill fear in women and medical professionals, are baseless for several reasons.

Maternal Mortality

First, extremely poor data collection on maternal deaths and their causes as well as inaccurate data on the number of abortions performed in the United States have led to false claims that abortion is safer than childbirth.³

Abortion proponents claim that restricting abortion has a disparate negative impact on minority women. In taking a closer look, however, it is clear that this argument is not only disproven by science, but it also serves to further target minorities by creating even higher rates of induced abortion which will contribute to greater rates of maternal mortality – something that is already unacceptably high in the United States. It is noteworthy that there are significant differences in birth outcomes in black women when compared with

³ Professional Ethics Committee of AAPLOG. (2019). *Induced Abortion & the Increased Risk of Maternal Mortality*. [Committee Opinion]. American Association of Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2020/01/FINAL-CO-6-Induced-Abortion-Increased-Risks-of-Maternal-Mortality.pdf>



non-Hispanic white women. The rates of natural losses are similar (16%), but 34% of pregnancies in black women end in induced abortion, compared to 11% for white women.⁶

Less than half of pregnancies in black women result in the birth of a live baby (48%). Induced abortion is 3.7 times more common in black women than in non-Hispanic white women, and black women more commonly have later abortions (13%) compared with white women (9%). It is known that the risk of death from induced abortion increases by 38% for every week after eight weeks gestation.⁷ It is possible that the higher rate of legal induced abortion for black women may account for a significant portion of the racial disparity noted in pregnancy mortality. This data, especially in relation to abortion's effects on maternal mortality, unequivocally support preventing induced abortions at least in the 2nd and 3rd trimester (later abortions).

When looking at countries where comprehensive and transparent data collection is performed, a much clearer picture of the impact of abortion is presented. According to a 2016 study conducted in Finland, and published in the *British Journal of Obstetrics and Gynecology*, after termination of pregnancy (induced abortions), mortality rates were the highest (other than for deaths from chronic medical problems). For example, the mortality rate for external causes was 8.1/100,000 among pregnant women and after pregnancies ending with delivery, whereas after termination of pregnancy, the mortality was sixfold higher (49.5/100,000). Importantly, for all pregnancy outcomes, in all age groups under 40, mortality rates were highest after termination of pregnancy.⁸

A study of maternal mortality data from 32 states in Mexico by Koch, et al, revealed that laws that restrict abortion do not lead to an increase in maternal mortality - a claim that is made by many who oppose state abortion restrictions. Koch's study showed that states with less permissive abortion laws exhibited lower maternal mortality ratios (MMR) overall (38.3 vs 49.6.), MMR with any abortifacient (2.7 vs 3.7) and induced abortion mortality ratio (0.9 vs 1.7) than more permissive states.⁹

Geographically diverse countries - such as El Salvador, Chile, Poland, and Nicaragua - which prohibit abortion after previously allowing it, have not seen their maternal mortality worsen. In fact, maternal mortality has improved. South Africa, on the other hand, has seen maternal mortality worsen after the legalization of abortion after its longstanding prohibition.¹⁰

Treating potentially life-threatening conditions in pregnancy – clearing up misinformation

False claims abound that state abortion restrictions will prevent physicians from being able to treat ectopic pregnancies, miscarriage, and other life-threatening complications in pregnancy (such as an intrauterine

⁶ Ibid.

⁷ Professional Ethics Committee of AAPLOG. (2019). *Induced Abortion & the Increased Risk of Maternal Mortality*. [Committee Opinion]. American Association of Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2020/01/FINAL-CO-6-Induced-Abortions-Increased-Risks-of-Maternal-Mortality.pdf>

⁸ Karalis, E., Ulander, V. M., Tapper, A. M., & Gissler, M. (2017). Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001–2012. *BJOG: An International Journal of Obstetrics & Gynecology*, 124(7), 1115–1121.

⁹ Koch E, Chireau M, Pliego F et al. Abortion legislation, maternal healthcare, fertility, female literacy, sanitation, violence against women and maternal death: a natural experiment in 32 Mexican states. *BMJ Open* 2015;9:e006013. doi:10.1136/bmjopen-2014-006013.

¹⁰ Hegan MC, Foreman KJ, Naghavi M, et al. *Maternal mortality for 181 countries, 1989–2008: a systematic analysis of progress towards Millennium Development Goal 5*. *Lancet* 2010; 375: 1609–23



infection). This is blatantly absurd, as not a single state law restricting abortion prevents treating these conditions.

According to the Royal College of Obstetricians and Gynaecologists (RCOG), “When undertaking a termination of pregnancy, the intention is that the fetus should not survive and that the process of abortion should achieve this.”¹¹ Our intent when we treat an ectopic pregnancy or other life-threatening conditions in pregnancy is to save the life of the mother, not to directly end the life of the embryonic or fetal human being. Therefore, these are not abortions, a fact even Planned Parenthood acknowledges.¹² Life-threatening conditions in pregnancy most commonly occur after the point of viability (where the fetus can survive outside of the mother’s womb). In these situations, it is absolutely ludicrous to suggest that an induced abortion is needed. We simply deliver the mother and provide care for both her and her baby – something that is not only consistent with the oath we took as physicians to never intentionally harm our patients, but is also much more expedient than an abortion procedure at this stage of pregnancy. In the rare, but real, circumstances where this occurs prior to the point of viability (now 21-22 weeks in some centers), we can provide life-saving care to the mother in a way that also respects the dignity of her preborn child. Again, these interventions are not prevented by any law in this country.

A miscarriage, though medically coded as a *spontaneous* abortion, is a condition in which the embryonic or fetal human being has already passed away and therefore any treatment of a miscarriage would not be an induced abortion. For the 93%¹³ of practicing OB/GYN’s who do not perform abortions but have always been able to offer life-saving treatment to women, we can still do so, regardless of state laws on abortion. Our medical expertise and years of training make it very possible for us to discern when we need to intervene to save a woman’s life, and competent physicians, either on their own or in consultation with colleagues and subspecialists, who are monitoring their patients closely will be able to make this determination well before death is imminent. All OB/GYN residents are already trained in the procedures and treatments necessary to evacuate a woman’s uterus when medically indicated and laws restricting abortion will not impact this in any way. Specific training in induced abortion aimed at ending the life of our fetal patient is not needed.

Spurious claims of impact on physician numbers

Recently, an article from the Association of American Medical Colleges that looked at medical residency application numbers for the 2023-2024 cycle has been gaining a lot of attention. The article details how overall application numbers dropped, but that the drop was more dramatic in states with laws preventing abortion than in those with no abortion regulations.¹⁴ The authors imply that this drop is because of those states’ abortion laws. However, correlation is not causation. There are many factors that likely contributed to this decrease. Leading these factors is that this has been an “intentional goal” of the AAMC ERAS (residency match) system as well as individual specialties for several years – to decrease the number of applicants/residency spot. The report acknowledges that all residency programs filled, and OB/GYN

¹¹ Royal College of Obstetricians and Gynaecologists, “Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales,” at 29 (2010), available at: https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport_18may2010.pdf

¹² <https://www.plannedparenthood.org/learn/pregnancy/ectopic-pregnancy>

¹³ Desai S, Jones RK, Castle K. Estimating abortion provision and abortion referrals among United States obstetrician-gynecologists in private practice. *Contraception*. 2018 Apr;97(4):297-302. doi: 10.1016/j.contraception.2017.11.004. Epub 2017 Nov 21. PMID: 29174883. PMCID: PMC5942890.

¹⁴ <https://www.aamcresearchinstitute.org/our-work/data-snapshot/post-dobbs-2024>



actually saw an overall increase (albeit small). If medical students are avoiding states with pro-life laws, it also is likely because of the wealth of misinformation about being able to provide women with life-saving care in those states.

Impact of Induced Abortion on Women's Health

As stated previously, pregnancy is not a disease and induced abortion is not healthcare. It is not even a neutral option. The ramifications of abortions for women stretch beyond the short-term risks of the current pregnancy and into later pregnancies through the rise of preterm birth in women who have undergone abortive procedures. The Institute of Medicine (now known as the National Academy of Medicine) has listed induced abortion as an *immutable* risk factor for preterm birth (PTB).¹⁵ This increased risk of preterm birth is especially impactful in the black population, which has a 3-4x higher abortion rate and a 2x higher preterm birth rate than Caucasians.¹⁶

The association between abortion and PTB has been shown in more than 160 studies over 50 years. This doesn't just impact the woman's future children, it also impacts the woman herself. Mothers who deliver preterm are at a higher risk of medical complications later in life, including cardiovascular disease and stroke.¹⁷

Non-hispanic black race (compared with non-hispanic white race) is a consistent risk factor for preterm birth and adverse pregnancy outcomes in the United States. The risk associated with race is significant, in a large systematic review of 30 studies, black women were found to have a 2-fold increased risk of PTB (95% CI: 1.8–2.2; pooled odds ratio) compared with non-hispanic whites.¹⁸ Surgical abortions increase a woman's risk of PTB in future pregnancies by approximately 35% after one abortion and up to 90% after two abortions.¹⁹

In addition to the physical ramifications of abortive procedures, there is also a direct relationship between abortions and mental health complications. As America battles its largest mental health epidemic to date, it is appalling that lawmakers would oppose legislation that would limit something shown to worsen mental health outcomes and suicide rates. States should be able to pass laws that will protect both the physical and mental health of their citizens.

From 1993 to 2018, there were 75 studies examining the abortion-mental health link, of which two-thirds showed an increased risk of mental health complications after abortion. The National Academy of Science report²⁰ on abortion ignored the majority of these, choosing, instead, to review only 7 studies. Five of these

¹⁵ <https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy>.

¹⁶ Butler, A. S., & Behrman, R. E. (Eds.). (2007). *Preterm birth: causes, consequences, and prevention*. National Academies Press.

¹⁷ Schaaf JM, Liem SM, Mol BW, Abu-Hanna A, Ravelli AC. *Ethnic and racial disparities in the risk of preterm birth: a systematic review and meta-analysis*. *Am J Perinatol*. 2013 Jun; 30(6):433-50.

¹⁸ Manuck TA. *Racial and ethnic differences in preterm birth: A complex, multifactorial problem*. *Semin Perinatol*. 2017;41(8):511-518. doi: 10.1053/j.semper.2017.08.010

¹⁹ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Risks of Preterm Birth* [Practice Bulletin]. American Association of Pro-life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-PRACTICE-BULLETIN-5-Abortion-Preterm-Birth.pdf>

²⁰ National Academies of Sciences, Engineering, and Medicine. 2018. *The Safety and Quality of Abortion Care in the United States*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24950>



studies were derived from the same group of women, known as the Turnaway cohort. There are several well-known problems with the Turnaway cohort.

The Turnaway studies were done through ANSIRH (Advancing New Standards in Reproductive Health), a pro-abortion research group at the University of California at San Francisco. The Turnaway cohort itself had poor participation rates and a high attrition rate - only 37% of women responded and an additional 44% dropped out - leaving a cohort of only 17% of those surveyed and increasing the risk of self-selection bias towards women less wounded by their abortions. The cohort also left out important demographic factors known to increase the risk of adverse mental health outcomes, such as gestational age at the time of abortion. An abortion done after the first trimester is a significant risk factor for subsequent psychiatric distress.²¹ Also, their own study found that more than 96% of women who had been denied abortions were glad they didn't have an abortion five years later.

If the 14 risk factors for adverse mental health outcomes determined by the American Psychological Association are applied to women seeking abortions, then the majority of women who abort are at risk for adverse mental health outcomes.²²

The most comprehensive review of available literature revealed that 49 out of 75 of the studies (65%) showed a positive correlation between abortion and adverse mental health outcomes. Induced abortion significantly increases the risk for depression, anxiety, substance abuse, and suicidal ideation and behavior - even when compared to women with unintended pregnancies who carried to term.²³ The Finland study on maternal mortality showed an alarming 7x higher suicide rate after abortion when compared to giving birth. The mortality rate for suicides was 3.3/100,000 in ongoing pregnancies and pregnancies ending in birth while it was 21.8/100,000 after termination of pregnancy and 10.2/100,000 among non-pregnant women - actually showing a *protective* effect from giving birth.²⁴

There is consensus amongst most social science scholars that a minimum of 20-30% of post-abortive women suffer from serious, prolonged negative psychological consequences - yielding at least 186,000 new cases of mental health problems each year.²⁵ Given the current mental health crisis in the U.S., it is incumbent upon us as a medical profession to do everything that we can to help improve the mental health of our patients. Decreasing the number of abortions in this country, and instead giving women the support they truly desire, would be a big step towards accomplishing this.

A recent peer-reviewed study showed that only 1/3 of abortions were considered "wanted", nearly 1 in 4 women reported feeling forced or coerced into their abortion decision, and a staggering 60% of women

²¹ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health*. [Practice Bulletin]. American Association of Pro-Life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB17.pdf>

²² American Psychological Association, Task Force on Mental Health and Abortion. (2008). *Report of the Task Force on Mental Health and Abortion*. Washington, DC: Author. Retrieved from <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>

²³ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health*. [Practice Bulletin]. American Association of Pro-life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB17.pdf>

²⁴ Karalis, E., Ulander, V. M., Tapper, A. M., & Gissler, M. (2017). Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001-2012. *IJOG: An International Journal of Obstetrics & Gynecology*, 124(7), 1115-1121.

²⁵ Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). *Abortion and Mental Health*. [Practice Bulletin]. American Association of Pro-life Obstetricians & Gynecologists. <https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB17.pdf>



Further, an in person visit and ultrasound are required to adequately rule out an ectopic pregnancy, one of the main contraindications to chemical abortions³¹ and one of the leading causes of maternal death in the first trimester. Ectopic pregnancies occur in 1 in 50 pregnancies and are life-threatening. The symptoms of a rupturing ectopic pregnancy are very similar to symptoms from a chemical abortion – pain and bleeding. A delay in diagnosis by even a few hours can be catastrophic. And yet, the same abortion proponents who are falsely claiming that women won't be able to receive ectopic pregnancy treatment if abortion is restricted are the same people claiming that abortion drugs being dispensed online without proper screening for ectopic pregnancy is completely safe.

Finally, it is imperative that women seeking abortions be screened for coercion, intimate partner violence (IPV), and trafficking. For many trafficking victims, an interaction with a healthcare professional is one of their only chances of finding help.³² Not only does online provision of these drugs not allow for adequate screening for these abuses, but it potentially supplies abusers with a supply of drugs to force abortions on their victims. Women deserve better care and support than this irresponsible dispensing of potentially dangerous drugs provides.

The Abortion Industry has Abandoned Women

Women seeking abortions deserve the same level of healthcare as any other woman. The cases of patient mistreatment, of physicians practicing outside of their area of expertise and of abandonment by abortion centers after the conclusion of the procedure is unacceptable, unethical, and irresponsible. The ramifications of these procedures are not felt by the providers of abortions, or by their clinics, but instead by the women who are left alone and in the dark as to how, when, or where to seek treatment when complications unavoidably arise.³³

While many claim that abortion restrictions interfere with the patient/physician relationship, many abortion providers have no previously established relationship with the patients they see. These providers subsequently leave the aftercare of said patient to other physicians who do have that previous relationship or to physicians in the patient's local emergency department.

Unfortunately, this negligent model of care has been propped-up by large medical organizations claiming to be leaders in women's healthcare. A glaring example of placing a political agenda ahead of sound medical care can be found in the largest medical membership organization in the United States for obstetricians and gynecologists, of which I was once a member.

While the American College of Obstetricians and Gynecologists (ACOG) claims to represent all OB/GYN's in the U.S. and to be the standard setting organization for the practice of obstetrics, they have a clear double standard when it comes to abortion and they have not supported even common-sense regulations that would

³¹ https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687o020b1.pdf

³² AAPLOG, "Committee Opinion 5: Joint Committee Opinion Pornography, Sex Trafficking and Abortion," 2019. <https://aaplog.org/wp-content/uploads/2019/07/revised-AAPLOG-Joint-CO-5-Pornography-Sex-Trafficking-and-Abortion-with-ACPOds-logo-2.pdf>

³³ Brief of Amicus Curiae American Association of Pro-Life Obstetricians and Gynecologists in Support of Rebekah Gee, Secretary, Louisiana Dept. of Health and Hospitals, Case Nos. 18-1323 & 18-1460. Accessible at: https://www.supremecourt.gov/DocketPDF/18/18-1323/126927/20191227154424689_AAPLOG%20Amicus%20Brief.pdf



ensure women seeking abortions are cared for under the safest possible conditions and receive fully informed consent.³⁴

The risks of abortion increase significantly the further along in pregnancy a woman is, and so accurate assessment of her gestational age is crucial. In their Committee Opinion #815, titled "Increasing Access to Abortion", ACOG states that ultrasounds are "medically unnecessary" prior to abortions.³⁵ Yet, their own Committee Opinion on establishing due dates in pregnancy states that only approximately 50% of women will be able to accurately recall their last menstrual period - and a pregnancy without an ultrasound examination that confirms or revises the estimated due date before 7 weeks of gestational age should be considered sub-optimally dated.³⁶ This is important because without an accurate dating of their pregnancies, women will not be able to provide informed consent which requires an understanding of their risks for hemorrhage, retained tissue and emergency surgery—all of which depend on gestational age of the pregnancy.

ACOG also claims that admitting privileges or formal patient handoffs are medically unnecessary for women experiencing abortion complications.³⁷ And yet, their Committee Opinion #517 "Communication Strategies for Patient Handoffs" states:

Patient handoffs are a necessary component of current medical care...Accurate communication of information about a patient from one member of the health care team to another is a critical element of patient care and safety...One of the leading causes of medical errors is a breakdown in communication...One predictable and critical communication event is the patient handoff. A handoff may be described as the transfer of patient information and knowledge, along with authority and responsibility, from one clinician or team of clinicians to another clinician or team of clinicians.³⁸

ACOG opposes mandatory reflection periods before abortions, and yet the data support that many women are either unsure of their decisions or pressured into them.³⁹ A 2004 study that spoke with women who had undergone abortions in the U.S. showed the importance of waiting periods, increased counseling and in person visits to screen for coercion⁴⁰.

³⁴ *Ibid*

³⁵ Committee on Health Care for Underserved Women. (2020). *Increasing Access to Abortion*. [Committee Opinion]. American College of Obstetricians & Gynecologists. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion>

³⁶ Committee on Obstetric Practice. (2017). *Methods for Estimating Due Date*. [Committee Opinion]. American College of Obstetricians & Gynecologists. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date.pdf>

³⁷ Brief of amici curiae American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics, American College of Nurse-Midwives, American College of Osteopathic Obstetricians and Gynecologists, American College of Physicians, American Society for Reproductive Medicine, National Association of Nurse Practitioners in Women's Health, North American Society for Pediatric and Adolescent Gynecology, and Society for Maternal-fetal Medicine in Support of Petitioners, Case No. 18-1323. Accessible at: https://www.supremecourt.gov/DocketPDF/18/18-1323/100434/20190520175434029_18-1323%20ACOG%20et%20al.%20v.%20amicus%20brief.pdf

³⁸ Committee on Patient Safety and Quality Improvement (2007). *Communication Strategies for Patient Handoffs*. [Committee Opinion]. American College of Obstetricians & Gynecologists. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/communication-strategies-for-patient-handoffs>

³⁹ Committee on Health Care for Underserved Women. (2014). *Increasing Access to Abortion*. [Committee Opinion]. American College of Obstetricians & Gynecologists. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/increasing-access-to-abortion>

⁴⁰ Ruz, V. M., Coleman, P. K., Ruz, J. J., & Reardon, D. C. (2004). Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. *Medical Science Monitor*, 10(10), SR5-SR16.



- 67% stated they received no counseling prior to their abortion
- Only 11% felt that the counseling they received prior to their abortion was adequate
- Only 17% were counseled on alternatives
- 64% of women responded that they felt pressured to have the abortion
- 54% of women were unsure about their abortion decision at the time
- 30% of women who responded had health complications after their abortions
- 36% of women had suicidal ideations after their abortions and 54% felt bad about their decision
- 60% of women stated that they felt "part of me died"
- Only 4% claimed to feel more in control of their life after their abortion

ACOG's position on abortion, which is radically out of step with the majority of their members, was made crystal clear in a statement in a 2023 Washington Post Letter to the Editor: "Abortion is safe. It improves and saves lives, and it must be available *without restrictions, without limitations and without barriers...*" (emphasis mine).⁴¹ This same call for induced abortion without any restrictions or regulations (including gestational age limits which the vast majority of Americans support) is echoed in the so-called "Women's Health Protection Act" which would be more aptly named the "Abortion Until Birth for Any Reason Act."

Providing True Healthcare and Support for Women

As stated above, the majority of women who have abortions actually desired to carry their pregnancies to term and deliver their children. That any woman would feel that she had to choose to end the life of her child simply because she didn't have appropriate support in a country like the United States is a travesty and something we should all be united in solving. Induced abortion has long been touted as a panacea for many challenges that women face, and it has failed to be a solution to anything. Rather than focusing our attention on "increasing access" to abortion, we should be focusing on real solutions for women and improving the healthcare that pregnant women receive. Examples of unifying policies include expanding support for pregnancy centers that are often a first point of contact and could be supported to provide early prenatal care, expanding support for working mothers (including transportation and childcare), encouraging involvement of fathers, and prioritizing full service health clinics in maternal care deserts that would be able to provide low-risk prenatal care and appropriate and timely referrals to higher level care when needed. I don't propose to know every possible solution, but I do know that when induced abortion is the automatic answer for any challenging pregnancy, we will never find the right solutions.

We have a lot of work to do in this country to improve maternity care for women – none of which requires intentionally ending the lives of vulnerable human beings or exposing women to the harms of induced abortion. We also owe it to women to be sure they receive accurate information – not fearmongering that tells them they won't be able to receive the life-saving care that they need. Stories of women being sent home to "get sicker" before they can receive care highlight the lack of proper explanation of state pro-life protections. For those of us who have practiced our entire careers without performing procedures that intend the death of our fetal patients, we know that providing women with excellent healthcare in states where abortion is illegal is not only possible, it can produce the best outcomes. We are leading the way in showing how to provide true healthcare for all of our patients – not a band-aid for social issues that need to

⁴¹ <https://www.washingtonpost.com/opinions/2023/08/30/abortion-debate-honesty-matters/>



be addressed outside of the medical profession. We are also working to restore the integrity of the physician-patient relationship by restoring the trust that patients should have that their physician is recommending what is best for their health and the health of their child based on the most current medical evidence and informed by the ethical principles that have guided the practice of medicine for millennia.⁴² This also requires physicians having accurate information about their state laws so that they do not hesitate to provide indicated life-saving care to women and, when possible, their children. Our patients are empowered when they are given accurate information, fully informed consent and real healthcare solutions rather than a political narrative.

Respectfully submitted,

Christina Francis, MD, dip ABOG
CEO, American Association of Prolife Obstetricians and Gynecologists (AAPLOG)

⁴² The Hippocratic Oath forbids doctors to perform abortion, stating "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy." William C. Shid, Jr., M.D., Medical Definition of the Hippocratic Oath (2018), available at: <https://www.medicinenet.com/script/main/art.asp?articlekey=20909>

[SUMMARY STATEMENT OF CHRISTINA FRANCIS]

As a board-certified OB/GYN Hospitalist who manages both high-and low-risk pregnancies and has delivered thousands of babies, I have the distinct privilege to be with women and their families during the most exciting, challenging, and sometimes heartbreaking times of their lives. I am also here as an advocate for my patients.

With the advancements in medical technology and understanding over the last 50+ years, it is now undisputed fact that, at the moment of fertilization, a distinct, living and whole human being comes into existence.

While most pregnancy complications threatening the mother's life occur after the point of fetal viability (currently approximately 22 weeks of pregnancy), they can occur before this point. The decision to intervene in these situations, especially preterm, is extremely difficult and not one that I take lightly. These interventions are not induced abortions.

There has been a lot of false information being spread that laws limiting abortion will prevent these life-saving treatments, but this is simply untrue. Not only do NO state laws currently on the books prohibit these treatments, but even state laws restricting abortion pre-*Roe* allowed for them. The more than 7,000 members of AAPLOG, the American Association of Pro-life OB/GYNs, along with the remainder of the 76–93 percent of OB/GYNs who do not perform abortions, know that induced abortion does not need to be legal in order to ensure we can provide our patients with excellent healthcare.

In fact, excellent healthcare does not include induced abortion at all. Induced abortion has no health benefits to my patients—it ends the life of one and often causes significant harm to the other. For instance, there are more than 160 studies that show an increased risk of preterm birth in future pregnancies after surgical abortion.

Abortion also leads to a significant increased risk of adverse mental health outcomes. The vast majority of the literature on this issue shows long-lasting mental health effects from abortion including depression, anxiety, drug abuse and suicide for at least 20–30 percent of women. One large study showed that women who had abortions had a **7x increased risk** of suicide compared to women who carried their pregnancies to term.

The other witnesses and I have something essential in common. I assume we all desire for women to have the best possible healthcare and for them and their children. Pro-life laws have not created a women's healthcare "nightmare"—the idea that induced abortion is the only way women can be successful or healthy has. We now have the opportunity to change course—and tens of thousands of physicians across the country who do not perform induced abortions are ready to lead the way as we empower women with accurate information and excellent healthcare.

Senator MURRAY. Ms. Ohden.

STATEMENT OF MELISSA OHDEN, MSW, FOUNDER AND CHIEF EXECUTIVE OFFICER, THE ABORTION SURVIVORS NETWORK, KANSAS CITY, MI

Ms. OHDEN. Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for inviting me to today's hearing. I am Melissa Ohden, the survivor of a failed saline infusion abortion, and the founder and CEO of the Abortion Survivors Network.

Babies survived abortions before *Roe v. Wade*. We survived during *Roe v. Wade*, and babies are still surviving abortions no matter where or how the abortion is performed. These experiences highlight the fundamental and undeniable humanity of the pre-born and the needs, fears, and experiences of their mothers. I appreciate this opportunity to have a serious conversation about this issue and for stories that highlight the impact of abortion to be told.

Earlier this year, *The Washington Post* wrote a story about a woman named Evelyn that I want to share with you today. Evelyn's trips to abortion clinics ended differently than expected. Two separate attempts where medication abortion failed, and she was found to be too far along to abort a third time. If we're going to talk about women's experiences with abortion, then we need to include these stories in this discussion as well.

I empathize with Evelyn, shocked at discovering that her first medication abortion failed. As directly quoted, she fainted when she saw that there was a heartbeat on the ultrasound and was in and out of consciousness for about 5 minutes.

As a journalist Amber Ferguson wrote with an honesty I appreciate, "Evelyn says she didn't know that the pills sometimes didn't work". She later learned that 3 percent of medication abortions fail when the gestation reaches 70 days or 10 weeks according to the American College of Obstetricians and Gynecologists.

I can tell you that the Abortion Survivors Network hears these stories from women time and again. They're shocked to discover they're still pregnant with the baby they attempted to abort. They try to keep it a secret and often navigate it alone.

Whether they continue the pregnancy or attempt another abortion or multiple abortions as Evelyn did. As directly quoted, desperate Evelyn found a website aid access that shipped abortion medication across the country.

After speaking with a doctor by phone and paying \$150, she waited for pills that were being mailed from India. This second course of abortion drugs also failed to end her pregnancy. Evelyn's story and her daughter's life wasn't over yet. As the article continues, she found a clinic in Albuquerque that offered second trimester abortions. She was approaching the third trimester.

The clinic staff warned about the health risks of having a surgical abortion so late in her pregnancy, but helped connect her to two abortion organizations that covered the cost of her plane ticket, hotel food, and the \$12,000 procedure. We need to pause here and truly consider Evelyn and her daughter.

The support she was offered after the failure of two medication abortions was to pay for a plane ticket, lodging, food, and a \$12,000 abortion that posed risks to her health. This is an abysmal response to Evelyn and her baby. Evelyn needed emotional support, medical and mental healthcare, financial assistance. Evelyn's baby like me, deserved more than to be subjected to yet another attempt to end her life.

Could you imagine a child in your own life being subjected to so-called medical interventions intended to weaken, starve, burn, or dismember them limb by limb until they die? This is the reality of abortion and we should be ashamed of it. Evelyn was found to be 32 weeks pregnant.

According to Southwestern Women's Options, the clinic's doctors aren't trained to perform abortions after 24 weeks. Evelyn soon thereafter gave birth to her daughter and she made an adoption plan, an option they both can live with.

The nightmare here is not abortion bans. The nightmare is that abortion continues to be aggressively promoted, so that it is seen as the only option, like a plane ticket and \$12,000 for a late-term abortion.

I ask each of you to consider how different women’s and children’s lives, families, our society could be, if just as much money was spent to provide financial assistance, housing, education, and employment support, childcare, medical, and mental health care. This would lead to a new era of women’s empowerment that ends the generational trauma of abortion. This doesn’t have to be a dream. We can make it a reality.

[The prepared statement of Ms. Ohden follows.]

PREPARED STATEMENT OF MELISSA OHDEN

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for inviting me to today’s hearing.

I am a survivor of a failed saline infusion abortion and the Founder and CEO of The Abortion Survivors Network, which has connected with over 700 survivors of abortion procedures. Babies survived abortions before *Roe vs. Wade*, we survived during *Roe vs. Wade*, and babies are still surviving abortions, no matter where or how the abortion is performed, as I’ll be sharing today. These experiences highlight the fundamental and undeniable humanity of the preborn and the needs, fears, and experiences of their mothers.

I appreciate the opportunity to have a serious conversation about this issue and for stories that highlight the impact of abortion to be told. My hope is that today’s discussion is the catalyst for intellectual honesty, deeper conversations and understanding, and collective support across the aisle for women, children, and families.

Earlier this year, the Washington Post wrote a story about a woman named Evelyn. Evelyn was young and pregnant, and the article chronicled her decision to obtain an abortion and end her pregnancy. This is a common and familiar story, but this story had a plot twist. Her first abortion failed, her second also failed, but she persevered and sought a late-term abortion but was denied it. This, too, may be part of the familiar narratives. However, the redemption in her story is evident, as she decided to place her child for adoption and now has a relationship with her daughter and the woman who raises her.¹ Her story is one of a failed abortion, one that I am very familiar with but many try to deny or hide. When the term “abortion survivor” is dismissed as “fake news,” women like Evelyn and my birth mother, Ruth, are also being dismissed, their experience erased and denied with the experiences of those who survived—like Evelyn’s daughter and me.

If we are going to talk about women’s experiences with abortion and the nightmare of abortion, then we need to include these stories in the discussion, as well.

While Evelyn’s trips to abortion clinics ended differently than expected—two separate attempts with medication abortion failed, and she was found to be too far along to abort a third time—they stand as proof that a pregnancy can continue after an abortion. Some of the most powerful words in this article came from the journalist, who expanded on and called attention to women’s healthcare in America. Let me be clear: Women in America and around the world deserve better than abortion.

I empathize with Evelyn’s shock at discovering that her first medication abortion failed. When a family friend and nurse arranged for bloodwork and an ultrasound at a hospital after months passed without her menstrual cycle returning, as directly quoted, she “fainted when she saw that there was a heartbeat, and was in and out of consciousness for about 5 minutes” (1).

As the journalist Amber Ferguson wrote with an honesty I appreciate, “Evelyn says she didn’t know the pills sometimes didn’t work. It is a rare occurrence, but she later learned that 3 percent of medication abortions fail when gestation reaches 70 days, or 10 weeks, according to the American College of Obstetricians and Gynecologists. The odds of failure increase if the patient waits longer than prescribed to take the second dose of the medication, several medical experts said” (1).

¹ Ferguson, Amber. “After abortion attempts, two women now bound by child.” Apr 16 2024. The Washington Post.

Abortion bans have not ended abortion—we’ve merely seen a shift to abortion pills. These pills have a lower success rate and result in women becoming their own DIY abortionist. The results of this access to abortion are staggering, nearly 1–8 percent of abortion pills fail, which means that women are still facing the same challenges as before, and put themselves and their child at risk for repeat abortion attempts (2345).

How could Evelyn know this when women aren’t told this information? *The Abortion Survivors Network* hears these stories from women time and time again—they are shocked to discover they are still pregnant with the baby they attempted to abort. They are unaware that abortion procedures, including medication abortion, can fail. They feel shame and guilt, uncertainty and fear about their baby’s future. They try to keep this a secret and often navigate it alone—whether they continue the pregnancy or attempt another abortion—or multiple abortions—as Evelyn did.

Women nationwide could identify with Evelyn’s experience because it weaves several threads of an abortion experience. “Desperate, Evelyn found a website, Aid Access, that shipped abortion medication across the country. After speaking with a doctor by phone and paying \$150, she waited for pills that were being mailed from India. Evelyn had told the doctor she wasn’t sure the date of her last period” (1).

Shocking as it was for Evelyn, this second course of abortion drugs also failed to end her pregnancy.

This was not what Evelyn was told would happen. It must have been agonizing when she realized that not one, but now two medication abortions failed to end her pregnancy. But her story, and her daughter’s story—her daughter’s life—wasn’t over yet.

As the article continues, “She found a clinic in Albuquerque that offered second-trimester abortions. She was past the halfway point in her pregnancy and approaching the third trimester, but she still had time, Evelyn told herself. The clinic staff warned about the health risks of having a surgical abortion so late in her pregnancy but helped connect her to two abortion organizations that covered the cost of her plane ticket, hotel, food and the \$12,000 procedure . . .” (1).

We need to pause here and truly consider Evelyn and her daughter.

The support she was offered after the failure of two medication abortions was to pay for her plane ticket, lodging, food, and the \$12,000 abortion that posed risks to her health.

This is an abysmal response to Evelyn and her baby. Evelyn needed emotional support, medical and mental health care, financial assistance, and answers to the questions she had about the impact medication abortion attempts had on her developing baby. Evelyn’s baby deserved more than to be subjected to yet another attempt to end her life. *Can you imagine a child in your own life subjected to so called “medical treatments” intended to weaken, starve, burn or dismember them limb by limb until they die?*

This is the reality of abortion. *And we should be ashamed of it.*

Yet this story did not end in an abortion clinic. ‘I’m so sorry,’ Evelyn remembers the nurse telling her, looking at the screen. ‘You are too far along, 32 weeks pregnant,’ she said, pausing before adding, ‘We can’t help you.’ The clinic’s doctors aren’t trained to perform abortions after 24 weeks, according to Southwestern Women’s Options.

“Suddenly out of options for ending the pregnancy, Evelyn began to consider a future that had once seemed impossible. She would be giving birth” (1).

In *Deaths and severe adverse events after the use of mifepristone as an abortifacient*,² the researchers found that in 452 patients with ongoing pregnancy after the use of mifepristone—102 (22.57 percent) chose to continue the pregnancy, 148 (32.74 percent) terminated again, one miscarried and 201 (44.7 percent) had unknown outcomes. Although there are a number of ways to interpret these statistics, for today’s hearing to I want to emphasize the researchers’ concluding concern:

“The significant number of women who chose to continue their pregnancy after initially choosing termination raises concerns regarding pre-abortion counseling and informed consent they received . . . Additionally, the high percentage of women with ongoing pregnancies for whom there is no follow-up or known outcome is concerning. As health care providers, we are to con-

² Aultman, Kathi et al. “Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019.” *Issues in law & medicine* vol. 36,1(2021):3–26.

tinue to care for our patients and manage any complications yet in the AER's (Adverse Event Reports) we reviewed this was not the case for the abortion provider. **Furthermore a Federal directory of known outcomes and birth defects is imperative**" (2).

This hearing purports that abortion bans have caused a nightmare for pregnant women who are facing an unplanned, unwanted, or a complicated pregnancy. I want to correct that false narrative and remind you all that the nightmare existed before any bans took effect. The nightmare is that women have been made to believe that pregnancy is a problem. The nightmare is that women are told abortion will solve that problem.

The nightmare is that this "solution" continues to be aggressively promoted so that it is seen as the *only* solution—like a plane ticket and \$12,000 for a late-term abortion. I ask you to consider how different women's lives, children's lives, families, our society could be if just as much money was spent to provide financial assistance, housing, education and employment support, childcare, and medical and mental health care. This would lead to a new era of women's empowerment, that ends the generational trauma of abortion—if that too pricey, then perhaps, we are spending too much money helping women get abortions.

When women know there is support available to them outside of seeking an abortion, then they are empowered and will make choices that everyone can live with. Evelyn's story proves this can happen. My story, and countless others, are proof this is an attainable reality in America, it is not just a dream.

Research Related to Abortion Survivors

Compiled by
The Abortion Survivors Network

Chemical Abortion – References to Ongoing Pregnancy, Failure, and Efficacy

[The efficacy of medical abortion: a meta-analysis](#)

From the text: *"This meta-analysis estimates rates of primary clinical outcomes of medical abortion (successful abortion, incomplete abortion, and viable pregnancy) and compares them by regimen and gestational age...We found that efficacy decreases with increasing gestational age ($p < 0.001$), and differences by regimen are not statistically significant except at gestational age ≥ 57 days...We conclude that both mifepristone and methotrexate, when administered with misoprostol, have high levels of success at ≤ 49 days gestation but may have lower efficacy at longer gestation."*

[Medical Abortion in Early Pregnancy](#)

From the text: *"Initially, clinical investigators administered Mifepristone alone for early abortion. For gestations up to 49 days...continuing pregnancies [occurred] in 7-40%...The single largest medical abortion trial included women through 49 days' gestation...Failures included continuing pregnancies (12%)...Aubeny and Peyron et al. performed a multicenter trial that included 1,108 women...continuing pregnancy rates increased with advancing gestational age...A randomized, blinded study in India evaluated a routine second dose of Misoprostol...Continuing pregnancy rates were significantly different. Drugs used for medical abortion may increase the risk of birth defects in continuing pregnancies."*

The time gap between doses of mifepristone and misoprostol influences the percentage of continuing pregnancies. Three studies are listed with gap times from 15 minutes to 25 hours and continuing pregnancy rates from 0.1 to 0.7%. The greater the wait between medications the greater the likelihood of continuing pregnancy.

With just vaginal misoprostol continuing pregnancy occurs in 4-10% of women.

[Buccal Versus Vaginal Misoprostol Administration for the Induction of First and Second Trimester Abortions](#)

From the text: "Patients seeking abortion in second trimester were given 200 mg mifepristone followed by misoprostol 6 hourly for maximum of 6 doses by buccal or vaginal route...Three patients had continued pregnancy after maximum of 6 doses of misoprostol (36 h after first dose)."

[First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review](#)

From the text: "We identified 87 trials that collectively included 120 groups of women treated with a regimen of interest. Of the 47,283 treated subjects in these groups, abortion outcome data were reported for 45,528 (96%). Treatment failure occurred in 2,192 (4.8%) of these evaluable subjects. Ongoing pregnancy was reported in 1.1% (499/45,150) of the evaluable subjects in the 117 trial groups reporting this outcome. The risk of medical abortion failure was higher among trial groups in which at least 25% of subjects had gestational age >8 weeks, the specified interval between mifepristone and misoprostol was less than 24 h, the total misoprostol dose was 400 mcg (rather than higher), or the misoprostol was administered by the oral route (rather than by vaginal, buccal, or sublingual routes)."

[The efficacy of medical abortion: a meta-analysis](#)

From the text: "For gestations \leq 49 days, mean rates of...ongoing (viable) pregnancy [were] 1-3%. For gestations of 50-56 days, the mean rate of...ongoing pregnancy [was] 3-5%. For \geq 57 days, success was lower for mifepristone/misoprostol (85%, 95% confidence interval 78-91%) than for mifepristone/other prostaglandin analogues 95% (CI 91-98%, $p = 0.006$)."

[Two Distinct Oral Routes of Misoprostol in Mifepristone Medical Abortion](#)

From the text: "Ongoing pregnancy [through 49 days' gestation] occurred in 3.5% (15 of 426) of women who took oral misoprostol compared with 1.0% (4 of 421) of women in the buccal group (P.012; RR 3.71, 95% CI 1.24 –11.07)...Furthermore, in this gestational age group [57–63 days], there were significantly more ongoing pregnancies among women who took misoprostol orally (7.9% [9 of 114]) compared with buccally (1.7% [2 of 115]; P.029, RR 4.54, 95% CI 1.0 –20.55)."

[Deaths and Severe Adverse Events After the Use of Mifepristone](#)

From the text: "[from FDA documents there were] 2660 (83.20%) Codable US AERs. Of these, 20 were Deaths, 529 were Life-threatening, 1957 were Severe, 151 were Moderate, and 3 were Mild...Of 452 patients with ongoing pregnancies, 102 (22.57%) chose to keep their baby, 148 (32.74%) had terminations, 1 (0.22%) miscarried, and 201 (44.47%) had unknown outcomes. Of those with an unknown outcome, there were 44 patients referred or scheduled for termination, who did not follow through (39 no-showed, 3 canceled, 2 did not schedule)...A mandatory registry of ongoing pregnancies is essential considering the number of ongoing pregnancies especially considering the known teratogenicity of misoprostol."

"The 2016 changes in the Regimen and Prescriber Agreement extended the original gestational age limit from 49 days to 70 days, changed the mifepristone dose from 600 mg to 200 mg orally, changed the misoprostol dose from 400 mcg orally on Day 3 to 800 mcg buccally on Day 2 or 3, allowed non-physicians to become prescribers, reduced the number of required office visits from 3 to just one initial office visit...The requirement to report ongoing pregnancies that are not terminated was also eliminated."

[Mifepristone With Buccal Misoprostol for Medical Abortion](#)

From the text: "The overall efficacy of mifepristone followed by buccal misoprostol is 96.7% (95% confidence interval [CI] 96.5–96.8%) and the continuing pregnancy rate

is 0.8% (95% CI 0.7–0.9%) in approximately 33,000 pregnancies through 63 days of gestation...Currently available data suggest that regimens with a 24-hour time interval between mifepristone and buccal misoprostol administration are slightly less effective than those with a 24- to 48-hour interval."

[Medical abortion in the late first trimester: a systematic review](#)

From the text: "Medical abortion, as compared with surgical abortion, was effective in the late first trimester (94.6% versus 97.9% complete abortion). A combined regimen of mifepristone and misoprostol was significantly more effective than misoprostol alone (90.4 versus 81.6% complete abortion). Complete abortion rates for all regimens investigated ranged from 78.6% to 94.6%. Success rates were higher with repeat dosing of misoprostol both in combination regimens and alone, and with vaginal compared with oral administration for repeat dosing."

[Complications after Second Trimester Surgical and Medical Abortion](#) (Failure - Born-Alive Infant)

From the text: One randomised controlled trial was identified that compared outcomes between D&E and mifepristone–misoprostol medical abortion in the second trimester...The study was stopped after one year with only 18 enrolled subjects...Women assigned to receive mifepristone–misoprostol reported significantly more pain than those undergoing D&E ($p=0.03$). Although there were no statistically significant differences in complications between the two groups, six of nine women randomised to mifepristone–misoprostol had one or more adverse events associated with the procedure...one woman delivered a fetus that showed signs of life.

Chemical Abortion Reversal

[A case series detailing the successful reversal of the effects of mifepristone using progesterone](#)

From the text: "Intramuscular progesterone and high dose oral progesterone were

the most effective with reversal rates of 64% ($P < 0.001$) and 68% ($P < 0.001$), respectively. There was no apparent increased risk of birth defects. Conclusions: The reversal of the effects of mifepristone using progesterone is safe and effective."

[Reversal of medication abortion with progesterone: a systematic review](#)

From the text: "Data were available for 561 individuals who received progesterone after mifepristone, of whom 271 (48%) had ongoing pregnancies. The quality of the evidence in the case series was low due to methodological and ethical issues. Enrollment in the randomised trial stopped early due to bleeding events in both arms. The ongoing pregnancy rate for individuals ≤ 7 weeks who received progesterone was 42% (95% CI 37-48) compared with 22% (95% CI 11-39) for mifepristone alone. At 7-8 weeks, the ongoing pregnancy rate was 62% (95% CI 52-71) in the progesterone group and 50% (95% CI 15- 85) in the mifepristone alone group. Conclusion: Based mostly on poor-quality data, it appears the ongoing pregnancy rate in individuals treated with progesterone after mifepristone is not significantly higher compared to that of individuals receiving mifepristone alone."

Surgical Abortion Failure – Continuing Pregnancy

[Early surgical abortion: Efficacy and safety](#)

From the text: "A total of 1132 eligible women had an early surgical abortion at Planned Parenthood between January 1, 1998, and August 31, 2000...2% of women had failed attempted abortions."

Surgical Abortion Failure – Born-Alive Infant

[Born-Alive Abortion Survivors: Just the Facts](#)

Babies have been known to survive abortion. At the start of 2023, 10 states required reporting on abortion survivors. There is no federal criminal penalty for neglecting to provide care to an infant who survives an abortion. 38 states have laws protecting born-alive infants, however, only 18 have sufficient protections. Born-Alive Abortion Survivor Legislation would require reasonable medical care be provided to surviving

infants. This is important since abortionists are generally not accountable to anyone for the care of a surviving infant.

[Estimated Number of Born-Alive Abortion Survivors from Extrapolated Canadian Data](#)

The United States lacks sufficient born-alive abortion recording requirements. The Canadian government funds institutions that collect data on abortion survivors within Canada. Mostly the same types of abortion procedures are performed in Canada as in the United States with similarly ranked healthcare performance. In Canada, an average of 0.21% of surgical abortions result in a live birth. If this rate holds true for the United States, then based on the CDC and Johnson's Archive abortion numbers, there are an average of 1,734 survivors each year.

[Questions and Answers on Born-Alive Abortion Survivors](#)

Late-term abortions still happen in the U.S. and frequently for the same reasons as earlier abortions - not because of fatal defects. There are many witnesses of abortion survival, both from personal stories and from state, CDC, and Canadian data. While life should be a basic right, only 18 states have adequate protections for born-alive abortion survivors.

Efficacy of Medical Versus Surgical Abortion

[Randomized comparison of efficacy, acceptability and cost of medical versus surgical abortion](#)

From the text: Comparing abortion failure rates between medical and surgical abortion is difficult because the definition of a "failure" is inherently biased by the procedure itself. Since the goal of a medical abortion is to achieve complete expulsion without requiring a surgical procedure, a suction aspiration performed for any reason (including incomplete abortion, hemorrhage, continuing [viable] pregnancy, or patient request) is considered a failure of the method [4]. However, with surgical abortion, a repeat aspiration for an incomplete abortion, hemorrhage, or hematometra is considered a "complication," but not a "failure." After a surgical

abortion, the procedure is considered to be a failure only if there is a continuing pregnancy.

[Medical versus surgical abortion efficacy, complications and leave of absence compared in a partly randomized study](#)

From the text: "The number of complications was identical after the two methods, but surgical abortion was associated with a higher success rate [97.7% (708/725) vs. 94.1% (386/410)]...We conclude that the chance of a primary successful termination at GA \leq 63 days is higher after a surgical abortion in general anesthesia compared to a medical abortion induced with 600 mg mifepristone and 1 mg gemeprost."

[Medical versus surgical abortion](#)

From the text: "Medical regimen had more side effects than surgical abortion, including bleeding, cramping, nausea and vomiting. Only fever was more frequent in the surgical method. The failure rates for medical abortion exceeded those for surgical abortion, 16.0% vs. 4.0%."

[SUMMARY STATEMENT OF MELISSA OHDEN]

Babies survived abortions before *Roe vs. Wade*, we survived during *Roe vs. Wade*, and babies are still surviving abortions, no matter where or how the abortion is performed. These experiences highlight the fundamental and undeniable humanity of the preborn and the needs, fears, and experiences of their mothers.

Earlier this year, the Washington Post wrote a story about a woman named Evelyn. Evelyn was young and pregnant, and the article chronicled her decision to obtain an abortion and end her pregnancy. Her first abortion failed, her second also failed, but she persevered and sought a late-term abortion but was denied it. If we are going to talk about women's experiences with abortion and the nightmare of abortion, then we need to include these stories in the discussion, as well.

Abortion bans have not ended abortion—we've merely seen a shift to medication abortion. These pills have a lower success rate and result in women becoming their own DIY abortionist. The results of this access to abortion are staggering, nearly 1–8 percent of abortion pills fail, which means that women are still facing the same challenges as before, and put themselves and their child at risk for repeat abortion attempts.

This hearing purports that abortion bans have caused a nightmare for pregnant women who are facing an unplanned, unwanted, or a complicated pregnancy. The nightmare is that women are told abortion will solve that problem. The nightmare is that this "solution" continues to be aggressively promoted so that it is seen as the *only* solution—like a plane ticket and \$12,000 for a late-term abortion.

Senator MURRAY. Thank you to all of our witnesses. We will now begin a round of 5-minute questions and I'll ask my colleagues to keep track of your clock and stay within those 5 minutes.

Mady, I want to start with you. First off, thank you so much for being here today, telling your story. I know it is not easy and it takes a lot of courage to be here in front of all these people to talk about something so personal to you. We really appreciate it.

You touched upon in your remarks many hoops that you had to jump through just to be able to get your abortion, including traveling, I think you said, over 700 miles round trip away from your home in Texas to Mississippi. Talk a little bit about how you felt when you were forced to drive 13 hours, out of state, to get care. What was going through your head?

Ms. ANDERSON. Thank you so much for that question, Senator. There was a lot going through my mind when I was having to go through the travel. Like I said in my testimony, I was extremely anxious and sleep deprived, so a little bit delirious in the part of just wanting to sleep and feel relaxed. I felt very on edge, constantly fearing what would be thrown at me next.

Senator MURRAY. How'd you feel after receiving care in Mississippi, on the way back home?

Ms. ANDERSON. When I was able to get my abortion and receive care, that was the first time I was able to sleep more than 3 hours and I woke up and I looked at my mom and I started crying. Because I was like, I got to sleep, I can finally breathe, and this huge weight just lifted off my chest.

Senator MURRAY. It's your life and your choice.

Ms. ANDERSON. Absolutely.

Senator MURRAY. Dr. Francis, I have a question for you and I want a simple yes or no. Do you believe that women should have access to plan B? Yes, or no?

Dr. FRANCIS. I believe women deserve to have accurate information about their healthcare.

Senator MURRAY. I'm not asking you that question. Do you believe that women should have access to plan B?

Dr. FRANCIS. I think that women should be given any medication under the supervision of a physician.

Senator MURRAY. You support access to plan B?

Dr. FRANCIS. I support women having access to accurate information and care from a physician.

Senator MURRAY. Do you believe that women should have access to medication abortion? Just yes or no.

Dr. FRANCIS. Chemical abortion are dangerous high-risk drugs.

Senator MURRAY. No. Do you believe women should have access to IUDs? Yes, or no?

Dr. FRANCIS. I believe that again, women should receive comprehensive healthcare access under the direction of a physician.

Senator MURRAY. Access to IUDs. Do you believe women should have access to IUDs? Yes, or no?

Dr. FRANCIS. I believe that women should have access to OB-GYN physicians who can counsel them about all of their options.

Senator MURRAY. I take that as a no. And I want to ask you for the record today, do you think that IUDs and emergency contraceptives are abortifacients? Yes, or no?

Dr. FRANCIS. If you look at the package inserts for such as the copper IUD, it actually clearly states that they do prevent implantation, even if fertilization has occurred, which would classify that as an abortive for patients—per the package insert.

Senator MURRAY. Okay. I just want to, for the record, Dr. Francis, your organization has taken the mind-boggling position in defiance of nearly all medical experts that abortion is never necessary to save a woman's life. According to resources that were put out by your organization, you recommend that in cases of dangerous pregnancy complications, like a massive placental abruption, women should be forced to labor for 24 hours, even if that means being treated with blood transfusions in intensive care, and even if their pregnancy is non-viable in the first place, just so they can deliver an "intact" fetus.

It has also been well-documented how your organization is working behind the scenes with Republican lawmakers to redefine certain kinds of contraceptives as abortions, so you can ultimately ban those types of contraception. I think that is incredibly alarming.

It's really important for people to understand the Republican minority has specifically invited you to this hearing today, despite those dangerous positions.

For the information of all Senators, we are going to be voting this week on the right to contraception. And I hope everyone truly thinks about what that means for women and how it would change our entire country and our women's rights moving forward across the board. So, I just wanted to make that very clear.

I just have a few seconds left, Dr. Verma really quickly. Many states, yours included, require many, a lot of time, a lot of con-

sulting, a lot of multiple trips to doctors. How does that affect the healthcare system in general?

Dr. VERMA. It immensely affects the healthcare system to make basic medical decisions about whether we can provide care to a patient in front of us. We're often having to involve legal representatives, hospital administration, that creates delays in care instead of just being able to provide the care that we know is right for the patient sitting in front of us.

Senator MURRAY. Thank you. And I am out of time, so I will turn it to Senator Cassidy.

Senator CASSIDY. I'll defer to Senator Mullin.

Senator MULLIN. Thank you. And thank you, Chairwoman. I just want to actually commend everybody for actually having a good conversation here. I expected this to actually be pretty rambunctious, and so for that, I'm probably going to leave a lot of my questions out because I came here to be punchy.

[Laughter.]

Senator MULLIN. I think it's important that I share a story. And then I do have a couple of questions too, because I do appreciate everybody's opinion. And that's what this is about, is about having a conversation. And I think put in a context of why I'm so pro-life may help a little bit of the understand our positions, right?

I've been married for 27 years. I got married when I was 19. My wife was 18. First question my father-in-law asked me when I asked to marry my wife, Christie is, is she pregnant?

I was like, no, I don't think so. And at 7 years later, we were still trying to have kids. And my wife had endometriosis, and it took a long time to have kids. We went through everything you can think of in vitro, through shots, through you can imagine. And then she got pregnant, and that was my Christmas gift, 1 year I got out of my stocking.

It was quite an exciting time and we went through the pregnancy and we went to the first doctor visit and how excited it was. And then we went later on and we heard the heartbeat the first time. And I'm going to tell you, that was a child to me. I mean, I was so excited. We were thinking them names. We were going through the whole process. And man, I can't tell you the excitement I had.

I literally, I'm not even a crier at that time. Now, I talk about my kids, I cry all the time. But I remember getting emotional for the first time and I was thinking, what is this inside of me, a tear about to drop out of my eyes.

But then while through the pregnancy, she went back in and she had a miscarriage. That was a death to us, hundred percent death to us, so no one will say that wasn't a death. That was a child when I heard the heartbeat, and it was a death when we didn't hear the heartbeat. And it was extremely difficult for my wife and I.

Fortunately, literally, the month that child was due to be born, we found out we were pregnant again. And his name is Jim Martin Mullin, and after my dad.

15 months later, we had another one because people that tell you, you can't get pregnant when breastfeeding, lies, because you can. And his name is Andrew Daniel Mullin.

Three years later, after the doctor said she couldn't get pregnant anymore, and she was going to have to have a hysterectomy, we had another one. And her name is Larra, and she's 15, Larra Mullin, and lord, she's 15. And love her to death.

Then my wife and I decided we were not going to have kids anymore, and I got a vasectomy and she got an ablation. And yet we still collected three more kids. Because there were three kids that deserved a home and two mothers that loved those children so much instead of aborting them, they were brave enough to carry them.

Gave Christie and I an opportunity to love these three wonderful kids, two twins named Ivy and Lynette that we'd adopted when they were 2 years old, and now they're 13. And Jace, who is wrestling at Oklahoma State as we speak, I was in Ohio with him this week. And his mother was just barely 20 years old. And the twins' mother was 15 when she got pregnant.

I thank God every day, literally every day that those mothers gave Christie and I an opportunity to be blessed and be loved by these three kids.

There's options. What's sad is when you look at statistically speaking is that, over 50 percent of the pregnancies inside the United States is unplanned, but 50 percent of all pregnancies also end in abortion. That's sad. I mean, you're lucky to be born right now, and inside DC its 51.5 percent of all pregnancies, meaning we end more pregnancies here in Washington DC than we actually have. Something's wrong.

Abortion has become almost a point of convenience. While we understand it's unplanned, but that child deserves an opportunity to be in a loving home, just like my three kids are. I tell everybody we had three, we got stuck with, and three we chose. Which ones do you think we love the most?

I'm blessed, Christy and I are blessed, but we got to talk about the reality here. And we're not talking about rape and incest and high-risk births. Those account for less than 9.5 percent of all births out there. 8 percent are high risk, 1 percent are rape, point less than 0.5 percent of from incest. We're not talking about those abortions; we're talking about others.

Guys, we can do better as a country. And that's what this conversation is about. We have to talk about it. Just give these kids an opportunity to live. They'll bless somebody, because Our kids bless us every single day. With that I yield back.

Senator MURRAY. Senator Sanders.

The CHAIR. Let me thank all of the panelists for their testimony. I think we can all agree that the issue we're discussing today is an emotional issue. It is a difficult issue. And sincerely people have different points of view on the issue.

I would like to direct my questioning to doctors Verma and Linton, and ask them this. No doubt you have experienced women and their partners who have jumped for joy when they learned that

they were pregnant and that you did everything you could to make sure that the pregnancy was successful.

I suspect you have also met with many women who, for a variety of reasons, whatever they may be, health reasons, economic reasons did not jump for joy when they learned that they were pregnant.

My question to you is a pretty simple one. I'm assuming that you have worked with people in all walks of life, all the economic levels, races, so forth. Who do you think is best prepared to make the decision about the future of that pregnancy? Is it people in a legislature, generally speaking often dominated by men, or would it be the people who are feeling the impact of that pregnancy?

Understanding, I would suspect you've never told anybody they should not have an abortion, right? We respect people's different points of view. Who should make that decision based on your experience? Dr. Verma.

Dr. VERMA. Yes. Thank you for that question. Based on my experience, people are the experts in their own lives and are able to make these really complicated decisions about their own lives.

I want to say I appreciate Senator Mullin sharing that story. I, myself have struggled with infertility, and I've experienced a first trimester miscarriage that I found devastating. And so, I am not at all saying that pregnancies don't have value. That value is different for different people, and the way that people connect with their pregnancies is different.

Each person is capable of making these really important, sometimes complex, sometimes difficult decisions about their healthcare and their life. Even if that sometimes means ending a pregnancy.

The CHAIR. Dr. Linton on this enormously personal decision, should it be a state legislature that makes it for every woman in the state, or should it be the woman herself?

Dr. LINTON. I agree wholeheartedly with Dr. Verma. I think this is a decision that only the patient can make. Every single patient situation is unique. Our patients live very complicated lives. And I think that we have to trust them.

Our job as physicians is to meet patients where they are, provide them the information that they need, and then support them in whatever decision they make for themselves and for their futures.

The CHAIR. All right, let me ask the doctors again. If you were a young physician wanting to practice medicine, would you gravitate to a state which has a harsh anti-abortion law?

Dr. VERMA. Thank you. This is really difficult for me. I'm from the south. I love the south. It is my home, and it has been really hard to grapple with wanting to serve my community, but being in an environment where I have to face threats of criminal prosecution, of having my license removed for simply providing medicine.

I have had thoughts about leaving, even though I love my home and my community, and I talk to medical students and residents every day who are in that same position. They love the south, they're from the south, but are choosing to leave because they can't get the training and they can't practice in the way that they want to.

The CHAIR. A time when there is already a shortage of physicians in that area. Correct?

Dr. VERMA. Yes. And in Georgia, 50 percent of counties do not have an OB-GYN. And as doctors leave, that doesn't just affect access to abortion care, it affects access to all types of care, to prenatal care, to miscarriage management.

Already at the hospital I work at, I see patients coming to labor and delivery who have received no prenatal care because they haven't had access to that care that's just going to get worse and worse and make pregnancy riskier and more dangerous.

The CHAIR. Excellent. Your experience regarding that?

Dr. LINTON. I would agree. I think that the concerns that I hear from trainees are sort of twofold. The first is similar to what Dr. Verma was speaking about, wanting to make sure they receive that comprehensive training. They want to be able to go into practice and feel prepared that they can provide whatever care is necessary to serve their patients.

But I think it's also important to remember most of our trainees are of reproductive age, and they also need to think about what would happen if they experienced an unintended pregnancy or an unexpected health outcome. So, yes, I have heard from many of my trainees concerns about staying in state or certainly about thinking about these restrictions when deciding where they aim to practice in the future.

The CHAIR. Thank you.

Senator MURRAY. Senator Cassidy.

Senator CASSIDY. Thank you, Madam Chair. Ms. Ohden, thank you for sharing your story. Thank you all. This is a very difficult topic and this is part of that dialog and so, so thank you all. Ms. Ohden, I understand that you have a child with special needs. Can you relate the counseling you received where you suggested that you get an abortion or how can you relate that?

Ms. OHDEN. I do appreciate everyone sharing such personal stories. I think this is part of what we need to do is share our stories more, but listen more as well. No matter what side of the aisle we're sitting on.

Not only am I someone who survived an attempt to end my life at approximately 31 weeks gestation by a saline infusion abortion, I'm also a woman who has had a first trimester miscarriage and have felt that pain. And not just myself, my husband as well. I remember his pain so distinctly.

I also have a child who was born with complex medical needs. I was 36 years old, fast approaching 37. And so even prior to finding out that my daughter had a prenatal diagnosis, I was being pressured time and time again with conversations about abortion because of my advanced maternal age at 36.

To the point that even prior to my 20-week ultrasound, I had to call up the OB-GYN's office and let them know that I found it so offensive for them to continue to state abortion time and time again based on my own personal history that I was asking, they not do it again, or I would need to go to another practice.

I can tell you my daughter is almost 10. She is an incredible young woman who has overcome a lot. And as she is raised, to know that she has the same dignity and value as everyone else in the room. That everyone is made differently. And yes, some of us see different doctors for different health issues at different times, but she is someone who experiences incredible joy and is living a great life.

Senator CASSIDY. Thank you. Dr. Francis, I think that Senator Murray was suggesting that you were trying to duck her question when you said that people needed to be counseled, but your testimony is very nuanced.

Now, some of the testimony we've heard has suggested somehow that women, particularly minority women, particularly African American women, and their long-term health outcome is hurt by not having ready access to abortion.

Yet you quote data, and I just compliment you on just how this is chockfull of references and studies, it's like a white paper. Can you give a little bit more nuance about how someone should be counseled that abortion does not necessarily save a life? In some ways, it brings further complications.

Dr. FRANCIS. Yes, absolutely. Thank you, Senator Cassidy, for that question. As you said, we do see disparate health outcomes in this country, unfortunately especially in minority women. But we also see that Black women have a much higher rate of abortion than do white women.

This has not improved their health outcomes. In fact, their maternal mortality rates are worse. Their preterm birth rates are worse. And, as I stated, there are more than 160 studies that show a link between surgical abortions and preterm birth. In fact, the patient whose story between—

Senator CASSIDY. Wait, surgical abortion and preterm birth?

Dr. FRANCIS. Yes, preterm birth in future pregnancies. In fact, the Institute of Medicine has acknowledged that surgical induced abortions are an immutable risk factor for preterm birth in future pregnancies.

Senator CASSIDY. The increased loss of unborn or miscarriage children in some, may be, you're saying there may be a causation associated with their previous history of abortion.

Dr. FRANCIS. Correct. That's what the studies suggest.

Senator CASSIDY. Is there academic literature supporting that?

Dr. FRANCIS. 100 percent. There are very large systematic reviews, and as I said, the Institute of Medicine has acknowledged this as well.

Senator CASSIDY. When you say in response to Senator Murray that someone should be counseled, they should be counseled!

Dr. FRANCIS. Absolutely. In fact, that patient that I sat with who had lost her fifth child due to a condition called cervical insufficiency, where her uterus literally could not hold a baby in, to the point of viability anymore. One of the things I thought about is, let me just—

Senator CASSIDY. Just because we have limited time, and you also quote data showing that in countries that have prohibited abortion after previously not allowing it, maternal mortality has not worsened. Suggesting that this kind of idea that abortion saves women's lives has not been borne out by empiric experience.

Dr. FRANCIS. Correct.

Senator CASSIDY. Dr. Linton. In your testimony, you say something along the lines that suggesting that there shouldn't be any restriction, but I go back to that child. Now we know it's rare for someone late term without a reason to have a child like this aborted, but it does occur. And in nine states plus a city in which we are currently, it's allowed.

Does this child really have no rights whatsoever? I mean, should that child, knowing I'm giving you the hypothesis, the mama does not have a risk, this is just a decision to abort.

Is there no consideration to be given of this? Because I have to understand, we have to have a dialog, but I'm seeing if there's actually a common ground here. Your mic, please.

Dr. LINTON. Thank you, Senator Cassidy for that question. I think that these sorts of extreme hypotheticals really give no—

Senator CASSIDY. No, these occur and it's legal. And this side, the Democratic aisle actually wants that to be the law of the land.

Dr. LINTON. I think what you are describing is—

Senator CASSIDY. My question is—because now I'm going to just say Senator Murray thought Dr. Francis was trying to duck. Maybe it's a yes or no. If it's not for the health of the mama, the life of the mama, et cetera, should this child have no rights in the decision to abort at week 40 when otherwise if the child was delivered, the child would be alive.

Dr. LINTON. Senator Cassidy, respectfully, I don't think this is a question that we can whittle down to a yes or no. I think pregnancy is much more complicated than that.

Senator CASSIDY. Do they have a right?

Dr. LINTON. I would say that every situation is unique. And when a patient presents—

Senator CASSIDY. I will say at this point, the inability to answer that is troubling. And with that I yield, because I'm a minute over. I'm sorry.

Senator MURRAY. Senator Casey.

Senator CASEY. I was going to ask a question to Dr. Verma. Dr. Linton, anything else you wanted to say in response?

Dr. LINTON. Thank you, Senator. No, I was simply going to say that I think every situation is unique and our job as physicians is to take all of the information that a patient provides us and give them the option to decide what is best for themselves and for their bodies. Thank you.

Senator CASEY. Thank you. And I'll start with Dr. Verma. I want to go to Dr. Verma in page one of your testimony, you say, and I quote, I've seen young moms with worsening medical conditions that make their pregnancies very high risk. And couples whose deeply desired pregnancies are in the process of miscarrying, be

turned away or forced to leave their communities to access needed healthcare.

Tell me how that reality that has surfaced most recently. Tell me how that reality has affected your ability to care for your patients, No. 1. And No. 2, how has your relationship with those patients changed?

Dr. VERMA. Thank you for that question. It has been devastating to have to look at patients and say, I can't help you. I can't provide this care, or I have to wait for you to get sicker before I can potentially provide this care.

It creates a huge amount of mistrust that patients have for both the healthcare system and the government. There is not a line in the sand where someone goes from being totally fine to acutely dying. It's often a continuum. And even when state laws like Georgia's have exceptions for things like medical emergency, it's unclear to us as the doctors when we can intervene.

If I could just take a second to go back to Dr. Cassidy's point here. I just really want to highlight that the situation of doing an abortion at the moment of birth doesn't happen. As a doctor who provides full spectrum reproductive healthcare, including OB care, I love taking care of people on labor and delivery. I provide abortion care. That doesn't happen.

It is a false hypothetical that is meant to create additional stigma around abortion care. If a patient comes in at 40 weeks, their options are a C-section and a vaginal delivery. And this misinformation is really dangerous to our patients.

I also just want to highlight that 90 percent of abortions in this country occur in the first trimester, and less than 1 percent are occurring after 20 weeks, when in most cases, something has gone terribly wrong with the patient or the pregnancy. And that person really needs that care for some reason.

Senator CASEY. Doctor, thank you. And I want to turn to Dr. Linton for her to make reference to her testimony. I'm looking at both pages. The bottom of page 2 and the top of page 3. On page 2, you pose this question, "When would an abortion be necessary, quote, to save the life of the mother?"

You point to a couple of examples. "What about a patient who presents with heavy bleeding in the first trimester, but there is still fetal cardiac activity on ultrasound. Can I remove the pregnancy to stop the bleeding? Do I have to wait for a certain amount of blood loss?"

Then you continue at the top of the page with a few more examples. "A pregnant patient with unresolved congestive heart failure from her last pregnancy that puts her at higher risk of dying in this pregnancy. What percent chance of death does she need?"

Next question. "What about a patient with a newly diagnosed breast cancer at 8 weeks of pregnancy who cannot start chemotherapy or radiation while she's pregnant, is delaying her treatment until after delivery a risk to her life?"

Finally, at least of the examples I'm pointing out, "What about a patient with a blood clotting disorder where pregnancy will further increase the risk of a pulmonary embolism or stroke? Is the

risk of a blood clot enough, or do I have to wait until the actual stroke occurs?"

You go on from there with other examples and you say, "These are real patients that my colleagues and I have encountered." I'd ask you the same question. How has that reality since the *Dobbs* decision changed your ability to care for your patients and your relationship with your patients?

Dr. LINTON. Thank you for that. I think I would go back to that same idea of this culture now of confusion and fear. All of those cases that I mentioned in my oral and written testimony, those are real patients that I have encountered, that my partners and I debated, did we meet this, arbitrary phrase from an 1849 law or not? Do we need to call lawyers? Do we have to consult other physicians?

We were not able to just follow the medicine in these cases, and adding words such as imminent death or immediate death, that doesn't help clarify anything further. So, I would reiterate what Dr. Verma said. These are impacting our ability to care for the patients in front of us in a timely and appropriate way.

Senator CASEY. Thank you.

[Technical problems]

Senator MURKOWSKI. I want to thank you all for being here for your testimony and for sharing deeply personal stories. As has been repeated here, and we know to be true, access to, to reproductive care, the issue of abortion itself, decision to terminate a pregnancy is deeply, deeply personal. It's complicated.

Clearly there are views that Americans have on this issue that present deep and conflicting convictions. And so just the ability, the opportunity to have true discussion and conversation about it, I think is important.

I have been pretty clear where I stand on this issue. I think the choice to have an abortion should ultimately be in the hands of the woman, of the individual, not the government. But I also believe that it's reasonable not to require those who are firmly opposed to abortion to support it with their income tax dollars, and that providers who do not wish to be involved in abortion should not be forced to do so.

That's why I've worked with several other colleagues here. Senator Collins, Kaine, Sinema, and I have this bipartisan legislation to ensure that the rights that women have relied on for the past 50-some-odd years, those that were set out *Roe* and in *Griswold* are protected. I think that they should be protected.

We establish a Federal right to choose and reaffirm the right to contraceptive access without raising concerns about religious freedom and provider conscience protections. So, my position on this is clear, but I'm also pretty clear-eyed in recognizing that it's unlikely that the Congress is going to pass legislation that would establish clearly that right to abortion, certainly in this Congress.

But I will tell you, I continue to hear from so many in my state, women in Alaska who are concerned about access to abortion, access to reproductive services, even while we are a state where we

have included in our state's constitution, a right to privacy that protects that access to abortion.

But what we have seen from decisions across the country in the lower 48, is a ripple effect that has come all the way up to the North. Planned Parenthood in South Soldotna Alaska location closed in anticipation of the trigger laws that were coming online that would require more resources in other states.

We think that we are far enough that we're protected, that access is protected, but there are implications that move beyond those state boundaries. And so women are asking me about access. We are a very, very rural state in the first place. Access to providers is limited in the first place. And certainly, access to abortion has also been limited.

I am going to throw this out to anybody on the panel. What can we do practically, right now, to help ameliorate some of what we are seeing with the impact of the *Dobbs* decision to ensure that women do have access to the care that they need now.

I wasn't here when you presented your testimony Ms. Anderson, but I can't imagine how difficult, when you're already in a very stressful situation, the thought that I might have to travel hundreds of miles, extraordinary expenses to travel, but the access to care is so limited. I've given you no time to answer, but does anybody have anything, Ms. Lopez, go ahead.

Ms. LOPEZ. I'm happy to answer. Thank you for the question and for the describing the experience in Alaska. I mean, I think one of the things we can do, Senator, is ensure that we can maintain access to medication abortion, right? Medication, abortion now accounts for two-thirds of all abortions in this country as of 2023.

In rural areas like yours, it's incredibly important to have that option via telehealth for folks who can't reach a provider or when they live in communities as the doctor said, that don't have providers given the limited access to providers that they have. And so maintaining access to a method that we know is safe and effective based on decades of widespread use and study I think becomes critically important.

Senator MURKOWSKI. Thank you for saying that. I absolutely agree. Thank you, Mr. Chairman. Thank you.

Senator MURRAY. Thank you.

Senator Murphy.

Senator MURPHY. Thank you, Senator Murray. Thank you all for being here today for your testimony. In Connecticut we often hear from our physicians that we should not labor under the belief that there are safe states, right? Connecticut is a state today that protects the right to full reproductive healthcare for women, for families.

But we know what the agenda is. We know that the agenda of Republicans in the Senate and Congress is to pass a national abortion ban, and we are potentially months or years away from losing those protections in Connecticut.

But the doctors in my state tell me that this myth of the safe state is also due to the fact that the bans that are being passed in states that aren't Connecticut are fundamentally changing the

practice of medicine and medical knowledge in the United States. And so, Senator Sanders started to explore, I think this really important issue, but I wanted to build on his questioning. I think I have two questions to ask, and maybe I'll pose the first one to Dr. Verma and Dr. Linton.

What does it mean that we now have a growing number of states that are not training physicians in the suite of services related to pregnancy loss?

What does it mean that we have physicians today that are emerging from education in those states that potentially do not have the full scope of training on how to manage medical challenges like miscarriages or complications such as infections or hemorrhaging that could stem from pregnancy loss? This seems like a significant challenge for our Country.

How is medical education changing when you have so many residents and medical students who are simply not getting the same kind of comprehensive education around reproductive healthcare?

Dr. VERMA. Thank you for that question. Over 50 percent of OB-GYN residencies are in states that have enacted bans or very restrictive abortion laws, and that's absolutely affecting resident training and medical student training. I think it's important to highlight here that it's the same procedures, the same medications that we use when we're providing abortion care that we also use when someone comes in experiencing a miscarriage or experiencing a pregnancy loss.

It's very concerning that more and more doctors are not going to be able to provide all options for care to someone who comes in, for example, at 14 weeks bleeding after breaking their water and is sick and needs care.

I absolutely think this is going to affect the ability for people to get all types of care across the country. It's particularly going to affect women in rural areas in certain parts of the country. And I think that's really devastating when we're already experiencing such a healthcare crisis and maternal mortality crisis.

Senator MURPHY. Dr. Linton.

Dr. LINTON. I agree with Dr. Verma, I will say immediately after the *Dobbs* decision, there are certain requirements that trainees have to achieve or things that they have to learn in order to satisfy the requirements of residency training, specifically in OB-GYN.

I can tell you that in the immediate after fact of aftermath of *Dobbs*, trying to find places for those learners to go and receive that training was incredibly difficult. As you mentioned, one of the safe states or haven states not only are these states being asked to take care of an influx of patients, we are also asking them to take care of an influx of learners. And all of that is just being compounded and compounded.

I agree with Dr. Verma. I am concerned about the future of our ability of our workforce to be able to care for patients in a variety of settings.

Senator MURPHY. Well, Ms. Lopez, let me ask you that question about the broader workforce challenge, because our state reports that we are seeing an influx of individuals for training, but what

we also know is that in states that have passed these abortion bans, they have seen a 10 percent decline in applications for OB-GYN residencies.

We're not seeing a 10 percent increase in our states, in part because we have a set number of residency slots that's not going to change overnight. And so, the net effect here at a moment when we were already desperate for more individuals to go into this care, seems to be a doubling down of a workforce crisis that is going to affect every woman and every family across this country, no matter which state you live in.

Ms. LOPEZ. Absolutely. Thanks, Senator, for that question. Absolutely. And these folks are not just providing abortion care, right? They're providing the full range of reproductive care, which means that if you are seeking prenatal care or contraception or IVF or any of the number of reproductive care options, you will not have those providers available.

We already have maternity care deserts around this country. Those will only increase as well. And I think it also forces doctors to think about, do they want to risk criminalization for providing this standard medical care, this basic medical care.

Senator MURRAY. Thank you.

Senator Budd.

Senator BUDD. Thank you, Madam Chair. Thank the panel and for your stories and testimonies. So, after the Biden administration's FDA, it ended in-person dispensing requirements. As I understand, chemical drugs are now routinely available without any medical supervision.

Dr. Francis, can you tell us about abortion reversal pills and why it's important for states to make sure that pregnant women have access to information about these pills? Particularly those women who are considering abortion? Dr. Francis.

Dr. FRANCIS. Thank you, Senator Budd, for your question. If I can first just highlight the dangers of the, the FDA's decision to lift that in-person dispensing requirement, because that will tie into abortion pill reversal as well.

What that removes from women is any kind of medical oversight. It removes the opportunity to document how far along in their pregnancy they are. Many women are wrong about how far along in their pregnancy they are. And we know that the farther along in pregnancy a woman takes those drugs, the higher the risk of complications.

It also removes the possibility of adequately screening for ectopic pregnancy. And it also removes the real possibility for a woman to receive fully informed consent. That's a really important part of ensuring that before a woman takes these drugs, that she is in fact not only sure of her decision, but aware of the potential risks that she's facing by taking those drugs.

We know that now women are receiving less counseling, more and more women are deciding after taking that first drug, the mifepristone pill, that they regret their decision and they desire to save their child's life.

I know this because I'm a member of the Abortion Pill Reversal Network. I'm a provider of that treatment, which involves giving a woman natural progesterone, which can counteract the effects of the first mifepristone.

It's essential that women are aware of this, not only because they're not receiving adequate counseling now before they receive these drugs, but so that they know if they make the choice, if we really are supportive of women having choices, we should support their choice if they decide that they regret their abortion and, and would like to save their child's life.

Senator BUDD. Thank you. So, you're saying that there's more dangerous health outcomes with the lifting of the medical supervision, correct?

Dr. FRANCIS. Absolutely. So, even according to the FDA's own data, 1 in 25 women who take these drugs even with medical supervision, will end up in the emergency room. But I can tell you, having gone down to the emergency room in my own hospital many times to care for women who are facing life-threatening complications after taking these drugs, it is more common now that they're not being seen in person first.

Senator BUDD. What's the window of time from taking the chemical abortion drugs to the reversal?

Dr. FRANCIS. It's most effective if it's taken within the first 72 hours, but especially within the first 24 hours. So, it's imperative that women have this information so that they know if they change their mind that there is a treatment that they can access.

Senator BUDD. In light of FDA ending in-person dispensing requirements for these drugs, could you talk about how human traffickers are exploiting the lack of protections that used to exist for women?

Dr. FRANCIS. Well we certainly know that there's a link between human trafficking and forced abortions that's been shown very clearly. And it's also been shown that one of the main points of contact for a trafficking victim to get help is actually with a medical professional.

What we've done now is we have removed that point of help for a woman, and we've also allowed for traffickers, a way for them to be able to access these drugs online. It's been well documented that women who are not pregnant are receiving these drugs after going online and ordering them.

I personally talked with a woman who is in her sixties who got these drugs. She just wanted to see if she was able to get it, and she was able to get these drugs. So, it is now possible for anyone to go online, get these drugs. Traffickers could stockpile them so that they could force them on their victims, to force abortions as they have in the past.

Senator BUDD. Can you walk me through some of the ramifications of S. 4381 given that it waives protections from the Religious Freedom Restoration Act? This is the Contraception Legislation that's before us right now. So, I believe it's S. 4381 and it waives protections from the Religious Freedom Restoration Act.

Dr. FRANCIS. Thank you for the opportunity to also clarify, I think one misunderstanding of my organization's position on contraception. So, we actually don't take an official position on contraception.

However, we would support the right of any physician to abstain from prescribing any medication or participating in any procedure that violated either their religious beliefs or violated their own conscience. And if they feel that it violates the oath that they took as a physician, then we would support the right for any physician to be able to abstain from prescribing those medications.

Senator BUDD. Thank you, thank you panel.

Senator MURRAY. Senator Hassan.

Senator HASSAN. Well, thank you very much, Senator Murray, and to the Chair, and Ranking Member Cassidy. Thank you for this hearing, and to all of the witnesses, thank you for being here today. I've received thousands of messages from constituents in New Hampshire urging me to protect reproductive freedom since the Supreme Court overturned *Roe v. Wade*.

On that day, the women of America lost a fundamental freedom. Every woman should have the right to control her own life, and that includes the right to make her own healthcare decisions. And with deep respect for my colleagues on the other side of the dais, women know what a pregnancy is.

I too in response to Senator Mullin, I had a miscarriage at 12 weeks in a pregnancy between the birth of my son and the birth of my daughter. It was as devastating for me and my husband and our family as Senator Mullin described the devastation that he and his family experienced.

Right now, though, women are facing a danger in our Country that is real and it is grave. And that includes women like one of my constituents, who was carrying twins and discovered in the third trimester that one of the twins could prove fatal to the other.

Now, think about the decision that she and her physicians had to make as they grappled with this very rare, very difficult medical challenge and the impact of the abortion ban in New Hampshire on her and her physician as they tried to figure out what to do.

A few questions. Dr. Linton, abortion bans are impacting multiple facets of women's healthcare. Miscarriage is common, and as we've just talked about, it can be devastating. One in five pregnancies in the United States results in miscarriage. In places where abortion bans are in place, some women experiencing miscarriages who need immediate medical attention are being denied the healthcare that they need because doctors fear criminal penalties if they treat these women.

Can you discuss how abortion bans are jeopardizing the health of women who are having miscarriages?

Dr. LINTON. Thank you for that question. Yes. I think that it goes back again to this idea of confusion. These laws are not written by physicians. Many of them are written before the era of modern medicine, before we had ultrasounds and modern diagnoses that we use today. So, asking a physician to interpret a law, not

only through a medical lens, but through a modern lens, can be very difficult.

We are physicians. We are not lawyers. We did not go to medical school to make very intricate legal decisions. And so as much as sometimes I obviously—my biggest concern is for the patient in that situation. And yet at the same time, I can't necessarily blame the physician for having this fear over confusion of whether or not they can provide care. We need to focus on letting physicians make medical decisions to be able to care for the patients in front of them.

Senator HASSAN. Thank you. Dr. Verma, abortion bans and restrictions are even making it harder for women to get prenatal care that supports the wellbeing of women and their babies. It's harder than ever to recruit obstetricians, as you all have talked about and, gynecologists, to practice in rural areas across the country, especially once you factor in abortion bans, including those that could put doctors and their patients in jail.

Dr. Verma, what is the impact of abortion bans on doctors who are trying to do their jobs? In particular, how are these bans limiting women's access to care in rural areas?

Dr. VERMA. Absolutely. Thank you for that question. Even pre—*Dobbs* I was seeing patients in Georgia that were traveling significant distances to get to a hospital where they could get prenatal care to get to a doctor who took Medicaid, if that is their insurance.

There are multiple barriers that women are already facing. What we're seeing is as more doctors leave these states because of abortion bans, those distances that patients are having to travel are getting further and further.

Patients are also scared. One of the things I do in my practice is I do preconception counseling visits where I sit down with a patient who wants to get pregnant and talk to them about how to optimize that pregnancy. So, starting a prenatal vitamin, getting off any medications that are dangerous for the pregnancy.

Since *Dobbs*, I'm hearing again and again, patients are asking, what happens if I get pregnant and something goes wrong? And these are patients with desired pregnancies. They are so afraid that something is going to go wrong and they won't be able to get the care that they need. And it's affecting people's decisions about whether to expand their family, even if that's something they want.

Senator HASSAN. Absolutely. Thank you. I am almost out of time. So, a quick question for Ms. Lopez. Since *Roe v. Wade* was overturned, it's more critical now than ever that women can access contraception. Most forms of health insurance cover birth control.

However, there are nearly 1 million women of reproductive age who are enrolled in Medicare because of a disability, and they don't have guaranteed access to contraception. I'm working on a bill that will close this contraception coverage gap by requiring Medicare to cover all forms of contraception, allowing women with disabilities to get the type of contraception they want and need. Can you speak to the importance of requiring Medicare to cover contraception?

Ms. LOPEZ. Thank you. And thank you for your championship of that legislation. Yes. It's critical for all people who can become

pregnant to have access to contraception, so that, they can plan their families appropriately. So, that they can determine if, when, and how they want to start a family. And that includes folks on the margins, including disabled people. So, thank you again.

Senator HASSAN. Thank you very much. Thank you.

Senator MURRAY. Thank you.

Senator Marshall.

Senator MARSHALL. Thank you, Madam Chair. Dr. Linton, how many babies have you delivered in the past month or two?

Dr. LINTON. I would say probably in the tens to twenties. Okay.

Senator MARSHALL. Dr. Verma, how many babies have you delivered in the past month or two?

Dr. VERMA. That's a good question. I'm terrible at estimating, but over my career, thousands.

Senator MARSHALL. You're still active, you're still actively delivering babies.

Dr. VERMA. Oh, yes, yes, I do labor and delivery shifts every week.

Senator MARSHALL. How often or what type of range would you do sonograms on a pregnant woman, let's say before their fourth month or pregnancy, hardly ever, a lot, sometimes?

Dr. VERMA. Yes, I see patients with all kinds of pregnancies. Sure. And usually when a patient comes in and is has a positive pregnancy test, I talk to patients that want to continue this pregnancy—

Senator MARSHALL. Like, my question is, how often do you use sonograms on your routine prenatal visits? Before 16, 8 weeks or so?

Dr. VERMA. We usually do an initial ultrasound to confirm that the pregnancy is there.

Senator MARSHALL. Prenatal pregnancy, first visit, usually you're doing a sonogram to confirm the pregnancy. Dr. Linton, how often are you doing sonograms in the first, trimester or early second on a routine OB situation?

Dr. LINTON. To be very clear, I work on labor and delivery and I deliver babies, but I do not provide prenatal care.

Senator MARSHALL. Thank you. So then, Dr. Linton, do you deliver a 23–24-week baby, I'm sure before?

Dr. LINTON. Yes.

Senator MARSHALL. When that baby's delivered, you call in anesthesia, you call the NICU, you call everybody you can in to help that baby, right?

Dr. LINTON. It depends on the clinical scenario. But yes, if it's a desired pregnancy and the patient has voiced the desire for resuscitation, then we have NICU present at that delivery.

Senator MARSHALL. You've also done abortions at 23, 24 weeks as well?

Dr. LINTON. In my training, I provide the standard of care in line with medical law.

Senator MARSHALL. I'm just asking that. I'm not sure. You're not ashamed of it. You've done abortions with the baby's 23, 24 weeks.

Dr. LINTON. I provide the care that I'm trained to do based on the state laws where I live in.

Senator MARSHALL. Dr. Verma, you've done abortions and you've delivered babies at 23, 24 weeks, full resuscitation, at the same time you've done abortions on those as well.

Dr. VERMA. I think what you're highlighting here is the complexity of what we do.

Senator MARSHALL. No, that's not my question. I get to ask the question here. I'm not asking for a lecture. Is there any distress in your mind or your heart after doing an abortion? On the one hand, you're delivering a baby at 23 weeks and—all out resuscitate the baby, you feel horrible. It doesn't make it, then you do an abortion on that same—how does that make you feel?

Dr. VERMA. I appreciate the question. I think it's a great question. And again, like I was saying, this is why this is so complicated. I feel that complexity, like I said, I've experienced a first trimester loss myself, and I found that loss devastating. So, this is complicated, but I also know that my patients are able to make these really complicated decisions about their health and lives.

Senator MARSHALL. Thank you very much. Dr. Linton, what pregnancy category of drug is mifepristone?

Dr. LINTON. I'm sorry, Senator. Off the top of my head, I can't tell you the class.

Senator MARSHALL. Dr. Verma, do you know what type of pregnancy category drug mifepristone is?

Dr. VERMA. I know mifepristone is incredibly safe based on decades of data about—

Senator MARSHALL. Do you know that what category of drug that is in pregnancy?

Dr. LINTON. I can tell you we use Misoprostol for a variety of reasons, including for desired pregnancies, on labor and delivery every day.

Senator MARSHALL. They're both category X drugs. Okay. I'm going to tell you the answer. They're both categories. So, you-all are prescribing these drugs and you don't know what category of drug it is. And why is it a category X drug? Because it causes fetal malformations, right? So, it causes fetal malformations.

Dr. VERMA. Those categories that you're describing are actually based on politics. The mifepristone is safer than Tylenol and Viagra.

Senator MARSHALL. You're saying that FDA is based upon politics. The FDA is saying this is a category X drug. Would you agree with me that these abortion pills are less effective at 14 weeks as opposed to 8 weeks? Dr. Linton.

Dr. LINTON. Yes. I would say that our data does support with increasing gestational ages, that sometimes we have to modify the protocol, but generally they're more effective at earlier gestational ages, depending on the protocol you use.

Senator MARSHALL. What I'm confused about is, and I've never prescribed this drug, I've taken care of lots of patients that have complications from these drugs.

I'm confused why you do a sonogram in a routine pregnancy to establish gestational age. That's the only main reason you're doing pregnancies in the first trimester, early second trimester. Because the spine is not developed, the heart is not developed. So, you're basically doing it for gestational age.

You're recognizing that so many women come in and they're a month off of their gestational age. So, why wouldn't you want to do a sonogram on every person you see before you prescribe this drug, realizing that it has decreased effectiveness at 14 weeks than at 10 weeks, so therefore, you're prescribing a category X drug to a pregnancy that has a possibility of not being aborted.

You're increasing the risk of fetal anomalies. It just doesn't add up to me. Why are you scared to do a sonogram? Wouldn't you think if you were doing an abortion procedure on a 12-weeker versus a baby, that's actually 20 weeks that it would change everything? I'm just appalled that why you all are so afraid of doing sonograms. Thank you so much. And I yield back.

Senator MURRAY. I'll allow you time to answer that question, Dr. Verma.

Dr. VERMA. Thank you. And I will say, as a doctor who actually does provide this care to patients and is currently practicing, we actually often do sonograms if there's any questions.

When we see a patient and we're providing medication abortion via telemedicine, we go through screening questionnaires, and if there's any concern, we absolutely do a sonogram. So, that isn't really an accurate representation of how this practice of medicine works.

Senator MURRAY. Thank you.

Senator Smith.

Senator SMITH. Thank you so much. Welcome everybody. I'm appreciating very much all of you being here. I want to just follow-up a little bit on the question about medication abortion. So, mifepristone has been lawfully prescribed to patients since 2000. I'll just ask Dr. Verma, how safe is medication abortion and how effective is it?

Dr. VERMA. Thank you for that question. Medication abortion is incredibly safe and effective. In a recent study of 20,000 patients that have undergone medication abortion, the rate of adverse events was 0.38 percent. So, very, very low. Only about 1 percent of those patients came to the emergency room after the process. And of those people, about 40 percent didn't need any treatment.

We know that medication abortion is incredibly safe and effective. And I also want to highlight how dangerous misinformation about the practice of medicine is for our patients, for physicians.

The American Board of OB-GYNs, which is the board that certifies all of us OB-GYNs at this table, has asserted that abortion care is safe, is effective, that medication abortion is safe, that abortion reversal is not something that we can, in good faith offer to

our patients because it can cause serious risks of bleeding and hemorrhage.

That abortion care does not cause preterm birth. And so I just want to highlight some of that misinformation that we've heard today because it can be very dangerous and contradicts what the American Board of OB-GYNs and American College of OB-GYNs asserts.

Senator SMITH. We've heard a few things also today about abortion reversal drugs, saline abortions, is there any misinformation that you'd like to clear up there as well?

Dr. VERMA. Yes, thank you for that question. Saline abortions is not something that is done in the practice of modern medicine. I have been practicing for about a decade, have never seen or heard of it. So, that is not a practice that is done.

For abortion reversal, my colleagues and I actually studied whether this is a treatment that we could offer to our patients, because if it was a safe treatment and a patient wanted it, I'd be happy to offer it. I am happy to support my patients who want to continue a pregnancy, end, a pregnancy, whatever is right for them.

We found we had to stop that study early because people were experiencing significant bleeding and were at risk. And so, it is not a safe treatment that is available to patients, that is misinformation.

Senator SMITH. Thank you. And maybe I'll ask Dr. Linton this. I'd like to ask you this question about whether telemedicine for medication abortion is also safe and effective.

Dr. LINTON. Thank you for that. I would reiterate what Dr. Verma said. When we are thinking about providing medication abortion via telemedicine, we have screening questions. And if there are any red flags, if someone does not have a regular menstrual cycle, if somebody is concerned about bleeding or cramping, then they are not eligible for a medication abortion via telemedicine.

Of course, our utmost priority in every single patient encounter is patient safety.

Senator SMITH. Thank you. Ms. Lopez, thank you so much for being here. As you all know, Louisiana recently enacted a law that adds mifepristone and misoprostol, which is another drug used to manage abortion to the state's controlled substances list.

This law would criminalize anyone who possesses the drug without a valid prescription, and it puts it in the same category as opioids.

[Laughter.]

Senator SMITH. I'm just wondering, is there any reason, I mean, what do you make of that? And do you believe that medication abortion should be put in the same classification as other dangerous controlled substances?

Ms. LOPEZ. The easy answer is no. And I think my colleagues have really reiterated how safe and effective medication abortion is.

We have two decades of widespread use of study of this drug. So, we know that it is safe and effective both here and globally.

It has also become an incredibly important option for folks to access abortion care. Two-thirds of abortions are now via medication abortion. And so any effort to restrict it further is simply an effort to make abortion more difficult to obtain.

Senator SMITH. What impact does that have on women, for example, living in rural communities, people who struggle already to get access to care, including women who are marginalized in so many other ways and don't get access to care?

Ms. LOPEZ. Yes. The folks who are most impacted by all of these abortion restrictions are folks who are already marginalized by our healthcare system. So, folks of color, the underinsured young folks, LGBTQ folks and folks who, as you said, Senator, live in rural communities. And so it makes it harder to get.

We know now that one in five abortion seekers, is traveling out of state to get care. So, it means they're leaving their home communities at significant financial, logistical, and emotional cost to themselves and their families.

Senator SMITH. Thank you, Chair Murray.

Senator MURRAY. Well, as Senator Baldwin is settling in, I just want to ask unanimous consent to enter into the record seven statements in support of abortion access and reproductive freedom. Without objection.

[The following information can be found on page 74 in Additional Material:]

Senator MURRAY. Senator Baldwin.

Senator BALDWIN. Thank you. I want to thank you, Senator Murray, and Chairman Sanders, for holding this hearing. Because in the wake of the overturning of *Roe*, I think we must keep drawing attention to the dire consequences on women's health across this country, and particularly in my home state, States like Wisconsin.

Before the Supreme Court overturned *Roe v. Wade*, generations of women in this country had only known a country with the right to abortion care. And they only knew a country where every woman had the freedom to make their own choices about if and when to start a family. But when those freedoms were stripped away, Wisconsinites were sent back to the year 1849. They live under a pre-Civil war criminal ban on abortion care.

I've heard such horrifying stories since that ban went into effect, about women bleeding out, about contracting life-threatening infections before receiving care, about women forced to travel hours and hours away from their families and support systems to receive care for an unviable pregnancy.

Thankfully, more recently Wisconsin has been able to take important steps to restore abortion services in three communities, three counties. We have 72 counties. However, without access to care statewide, too many Wisconsinites must still drive hours, take time off work, arrange for childcare and face medically unnecessary barriers before getting the healthcare they need. And while some people, say it should be the state or the Federal Government who

should decide abortion rights, I believe it's women who should decide about these issues.

That's why we must pass the Women's Health Protection Act which I author, ensuring that women have the right to make healthcare decisions and freedom to access abortion care no matter where they live. Dr. Linton, and I'm so glad that you are here today to share your experience about providing care in Wisconsin.

Your testimony highlights the impossible landscape that you and other providers have been forced to navigate in the wake of the *Dobbs* decision and the effects on real patients in the State of Wisconsin. These stories aren't hypotheticals. They're about real people, and I wanted you to tell us a little bit more about how patients in Wisconsin were affected immediately after *Dobbs*.

How was the *Dobbs* decision and Wisconsin's archaic 1849 law, and how that has harmed Wisconsinites? And I imagine there were people who had appointments for care on the day that the *Dobbs* decision came out.

Dr. LINTON. Absolutely. Thank you, Senator Baldwin. So, yes, you're exactly right. Because of the 1849 law, this was not a law that if *Dobbs* was passed, then we had 30 days or 90 days or whatever. It was of course, as we've mentioned a couple times, there have been questions about the enforceability, but because of the risks of \$10,000 fines in 6 years in prison that went into effect for us immediately.

At 9:10 am, on the 24th of June, we ceased providing care at that moment. We had patients in our clinic, we had patients scheduled the next day, and staff members had to go out into the lobby and tell them, because of something that just happened states away, you cannot receive care here today. And it was, it was incredibly difficult for patients and staff to try to figure out next steps to help them get healthcare.

Senator BALDWIN. Thank you. I've introduced legislation that I just described, the Women's Health Protection Act. This bill would guarantee that doctors have the freedom to provide abortion care and give patients the ability to receive the care they need nationwide. How would passage of that act impact in Wisconsin and improve care for patients right now?

Dr. LINTON. Thank you. And as a Wisconsinite, I do want to thank you very much for your leadership on this issue. As I mentioned, we have and as you mentioned, we've resumed abortion care in Wisconsin, but the future of abortion access in Wisconsin is anything but clear.

Even as we are providing abortion care right now, we are still practicing under medically unnecessary restrictions, including 24 hour waiting periods, ban on telemedicine, parental consent law, mandatory ultrasounds, et cetera.

As a physician who sees the impact of these restrictions every single day, I can tell you that Federal protections for abortion access will only improve the care that we can provide our patients in Wisconsin.

Senator BALDWIN. Thank you. And what do you want us to know about the current state of—tell us how these barriers that you just

described that are in part of state law, how do they affect patients that you see?

Dr. LINTON. I think first and foremost, they delay care. We know, as you mentioned, abortion is only accessible in Wisconsin right now in three counties. Our state is a lot bigger than three counties, so patients are already having to travel long distances.

We know that 24-hour bans are often not 24 hours. We have a same physician law in the State of Wisconsin. So, the patient has to see the same physician for a counseling appointment, to receive their medication abortion. So, oftentimes between those two appointments, it can be a week or plus before they can come back. And abortion is an incredibly time sensitive procedure.

All of these additional restrictions are creating hoops and barriers for patients to receive routine or what should be routine healthcare.

Senator BALDWIN. Thank you.

Senator MURRAY. Thank you.

Senator KAINE.

Senator KAINE. Thank you. Well, like many who spoke of today, I think the *Dobbs* decision was a disaster, both in terms of the human consequences of it, but also the radical nature of undoing not just 50 years of *Roe v. Wade*, but a hundred years of 14th Amendment precedent, that began with cases like whether parents should be able to make their own choices about whether their kids go to parochial schools or not, should parents be able to make their own choices about educating their children to speak German, should people be able to marry who they want. And the Supreme Court's decision to cast out, not just *Roe*, but then jeopardize all of these other rights that we've taken for granted for a century, has had just a set of horrible consequences.

I think we need a national protection. I have a bipartisan bill that would protect both *Griswold* and *Roe* and restore to where we are, pre-*Dobbs*, and make plain, that your rights shouldn't depend on what zip code you live in. Your rights shouldn't depend on who your state legislature is.

The notion in *Dobbs* at the Supreme Court said, but don't worry, you can go to your state legislature, when most of the state legislatures in the country, I mean, look at Congress, that's 26 percent women. That's called comfort, to say women's rights, well you can just count on the legislature to do it right, when women are so underrepresented in most of our legislatures, and that's why we have a constitution.

The Constitution and the Bill of Rights is designed to protect core freedoms. Even if the majority is against you, there's something that you should get living in this country, even if you're just one person that the majority can't trample upon.

Virginia, thank goodness, is one of the few states that essentially still follow *Roe*. There was the basic framework established by *Roe*, minimal regulation of abortion, pre viability, some more significant regulation, post-viability. That's where Virginia is. Not everybody likes that. For some it's not enough, for some, it's too much.

But Virginia has basically done that, and that has put Virginia in an unusual position because we're the last state in the South that really still provides women and all the rights that *Roe* guaranteed to them for half a century.

Ms. Lopez, you alluded to this in your testimony, but there's an unusual burden in these instances where states like Virginia are protecting reproductive freedom, but surrounded by others that aren't.

There was a story in the Washington Post recently, and I mean, here's an example. A woman drove from Houston, Texas to Fort Lauderdale, an 18-hour drive to access reproductive care. She hadn't heard that the Florida 6-week ban had gone into effect, so with no other option and 9 weeks pregnant, she then drove an additional 12 hours to Virginia to receive care.

After she legally was able to terminate her pregnancy at 9 weeks, she then had a 17-hour drive home back to Texas. I think it's just outrageous that we're making people do that. But talk a little bit about the burden with this patchwork of some states protecting women's reproductive freedom and many states not.

Ms. LOPEZ. Yes. Thank you, Senator, for the question. And as I stated in my testimony now one in five abortion seekers are traveling outside of their state to places like Virginia to seek care, which—

Senator KAINE. You said it was 160,000. 80,000 before *Dobbs*, 160,000 since.

Ms. LOPEZ. Yes. And what we know is that increases in places like your state, and for our providers, that increases the number of patients they're getting. So, both the residents that they're serving within their own state, and now this influx of patients, which means that there's going to be an increased waiting time.

If you think about all of the barriers, that someone having to leave their home community, figure out how they're going to pay for the procedure, take off work, find childcare, because most people who seek abortion are also parents themselves. Go to an unfamiliar place probably have to wait. And then also have costs on the ground, the financial, logistical, and ultimately the emotional barriers are ridiculous and sometimes insurmountable, and ultimately could be forcing some people to carry pregnancies to term.

Senator KAINE. Then finally, this is a hearing that is about how abortion bans have created a health care nightmare. That's the title of the hearing. But the *Dobbs* decision also impacted a whole lot of other rights.

Again, this whole 14th amendment jurisprudence since the mid 19-teens, including the right to contraception in Virginia, because of the logic of the opinion Virginia legislators see a price. And Ghazala Hashmi, two friends of mine in the Virginia General Assembly introduced a contraception protection in Virginia law that was passed overwhelmingly by the legislature, but our Governor vetoed it.

Are you seeing other states taking the green light of *Dobbs*, to put into question contraception, in vitro and other important health care services?

Ms. LOPEZ. Absolutely. Senator, not just contraception, but efforts to defund Planned Parenthood continue, to limit or defund Title X, access to contraception for everyone, other restrictions on minors' access to care, IVF.

Then we're also seeing kind of similar efforts around transgender and gender affirming care. Those are all interrelated and all efforts to limit access to basic reproductive healthcare.

Senator KAINE. Well, just as I conclude, to my colleagues, Elizabeth Carr, the first child born via IVF in the United States was born in Virginia in 1981. And I had her as my guest at the State of Union. And she said, when the Alabama Supreme Court rendered the ruling that then led the Alabama health care providers to stop IVF, she said, for the first time in my life, I felt like an endangered species. No one should be made to feel that way.

Thank you. I yield back.

Senator MURRAY. Thank you. That will conclude our hearing for today. I will give you a closing statement. I want to thank everybody who's joined us in this discussion. Senator Cassidy, I'll allow you the closing remarks, and I have not yet voted, so keep it short.

Senator CASSIDY. First, I'd like to ask unanimous consent to enter into the record an Op-ed written by Kelly Crawford, founder and executive director of Abel Speaks, an organization, created in memory of her son who was diagnosed with Trisomy 18. The organization supports families. I think they would feel, just as Senator Kaine, they feel as if the children who were born with trisomy 18, are being selectively aborted. And that, of course, makes them feel like their lives are threatened.

[The following information can be found on page 114 in Additional Material:]

Dr. Verma, just a quick question. You rightly point out that rarely is this done. Would you agree, therefore, that it would be reasonable to restrict late term abortions?

Dr. VERMA. First, late term abortion is not a medical term. We tend to say abortion later in pregnancy.

Senator CASSIDY. Just this, would you find it reasonable that after some week, that it would be reasonable to restrict an abortion after a certain period of week, given that it saves life the mother and such like that. Because I think that's really the crux.

Is there any kind of limit that will be placed, if you say, this hardly ever happens or never happens, I think was your words. Would it be reasonable then to restrict when this would occur?

Dr. VERMA. When I provide abortion care later in pregnancy, I want you to envision a patient who has a nursery designed, a name picked out, who is diagnosed with a terrible fetal anomaly or a worsening health condition—

Senator CASSIDY. This is not a theoretical, I'm just saying if the child is otherwise well, and the mother's health is well, since you are saying this hardly ever happens, is it reasonable to have—

Dr. VERMA. I would say abortion at the moment of birth does not happen. I also take care of patients who need abortion care later in pregnancy for many different reasons—

Senator CASSIDY. I respected, by the way, I really did respect you speaking of that tension between the week 23 that you would abort and the week 23 threes that you would resuscitate. I don't mean to be confrontative, but you're avoiding the dialog here.

Dr. VERMA. No, no, I totally hear you. And I'm not trying to be confrontational. I'm just trying to highlight what these situations actually look like. So, for example, getting an abortion care later in pregnancy for someone—

Senator CASSIDY. I'm sorry. I'm not going to get an answer that. Dr. Francis, will you just finish up on that question, please?

Dr. FRANCIS. Absolutely. Well I think certainly beyond the point where a child can survive outside of his or her mother, there would never be a reason you would need to intentionally end that child's life. You would simply deliver that baby, you'd take care of mom, and you'd take care of baby in an appropriate way. And I think that's something that I would hope that all of us at this table could agree upon.

Senator CASSIDY. With that I yield. Thank you.

The CHAIR. Let me just give Dr. Verma, I don't think that Senator Cassidy gave you the opportunity to respond effectively. Take 2 minutes to respond and say what you wanted to say.

Dr. VERMA. I appreciate it. I was just trying to paint a picture as a doctor who's actually sitting with these patients and providing this full spectrum of care, what this care actually looks like. So, when I'm providing care for a patient, for example, that comes in later in pregnancy, a lot of times that's a patient who's received a terrible fetal diagnosis and is having to make that difficult, difficult decision. They have a nursery set up, they have a name picked out, and what they need from me as their doctor is support.

I have some patients that choose to continue that pregnancy and deliver at term and other patients who say, that's too traumatic. I can't do that. And my job is to support them in both of those situations with whatever is right in their life.

I think as doctors, we all recognize that providing lifesaving care sometimes means ending a pregnancy. And to call that care something besides an abortion is an issue of semantics to further a political agenda.

The care that we're referring to that sometimes means ending a pregnancy, that is abortion care, and that is what we are talking about here. And is sometimes necessary lifesaving care for our patients who come in needing this care for a variety of reasons.

Senator MURRAY. Thank you for that comment. And I'll just say that as Dr. Verma said, abortion up until the moment of birth doesn't happen. Abortions that are later in pregnancy are extraordinarily rare, and they occur essentially only when a pregnancy is non-viable and the mother risks severe injury or death by remaining pregnant.

The Democratic position on abortion is simple and mainstream. We want to ensure that every woman has the right to receive abortion care, should she need it. The decision to have an abortion is extremely personal, and that should be made in every instant by the patient and their doctor, not by politicians. That is our position.

With that, I just want to end this hearing by saying that this is the truth. This is a topic that is absolutely not going to go away, because women are going to continue suffering under Republican's extreme abortion bans. They're going to continue to have to travel, thousands of miles, and scrape together thousands of dollars to get the care when they need an abortion.

Pregnant women are experiencing health emergencies and will continue being turned away from hospitals because politicians have made doctors wait until women get sicker and sicker before they're allowed to treat them.

More and more women will continue being forced to stay pregnant, forced into motherhood against their will. This is not something you forget. It's not a reality that you ignore. It's not a status quo you get used to. And make no mistake, women are standing up, they are speaking out, and they're fighting back to defend their rights that have been ripped away.

Democrats are going to continue to stand with women, lift their voices up like today, and push with everything we've got, to restore every woman's right to access abortion care in this country.

With that, for any Senators who wish to ask additional questions, questions for the record will be due in 10 business days, June 18th, by 5 p.m.

Senator MURRAY. The Committee stands adjourned.

Thank you.

ADDITIONAL CONTENT



Clear and Growing Evidence That Dobbs Is Harming Reproductive Health and Freedom

Kelly Baden, Guttmacher Institute, Joerg Dreweke, Guttmacher Institute and Candace Gibson, Guttmacher Institute

Two years after the US Supreme Court revoked the constitutional right to abortion, an increasingly robust body of evidence is emerging that illustrates the myriad harms caused and exacerbated by the *Dobbs v. Jackson Women's Health Organization* decision. Several dozen peer-reviewed studies and other rigorous research conducted since June 2022 illustrate key facets of the impact of *Dobbs*, including data on changes in clinic numbers, abortion incidence and travel for abortion care. This empirical evidence is complemented by valuable insights from other sources, such as reports from advocacy organizations with deep expertise in different areas of reproductive health and rights, as well as stories from reputable media outlets.

It is valuable to examine this growing evidence base to gain a deeper understanding of how the volatile, chaotic legal landscape that erupted in the wake of *Dobbs* has affected abortion access in the United States. It is also important to acknowledge that our understanding remains incomplete and that the full scope of harms caused by the ruling may not be clear for years to come. However, the evidence suggests that it will not be easy to repair the devastation caused by the *Dobbs* decision. Documenting its adverse effects is critical to our goals of mitigating and reversing the decision's impact, and ultimately restoring and reimagining abortion rights nationwide.

Accumulating Evidence Shows a Broad Range of Impacts

Several research efforts—including the #WeCount project by the Society for Family Planning and Guttmacher's Monthly Abortion Provision Study—were specifically designed to generate high-quality data on an accelerated timetable to help policymakers and others gauge impacts nearly in real time. The empirical evidence is complemented and further contextualized by reports, stories, surveys and other sources that offer a clearer picture of the wide-ranging effects of overturning *Roe v. Wade*.

Fewer Abortion Clinics and Shifts in Provision

Within 30 days of the *Dobbs* decision, 43 clinics in 11 states had stopped providing abortion care. By 100 days after the decision, this had increased to 66 clinics in 15 states; no abortion-providing facilities operated in the 14 states enforcing total abortion bans.

Between 2020 and March 31, 2024, the total number of brick-and-mortar clinics providing abortion care in the United States declined by 5%, from 807 to 765, according to forthcoming Guttmacher research. This trend is likely to continue, following the May 1 implementation of a

six-week ban in Florida, where 54 clinics provided abortion care, and ongoing legal chaos over potential enforcement of a total ban in Arizona, which has seven abortion clinics.

In the District of Columbia and the 36 states that do not have total bans in effect, 20 additional facilities began providing care, representing a 3% increase for those states, according to forthcoming Guttmacher research. This is welcome news and helps improve access there, but it does not mitigate the loss of access in states with total or early gestational bans.

New Models for Abortion Care

Brick-and-mortar facilities provide more than three-quarters of all abortions, but a new type of provider—virtual, or online-only, clinics—is expanding care options by offering medication abortion services via telehealth. Research by the #WeCount project shows that virtual-only telehealth abortions accounted for almost one in five abortions (18%) from October to December 2023, an average of nearly 16,000 abortions per month.

A critically important subset of telehealth abortions is those provided by clinicians in states supportive of abortion rights to people in states with total or telemedicine abortion bans. Six states (California, Colorado, Massachusetts, New York, Vermont and Washington) have shield laws in effect to ensure that abortion providers can offer said care regardless of a patient's location. The #WeCount project found that nearly 6,000 people per month in states with bans or severe restrictions on abortion have accessed medication abortion this way.

Post-*Dobbs*, the importance of self-managed medication abortion has also increased, as more people have been obtaining medication abortion in other, novel ways. An examination of abortion pill distribution by online vendors, telehealth organizations and community networks showed that pills for 27,800 more medication abortions were mailed in the six months after the *Dobbs* decision than the expected number had the ruling not been issued.

Crossing State Lines to Access Abortion

The proportion of patients traveling to other states to obtain abortion care has doubled in recent years, reaching nearly one in five in the first half of 2023, compared with one in 10 in 2020.

This surge in travel has largely been driven by post-*Dobbs* abortion bans and restrictions; notably, the sharpest increases in out-of-state patients occurred in Colorado, Illinois, Kansas and New Mexico, all of which border states with total abortion bans. Accessing abortion care likely came at great cost for many individuals who had to navigate the financial and logistical barriers to leaving their state for care.

Despite Bans, the Number of US Abortions Has Increased

The number of abortions in the United States has increased, despite the many total bans and other severe restrictions in effect: Guttmacher documented an 11% increase in clinician-provided abortions between 2020 and 2023, reflecting a continuation of a longer-term increase in abortion that started after 2017. However, the abortion incidence increase should not be misread to mean

that everyone who needed an abortion was able to get one. *Roe* was never enough to ensure full abortion access; additional restrictions imposed since *Dobbs*—most notably total bans and early gestational duration bans—have made access even worse.

For example, births decreased in almost all states from 2022 to 2023. But these decreases differed depending on whether a state had banned or protected abortion. For the first six months of 2023, the decrease in births in the 13 states with total abortion bans was lower than it would have been in the absence of these bans, compared with the 24 states where abortion was protected.

Contraceptive Care Has Been Impacted

Some research suggests that access to broader contraceptive care is worsening in the post-*Dobbs* era. Data collected from two surveys conducted pre- and post-*Dobbs* in Arizona, Iowa, New Jersey and Wisconsin of women aged 18–44 found that barriers to accessing contraceptives increased and reports of receiving high-quality contraceptive care decreased a year after the *Dobbs* decision.

While these changes cannot be causally attributed to the fall of *Roe*, the *Dobbs* decision came just three years after the “domestic gag rule” was imposed—Trump-Pence administration regulations that included sweeping and destructive changes to the Title X program, which is the only federal program dedicated to providing family planning services for low-income patients. As a result of the domestic gag rule and related anti-abortion policies, some patients shifted to a less-preferred contraceptive method. While the domestic gag rule was rolled back by the Biden administration in 2021, its effects continue to linger.

Impact on Providers and Patients

One qualitative study interviewed 54 obstetrician-gynecologists practicing in states with a total ban on abortion. They reported needing to delay necessary care until patients were at risk of death or permanent injury, confusion about whether providers could counsel patients on abortion, legal fears and uncertainties, and moral distress, among other concerns. About 60% of physicians considered leaving their state to practice elsewhere, and 11% actually did so. As providers leave hostile states, pregnant patients may suffer: “Maternity care deserts,” which are areas with few or no obstetric care resources, can mean long travel times for access to both basic and emergency care.

A separate survey of 569 ob-gyns showed that, nationally, one in five providers felt constraints on their ability to manage miscarriages and other pregnancy-related emergencies since *Dobbs*; in abortion ban states, four in 10 ob-gyns felt this way. Clear majorities also believed that their ability to manage pregnancy-related emergencies worsened and that racial inequities in maternal health increased.

Impact on Medical Students and Training

The post-*Dobbs* legal landscape also implicates medical training: medical students in states with total abortion bans must seek abortion training out of state. They may take a state's abortion legality into effect when considering residency applications. Diminished training opportunities can potentially lead to a decline in clinical skills, knowledge and experience, ultimately impacting patient experience and access to care.

Potential Erosion of People's Mental Health

The fallout from the *Dobbs* decision is one of many crises that people across the United States coped with in recent years, including the COVID-19 pandemic and other disruptive events. Data show that communities already marginalized within the health care system experienced worsening mental health during this time. Additional research is needed to understand how the mental health of these communities and the broader public is affected by anti-abortion policies and laws.

Potential Risks for Maternal Health

Research prior to *Dobbs* found that certain abortion restrictions were associated with higher rates of maternal mortality. One analysis highlighted that states that have banned abortion or are planning to ban abortion have fewer maternity care providers, more maternity care deserts and higher rates of maternal mortality and infant death than states where abortion is accessible. These inequities disproportionately harm Black and Indigenous communities, which have historically faced significantly higher rates of maternal mortality than their White peers.

Researchers have provided preliminary estimates regarding the risk of maternal mortality for individuals who can become pregnant if a national ban on abortion were to be enacted. Assuming that abortions were banned in all states, at the highest end, maternal mortality would increase by 24%, non-Hispanic Black people would face a 39% increase in maternal deaths.

Patients Facing Obstetric Emergencies

Journalists have tracked tragic stories of pregnant women desperately seeking emergency care to protect their own lives and health, only to be blocked from treatment by hospitals fearful of misinterpreting their state's abortion ban or because they do not qualify for the exceptions that may exist.

One report found that hospitals in Oklahoma could not clarify consistent policies for how clinicians should handle emergency obstetric care. Ongoing litigation in Texas documents how pregnant patients suffered during obstetric emergencies—risking their health and, in some cases, their lives—because of the hostile climate caused by Texas' abortion ban.

The Evidence Calls for a Robust Policy Response

Overturning *Roe* did not resolve the debates on abortion that have characterized the US political system for the past 50 years. Instead, it enabled the implementation of policies and laws that

have significantly altered the provision of abortion care, exacerbating the harms faced by individuals who are most marginalized in the health care system.

For instance, in the first quarter of 2024, four states introduced legislation—and one passed a law—criminalizing adults who support adolescents seeking abortion care. Earlier in the year, the Alabama Supreme Court’s decision to classify frozen embryos as “children” wreaked havoc on fertility treatment services and patients seeking in vitro fertilization (IVF). Moreover, the decision advanced the anti-abortion movement’s long-term goal to enshrine fetal personhood in both law and policy. These attacks on bodily autonomy, coupled with major cases before the US Supreme Court on abortion this term, signal that the policy and legal landscape will continue to shift, significantly affecting abortion provision.

We are just beginning to understand the scale of the *Dobbs* decision’s effect on providers, clinics, patients, support networks, maternal health and contraceptive care. Current research confirms what advocates have long known: that the loss of *Roe* would only create confusion, chaos and a deeply fractured landscape where a person’s zip code plays a consequential role in determining whether, where, when and how they can receive care. Future research will need to make sense of how policies that are either supportive of or antagonistic toward abortion rights will affect the sexual and reproductive health care delivery system overall.

It is imperative that advocates and policymakers at all levels of government take heed of this evidence and use it to champion a bold vision of abortion care that goes beyond what *Roe* promised. Only policies rooted in evidence and human rights will guarantee that all people have meaningful access to high-quality, affordable abortion care where they live and via the method they choose.



Statement for the Record

Regina Davis Moss, PhD, MPH, MCHES
President and CEO

In Our Own Voice: National Black Women's Reproductive Justice Agenda

**Senate Health, Education, Labor and Pensions (HELP) Hearing
"The Assault on Women's Freedoms: How Abortion Bans Have Created a Health Care
Nightmare Across America"**

June 6, 2024

Chair Sanders, Ranking Member Cassidy, and Honorable Members of the Senate HELP Committee,

Thank you for holding the "The Assault on Women's Freedoms: How Abortion Bans Have Created a Health Care Nightmare Across America" hearing. I appreciate the opportunity to share the views of In Our Own Voice: National Black Women's Reproductive Justice Agenda (In Our Own Voice). In Our Own Voice is a national-state partnership focused on uplifting the voices of Black women leaders at the national and state levels in our fight to secure Reproductive Justice for all women, girls, and gender expansive people. Our national-state partnership of eight Black women's Reproductive Justice organizations includes The Afiya Center (TX), Black Women for Wellness (CA), Black Women's Health Imperative (national), New Voices for Reproductive Justice (PA & OH), SisterLove, Inc. (GA), SisterReach (TN), SPARK Reproductive Justice NOW (GA), and Women with a Vision (LA). Our state enhancement partners include Birth in Color (VA), Oshun Family Center (PA), Wisdom Institute (MI), and the New Jersey Black Women Physicians Association (NJ).

Reproductive Justice Framework

Reproductive Justice is the human right to control our bodies, our sexuality, our gender, our work, and our reproduction. Reproductive Justice will be achieved when all people, regardless of race, gender and immigration status, have the economic, social, and political power and resources to define and make decisions about our bodies, health, sexuality, families, communities in all areas of our lives. *Access to safe, accessible, and affordable abortion care is essential to ensuring this right.*

Black women, girls, and gender expansive people need access to the full spectrum of reproductive health care to make the best reproductive decisions for themselves and their families. As highlighted by the Reproductive Justice framework, a lack of access to essential health care, like abortion care, can have a far-reaching impact on the lives of Black women and gender expansive people and their communities.

The Impact of *Dobbs* on Black Women and Gender Expansive People

Roe v. Wade was always the floor for Black women and gender expansive people in the United States and the *Dobbs* decision has had a devastating impact on communities that already had limited access to quality and affordable reproductive health care. For decades, policies like the Hyde Amendment already limited access to abortion care for Black women and gender expansive people who are more likely to be enrolled in federally funded insurance plans like Medicaid.¹ In addition, state imposed waiting periods, viability restrictions, and mandatory ultrasounds all create medically unnecessary barriers to care. The *Dobbs* decision has caused irreparable harm to our communities and as more states move to ban abortion care, Black communities are at the center of an access crisis. In a new analysis from In Our Own Voice and National Partnership for Women and Families, we found that more than 6.7 million Black women - 57 percent of all Black women ages 15-49 - live in 26 states that have banned or are likely to ban abortion.²

As states seek to further limit abortion care, fear of criminalization of pregnancy is rising in our communities. Our poll found that recent bans and restrictions made 34 percent of respondents think about the risk of being arrested in relation to a pregnancy, miscarriage, or abortion care.³ This fear is not unfounded - while many state criminalization laws have historically targeted providers, several states have begun to target “helpers,” anyone who helps people access

¹ *Re-Imagining policy: In Pursuit of Black Reproductive Justice*. In Our Own Voice: National Black Women's Reproductive Justice Agenda. (2023) <https://blackrj.org/wp-content/uploads/2023/06/RJPolicyAgenda2023.pdf>, pg. 15

² Kidd, C., Goodman, S., Gallagher Robbins, K. (2024, May). *State Abortion Bans Threaten Nearly 7 million Black Women, Exacerbate the Existing Black Maternal Mortality Crisis*. <https://blackrj.org/wp-content/uploads/2024/05/StateAbortionIssueBrief.pdf> pg. 2

³ In Our Own Voice: National Black Women's Reproductive Justice Agenda. (2024, March 25). *New election poll: The lives and voices of black families in 2024*. <https://blackrj.org/wp-content/uploads/2024/03/In-Our-Own-Voice-Lives-Voices-of-Black-Families-2024.pdf>

abortion care.⁴ Our communities need access to the full spectrum of reproductive health care in order to make the best decisions for themselves and should not fear criminalization when making personal decisions about their own bodies. Bans on abortion care cause confusion in states and make other forms of care like miscarriage management and emergency pregnancy care life threatening.

Economic Impact of Abortion Bans

For Black communities, intersecting economic barriers make traveling for care next to impossible. Black women are over-represented in service jobs, which are less likely to offer paid leave. They are also more likely to be the breadwinners of their families.⁵ For someone to travel for abortion care, they would need to take time off of work, find childcare, and find the financial resources to cover their care. For many, that simply isn't an option. Economic policies that support individuals and families like paid leave, affordable health care, and quality childcare are all necessary Reproductive Justice policies that allow Black women and gender expansive people to exercise their bodily autonomy.

Parallel Crises: Black Maternal Health and Abortion Access

Prior to the *Dobbs* decision, the United States was already facing a maternal health crisis that disproportionately impacted Black women and birthing people. Black women are three times more likely to die due to pregnancy related causes than their white counterparts.⁶ Factors like systemic racism and discrimination, lack of access to culturally competent care like doulas and midwives, and other social determinants of health, put Black women and birthing people at higher risk of experiencing complications during and after pregnancy.⁷ In a recent In Our Own Voice poll, a majority of Black women (54 percent) said they felt the effects of racial and gender

⁴Dellinger, J. & Pell, S.K. (2024 April 18). *The criminalization of abortion and surveillance of women in a post-Dobbs world*. Brookings. <https://www.brookings.edu/articles/the-criminalization-of-abortion-and-surveillance-of-women-in-a-post-dobbs-world/>

⁵ Milli, J. & Frye, J. (2022, June 9). *Black women need access to full paid family and medical leave*. Center for American Progress. <https://www.americanprogress.org/article/black-women-need-access-to-paid-family-and-medical-leave/>

⁶ Centers for Disease Control and Prevention (2024, April 8). Working together to reduce Black Maternal Mortality. Centers for Disease Control and Prevention. <https://www.cdc.gov/healthequity/features/maternalmortality/index.html>

⁷ *Re-Imagining policy: In Pursuit of Black Reproductive Justice*. In Our Own Voice: National Black Women's Reproductive Justice Agenda. (2023) <https://blackrj.org/wp-content/uploads/2023/06/RJPolicyAgenda2023.pdf>, pg.9

bias in the health care system.⁸ Abortion bans only further limit access to quality and affordable maternal health care.

Although the growing maternal health crisis is of growing concern to our organization, there is existing legislation aimed at lowering maternal mortality rates. In Our Own Voice supports the Black Maternal Health Omnibus Act, a historic set of bills designed to address the Black maternal health crisis by addressing the intersecting issues that impact the outcomes of Black women and birthing people, including food insecurity, lack of diverse perinatal workers, and maternal mental health. The Black Maternal Health Omnibus Act is a crucial step towards Reproductive Justice and is necessary to combat the concerning maternal health trends in the United States.

In conclusion, as we work to secure abortion access for all, our organization also believes we must address the maternal health crisis to secure Reproductive Justice for all. Black women and gender expansive people are disproportionately impacted by abortion bans and the maternal health crisis and it is critical that we address both to ensure Black families can thrive. Thank you to the committee for its leadership in addressing these critical issues and I look forward to working collaboratively on building a Reproductive Justice future.

Sincerely,

Regina Davis Moss, PhD, MPH, MCHES
President and CEO

In Our Own Voice: National Black Women's Reproductive Justice Agenda

⁸ In Our Own Voice: National Black Women's Reproductive Justice Agenda. (2024, March 25). *New election poll: The lives and voices of black families in 2024*. https://blackrj.org/wp-content/uploads/2024/03/In-Our-Own-Voice_-_Lives-Voices-of-Black-Families-2024.pdf

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National Council of Jewish Women

**National Council of Jewish Women Statement for the Record
The Assault on Women's Freedoms: How Abortion Bans Have Created a Health Care
Nightmare Across America**

United States Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chair Sanders, Ranking Member Cassidy, and Members of the Senate
Committee on Health, Education, Labor and Pensions:

Since our founding in 1893, National Council of Jewish Women (NCJW) has boldly imagined a world where women, children, and families are fully valued and supported. We have consistently dedicated ourselves to the pursuit of equity and justice through a powerful combination of community organizing, education, direct service, and advocacy. We carry with us the tradition of safeguarding the individual rights of freedoms for women, children, and families. United by our Jewish values, we mobilize our network of 50 local sections and over 210,000 advocates to make this vision a reality at all levels of government and in communities across the United States.

Today's hearing, *The Assault on Women's Freedoms: How Abortion Bans Have Created a Health Care Nightmare Across America*, provides an important opportunity to illustrate the devastating, real-world impacts of the *Dobbs v. Jackson Women's Health Organization* (hereafter *Dobbs*) ruling. Within just thirty days of the *Dobbs* decision, forty-three clinics in eleven states stopped providing abortion care.¹ In 100 days, sixty-six clinics in fifteen states stopped providing abortion care.² No abortion-providing facilities operated in the fourteen states enforcing total abortion bans.³

People across our country continue to be affected by the relentless attacks on abortion access and other forms of reproductive health care because the *Dobbs* decision impacted more than just abortion. The ruling has negatively impacted access to reproductive health care as a whole, including access to contraception, medication abortion, emergency abortion care, and IVF. *Dobbs* has emboldened state legislatures to move forward harmful policies that not only negatively affect individuals seeking reproductive health care, but also target abortion providers, reproductive health care organizations, and people working to help individuals access reproductive health care.

¹ [Clear and Growing Evidence That Dobbs Is Harming Reproductive Health and Freedom | Guttmacher Institute.](#)

² *Id.*

³ *Id.*

The stakes have never been higher for the women, children, and families in our country. The unfortunate message they are hearing through the repeated jeopardization of their health care is that their decisions, lives, and health care do not matter.

NCJW is proud to stand alongside other reproductive and civil rights organizations in support of federal legislation and policies which fiercely advocate for safe abortion access and other forms of reproductive health care. We thank this Committee for holding this hearing to shed further light on the negative consequences that restricting reproductive health care has on our country.

If you have any questions, please contact Smriti Krishnan, Legislative Counsel, at skrishnan@nciw.org.

Sincerely,
Darcy Hirsh
Director of Government Relations and Advocacy
National Council of Jewish Women



**Written Statement for the Record by the National Partnership for Women & Families
Submitted to the U.S. Senate Committee on Health, Education, Labor & Pensions
Hearing on "The Assault on Women's Freedoms: How Abortion Bans Have Created a
Health Care Nightmare Across America"
June 4, 2024**

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality, affordable health care and policies that help all people meet the dual demands of work and family. We write in support of the Senate Committee on Health, Education, Labor & Pensions hearing on "The Assault on Women's Freedoms: How Abortion Bans Have Created a Health Care Nightmare Across America" and in support of policies that enable pregnant people to have meaningful access to the full range of reproductive health care, including abortion.

In collaboration with Physicians for Reproductive Health, we published an issue brief this March titled "*Dobbs*' Erosion of the Health Care Workforce: Harms to Providers and Patients," which discusses the far-reaching impacts of the *Dobbs* decision on reproductive health care providers. These harms include exacerbating workforce shortages, threatening the OB/GYN pipeline, worsening the maternal health crisis, and forcing providers to relocate their families or cease providing care altogether.

Please find attached the issue brief as part of the National Partnership's written statement for the record.

***Dobbs*' Erosion of the Health Care Workforce: Harms to Providers and Patients**

MARCH 2024

The Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, and extreme abortion bans and restrictions passed by states even prior to then, have had far reaching impacts on health care providers and the communities they care for.

Providers have been forced to shift the care or services they provide, relocate, or cease offering care altogether in response to restrictive state laws, the increasing threats of criminalization, and threats to medical licensures. Training opportunities in sexual and reproductive health care for those in restrictive states have severely diminished and become even more difficult to access. And existing provider shortages have been exacerbated by these public policy decisions, as well as by multiple ongoing public health crises. These challenges both undermine the health care workforce and hurt patients, whose ability to access evidence-based, high-quality, and equitable health care is further limited. Moreover, these harms are not limited to the reproductive health care context; there have been far-reaching consequences for maternal health and health care writ large.

Dobbs has directly harmed providers in several ways. The inability to provide care that they know to be routine and necessary for patients — and the climate of fear, confusion, and increased legal risk — have had both tangible and intangible negative effects on them. These include the economic costs of being forced to relocate to a new state in order to continue practicing medicine, the mental health toll of moral injury and seeing patients denied access to care, the financial and emotional cost of taking on legal risk, the threats to their physical safety from providing abortion care in increasingly hostile environments, among others. While we are already beginning to see these widespread impacts on the health care provider workforce in the short time since the *Dobbs* decision was rendered, we expect these consequences to intensify as providers continue to try

and meet demand for critical health care services amidst a constantly changing and adverse legal environment.

This issue brief documents these various harms to both patients and providers, and includes real-life stories from providers that illustrate the very difficult and complex questions they are facing. It also offers policy solutions to help address these harms and invest in a health care system that better meets the needs of both patients and providers.

***Dobbs* has intensified the health care provider shortage**

The *Dobbs* decision accelerated a growing health care workforce shortage. This crisis is fueled by several interrelated drivers, including burnout, a global COVID-19 pandemic, lack of worker-supportive policies, and stagnation in health system reforms such as inadequate provider reimbursements, misaligned incentives, and limited investment in multidisciplinary care teams at the state and federal levels.

The American Association of Medical Colleges (AAMC) currently projects a national physician shortfall across all primary care and specialties of at least 37,000, and potentially over 100,000, over the next decade.¹ The shortage of obstetrician-gynecologists (OB-GYNs), family medicine physicians, adolescent medicine doctors, and internal medicine providers is particularly concerning. For example, the American College of Obstetricians and Gynecologists (ACOG) estimated that in 2020, there was a shortage of 8,800 practicing OB-GYNs nationwide, with more than half of all U.S. counties lacking *any* practicing OB-GYN at all.² And, already, 30% of patients do not have a primary care doctor due to a shortage of family medicine providers.³ These provider shortages are not limited to physicians; the same factors are also driving a shortage of nurses. As one example, one study predicts a national deficit of nearly one million registered nurse jobs by 2030.⁴ Provider shortages extend to advanced practice clinicians, including midwives. In addition to the aforementioned factors, midwives and other community health providers in particular have also been forced to grapple with a history of racial, gender, and economic discrimination within their workplaces, alongside unnecessary, burdensome restrictions, including physician supervision requirements and scope of practice limitations.⁵

Unfortunately, in addition to shortages in the *overall* number of providers, the persistent lack of diversity among existing providers is especially troubling considering ongoing, intractable racial and ethnic health inequities. Only about 5.7% of physicians are Black or

African American and 6% are Hispanic,⁵ even though they make up 14% and 19% of the U.S. population respectively.⁶ This lack of diversity matters because evidence shows that racial concordance between patients and providers has a direct impact not only on trust, which has been shown to be the cornerstone of patient-provider relationships, but on health outcomes as well.⁷ People of color continue to grapple with a health care system that routinely fails to treat them with respect, operates in untrustworthy ways, and is rife with medical racism and bias.⁸ Inequities in outcomes are well-documented, and evidence shows that patients of color are more likely to be misdiagnosed than white patients.⁹ For example, when Black people receive care from a provider of a different race, they are routinely offered fewer effective interventions or treatments.¹⁰ Another study found that Black men treated by Black physicians had better patient interactions and were more likely to agree to preventative services like cardiovascular screenings and immunizations that help combat rates of chronic disease, compared to Black men who were treated by providers who were not Black.¹¹ The study also estimates that if more Black people were seen by Black physicians, the Black-white heart disease mortality gap could be reduced by 19%.¹²

Looking specifically at reproductive health care, one study found that about one in four patients who identified as Black and roughly one in six who identified as Latinx reported race or ethnicity-based discrimination when seeking abortion care.¹³ That discrimination translated to negative experiences of care and poorer care quality, including less time with the physician, less patient care involvement, and lower quality physician communication.¹⁴

Increasing diversity in the health care workforce, especially among reproductive health care providers, will enable more patients of color to receive care from providers with the same racial or ethnic background, leading to more favorable care interactions and improved health outcomes.¹⁵ Unfortunately, another recent pair of Supreme Court decisions, *Students for Fair Admissions, Inc. (SFFA) v. President & Fellows of Harvard College* and *SFFA v. University of North Carolina*, roll back protections for affirmative action in higher education and will likely make it even harder to bring qualified and talented people of color into the health care professions pipeline.¹⁶ Studies show that affirmative action bans at the state level have led to about a 17% decline in the matriculation of medical school students who are underrepresented students of color;¹⁷ this trend will likely only spread nationwide and worsen in the coming years.

⁵ We use the term “Hispanic” here because that is the language used in the studies referenced. Where possible, we use terminology like “Latine/x,” which encompasses shared culture, ethnicity, and identity and not racial categories, and which also challenges the gender binary in the Spanish language and embraces the diversity of genders that often are actively erased from spaces.

As more abortion bans and restrictions are implemented, the existing shortage of sexual and reproductive health care providers will continue to grow. It is no surprise that the states with the most restrictive reproductive health policies are among the states that already have the fewest physicians per capita, including, for example, Idaho, Mississippi, Oklahoma, Wyoming, and Arkansas.¹⁸ Currently millions of Black and Latinx people of reproductive age live in states with the most restrictive abortion bans,¹⁹ and while health care providers are more likely to continue living and practicing where they complete their training, abortion bans and restrictions mean that there are fewer opportunities for providers of color to train in and continue working to care for their communities.

***Dobbs* is harming reproductive health care providers' well-being and economic security**

The *Dobbs* ruling – on top of decades of increasing abortion restrictions – have further undermined both institutional and individual reproductive health care providers' financial security, health, and general well-being. In just the first hundred days post-*Dobbs*, at least sixty-six clinics, Planned Parenthood facilities, and doctors' offices stopped offering abortion care.²⁰ In addition, approximately half of clinics that were previously providing abortions in restrictive locations pivoted to providing only other services such as contraception and prenatal and maternal care.²¹ Other practices left the state entirely, relocating to less restrictive places. Reasons for closure or elimination of health care services include outright bans prohibiting provision of care, threat of criminal penalties including prison time, and other personal and legal risks associated with providing care in hostile states, including harassment and threats of violence. When clinics close or relocate, staff across the organization are impacted in many ways, including loss of employment.

On an individual provider level, the hostile legal landscape is forcing many to consider either leaving the health care industry entirely or moving to places with more legal protections and less legal risk. According to a recent survey of approximately one thousand health care workers, 11% said they "have considered leaving the health care industry due to states' implementation of abortion restrictions."²² Similar shares of workers said they would consider moving to states where abortion access is protected and that they are concerned about their job security. Already many providers have made the decision to relocate to less restrictive states, have ceased providing abortion care and pivoted instead to providing other types of essential sexual and reproductive health care, or have left the health care workforce entirely because of restrictive state laws.

"I chose to move to a state that would allow me to provide abortions to patients in a primary care setting. This was extremely difficult for me to find, especially since I am motivated to provide care for underserved patients (specifically at federally qualified health centers). Most FQHCs do not provide abortion care due to the Hyde Amendment. Fortunately, my job does allow this, but it required a move across the country."
— **Anonymous, MD, New York and Kansas**

The decision about whether or not to relocate undoubtedly impacts the availability of care in particular areas, but it is also a deeply personal question that has significant impacts on providers themselves. For providers who choose to move to a new state, there are the financial costs of securing housing, packing, transportation, obtaining new medical licensure, and more. The process of relocating takes time away from providing care and likely causes disruptions in income, which can be especially challenging for providers carrying student loan debt. There is also the emotional upheaval of uprooting oneself and one's family, moving away from communities and networks of support, children changing schools, and starting a life over again in a new and often unfamiliar area.

"I would say [the decision to move because of abortion restrictions has cost] over \$150,000 per year in lost job opportunities since 2021, as well as the cost of around \$20,000 to move, new medical licenses and DEA [registration fees] and in general to re-establish myself personally and professionally."
— **Mariana Montes, MD MPH, Illinois**

"There's a great amount of moral distress. I now work at an academic center, and there continues to be a lot of confusion about what is "legal," and what can prompt a civil suit. Added to that, our [Attorney General] threatens anyone who helps someone get a legal abortion — including hospital support staff, so that many are afraid of taking care of pregnant people who have medical reasons to end their pregnancies — it is frustrating and maddening to not do right by patients because people from hospital administration down are scared about what "might" happen. My sense of self as a provider is compromised — I never realized until Dobbs just how much of my personal identity was tied to being an abortion provider. My income has been significantly impacted — I make approximately 30% less than when I was providing abortion care. While I'm fortunate to have a spouse that does well financially, it still has caused a lot of anxiety, and we've had to make decisions based on finances that we never had to make before."

— **Anonymous, MD, Texas**

It is also essential to name that these shifts, from both institutions and individual providers, in response to abortion restrictions take a significant toll on the providers who wish to remain in their communities. While providers, abortion funds, support networks, and advocates continue to undertake herculean efforts to meet demands for care, it is not possible for individual providers who remain in restrictive states to meet the needs of entire communities alone. These providers also carry the tremendous emotional weight of being forced to limit access to essential patient care, or of risking their licensure or being criminalized.²³ In addition, providers who stay in restrictive states may incur added expenses such as higher malpractice insurance fees, increased security costs to counter harassment and threats of violence, and the expense of legal consultation or representation to address increased liability.

"I have strongly considered leaving for some time. It is increasingly difficult to be a practicing OB-GYN in Florida, let alone an abortion provider. I have family in Florida and have stayed for this reason. What this means is that I cannot practice to my highest ability. I have a specific skillset that I cannot use to provide care for patients. My ethics have also been compromised. I am forced to turn away patients I otherwise am able to care for and for whom I know this care is what is needed...It doesn't make sense and completely goes against medical ethics. What has felt important in staying in Florida is that I can still provide care to Floridians who need the care. I know that just because there are restrictions doesn't mean that people don't need their abortions."

— **Robyn Schickler, MD, Florida**

"I honestly would like to leave the state, however I have remained here due to family/work obligations. I know that patients in the state of Louisiana need access to health care more than ever, so at least I am helping to provide that for some of them. However, it has been challenging to not have somewhere to refer them to for abortion care in the state, knowing most can't travel out of state due to funding/transportation issues. I feel that the restrictive abortion laws are compromising patients' individual bodily autonomy, but also timely access to abortion care."

— **Neelima Sukhvasi, MD MPH, Louisiana**

"I have stayed in a restrictive state because I know the people of Ohio need and want excellent reproductive health care. Although we have many burdensome restrictions in place, at least we are able to provide abortion care to the people of Ohio and the surrounding states that have bans in place. Ohio already had a limited number of clinics for the size of its population, and now, with patients coming from surrounding states, there is even more need for trained, passionate abortion providers. Staying in a restrictive state is not without risks, and the fear of access to abortion being further restricted is still present even after a political win with the reproductive freedom amendment. Our clinics are heavily scrutinized, both from the state department of health and the protesters outside every day. The recent case of Brittany Watts facing charges for a miscarriage demonstrates the hostility of prosecutors in the state towards reproductive health care, even with a constitutional amendment in place."

— **Courtney Kerestes, MD, Ohio**

Lastly, providers who make the difficult decision to leave the health care workforce entirely are often sacrificing their income and economic stability, years of education and training, as well as a sense of mission and purpose from a profession that they are now having to leave behind.

These economic and emotional consequences may be felt most acutely by providers of color, who may have added layers of complexity as they consider whether to stay or relocate and the costs of either choice. For example, providers of color more frequently provide care in communities of color and may feel particularly compelled to stay in their communities because they recognize the importance of racial concordance between patients and providers and its role in improving health outcomes. In addition, providers of color may be at increased risk of being surveilled and criminalized in places where abortion bans and restrictions specifically target providers, so staying in a restrictive state means taking on that increased risk.²⁴ Providers of color also carry disproportionate debt from student loans, and so may be less likely to have resources to move to another state or less able to absorb the economic impacts of these shifts in the provider workforce.²⁵

Bans and restrictions on abortion care that continue to drive providers away and threaten the health and well-being of providers and their families are setting up impossible circumstances and perpetuating immense harm.

***Dobbs* is undermining medical education and training, diminishing the future health care workforce**

In addition to undermining the ability of current providers to practice medicine, the *Dobbs* decision has also fundamentally altered the landscape of education and training in medical schools and residencies. Importantly, education and training in abortion care, particularly opportunities for hands-on learning, have been limited in medical schools for decades prior to *Dobbs*. While U.S. medical schools require students to complete a rotation in obstetrics and gynecology, there is no requirement that the rotation include education or training related to abortion care. In 2020, researchers at Stanford University found that half of medical schools included no formal abortion training and, in some instances, provided only a single lecture on the procedure.²⁶ Not surprisingly, *Dobbs* has further exacerbated barriers to abortion training as states have moved rapidly to restrict or ban access to abortion entirely. In the face of heightened legal risk and increased uncertainty, it is likely that more medical schools located in restrictive states will cease to provide information or training in abortion care, if they did prior to *Dobbs* at all. Medical societies including ACOG and the American Medical Association (AMA) strongly support

comprehensive abortion education and training in medical school; but learners are increasingly missing out on this core competency as a result of abortion bans and restrictions, as well as heightened institutional anxiety as more states impose severe criminal and civil penalties on abortion provision.²⁷

Furthermore, it is estimated that 94% of abortions in the U.S. are provided in facilities outside of the traditional learning environment, such as hospitals and academic health centers.²⁸ Consequently, students who wish to obtain additional education and training in abortion care must seek out such training on their own. Even prior to *Dobbs*, this presented challenges to medical students, who must carry the burden of finding and obtaining this essential education and training. In the post-*Dobbs* environment, with many medical schools located in states that ban or heavily restrict access to abortion care, it is nearly impossible for many students to obtain the hands-on learning required of all medical students prior to matriculation.

The ripple effects of the Supreme Court's decision are not limited to abortion-specific education in medical schools. For example, in the wake of abortion restrictions and the legal uncertainty that bans have created for institutions, providers, and learners, many training rotations and electives in other areas of family planning, such as contraception and fertility care, were canceled. Some institutions also expressed fear that they would no longer be able to provide education on subjects that are sometimes deemed "controversial," like medical ethics, and that they may be limited from providing learners with education about the full range of treatment options available for certain medical conditions, which in some cases includes abortion, without opening the institution or themselves to increased legal risk for providing or facilitating abortion care.²⁹

As learners matriculate through medical residency programs, they are also missing essential educational and training opportunities as a result of *Dobbs*. For more than twenty-five years the Accreditation Council for Graduate Medical Education (ACGME) has had an explicit requirement that all OB-GYN residency programs seeking accreditation provide access to routine abortion training. Following *Dobbs*, ACGME issued guidance stating that if a program is in a legally restrictive location, the program has a responsibility to provide access to abortion training in a place without legal restrictions.³⁰ Training in abortion care is considered a core competency in OB-GYN residencies and is essential for other physician specialties, including family medicine, adolescent medicine, and internal medicine physicians who often provide abortion care.³¹ Given that nearly one in four women will have an abortion in their lifetime, it is critical that providers acquire this skill. Abortion may also be indicated in urgent medical situations complicated by pregnancy such as pre-eclampsia, hemorrhage, and severe pulmonary hypertension. Additionally, when managing miscarriage or pregnancy

loss, abortion training can be lifesaving.³² This training also allows residents to achieve competency in skills they will use over the course of their careers, such as the provision of pelvic exams, administration of anesthesia, and patient education. In short, training in abortion care is essential to ensure the health and well-being of pregnant people and is especially necessary considering the country's ongoing — and worsening — maternal health crisis.

Dobbs has not only made it more difficult for physicians to get the training they require to adequately care for their communities, it has also impacted the decision of some graduating physicians regarding their chosen practice specialty and location — undermining access to essential forms of care and exacerbating inequities across communities. One survey found that among third and fourth year medical students, nearly 60% said they were unlikely to apply to residency programs in states that restrict abortion.³³ Relatedly, data from the Association of American Medical Colleges (AAMC) shows that applications for residency programs in states with abortion restrictions fell by 3%; this shift fell hardest in obstetrics and gynecology, in which programs saw a 5.2% drop in application volume.³⁴ In states with complete abortion bans, the number of applicants to OB-GYN residency programs fell by more than 10% when compared to the prior year.

Providers often remain in the communities in which they train.³⁵ However, the *Dobbs* decision is causing many residents to reconsider remaining in states where they have trained if those states restrict abortion care. In a 2023 survey of graduating residents from residencies with Ryan Residency Training Programs, a national initiative designed to integrate family planning and abortion training into OB-GYN residencies,³⁶ 17.6% of residents indicated that the *Dobbs* decision changed their location of intended future practice or fellowship plans.³⁶ Residents who, prior to *Dobbs*, indicated they intended to remain or practice in abortion-restrictive states were eight times more likely to have changed their practice plans as compared to those who intended to practice and remain in states with additional protections. When people seeking comprehensive sexual, reproductive, and maternal health care are unable to access providers in their community who are adequately trained to care for them, the consequences to individual health and well-being are devastating.

³⁶ To help programs meet the Accreditation Council for Graduate Medical Education (ACGME) mandate for routine abortion training in obstetrics and gynecology (OB-GYN) training programs, Dr. Uta Landy created the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning in 1999. The Ryan Program works directly with OB-GYN residency programs to integrate training in abortion and contraception care (family planning) as a required rotation. All programs establish or expand abortion services in their teaching hospitals and may also create new partnerships with local clinics to train residents. <https://ryanprogram.org/home/overview/>

"I am currently practicing in a state with restrictions. I am here because I have family and it is where I wanted to train however the restrictions have increased since I came here, and I feel that my patients and doctors are suffering because of them. I think patients' health is at risk, and I have seen patient care be altered due to the law. I think doctors are now under more stress because they have been put in a position to determine what a vague law means and potentially risk [their] freedom to provide evidence based and patient centered care."

— **Abby Schultz, MD, North Carolina**

Dobbs' overall erosion of the provider workforce is hurting patients

As discussed above, the *Dobbs* decision has cratered the availability of reproductive health care services for people across the country — precisely as intended. In the context of the escalating overall health care provider shortage, this is extremely worrying. A February 2023 HealthDay poll found that 35% of patients noticed or were affected by health care staffing shortages, and nearly three out of four adults who tried to obtain health care in the previous six months experienced delays in receiving care.³⁷ More than half of them noted they were worried they would not receive needed medical care due to staffing shortages.³⁸

In the reproductive health context specifically, *Dobbs* had an immediate and direct impact on access to essential forms of health care as states banned abortion care outright.³⁹ Even in states where abortion is nominally available — such as places where there are gestational age bans or so-called exceptions for the "life of the mother" — those exceptions are so narrow that they are meaningless. They do not increase the likelihood of a person's ability to access care or a provider's ability to provide it. For example, in states with gestational restrictions (in other words, limits on abortion after a certain point in pregnancy), only 10% of OB-GYNs offer abortion care, as opposed to states that do not have gestational restrictions where 29% offer abortion care.⁴⁰

Robust research demonstrates that when people seek abortions but are denied care, there are short- and long-term harms across nearly all dimensions of their lives, from decreased health and well-being, to lower educational and career attainment, to higher risks of poverty, to negative effects on any current and future children.⁴¹ For those who are able to access abortion, doing so often comes at considerable economic and personal cost. For example, people have to travel long distances, often across state lines, which requires arranging for time off work (often in the absence of paid sick days),

paying for childcare, shouldering transportation and lodging costs, and more.⁴² In 2023, it is estimated that one in five people are forced to travel for abortion care,⁴³ and 14% of the U.S. population is now more than 200 miles from the nearest abortion facility.⁴⁴ States without legal restrictions or barriers are also impacted. Providers in states where abortion remains legal report seeing at least double the number of patients now, which is increasing wait times for appointments and makes it more difficult for people to access care where they live.⁴⁵

Dobbs has also contributed to a significant reduction in the availability of health care services beyond abortion care.⁴⁶ This has been especially prevalent in the maternal health context, where, as a direct result of abortion bans, pregnant people are being denied miscarriage care, turned away from hospital emergency departments until their health deteriorates substantially enough to “qualify” for abortion care, or forced to travel long distances while in acute medical crisis in order to receive life-saving abortions.⁴⁷

Abortion restrictions — in combination with the lack of available and trained providers — have also pushed even routine pregnancy-related care far out of reach for millions of people. For example, providers have expressed that *Dobbs* has worsened the patient-provider relationship and negatively affected their ability to provide evidence-based care.⁴⁸ Providers are reporting delays of as many as three months for patients scheduling prenatal visits and ultrasound appointments.⁴⁹ Patients with pregnancy complications or medically complex pregnancies are also reporting long wait times to connect with providers and needed services.⁵⁰ Some hospitals have even been forced to close their labor and delivery units or shut down entirely in part due to provider shortages as a result of abortion bans, cutting off care for entire communities and especially harming pregnant people who lack the ability to travel long distances.⁵¹ Importantly, nearly one-third of U.S. counties, where more than 2.2 million people of childbearing age reside, have been designated as maternity care deserts, with neither a hospital maternity unit, nor a birth center, OB-GYN, or certified nurse-midwife.⁵² In these areas, it is virtually impossible for patients to receive any care, let alone high-quality reproductive and maternal health care. Delays in or inability to access care can result in poor health outcomes for both the pregnant person and the infant, including increased risk of potentially dangerous medical conditions and outcomes such as preeclampsia and gestational diabetes, low birth weight, and maternal and infant mortality.⁵³

This aspect of the provider workforce crisis, exacerbated by *Dobbs*, is especially egregious in light of the U.S.’s ongoing — and in fact worsening — maternal health crisis.⁵⁴ Data shows that maternal and infant death rates are higher and have increased twice as fast in states that ban or restrict abortion,⁵⁵ and both abortion bans and lack of

high-quality maternal health care disproportionately harm Black, Indigenous, and other people of color. More specifically, the pregnancy-related mortality rate for Black women in the U.S. is three to four times higher than the rate for white women, and other women and birthing people of color also face elevated rates of mortality and morbidity.⁵⁶ Given that people of color are both more likely to live in states with abortion bans and also face greater barriers to accessing care,⁵⁷ these inequities will likely get worse as the provider shortage and attacks on reproductive health care grow.

Policy Recommendations

Addressing the multifaceted harms caused by the *Dobbs* decision and abortion bans on the U.S. health care workforce and on access to health care requires bold congressional action. These legislative priorities must include investing in the reproductive health care provider pipeline and workforce and addressing broader shortages in primary care and maternal health care, in addition to enshrining protections for abortion access into law. Key bills include:

- S. 2024/H.R. 4147 Reproductive Health Care Training Act
- S. 1297/H.R. 2907 Let Doctors Provide Health Care Act
- S. 1031/H.R. 561 EACH Act
- H.R. 4303 Abortion Justice Act
- S. 701/H.R. 12 Women's Health Protection Act
- S. 100/H.R. 547 Better Care Better Jobs Act
- S. 2840 Bipartisan Primary Care and Health Workforce Act
- Reproductive Health Care Accessibility Act
- S. 1851/H.R. 3768 Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act
- S. 1606 / H.R. 3305 Black Maternal Health Momnibus
- S. 1710 / H.R. 3523 Perinatal Workforce Act
- HRSA Title VII and Title VIII Programs

This report was authored by MiQuel Davies, Director of Public Policy, Physicians for Reproductive Health and Meera Rajput, Huber Reproductive Health Equity Legal Fellow, National Partnership for Women & Families.

The following people also contributed to the development of this report:

- Dr. Jamila Perritt, President & CEO, Physicians for Reproductive Health
- Sinsi Hernández-Cancio, Vice President for Health Justice, National Partnership for Women & Families
- Shaina Goodman, Director of Reproductive Health and Rights, National Partnership for Women & Families
- Jessi Leigh Swenson, Director of Congressional Relations for Health Justice, National Partnership for Women & Families
- Jessica Mason, Senior Policy Analyst for Economic Justice, National Partnership for Women & Families

We are especially grateful to the providers who shared their stories for this report and who provide essential health care to people daily.

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The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality, affordable health care and policies that help all people meet the dual demands of work and family. More information is available at NationalPartnership.org.

Physicians for Reproductive Health is your source for background information and firsthand insight into reproductive health care. Our doctors are nationally recognized experts who can explain how political restrictions limits the delivery of reproductive health care and offer an insider's perspective on new developments in reproductive medicine. More information is available at PRH.org.

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The Honorable Bernie Sanders

Chairman

U.S. Senate Committee on Health,
Education, Labor & Pensions

428 Senate Dirksen Office Building

Washington D.C. 20510

The Honorable Bill Cassidy

Ranking Member

U.S. Senate Committee on Health,
Education, Labor & Pensions

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Chairman Sanders and Ranking Member Cassidy:

As an organization dedicated to achieving reproductive well-being for every person, we want to highlight the importance of access to abortion and urge congressional action as we continue to see pregnant people denied the health care that they deserve. Power to Decide is a private, non-partisan, nonprofit organization that works to ensure all people — no matter who they are, where they live, or what their economic status might be — have the power to decide if, when and under what circumstances to get pregnant or have a child.

Unfortunately, we are far from achieving that goal. In June 2022, the United States Supreme Court issued its decision in *Dobbs v. Jackson Women's Health Organization*, overturning its own precedent in *Roe* and upending the constitutional right to abortion. What has followed since has been a chaotic landscape that has resulted in an uneven patchwork of abortion access for countless people across the country. At least 14 states have made abortion illegal since the Court's decision in *Dobbs*¹. This ruling has resulted in diminished quality of sexual and reproductive health care and upended abortion access for entire reasons of the United States.² Further, the erosion of abortion rights has also exacerbated and already dire maternal mortality and morbidity crisis.³

¹ Center for Reproductive Rights. *After Roe Fell: Abortion laws by State*.
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³ Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions* (Commonwealth Fund, Dec. 2022).
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Since the Supreme Court's decision, researchers have noted declines in sexual activity in several states.⁴ Further, there have also been changes in contraceptive care and access. In Arizona, Iowa, and Wisconsin, researchers noted a 4 percent increase in reproductive aged women who reported trouble and/or delays in accessing their preferred contraception.⁵ In those states in addition to New Jersey, young people, queer and gender expansive people, women born outside the United States, and people with low incomes reported increase barriers to contraceptive care.

In this new landscape, getting accurate information, resources and accessing abortion and other sexual and reproductive health care services continues to be filled with obstacles. A 2023 Power to Decide survey found that 73% of respondents between the ages of 15-29 said they did not know of a health care provider or clinic where they could go to get an abortion if they needed one in the near future.⁶ In fact, Power to Decide's [AbortionFinder](#) website has received over 7 million visits since *Dobbs*, underscoring the fearfulness, confusion, chaos, and hurdles many people are facing simply trying to access health care.

For many marginalized communities, true bodily autonomy and access to sexual and reproductive health care has never truly been a reality. Historically, Black, Indigenous, Latina/x, and Asian American and Pacific Islander, LGBTQIA+, and people with disabilities have been denied true bodily autonomy and access to reproductive well-being. From the sexual violence, forced birth, and medical experimentation of enslaved women- to the forced sterilization of women of color and people with disabilities, the often-intentional oppression and violence towards these and other marginalized communities cannot be divorced from the history of sexual and reproductive health care in the United States.

Presently, marginalized communities continue to be disproportionately impacted by a lack of access to information, resources, and care. More than a quarter million of Asian and Pacific Islander women⁷, more than 6.7 Latinas⁸, and more than 6.7 Black women live in states where abortion is banned.⁹ Even before

⁴ Kavanaugh, L. Megan & Friedrich-Karnik, *Has the fall of Roe changed contraceptive access and use?* New research from four US states offers critical insights, *Health Affairs Scholar*, Volume 2, Issue 2, February 2024, qxae016, <https://doi.org/10.1093/haschl/qxae016>

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⁸ Gibson, C., Goodman, S., & Gallagher Robbins, K. (2023, October 3). *State abortion bans threaten 6.7 million latinias*. National Partnership for Women & Families. <https://nationalpartnership.org/report/state-abortion-bans-threaten-latinas/>

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Roe, many communities struggled to access abortion care due to bans and restrictions such as the Hyde and Weldon Amendments, targeted regulations of abortion providers (TRAP laws), a lack of coverage, or discrimination in health care. After *Roe*, barriers to care are exacerbated and for many, they are insurmountable.

As an organization dedicated to achieving reproductive well-being for all who is led by a practicing OB-GYN and abortion provider, we know that it is imperative that policymakers act to go beyond *Roe* and work to ensure access to abortion care for all who need it. Thank you for the opportunity to submit this statement for the record. If you have any questions, please reach out to Monica Edwards, Senior Manager, Public Policy at Power to decide at medwards@powertodecide.org.

Sincerely,

Rachel Fey,



Vice President, Policy & Strategic Partnerships

Power to Decide



Statement of Reproductive Freedom for All
U.S. Senate Committee on Health, Education, Labor and Pensions
The Assault on Women's Freedoms: How Abortion Bans Have Created a Health Care
Nightmare Across America
June 4, 2024

We thank you for the opportunity to submit a statement to the Committee on this critical issue, and for highlighting the continued assault on reproductive freedoms in the wake of *Dobbs v. Jackson Women's Health Organization*. Reproductive Freedom for All, formerly NARAL Pro-Choice America, is a national advocacy organization dedicated to protecting and advancing reproductive freedom. For over 50 years, Reproductive Freedom for All has fought to protect and advance reproductive freedom at the federal and state levels—including access to abortion care, birth control, pregnancy and post-partum care, and paid family leave. Through education, organizing, and influencing public policy, Reproductive Freedom for All and our 4 million members from every corner of the country work to guarantee every individual the freedom to make personal decisions about their lives, bodies, and futures, free from political interference. For this reason, we are submitting this statement to highlight the far-reaching impact of the U.S. Supreme Court decision to end the federal constitutional right to abortion and to call on Congress to use its authority to protect reproductive freedom and lock the right to abortion into federal law.

Abortion rights and access are facing a crisis in the United States. Despite overwhelming public support for the legal right to abortion, we are in the midst of an all-out assault on reproductive freedom. The U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* overturned *Roe v. Wade*, ending the constitutional right to abortion as we know it and signaling an ominous sign for the future of abortion rights in this country. The Court's ruling has empowered extremist state lawmakers to enforce draconian restrictions or total bans on abortion, which are now in place in 21 states.¹

The negative impacts of this cruel Supreme Court decision cannot be overstated. This horrifying rollback of our fundamental rights is causing immediate and devastating harm to millions of people across the country who can no longer access necessary care in their own communities. Bans on abortion especially harm those already marginalized by our systems and institutions. Losing *Roe* only compounded the problem: Women; Black, Latina/x, Asian American, Native Hawaiian, Pacific Islander, and Indigenous people; those working to make ends meet; the LGBTQ+ community; immigrants; young people; those living in rural communities; people with disabilities, and other historically oppressed communities are disproportionately impacted by these attacks on reproductive freedom.

The *Dobbs* decision was the culmination of a decades-long campaign waged by the anti-abortion movement and the politicians that did its bidding to end *Roe* and decimate reproductive freedom. Even before *Roe* was overturned by the Court—though *Roe's* protections

were never as universal in practice as they should have been—assaults against abortion access had been escalating. In the decade leading up to the *Dobbs* decision, state lawmakers seeking to advance their agenda of power and control had passed hundreds of state-level attacks on abortion access to make care extremely difficult, if not impossible, to access for many people across the country. According to the Guttmacher Institute, in 2022 alone, 563 provisions to restrict abortion access were introduced at the state level.¹¹ These systematic attacks on reproductive freedom and abortion intentionally push access out of reach, and some go as far as criminalizing pregnant people and doctors who provide abortion care.

Following the Court's decision, anti-abortion extremists have made it clear that they want further restrictions, harms, surveillance, and criminalization. Extreme efforts to criminalize abortion do not stop at doctors or medical providers. People seeking abortion and those who help them are already being prosecuted for pregnancy outcomes including pregnancy loss, self-managing abortion care, or even the suspicion of it.¹² Just last month, Louisiana Governor Jeff Landry signed a bill to make medication abortion schedule IV drugs, with incarceration and fines for possession of medication abortion without a prescription, gravely impacting those who choose to self-manage their abortion and people who may assist others in their abortion. Criminalizing people for having an abortion, experiencing a miscarriage or stillbirth, or any other pregnancy outcome only exacerbates racial inequities and is just one of the many ways that Black, Indigenous, and other people of color have been criminalized. The anti-abortion movement's goal has always been to control and criminalize women and pregnant people.

What we are observing in the aftermath of the *Dobbs* decision is only the beginning. We know that those hostile to abortion never intended to stop at overturning *Roe*. Anti-abortion politicians have only been emboldened by the Supreme Court's disregard for the health and well-being of millions of Americans. After denying that their goal was to ban abortion care nationwide, Republican lawmakers in Congress introduced a federal abortion ban declaring life begins at conception, which they outrageously billed as "moderate." Never in our country's history has such a ban existed, and the consequences on our lives and our freedoms would be catastrophic. Regardless of claims of "moderation," "exceptions," or "compromise," Republicans and anti-abortion extremists are working in lockstep to pass a national ban. This extreme agenda is fundamentally out of step with what the vast majority of Americans want.

Extremists are utilizing the fringe ideology of "fetal personhood" to push their radical attempts to restrict reproductive freedom. "Fetal personhood" is a concept that attempts to consider a fetus to be a legal person; these measures are a blatant attempt to force religious beliefs into law and continue the crusade against reproductive freedom. Laws that seek to establish that life starts at conception could not only criminalize abortion care, but could also criminalize assisted reproductive technology like IVF, as well as certain birth control methods, based solely on medical disinformation and the goal of forcing select religious beliefs into law. In addition to the aforementioned Life at Conception Act, which defines "human being" to include the moment of fertilization, and fails to include a carveout for IVF, Republicans have sought to

establish fetal personhood through other areas of the law including the tax code through bills like the so-called Providing for Life Act.

We also saw the far-reaching impact of these efforts when the Alabama Supreme Court ruled that frozen embryos used in IVF are children in wrongful death claims, resulting in the cessation of IVF treatment in the state. In response, Senate Democrats—led by Senator Tammy Duckworth—acted to federally protect IVF and other fertility treatments through unanimous consent, but this effort was blocked by Senate Republicans. While the Alabama state legislature responded by passing legislation to protect access to IVF in the face of political backlash, the legislation was not enough for all IVF providers in the state to resume providing care. The Alabama Supreme Court decision is not an isolated incident, as ideologues have been working for years to push personhood legislation. This ruling will motivate extremists to enact similar policies throughout the country.

In *Dobbs*, the Court claimed to be leaving abortion rights up to the states. Yet justices will soon be weighing in on abortion rights again in two cases. Both cases are of incredible consequence, and the potential harm is incalculable. We are seeing the right-wing agenda at work in *Alliance for Hippocratic Medicine (AHM) v. U.S. Food and Drug Administration (FDA)*. In November 2022, anti-abortion extremists filed a suit aimed at eliminating medication abortion care—the most common method of abortion—as we know it. They filed this radical, lawless suit specifically in Amarillo, Texas, where it was guaranteed to be ruled on by a Trump-appointed, known anti-reproductive freedom zealot: Judge Matthew Kacsmaryk. Kacsmaryk issued a preliminary ruling which disregarded basic principles of law and parroted extremist talking points, granting the anti-choice plaintiffs' request to block access to mifepristone while underlying litigation continues. Two of the key cases he cited in his ruling to severely restrict mifepristone have been retracted because of unreliable findings.

On appeal, a three-judge panel on the Fifth Circuit Court of Appeals, two of whom were anti-abortion Trump nominees, refused to grant the request to overturn Kacsmaryk's ruling. Instead, they decided to reinstate medically unnecessary and outdated restrictions on mifepristone that had been lifted by the FDA based on extensive evidence of the safety and efficacy of the medication. In April 2023, the Supreme Court granted the Department of Justice's request for a stay, blocking lower courts' dangerous rulings as the case proceeded. But in December 2023, the Supreme Court agreed to take up the case, and heard oral arguments in March 2024. During oral arguments, Justices Alito and Thomas perpetuated disinformation about the safety of mifepristone—putting their brazen, anti-abortion ideology on full display. These interjections by Alito and Thomas were not surprising, however, as they followed both their involvement in enthusiastically overturning the constitutional right to abortion in *Dobbs* and the revelation of numerous ethics and corruption allegations connecting the justices to far-right, anti-abortion extremists. This case has the potential to further devastate access to crucial abortion care if the Supreme Court sides with extremists and imposes medically unnecessary restrictions that would roll back access—even in states

where abortion is protected. This would have catastrophic effects in a landscape where anti-abortion extremists are working overtime to push abortion care further out of reach.

AHM v. FDA is not the only key reproductive freedom case the Court will consider this session. Following *Dobbs*, the U.S. Department of Health and Human Services (HHS) issued guidance to hospitals reasserting that they are required to provide emergency care, which explicitly includes emergency abortion care, under the Emergency Medical Treatment and Active Labor Act (EMTALA). The guidance reiterated that health care providers at hospital emergency rooms must provide abortion care when it is necessary to stabilize a patient, even where there is a state ban or other abortion restrictions in place, because of the general principle that federal law overrides state law when they conflict. Despite attorneys for the federal government arguing that EMTALA protects the right to abortion in these potentially life-saving situations, anti-abortion judges have rejected these arguments out of hand, setting up a crucial battle for reproductive freedom at the Supreme Court. In January of this year, the Supreme Court in *United States v. Idaho* allowed Idaho to enforce its strict abortion ban even when it conflicts with EMTALA, making it a crime to perform an abortion unless a doctor can show the patient's life is at stake. Idaho Republicans are fighting to ensure doctors cannot perform abortions even in cases where the patient's health is in "serious jeopardy", or where they face other serious complications, in direct conflict with federal law.

All people – no matter who they are or where they live – should have the freedom to make their own decisions about whether to start or grow a family, free from political interference. While the Court's egregious decision in *Dobbs* is nothing short of devastating, the fight for reproductive freedom is far from over. The vast majority of Americans are with us, with 8 in 10 Americans supporting the legal right to abortion.^{iv} Lawmakers who interfere with reproductive freedom do not represent the values of the overwhelming majority of people in this country. We urge Congress to pass legislation to lock the right to abortion into federal law.

ⁱ *Interactive Map: US Abortion Policies and Access After Roe*, Guttmacher Institute, (May 29, 2024), https://states.guttmacher.org/policies/?gad_source=1&gclid=CjwKCAjwzN-yBhAkEiwAYiO7oQvHxVeBSYEsEnxOxlWogXtFWoBRThsIlD6leqmpJ-X2iNXWljeZhoCB4wQAVD_RwE.

ⁱⁱ Elizabeth Nash & Peter Ephross, *State Policy Trends 2022: In a Devastating Year, US Supreme Court's Decision to Overturn Roe Leads to Bans, Confusion and Chaos*, Guttmacher Institute, (Dec. 19, 2022), <https://www.guttmacher.org/2022/12/state-policy-trends-2022-devastating-year-us-supreme-courts-decision-overturn-roe-leads>.

ⁱⁱⁱ *Texas Prosecutor Drops Murder Charge Against Woman Arrested for Self-Induced Abortion*, CBS NEWS, (Apr. 10, 2022), <https://www.cbsnews.com/news/lizelle-herrera-abortion-texas-murder-charge-dropped/>.

^{iv} Megan Brennan, *Record-High 47% in U.S. Think Abortion Is Morally Acceptable*, GALLUP, (Jun. 19, 2021), <https://news.gallup.com/poll/350756/record-high-think-abortion-morally-acceptable.aspx>; *Where Do Americans Stand on Abortion?* Gallup, (July 7, 2023), <https://news.gallup.com/poll/321143/americans-stand-abortion.aspx>.

Chair Sanders, Ranking Member Cassidy, and distinguished Members of the U.S. Senate Committee on Health, Education, Labor, and Pensions, thank you for the opportunity to provide this statement for the record on behalf of the American College of Obstetricians and Gynecologists (ACOG). ACOG is the foremost professional membership organization for obstetrician-gynecologists, with a membership of more than 60,000 physicians and partners dedicated to advancing women's health. As such, our members and their patients are uniquely impacted by state bans and restrictions on access to abortion, a common, sometimes life-saving procedure that is an essential component of comprehensive health care.

At ACOG, our mission is focused on improving the lives of all people seeking obstetric and gynecologic care, their families, and communities. Legislative interference in the practice of medicine threatens this mission. Since the decision in *Dobbs v. Jackson Women's Health Organization*, ACOG members in states with abortion bans have reported being forced to delay or deny evidence-based care; navigate excessive red tape before proceeding with medically necessary procedures; and send patients out of state for routine procedures they are trained to perform. The media routinely chronicles stories of pregnant individuals seeking emergency care to protect their own lives and health, only to be blocked from treatment by hospitals fearful of being second-guessed in their medical judgment, misinterpreting their state's laws or because the patient may not qualify for the narrow exceptions that exist. Some of our members fear for their safety after experiencing harassment and threats of violence. Our members in states with laws protecting access to abortion treat patients who have traveled long distances to obtain abortion care at their clinics, often at great personal cost and despite the risks of life-threatening complications along the way.

Abortion Bans Threaten Patients' Health, Lives, and Rights

The following anecdotes constitute a sample of the stories anonymously reported to ACOG by obstetrician-gynecologists on the front lines of post-*Dobbs* America. Each highlights one or more of the myriad ways abortion bans and restrictions harm patients, their families, and the physicians who care for them:

- An obstetrician-gynecologist in a northeastern state provided abortion care for three out-of-state patients in one week. Two of the three traveled over one thousand miles to reach the clinic.
- A wife and mother of three was found to be pregnant during preparation for a transplant. An abortion was recommended due to multiple medical conditions that made the pregnancy a risk to her life, but she did not receive one. In the third trimester, she experienced a fetal death and she, herself, died soon after, her husband and three children needlessly left behind.
- An obstetrician-gynecologist in a southern state was not permitted to terminate a pregnancy in which the fetus' chest contents were outside of the chest, a lethal anomaly. The patient traveled out of state for an abortion.
- An obstetrician-gynecologist in a southern state had to justify to a pharmacist why a 73-year-old patient required misoprostol, a drug used in medication abortion and to soften the cervix before certain gynecologic procedures.
- A patient in a southern state was pregnant with twins. One of the twins had multiple malformations and died in utero. Her water broke at 19 weeks, putting her at risk of deadly infection and making survival of the second twin unlikely. She was unable to have an abortion under the laws in her state. A few weeks later, the second twin died, at which point she was able to have an abortion. This experience contributed to the decision of the physician who reported this story to leave their state and practice elsewhere.
- An obstetrician-gynecologist in a mid-Atlantic state has seen a significant increase in the number of young women without children seeking sterilization procedures due to concerns about abortion and sterilization being unavailable to them in the future.

- An obstetrician-gynecologist in a southern state was contacted by social workers about an 11-year-old sex trafficking victim who was pregnant. Not only was the physician unable to perform an abortion under state law, but the social workers were unable to help the child obtain an abortion in another state without risking prosecution themselves.

Notably, states are enacting abortion bans at a time when the maternal mortality rate in the United States remains one of the highest among wealthy nations. In 2022, there were 22.3 maternal deaths per 100,000 live births.¹ The maternal mortality rate for Black women was 49.5 deaths per 100,000 live births and was significantly higher than the rate for White women (19.0).² Additionally, for every maternal mortality there are an estimated 20-30 cases of severe maternal morbidity, which the Centers for Disease Control and Prevention describes as “unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman’s health.”^{3,4,5} Examples of conditions classified as severe maternal morbidity when occurring during or shortly after pregnancy include hemorrhage, eclampsia, heart attack, heart failure, kidney failure, sepsis, aneurysm, and a host of other serious and life-threatening conditions.⁶ States with abortion bans or restrictions are more likely to have limited access to maternity care professionals and higher rates of maternal mortality and infant death, especially among people of color.⁷ In fact, maternal death rates in states with abortion restrictions were 62% higher than in states with greater abortion access.⁸

Abortion Bans Contribute to OB/GYN Burnout and Influence Where They Practice

When the law prohibits physicians from providing care consistent with their medical judgment, their training and ability, they may contemplate whether to cease practicing medicine in their home state and move themselves and their families elsewhere. For example, since enacting a total abortion ban, obstetrician-gynecologists and maternal-fetal medicine specialists in Idaho have reported leaving the state or retiring earlier than planned.^{9,10} While the focus has understandably been on those physicians leaving states with restrictive abortion laws to practice in more protective states, there are countless other physicians who are staying put and are forced to change their practice patterns out of fear for their personal and professional safety. Laws that overcomplicate patient care and introduce confusion and delays inhibit physicians’ ability provide timely, lifesaving care, unnecessarily jeopardizing patient health and causing moral injury for the physician. Informal polling of 258 resident, practicing, and retired obstetrician-gynecologists in Oklahoma found that nearly 80% of respondents believe they cannot provide care according to best practices/evidence-based medicine.¹¹ In Oklahoma, a state where more than one-half of counties classify as maternity care deserts, 58% of respondents indicated that they have thought about or were planning to leave Oklahoma to practice medicine in another state, and 18% expressed that they would leave if it were feasible at this time.¹²

There is also evidence that abortion bans are influencing future physicians’ decisions about where to pursue their residency training or whether to choose obstetrics and gynecology as a specialty. During the 2023-2024 residency application cycle, the number of applicants to obstetrics and gynecology residency programs dropped by 6.7% in states with abortion bans compared with a 0.4% increase in states where abortion remains legal.¹³ Of note, the decrease in interest in residency programs in states that banned or restricted access was not only found among specialties most likely to treat pregnant patients, such as obstetrics and gynecology and emergency medicine, but also among other specialties. In 2023, the number of applicants to all residency programs in states with near-total abortion bans declined by 4.2%, compared with a 0.6% drop in states where abortion remains legal.¹⁴

Laws that dissuade established and future physicians from training and practicing in certain states threaten to exacerbate physician shortages while access to maternity care is already at crisis levels in many parts of the country. “Maternity care deserts,” defined as counties that do not have a hospital or birth center offering obstetric care or any obstetric providers, comprise an estimated 36% of U.S. counties.¹⁵ Nearly

half of counties do not have a single practicing obstetrician-gynecologist and more than 200 rural hospitals stopped providing obstetric services during the past decade.^{300,301} In rural areas, loss of hospital-based obstetric services is associated with higher rates of out-of-hospital births and preterm births and lower use of prenatal care services.³⁰¹ Longer driving distances to the hospital to deliver are associated with greater risk of adverse maternal health outcomes, such as blood transfusion, unplanned operation, ruptured uterus, unplanned hysterectomy, and adverse infant health outcomes.³⁰¹ In Idaho, one hospital closed its labor and delivery wing, citing the “legal and political climate,” forcing patients to drive 46 miles further for labor and delivery care moving forward.^{301,302} Patients in a separate remote town in Idaho, whose local medical center paused labor and delivery services due to a lack of obstetrician-gynecologists, must now travel over 165 miles for their prenatal care and delivery.³⁰² ACOG is encouraged by Congress’ interest in addressing the maternal health crisis and maternity care deserts. However, without corrective action, these care deserts will continue to expand as clinics and hospitals close or limit services and clinicians are forced to make the difficult decision to leave their communities in restrictive states.

Emerging Threats to Abortion & Other Reproductive Health Care Services

The implications of the *Dobbs* decision reach beyond abortion care. Earlier this year, the Alabama Supreme Court ruled that embryos created through in-vitro fertilization (IVF) should be considered children, making it impossible to offer IVF services in Alabama without deviating widely from the standard of care. The University of Alabama at Birmingham hospital and two additional clinics temporarily halted IVF services in response to the de facto ban until the state legislature took emergency stop-gap corrective action.³⁰³ The state of Alabama deciding to confer “personhood” on embryos was a predictable application of *Dobbs*, yet one that the vast majority of Americans denounced regardless of their views on abortion.

ACOG is also deeply concerned about the potential outcomes of pending U.S. Supreme Court cases made possible by the *Dobbs* decision. Specifically, the fate of the Emergency Medical Treatment and Labor Act (EMTALA)—a law that requires hospitals to stabilize patients presenting with emergency conditions as a condition of receiving Medicare funding—remains uncertain. Pregnancy, particularly when coupled with comorbid conditions, can quickly evolve into a life-threatening situation necessitating emergency medical care, which may include abortion. Weakened or nonexistent EMTALA protections would empower states to prohibit physicians from providing critical medical interventions for pregnant people facing serious obstetric emergencies, increasing the gaps in access to care across the country and disproportionately harming people of color, people in rural areas, and those without robust financial resources—many of whom are more likely to experience health complications and to have those complications addressed in an emergency treatment setting.

ACOG members and patients also await a U.S. Supreme Court decision determining the future availability of mifepristone, an FDA-approved medication with decades of data reinforcing its safety, used for medication abortion and management of early pregnancy loss. The plaintiff’s attempt to reverse the long-standing FDA approval of mifepristone in *Alliance for Hippocratic Medicine v. FDA* interferes with and jeopardizes the practice of evidence-based medicine, the patient-physician relationship, and our drug regulatory system. Reimposing unnecessary regulatory burdens on mifepristone that are not supported by scientific evidence and not consistent with the current standard of care would deepen inequities and impose additional hurdles to receiving this medication for patients who may benefit from these and other treatments for maternal or other medical care unrelated to abortion.³⁰⁴

ACOG implores members of the Committee to consider the very real, harmful impacts state laws banning and restricting abortion have on their constituents and on the U.S. health care system. It is our hope that

today's hearing, coming nearly two years after our patients lost their constitutional right to evidence-based essential reproductive health care, will allow for a discussion that leads to meaningful proactive and corrective action.

Thank you for the opportunity to provide ACOG's perspective on this important topic. We look forward to serving as a partner and resource in future efforts to protect unimpeded access to the full spectrum of medical care, including abortion.

¹ Hoyert DL. Maternal mortality rates in the United States, 2022. NCHS Health E-Stats. 2024. DOI: <https://dx.doi.org/10.15620/cdc/152992>.

² *Ibid.*

³ Fink DA, Kilday D, Cao Z, et al. *Trends in Maternal Mortality and Severe Maternal Morbidity During Delivery-Related Hospitalizations in the United States, 2008 to 2021*. *JAMA Network Open*. 2023;6(6):e2317641. doi:10.1001/jamanetworkopen.2023.17641

⁴ Severe maternal morbidity in the United States. Centers for Disease Control and Prevention. July 3, 2023. Accessed May 1, 2024. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

⁵ How does CDC identify severe maternal morbidity? Centers for Disease Control and Prevention. July 3, 2023. Accessed May 1, 2024. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm>

⁶ Kheyfets A, Dhaurali S, Foyock P, Khan F, Lockley A, Miller B, Amutah-Onukagha N. *The impact of hostile abortion legislation on the United States maternal mortality crisis: a call for increased abortion education*. *Front Public Health*. 2023 Dec 5;11:1291668. doi:10.3389/fpubh.2023.1291668. Erratum in: *Front Public Health*. 2024 Feb 02;12:1358617. PMID: 38115843; PMCID: PMC10728320.

⁷ *Ibid.*

⁸ The Idaho Physician Well-Being Action Collaborative. *A Post Roe Idaho*. Idaho Coalition for Safe Healthcare (Feb 2024). <https://www.idahoesh.org/idaho-physician-wellbeing-action-collaborative>

⁹ Independent survey conducted by leadership of the Oklahoma Section of American College of Obstetricians and Gynecologists.

¹⁰ *Ibid.*

¹¹ Orgera K, Grover A. *Status with Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants*. Washington, DC: AAAMC; 2024. https://doi.org/10.15766/ra_i_dnhob2ma

¹² *Ibid.*

¹³ Brigrance C, Lucas R, Jones E, Davis A, Oinuma M, Mishkin K, Henderson Z. *Nowhere to go: maternity care deserts across the U.S.: 2022 report*. March of Dimes. 2022. https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf

¹⁴ *Ibid.*

¹⁵ Addressing the crisis in rural maternity care. Center for Healthcare Quality & Payment Reform. Accessed May 1, 2024. https://chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf

¹⁶ Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S. *Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States*. *JAMA*. 2018;319(12):1239–1247. doi:10.1001/jama.2018.1830

¹⁷ Mmion SC, Krans EE, Brooks MM, Mendez DD, Haggerty CL. *Association of Driving Distance to Maternity Hospitals and Maternal and Perinatal Outcomes*. *Obstet Gynecol*. 2022 Nov 1;140(5):812–819. doi:10.1097/AOG.0000000000004960. Epub 2022 Oct 5. PMID: 36201778.

¹⁸ Bonner General Health. (March 17, 2023). *Discontinuation of Labor & Delivery Services at Bonner General Hospital*. [Press Release]. <https://bonnergeneral.org/wp-content/uploads/2023/03/Bonner-General-Health-Press-Release-Closure-of-LD-3-17-2023.pdf>

¹⁹ Pfannenstiel K. *Idaho is losing OB-GYNs after strict abortion ban*. But health exceptions unlikely this year. *Idaho Capital Sun*. April 5, 2024. <https://idahocapitalsun.com/2024/04/05/idaho-is-losing-ob-gyns-after-strict-abortion-ban-but-health-exceptions-unlikely-this-year/>

²⁰ *Ibid.*

²¹ Bendix A. *Three Alabama clinics pause IVF services after court rules that embryos are children*. NBC News. Feb 21, 2024. <https://www.nbcnews.com/health/health-news/university-alabama-pauses-ivf-services-court-rules-embryos-are-children-cna139846>

²² *Food and Drug Administration v. Alliance for Hippocratic Medicine, Danco Laboratories, L.L.C., v. Alliance for Hippocratic Medicine, on petitions for writ of certiorari to the United States Court of Appeals for the Fifth Circuit*. Brief amicus curiae of American College of Obstetricians and Gynecologists, American Medical Association, Society for Maternal-Fetal Medicine, et al. 11 Oct 2023. https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/amicus-briefs/2023_20231012-fda-v-aha-danco-laboratories-llc-v-aha-us-court-appeals-fifth-circuit.pdf

Dallas Morning News Op-Ed ([Published](#) on March 8, 2024)

"How can you force a mom to suffer by making her carry a child that will die?"

That question in its various forms is one of several scenarios under scrutiny as the abortion debate is once again thrust to the forefront leading up to November.

Among the Bidens' guests of honor for the 2024 State of the Union address is a mother from DFW. After receiving a life-limiting diagnosis of Trisomy 18 for her daughter, she sued the state of Texas for the right to terminate the pregnancy. After being unsuccessful, she left the state to abort her daughter.

The narrative of the current administration and of the culture at large is clear: the compassionate response to parents in this situation is to permit them to end their child's life as soon as possible. Even those with generally "pro-life" convictions appear to embrace this perspective. My aim in this short piece is to set politics aside and share a different perspective — one that I am personally acquainted with because I, too, have received a Trisomy 18 diagnosis for my unborn child.

There are no words to describe the moment where you learn that your child's life may be far shorter than you'd ever hoped or imagined. The future you envisioned with your child begins slipping away. It feels impossible to know where to turn, and even take another step. I had to come to grips with the reality that my son's life would more than likely be short if his diagnosis held true. With that weight on our shoulders, we were encouraged to terminate the pregnancy and "try again for a better one" (which was to say, a healthier one).

However, I decided that if my son's death was impending, I wasn't going to be the one to set that date. Rather than have an abortion, I gave my son a name, and Abel Paul Crawford's earthly journey continued. I got to take care of my son for 15 days outside of the womb. Those two weeks were simultaneously the hardest and the happiest — the saddest and the sweetest — 15 days of my life.

People may think it would have been easier for us to choose the other route. But the truth is, terminating my son would not have spared me an ounce of loss or despair — it would have only robbed me of the joyful memories that forever mark my season with Abel. I never would have met and held my child. I wouldn't know what he looked like, and I wouldn't have heard the sound of his newborn cry. I wouldn't have gotten to bathe him, and change him, and feed him. I wouldn't have seen his full head of brown hair, or his sweetly clenched fists, or adorable clubbed foot that had his uncle's absurdly long toe.

These are memories I would never give up voluntarily. It's true that carrying my son with a life-limiting diagnosis is the hardest road I've ever walked. But it has also been my greatest privilege, and stewarding Abel's life has changed mine for the better. It turns out, joy and sorrow can and do coexist.

It also turns out that our story is not unique. Founded in 2018, Abel Speaks (www.abelspeaks.org) exists to support and empower families who have chosen to carry a child with a life-limiting diagnosis. The reality is that the vast majority of families who receive a life-limiting diagnosis for their child are advised to end that child's life. Those who continue the pregnancy do so with little support or resources, making a heavy journey all the more difficult — but it doesn't have to be this way.

Over the past 6 years, our reach has grown and we have served families in all 50 States and 8 other countries. Our experience with Abel has been echoed by over 400 families who have cherished their child's life and experienced hope and joy even in the midst of sorrow and grief. And they didn't have to walk this road alone.

Beyond the anecdotal evidence of the hundreds of families in our Abel Speaks community, a Duke University study from 2015 determined that women who terminated a child with a life-limiting diagnosis actually reported significantly more despair, more depression and more post-traumatic stress than women who continued the pregnancy. Psychologically, it actually benefits a woman's mental health to continue a pregnancy in situations like ours rather than choosing abortion.

My hope in writing this is that my son's humanity is now harder to ignore. As stories like ours continue to enter the public square, rather than getting caught up in intellectual sparring, I hope you will think about Abel and his inherent value and worth as a human. My son and children like him deserve to live and die with dignity, surrounded by people that love them. And in light of that, I hope that you realize there is only one truly compassionate response for any family receiving a life-limiting diagnosis.

Kelly Crawford
Founder & Executive Director

[Whereupon, at 12:16 p.m., the hearing was adjourned.]

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