S. HRG. 118–778

HEALTH IMPACTS OF ABORTION BAN ON GEORGIA WOMEN

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

JULY 23, 2024

DECATUR, GEORGIA

Serial No. J–118–73

Printed for the use of the Committee on the Judiciary

www.judiciary.senate.gov
www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
63–049 WASHINGTON : 2026

COMMITTEE ON THE JUDICIARY

RICHARD J. DURBIN, Illinois, *Chair*

SHELDON WHITEHOUSE, Rhode Island
AMY KLOBUCHAR, Minnesota
CHRISTOPHER A. COONS, Delaware
RICHARD BLUMENTHAL, Connecticut
MAZIE K. HIRONO, Hawaii
CORY A. BOOKER, New Jersey
ALEX PADILLA, California
JON OSSOFF, Georgia
PETER WELCH, Vermont
LAPHONZA BUTLER, California

LINDSEY O. GRAHAM, South Carolina, *Ranking Member*
CHARLES E. GRASSLEY, Iowa
JOHN CORNYN, Texas
MICHAEL S. LEE, Utah
TED CRUZ, Texas
JOSH HAWLEY, Missouri
TOM COTTON, Arkansas
JOHN KENNEDY, Louisiana
THOM TILLIS, North Carolina
MARSHA BLACKBURN, Tennessee

JOSEPH ZOGBY, *Chief Counsel and Staff Director*
KATHERINE NIKAS, *Republican Chief Counsel and Staff Director*

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

JON OSSOFF, Georgia, *Chair*

RICHARD BLUMENTHAL, Connecticut
PETER WELCH, Vermont
LAPHONZA BUTLER, California

MARSHA BLACKBURN, Tennessee, *Ranking Member*
JOHN KENNEDY, Louisiana
JOSH HAWLEY, Missouri

SARA SCHAUMBURG, *Democratic Chief Counsel*
KAITLYN LANE, *Republican Chief Counsel*

CONTENTS

OPENING STATEMENT

	Page
Ossoff, Hon. Jon	1

WITNESSES

Chandrasekaran, Suchitra, M.D., M.S.C.E.	4
Prepared statement	24
Questions submitted with no response returned	28
Panakam, Aisvarya, M.D.	6
Prepared statement	32
Responses to written questions	35
Verma, Nisha, M.D., M.P.H., F.A.C.O.G.	2
Prepared statement	43
Responses to written questions	45

HEALTH IMPACTS OF ABORTION BAN ON GEORGIA WOMEN

TUESDAY, JULY 23, 2024

UNITED STATES SENATE,
SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW,
COMMITTEE ON THE JUDICIARY,
Decatur, Georgia.

The Subcommittee met, pursuant to notice, at 9:35 a.m., in the Auditorium of Decatur City Hall, Decatur, Georgia, Hon. Jon Ossoff, Chair of the Subcommittee, presiding.

Present: Senator Ossoff [presiding].

OPENING STATEMENT OF HON. JON OSSOFF, A U.S. SENATOR FROM THE STATE OF GEORGIA

Chair OSSOFF. The Subcommittee on Human Rights and the Law will come to order. Good morning, everyone.

[Hearing attendees respond.]

Chair OSSOFF. Good morning.

I first want to take a moment to thank the City of Decatur and Mayor Garrett for opening your hall to us and for all you do for the city and the State. Thank you, Mayor, for having us.

We are here today to hear from doctors about how Georgia's abortion ban is impacting the health of women in our State. After the Supreme Court overturned *Roe v. Wade*, a Georgia law took effect banning abortion after just 6 weeks of pregnancy, at which point many women do not even know that they're pregnant.

The New York Times described Georgia's abortion ban as, quote, "one of the country's most restrictive laws."

The Subcommittee on Human Rights has convened this hearing roughly 2 years after the reversal of *Roe v. Wade* to hear directly from Georgia doctors and health experts about the impact on women's health of Georgia's 6-week abortion ban.

I want to thank our witnesses for taking the time to provide testimonies today. You are all busy and hardworking healthcare professionals. We appreciate your contributions.

I know this is a complex issue that evokes strong feelings across the State, that's why it's critical that the public hear directly from doctors about the consequences of Georgia's 6-week abortion ban.

We often hear politicians and elected officials weighing in on this issue. But today we're going to hear from the healthcare professionals who treat women and support them through pregnancy every day. On that note, without further ado, I will now swear in our witnesses.

I'll begin with introductions.

Dr. Nisha Verma is an OB-GYN providing reproductive healthcare in Atlanta, Georgia, and an assistant professor of gynecology and obstetrics specializing in complex family planning. She currently has a research grant to explore the impact of Georgia's 6-week abortion ban on individuals with high-risk pregnancies in the State of Georgia.

Dr. Suchitra Chandrasekaran is an associate professor in gynecology and obstetrics and a maternal fetal medicine specialist. She's also a member of the Society of Maternal Fetal Medicine Health Policy and Advocacy Committee, and sits on the Maternal Morbidity and Mortality Committee for the State of Georgia.

And Dr. Aisvarya Panakam is an OB-GYN resident in Pittsburgh, Pennsylvania, who originally hails from Cumming, Georgia. Before beginning her residency, she obtained her undergraduate education at Johns Hopkins University, completed a Fulbright Fellowship, and graduated from Harvard Medical School.

Before opening statements, we'll swear in the witnesses. So, if you would all please rise and raise your right hand.

[Witnesses are sworn in.]

Let the record reflect that the witnesses have answered in the affirmative, you may take your seats. We will now turn to the witnesses for opening statements beginning with Dr. Verma when you're ready.

STATEMENT OF NISHA VERMA, M.D., M.P.H., F.A.C.O.G., BOARD-CERTIFIED OB-GYN, AND FELLOW, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, ATLANTA, GEORGIA

Dr. VERMA. Thank you, Senator Ossoff, and thank you all for being here today. My name is Dr. Nisha Verma. I'm a board-certified, fellowship trained obstetrician and gynecologist providing full spectrum reproductive healthcare.

I'm a fellow with the American College of Obstetricians and Gynecologists, a nonpartisan evidence-based professional organization representing over 60,000 OB-GYNs.

I'm also a proud Southerner. I was born and raised in North Carolina, and currently provide care in Georgia. And I've lived in the Southeast for most of my life.

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 pregnant moms with worsening medical conditions 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 how abortion restrictions impact real people.

Shortly after Georgia's ban went into effect, I saw a high schooler that I'll call "V," who realized after missing her period that she might be pregnant. 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 can no longer perform her abortion in our State.

Unfortunately, "V" was unable to find the resources and support to leave Georgia for abortion care. Because of workforce shortages in rural Georgia where she lives, she also couldn't find a closeby doctor that could care for her for many months. So even though "V" was forced to continue her pregnancy against her will, she couldn't access the prenatal care she needed to keep herself and her pregnancy healthy.

After delivering her baby, "V" 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 that she wanted or planned for herself. This story, while heartbreaking, is not unique.

Over the past couple of years, I've conducted a research study to learn about the experiences of patients with high-risk pregnancies in Georgia who are attempting to access abortion care.

Through this work I've heard women describe again and again how Georgia's abortion restrictions exacerbate their suffering in already devastating situations and leave them feeling betrayed by a government and a healthcare system that is supposed to protect them.

One participant, "M," described breaking her water at 17 weeks when she had no chance of her baby ever developing lungs that would allow it to live outside of her. She went to the hospital but learned her doctors couldn't help her until she started bleeding or developed an infection.

"M" told me that, "to be denied the basic medical care I needed, to be told that I must first be at risk of dying, to be forced to relive losing my baby every day for 5 days because of Georgia's law, the trauma of that on top of my loss is devastating."

Another participant, "A," discussed how Georgia's ban rushed her into making a decision, instead of allowing her the time to get genetic testing on her pregnancy. She shared that her older son was diagnosed with a rare genetic condition that destroyed his lungs when he was just a few years old.

Now, instead of starting middle school with his peers, he is admitted to the hospital ICU and doctors have told "A" that he likely has less than a year to live. "A" describes the pain of seeing her son suffer, and when she found herself pregnant again, she knew that she could not have another child affected by the same genetic condition.

However, because this condition does not qualify for abortion care under Georgia's very narrow exceptions, and "A" could not risk leaving her son in the ICU to travel out of State later in pregnancy, she made the decision to get an abortion prior to Georgia's 6-week cutoff, before testing on the pregnancy was possible.

It is clear that women who need medical care are suffering because of Georgia's abortion restrictions.

We also know that these restrictions are not based in data or science. 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.

To make matters worse, doctors overwhelmed by laws that threaten to make us criminals for providing evidence-based life-saving care to our patients, are leaving their State.

In Georgia, where already over 50 percent of counties have no OB-GYNs, where we have one of the highest maternal mortality rates in the country, and where women, like my patient "V," struggle to access prenatal care, 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.

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

[The prepared statement of Dr. Verma appears as a submission for the record.]

Chair OSSOFF. Thank you so much Dr. Verma. We'll now turn to Dr. Chandrasekaran.

STATEMENT OF SUCHITRA CHANDRASEKARAN, M.D., M.S.C.E., SOCIETY FOR MATERNAL-FETAL MEDICINE, HEALTH POLICY AND ADVOCACY COMMITTEE, ATLANTA, GEORGIA

Dr. CHANDRASEKARAN. Thank you. Good morning, Senator Ossoff, and Members of the Subcommittee. My name is Dr. Suchitra Chandrasekaran. I'm a board certified and fellowship trained maternal-fetal medicine or MFM specialist, and I'm here today as a member of the Society of Maternal-Fetal Medicine to describe the harmful effect restrictions on reproductive health have on their patients, their families, and the clinicians that care for them.

As an MFM, I actually provide care for pregnant persons who experience complications that make their pregnancies high risk. I proudly take care of pregnancies affected by maternal health issues. They can range from hypertension, diabetes to cancer and complex life-threatening heart disease. Throughout this care, I perform ultrasound and provide genetic testing to assess fetal well-being.

As an MFM practicing in Georgia, what I want to tell this audience is that the Georgia abortion ban limits the ability of myself and my colleagues to provide evidence-based care and counseling, and significantly puts the well-being and lives of our patients at unnecessary risk.

Having previously practiced in States where I could provide full scope evidence-based care and counseling, I'm horrified and deeply saddened by the situation and the lack of choices our patients are given.

While I live and see these stories daily, I'm going to bring up a few of them here. And I want to say, that while I am using the word stories in this testimony for my patients, these are not stories—these are real life nightmares and tragedies.

So previously I practiced in the State of Washington and during one of those call shifts, I received a call about an individual in her second trimester with a pre-existing heart condition. This is actually pretty common in pregnancy, because pregnancy is a time where your heart actually really changes and that's often when pre-existing conditions might be diagnosed.

This patient had inadequate healthcare coverage and so this was the first time her condition was coming up. This was her first pregnancy and this was her dream—her dream to be a mother, to go through a pregnancy in a normal fashion.

But now she was facing her nightmare with a life-threatening heart condition, scared for her health and her baby's. Because of Washington State's protective abortion laws, I was able to offer abortion as an option, as a choice for her.

After many days of a lot of thought, weighing her risks and processes, she made the gut-wrenching and challenging decision to terminate that pregnancy, to focus on taking care of her heart so that she could potentially do this again.

Subsequently, this patient did have the opportunity to get her heart condition fixed and had her next pregnancy. And I had the personal joy and privilege of delivering that baby in her next pregnancy. I had held this woman's dead fetus wrapped in a knitted blanket in her first pregnancy. And I held her beautiful baby boy in her second pregnancy and cried tears of joy with her.

Fast forward 7 years, right, the dreaded morning of June 24th, 2022, when the United States Supreme Court released its decision on *Dobbs*.

Right as we heard the news, my sonographer brought my next ultrasound for me to review. This ultrasound was for a woman who had not had access to insurance or care until the early second trimester.

Access to healthcare is a major issue here in Georgia, which is burdened by the presence of many obstetric deserts or regions with limited medical access to prenatal-perinatal care. This woman was excited and eager to see her baby. It's her first ultrasound. I, however, saw a fetus with a significant cardiac defect.

Although this baby would be born alive, meaning that the case did not fit within Georgia's exception for medically futile pregnancies, the prognosis and quality of life after birth would be extremely limited. Even after multiple surgeries, the long-term outlook for this kind of a heart defect was questionable.

Ten minutes ago, before the scan, I would've counseled her on all of the risks and the termination option of this pregnancy. Ten minutes later, I walked into her room shell shocked, at how the only practice and counseling methods I had known for 15-plus years was now impacted. And I spoke to her about my concerns for the fetus and what the cardiac defect would mean for the infant when it was born.

As a doctor, my job is to support whatever decision the person wants to make, whether it's to continue a challenging pregnancy or whether to terminate. As a doctor, my job is to inform of all the risks and outcomes.

But now, as a doctor, my ability to counsel and provide all the opportunities was limited. My patient was in tears, knowing the

law had just gone into effect and I, too, only had tears to share with her at that moment—and the nightmare had begun.

Even before the *Dobbs* decision, the high maternal morbidity and mortality rates affecting the State of Georgia are well known. One of the largest drivers of this rate is maternal cardiac disease. Yet Georgia's ban forces women with very high-risk maternal cardiac conditions to carry their pregnancies, sometimes regardless of the dangers to a mother's health.

For example, I had a patient with a disease process called lupus. In its severe form, it can significantly affect a pregnancy and threaten maternal and fetal health, including kidney, heart damage, or a very preterm delivery.

This patient had a severe aversion with significant heart disease. She was in the late first trimester when she found out about her pregnancy. She was scared, knowing her very serious risk of becoming sick and facing health issues.

But now, even though she was only in the late first trimester, I couldn't provide her all the options. I couldn't provide her that full spectrum reproductive healthcare. I could talk about it, but I couldn't realistically help provide it. My hands were tied as a provider.

She didn't have the resources to obtain care anywhere else, and in a State where maternal morbidity and mortality are extremely high with cardiac risk factors, this abortion ban can only worsen this issue.

In a State where maternal mental health is another key contributor to morbidity and mortality, the trauma of being stripped of autonomy to make critical personal health decisions is real and long lasting. It's not just the now we have affected, we have detrimentally impacted long-term maternal morbidity and mortality in a State that already has high rates.

I'm committed to remaining in Georgia and providing the best possible care for my patients in this challenging environment. I have provided stories above. I have demonstrated what success can look like when full scope care can be provided. I have shown the aftermath of not being able to provide that care.

High-risk pregnancies are unexpected, life-threatening, emotionally traumatizing, and life-changing for all involved.

The current abortion ban in Georgia limits our ability to provide the compassionate and full spectrum reproductive counseling and choices to our patients and will only continue to worsen the overall future health of pregnant persons in Georgia. Thank you for having me today.

[The prepared statement of Dr. Chandrasekaran appears as a submission for the record.]

Chair OSSOFF. Thank you, Dr. Chandrasekaran. Dr. Panakam, please.

STATEMENT OF AISVARYA PANAKAM, M.D., FIRST-YEAR RESIDENT PHYSICIAN, PITTSBURGH, PENNSYLVANIA

Dr. PANAKAM. Good morning, Senator Ossoff and distinguished Members of the Human Rights and the Law Judiciary Subcommittee. My name is Dr. Aisvarya Panakam and I use she/her pronouns.

I'm a recent graduate of Harvard Medical School and a current resident physician in obstetrics and gynecology at an academic medical center in Pennsylvania. I'm testifying today in my personal capacity and thank you for this opportunity.

I grew up in Georgia and I, too, am a proud Southerner. After spending the past decade of my life studying in other parts of the country, I was very eager to return home, to my friends and family to complete my medical training. I'm here today to explain why I chose not to pursue OB-GYN residency in the South.

I was halfway through medical school when the *Dobbs* position ended the constitutional right to abortion. Immediately, trigger bans were initiated across the country, including here in Georgia. Over the next 2 years, every single Southern State instituted either a total ban or a prohibitively early gestational age ban on abortion.

When it came time to apply for residency, many applicants into OB-GYN, including myself, prioritized programs that offer training in full spectrum reproductive care, which includes abortion and miscarriage management.

It was a bitter day when I realized I wouldn't be able to receive this training to the same extent in any Southern State, including Georgia. Ultimately, I prioritized programs in other regions of the country.

To contextualize why I made this choice, I would like to share a few key facts. First, abortion is common. Prior to the *Dobbs* decision, 1 in 4 women of reproductive age in the United States was predicted to have an abortion by age 45.

Second, abortion is safe. It is one of the safest procedures that a person can undergo. For abortion to remain accessible and safe, reproductive health physicians, like myself, must receive this essential training.

The need for comprehensive training is also recognized by accrediting bodies. The Accreditation Council on Graduate Medical Education, or ACGME, requires that all OB-GYN residency programs provide their residents with comprehensive clinical experience in abortion.

However, since the *Dobbs* decision, an OB-GYN in the South now faces a myriad of uncertainties and often has more questions than answers. Will I have sufficient case volume? Will I learn to manage complex cases? Would I be able to confidently perform this procedure on my own?

Residency is a difficult process in and of itself. Additional roadblocks to obtaining necessary training will continue to dissuade talented physicians from practicing in the South and in other States with abortion restrictions.

It's important to recognize that abortion training gives OB-GYN an additional skillset that they can apply to diverse scenarios, including medical emergencies.

Even if an OB-GYN does not regularly perform abortions in their clinical practice after training, if they are trained in procedural abortion, they will be better equipped to manage a variety of different conditions. This includes miscarriage, hemorrhage, infection and many more. Training in abortion makes for a capable OB-GYN.

Georgia must prioritize the development of OB-GYNs because its maternal health outcomes are among the worst in this country. Half of Georgia's counties lack a single OB-GYN, leaving 1 in 3 women without access to essential healthcare. The sad truth is that Georgia desperately needs more OB-GYNs, but it is failing to attract them.

In 2022 to 2023, applications to OB-GYN residency in restricted States decreased by 5.6 percent. A recent survey of medical students applying into OB-GYNs shed light on a major reason: 73 percent of survey respondents reported that the *Dobbs* decision affected which programs they applied to, and this is the case for myself, as well.

I am deeply concerned about the dangers that Georgia's 6-week abortion ban creates for women. As a medical student in Massachusetts, I helped care for a Georgia woman whose fetus was diagnosed with severe genetic anomalies, even though it was well understood that her fetus would die either in utero or soon after delivery. She was unable to receive an abortion because her fetus still had a heartbeat.

It took her several days to arrange childcare for her young daughter and for her and her husband to come up to Massachusetts, get a hotel room, and get an appointment at the clinic that we were at. When she arrived to our clinic, her fetus had already passed and had been dead for several days.

She was admitted to the ICU for a life-threatening clotting disorder called disseminated intravascular coagulation, as well as massive immune dysregulation in the form of sepsis. Georgia's abortion ban jeopardized her life by delaying her access to care. She survived. Others have not.

This case reaffirmed my commitment to train in a place where abortions can be accessed by women who need them. I speak on behalf of the tens of thousands of medical students and physicians who are currently in the training pipeline, and who will make up the future healthcare workforce of this country.

States that severely restrict abortion access will struggle to attract and retain OB-GYN physicians. This will cause shortages to their physician workforce.

I made the difficult decision to not return home for my medical training. A lot of my peers have done the same. With the support of our lawmakers, we can expand abortion access, which in turn will help reverse this exodus of students, doctors, and health professionals leaving restricted States.

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

[The prepared statement of Dr. Panakam appears as a submission for the record.]

Chair OSSOFF. Thank you, Dr. Panakam. And thank you, all, for your opening statements.

I'd like to begin with, with a yes-or-no question for all of you. In your opinion, does Georgia's 6-week abortion ban endanger the lives of pregnant women in Georgia? Dr. Verma?

Dr. VERMA. Yes.

Chair OSSOFF. Dr. Chandrasekaran?

Dr. CHANDRASEKARAN. Yes.

Chair OSSOFF. Dr. Panakam?

Dr. PANAKAM. Yes.

Chair OSSOFF. Dr. Verma, Georgia's abortion ban contains an exception for medical emergencies, which the law defines as, quote, "a condition where an abortion is necessary in order to prevent the death of a pregnant woman, or a substantial and irreversible physical impairment of a major bodily function of the pregnant woman." Given that exception, why do you believe Georgia's law nevertheless endangers the lives of pregnant women in our State?

Dr. VERMA. For that question, you know, as doctors, we train for years and years and years to be able to sit in front of the patient in front of us and help them and their families make these complex individualized decisions.

Medicine is incredibly complicated. That's why we trained for so long. There's not a line in the sand where someone goes from being totally fine to acutely dying. A lot of times it is a continuum, and doctors, because of this law in Georgia, are forced to question, when can I intervene? How sick is sick enough? How much bleeding is too much bleeding? That delays care that forces patients to get sicker.

Georgia's exceptions in our abortion ban are incredibly extreme, and we've seen in the data, as well, that even when these types of exceptions exist, people with high-risk pregnancies are still denied care and have a harder time getting the care that they need.

Some are forced to continue very high-risk pregnancies. Some are forced to leave their communities. And all of that leads to people getting sicker and sicker.

Chair OSSOFF. Thank you, Dr. Verma. Dr. Chandrasekaran, can you weigh in here, where the so-called exception in the law, in cases where a pregnant woman's health is severely at risk, but perhaps not yet meeting this restrictive emergency standard?

Dr. CHANDRASEKARAN. I think this goes to the concept that biology is gray. Biology is not black and white. It's not a mathematical equation. If our bodies were mathematical equations, we could be running this very differently. And when biology is gray, pregnancy, which is now putting two lives, a mom, and a child, and making them interact with each other in a relationship of sorts, is extremely gray.

So when we say words such as "irreversible" or "futile," oftentimes by the time you've hit irreversible and futile, mom's life is already at significant risk. You've taken away her choice and capacity to make a decision to potentially avoid hitting irreversible and futile. And I think that's the challenge with the current abortion ban, and that's what directly affects overall maternal health—mental and physical.

Chair OSSOFF. Thank you, Dr. Chandrasekaran. And on that point, with respect to, quote, "medically futile pregnancy"—and that's the term in Georgia's extreme 6-week abortion ban.

A quote from the statute is, "in reasonable medical judgment, an unborn child has a profound and irremediable congenital or chromosomal abnormality that is incompatible with sustaining life after birth."

Does this exception meaningfully allow doctors in Georgia to provide adequate care, when a fetus has been diagnosed with a serious defect?

Dr. CHANDRASEKARAN. Unfortunately, not. Because again, fetal—fetal diagnostics is also a gray territory. When we see a heart defect, we can say what we overall think the prognosis might be.

But when we use words again such as futile, irreversible, irrevocably, what does that mean? How are we protected under that? How do you define that?

Biology changes. What might feel irrevocable to somebody may not be to someone else, and that becomes a very personal decision between a physician and the patient on what are they looking at? What are the outcomes for this fetus looking like?

And so unfortunately, when we use those words, it doesn't provide capacity to help the majority of our situations.

Now, the extreme situations are an exception. But the majority of our situations fall into, "We think this would be the prognosis." "This is the likely situation to happen." "This is likely the outcome."

That doesn't get covered.

Chair OSSOFF. Thank you. Dr. Verma, Georgia's law also contains a so-called exception for, quote, "removing a dead unborn child caused by spontaneous abortion," end quote. Does this exception meaningfully empower Georgia physicians to provide medically necessary care for miscarrying patients?

Dr. VERMA. It's a great question. I have absolutely seen situations where patients in the process of miscarrying are turned away or delayed from getting the care that they need in Georgia. Again, all of this is really complicated, I think that's why we keep going back to, medicine is incredibly complicated.

So I've had situations where a patient presents to the hospital, their cervix is opening, they're bleeding, they may have broken their water, but that pregnancy still has cardiac activity or a heartbeat. And there's a lot of uncertainty about whether doctors can act in that situation, when in that scenario they can act.

I've had patients, like some that I shared today in my testimony, that are turned away even though they're in the process of miscarrying, because that cardiac activity is still present and they're told you have to start bleeding more, you have to get sicker, you have to develop an infection.

And so often people are miscarrying, that's a process. And we are having to wait until later in that process until they get sicker, until they have more bleeding, until they have an infection, until we can intervene, instead of working with that patient to figure out what their needs and desires are, and when in the process it works for them for that treatment to happen.

Chair OSSOFF. Thank you, Dr. Verma.

Dr. Chandrasekaran, miscarriage management in Georgia's 6-week abortion ban. What's been your assessment and experience?

Dr. CHANDRASEKARAN. I think I can only echo what Dr. Verma has said. Here again, the term miscarriage encompasses a spectrum of situations. And so it can start with bleeding, it can start with continuing to have a heartbeat, it can start with water breaking at a time in your, you know, mid-second trimester, where now

the fetus, even if it were born, what would that look like in terms of lung development?

And then comes the question, a common discussion we have, how much bleeding is too much bleeding? Are they stable?

The other key thing to remember with—I always say this with pregnancy, is what seems normal 2 minutes before, can change in pregnancy very fast.

And so when we have these restrictions and you're told you have to wait until a tipping point, oftentimes once you've hit that tipping point, you've hit a point of severe discomfort, damage, and physical damage to mom. The procedure has become more complicated to do at that time, and now you have extra care issues and extra health issues going on.

So I think I can only repeat, it's complicated. It's not a black and white issue. And when we've taken away that discussion capacity between the physician and the patient to have that choice on what is best for the patient in that situation, by putting words that have to define that situation. It is inhibiting and limiting capacity for care.

Chair OSSOFF. Thank you. Dr. Verma, in your testimony you stated that Georgia's law threatens to make criminals out of doctors for providing necessary lifesaving care. Do doctors in Georgia fear the threat of criminal prosecution for providing necessary reproductive healthcare to pregnant women?

Dr. VERMA. Absolutely. So we are practicing in incred—again, we've said again and again, medicine is incredibly complex. We are trying to navigate this complexity under a law that says, if some—if a lawmaker or an attorney general decides we have made the wrong decision, we acted too soon, the consequences are criminal prosecution or having your license removed, your livelihood threatened.

And that's creating a huge chilling effect for doctors across the State. And so again, I've seen doctors that are limiting their scope of practice or saying, I'm just not going to take care of pregnant people anymore. I'm going to only do GYN care because they're so afraid of those very extreme consequences that makes the care deserts even larger in our State.

I've talked to physicians that are leaving the State completely because they're so afraid. And then I've seen doctors that are not able to take care of patients, that have to transfer them out of State, or transfer them to another hospital, and those patients get sicker and sicker.

And so, when we're trying to figure out, again, where in that "how sick is sick enough we can intervene," we know what the right thing to do is, medically. Right? That's what we train for, for all of these years, to work with our patients and make these medical decisions with our patients, with their families.

That's not the question. It is, what is this law that actually doesn't make any sense—that wasn't written by medical people? When does the law say I can intervene? And none of us know the answer to that.

And so navigating this environment is incredibly scary and confusing.

Chair OSSOFF. Thank you, Dr. Verma.

Dr. Chandrasekaran, you testified that you had a patient with severe lupus, which could have had significant impacts on maternal and fetal health. Can you explain in more detail what kinds of complications this patient risked as a result of being forced to continue her pregnancy with severe lupus?

Dr. CHANDRASEKARAN. Yes. So again, biology is complex and lupus is a process where for some reason your body thinks its own cells are not its own and seems to want to attack it, those are called autoimmune diseases.

And so, when you're undergoing a pregnancy which has its own physiological changes to your body, sometimes the body can turn against its own organs and really important organs—like the heart and the kidneys and the lungs.

And when that happens to mom, obviously that's going to put mom's life at significant risk. And then if mom's life is at risk, oftentimes that means we need to do a delivery because the pregnancy's adding to risk. And that can mean delivery of a baby at a very scary gestational age where the baby's life is at significant risk because baby isn't developed enough.

And so, these are very real situations that families can face leading to kind of long-term consequences for all the caretakers involved in that situation.

Chair OSSOFF. And as you know, as we've discussed, Georgia's law includes an exception for circumstances where termination is necessary to prevent a patient's death or, quote, "substantial and irreversible physical impairment of a major bodily function."

Yet you were unable in that case, to offer termination as an option to your patient with a condition that, as you just described to us, created a risk of severe health complications.

Why was the exception insufficient in this case? And how does the extremely narrow scope of this exception force doctors to put women in a position where they may continue to bleed, continue to be in pain, continue to take on greater and greater risk of irreversible harm, but doctors are unable to help?

Dr. CHANDRASEKARAN. The words, again, we use are, substantial and irreversible. Right? So I've taken care of many lupus patients now in my 15-plus years of practice. Some of them have severe issues. Some of them may not. Severity ranges on a scale.

So when we say substantial and irreversible, I'm going to go back to the question, what does substantial mean? And this is where that gray territory comes. We know kind of what substantial means.

I can talk to a patient and say, look, your chance of having cardiac failure might be this much. Your chance of having renal damage might be this much.

But what defines substantial in terms of the law? And also, what is substantial to each individual person in terms of the damage I'm giving them?

I never have a crystal ball. If I had a crystal ball, I could tell you exactly what's going to happen—we don't in medicine. And especially in a field like OB where you're dealing with two basically living organisms working kind of symbiotically with each other. And so when we use those words, it really limits that scope to feel

safe in knowing what defines substantial when that can vary in and of itself.

Chair OSSOFF. You described a patient whose fetus had a severe congenital heart abnormality and might either pass away in utero or survive and need extensive medical intervention with highly uncertain prospects for survival.

The patient did not have the choice to terminate the pregnancy under Georgia's law. Why wouldn't that fall within Georgia's exception for a medically futile pregnancy? And if the fetus survived past birth, perhaps requiring intensive neonatal care, perhaps in immense pain, what would that baby's quality of life look like?

Dr. CHANDRASEKARAN. So, again, the law puts the word futile, and so it is hard to predict that futility. Sometimes, yes, these babies can pass away in utero, sometimes they can pass away right after birth, and sometimes they might do okay with a surgery or so in terms of living.

But then that could mean, are they actually ever able to come home? Do they need to stay in an ICU the whole time? How are they recovering post-surgery?

Some of these babies can stay in a hospital for even a year up to post-birth just undergoing surgeries and undergoing care. So what does that put upon that life, that child, that family, that again is not covered in that medically futile?

If you ask medically futile, some of us can be at institutions where you can define certain diagnoses that yes, this is a hundred percent medically futile. Again, 99 percent of what we do, we can't predict that word medically futile, but we know that the risks are extremely high.

Chair OSSOFF. This conversation has been focused on legal terminology, complex medical dynamics. Your patients are human beings with immensely powerful emotions surrounding their pregnancy and their health.

What's it like as a doctor who cares about them to look into your patient's eyes, who are experiencing a health crisis, who have learned that their fetus may have a severe health complication, and not have a choice or be able to offer them a choice in those extremely difficult situations? What are those conversations, like that?

Dr. CHANDRASEKARAN. It's horrific. It's horrific. It's—it's awful.

It's almost degrading as a physician to not be able to do what you feel you need to do. And you're watching for what's protecting you in terms of a law. We will always do the best for our patients. I can say that as a physician, we will always do the best for our patients. We will always have open discussions.

But, to practice in a situation with an umbrella above you, that is limiting those discussions and having you also carry some of that emotional trauma and burden with your patient as you both are trying to navigate this with their families, is unfortunately a very horrific situation in the State and one that I agree with Dr. Verma, is potentially going to drive away good physicians from our State.

Chair OSSOFF. And we'll explore that dynamic more soon with Dr. Panakam.

But Dr. Verma, you stated that you see young mothers who have worsening medical conditions that make their pregnancies high risk, or who are miscarrying being turned away by doctors.

I think it's—I think it's critically important that the public understand that miscarrying women are being turned away by their doctors in this State right now because of this extreme abortion ban, or forced to leave their communities in order to access care.

We heard a story recently about a pregnant woman who had to travel to Massachusetts, and the fetus died in utero on the way, putting her at extreme risk upon her arrival out of State. Why are doctors in Georgia, Dr. Verma, turning away pregnant women in these circumstances?

Dr. VERMA. I think it goes back to how confusing these laws are. There is no way to create a law that takes every individual, every medical situation, every family into account. And so you can put into a law, you know—I've heard lawmakers who created these laws often say, well, there are exceptions. And so people that need care will get care.

One, I take care of patients who need abortion care for many different reasons. I would say the vast majority of them are excluded from getting care under this law. And the exceptions don't solve that problem. They're incredibly confusing, they don't make sense to the practice of medicine.

We talked about how miscarriage is often a process. There could be a time in that process when there's still a heartbeat or cardiac activity and doctors don't know if they can intervene. When we talk about medically futile pregnancy, there's no consideration of quality of life. Right?

So the patient I discussed that wouldn't qualify under Georgia's law because her baby once born could potentially live for years. But she would have to watch that baby suffer and die, if the baby was affected with the same genetic condition. And so the quality is not taken into account at all.

When we talk about the medical emergency exception, it is incredibly extreme and there are many people with high-risk pregnancies that aren't yet in that category of being, you know, immediately at risk of death.

One example I'll bring up, I had a patient with pulmonary hypertension, which is the condition where your lungs don't work correctly, your risk of death, if you continue the pregnancy, is as high as 50 percent. When we see that patient at, for example, 6 or 7 or 8 weeks, she often hasn't gotten a chance to get very sick yet.

Can we provide an abortion then? Or do we have to turn her away and say, come back when you get sicker, when your lungs aren't working anymore, when you have that 50, you know, when you are actually at risk of immediate death?

The right thing to do medically is to offer that patient the options of termination or continuing a pregnancy when we see her at 6 weeks. But under the law, it's often unclear if we can do that.

The last thing I'll just mention, I do think it's really important to recognize how this law takes these really important risk assessments away from people. So all of us take care of patients with very high-risk pregnancies, who choose to continue those pregnancies. And our job is to support them and optimize their health

and the health of their pregnancies. But that's a decision that a person should be able to make. Right?

And we also have patients who say, "That risk of continuing that pregnancy is too high." "I cannot risk dying and not be around for my existing children and my family." And that's also something that that person, not the State, should be able to choose to do. And so, it's not that people can't continue risky pregnancies, but that is a decision that people should be able to make.

Chair OSSOFF. You mentioned that many patients who have been denied care have expressed a sense of betrayal, too. Can you elaborate on why patients might feel betrayed in those circumstances?

Dr. VERMA. Absolutely. I think when people go to the doctor they expect to be able to get compassionate, evidence-based medical care. And, to be told, you can't get the same care that someone could get, for example, in Massachusetts where I previously practiced, or in Delaware, you can't get that care here.

Not because it isn't evidence-based, not because I don't have the skills to do it, but because our lawmakers have decided you don't deserve that care. You can't get that care here. That is a huge sense of betrayal. Right? I, I feel betrayed not being able to provide the care, patients feel betrayed.

We've created an environment in this country where your access to evidence-based care depends on your zip code, and your resources, and whether you can get out of State.

Chair OSSOFF. Thank you, Dr. Verma.

Dr. Panakam, you described a case, we just referred to it, again, that you witnessed at a clinic in Massachusetts, where a Georgia woman traveled to terminate a pregnancy after finding out her fetus had been diagnosed with severe abnormalities.

She wasn't able to terminate the pregnancy in Georgia, had to travel to Massachusetts instead, and by the time she arrived in Massachusetts, her fetus had been dead for several days.

Why wasn't this patient able to terminate her pregnancy in Georgia, under the exception for a medically futile pregnancy in the Georgia law?

Dr. PANAKAM. So, although this patient had a fetus with severe genetic anomalies, and it was well understood by all providers that the fetus would die in utero, or soon thereafter, she was not able to access an abortion because her baby still had a heartbeat. And that is the reason why she had to arrange alternate forms of clinical care and why she had to travel out of State.

And ultimately that delayed her care by several days. And in that time period, her pregnancy had deteriorated and she didn't even realize it until she ended up becoming very sick.

Chair OSSOFF. And what risks was she then faced with after the demise of the fetus in utero?

Dr. PANAKAM. So a demise of fetus in utero increases the risk of several alarming pregnancy complications. One is hemorrhage, so the risk of excessive bleeding. The second is infection, which is what happened to her. She had an uncontrolled infection because we were not able to evacuate the uterus and take out the source of her infection in a timely fashion. And as a result of that, she developed a systemic infection that almost cost her her life.

Chair OSSOFF. As a physician and as a Georgian, how did it make you feel to see a patient who was septic, whose life was now at risk because she'd been unable to access evidence-based care in her own State?

Dr. PANAKAM. It was really demoralizing. She was the first patient that I saw as a medical student from Georgia, and she suffered the worst consequence out of all the patients that I had taken care of in that clinic.

That patient, and many others like her, are the reason why I decided not to come back to Georgia for my medical training. Because I want to practice and I want to learn in a State where I can offer people the full spectrum of options and help them achieve the highest standard of health possible for them.

I don't want my hands to be tied by a law, by legislators, by people who have very little understanding of medicine. And because of that, how my patients suffer as a result.

Chair OSSOFF. And just to be clear, sepsis, after demise of the fetus in utero, this woman could have died. Correct?

Dr. PANAKAM. Absolutely. Sepsis is a leading cause of death in the United States. People often die from extremely, extremely low blood pressures, which we call septic shock or organ failure. And in her case, she was able to bounce back. But not everyone is so fortunate.

Chair OSSOFF. Did Georgia's 6-week abortion ban put your patient's life at risk?

Dr. PANAKAM. Absolutely. She wanted an abortion. She was not able to receive it in time, and as a result, her health deteriorated and she could have died.

Chair OSSOFF. You mentioned that you'd wanted to practice in your home State. And, as we heard earlier—you may have mentioned it, perhaps it was Dr. Verma—half of Georgia counties have no OB-GYN.

We heard Dr. Verma's story about a patient in rural Georgia who, being unable to access an abortion, was then marooned, without access to prenatal care—that increases risks for pregnant women.

You wanted to come practice where you were from, but you chose not to because of our State's abortion ban. How did it make you feel to be unable to choose to come and practice medicine in your home State where we have a dire need for professionals with your skills?

Dr. PANAKAM. I'm a good example of someone who wants to stay in Georgia. This is my community. The people I love are here. And I always envisioned a life here taking care of people. But that vision is not superseded by my need to do the right thing for my patients and my need to develop a skillset where I can respond effectively to medical emergencies, where I can appropriately advice and counsel my patients on the next step in their pregnancy and in their care.

And unlike my colleagues, I'm still very early in my training. And so, I speak from a place of potential. What is my potential to respond in the scenario? What is my potential to take care of people down the road? I make my decisions based off of who I want to be in a few years, in a decade, in a lifetime of service. And so,

at this point, that is—that person I want to become requires training outside of a restricted State.

Chair OSSOFF. And how did seeing this patient who had to travel from Georgia to Massachusetts, is septic, whose life's at risk because of Georgia's abortion ban, how did that influence your decision not to come home and practice OB-GYN medicine in Georgia?

Dr. PANAKAM. So the providers at the clinic I was working at knew how to respond to the scenario. They were extremely skilled in both the surgical management of her abortion, but also, you know, taking care of her when she was admitted to the ICU.

And I think we will see that more and more OB-GYNs are finishing their training in restricted States without a comfort level in offering or providing abortions. And that is due to a lack of exposure and training within their residency programs. I think that the patient I saw is one of many people who will not access this care because it is no longer legal where they come from.

But in turn for each of these patients, I think we will see many doctors who are not able to offer that care, because they were not trained in it or maybe they had some exposure, but that's not something that they feel comfortable doing independently without supervision.

Chair OSSOFF. Thank you, Dr. Panakam.

Dr. Chandrasekaran, as you know, Georgia has extraordinarily high rates of maternal morbidity and mortality, meaning women in Georgia have high rates of health complications and death related to pregnancy and childbirth.

Why are women in Georgia at such high risk of adverse outcomes from pregnancy and how do you expect Georgia's 6-week ban to affect maternal mortality and morbidity in Georgia?

Dr. CHANDRASEKARAN. Georgia's maternal morbidity and mortality rate is complicated, and it's layered. But many things contribute to it. I would say from kind of starting at a large eagle's eye view, access is a big issue. We've brought it up over and over again.

So, 6 weeks, to give context, is a time where many women don't even realize they're pregnant yet. Symptoms are barely starting at that time.

So, by the time they've realized they're pregnant and now potentially found a physician who can help them due to access, we're delaying care to be able to intervene or make decisions. So access is probably one of the big reasons for maternal morbidity and mortality.

Along with access then comes ability to give that care. So once access is gone, care isn't able to be given on time. That's also contributing to our issues with maternal morbidity and mortality. And then when care is not given on time, that's affecting overall health at a very granular level. So increased rates of diabetes, obesity, hypertension, all these cardiometabolic processes that contribute to pregnancy.

So it's a tiered model of what's causing that risk. And the abortion ban is only going to feed into all levels of that model.

Chair OSSOFF. Dr. Verma, how do you expect Georgia's 6-week abortion ban to affect maternal morbidity and mortality for pregnant women in Georgia?

Dr. VERMA. It's expected to worsen maternal morbidity and mortality in a State where we are already facing these terrible rates, terrible outcomes for pregnant patients. We've seen in the data that States that have abortion restrictions also tend to be the States that have worse maternal mortality and morbidity rates. And again, this is complex. It is very complex and there are multiple things that play into that.

But having that limited access to care, whether it's abortion care or prenatal care, definitely contributes to worsening outcomes for our pregnant people.

Chair OSSOFF. Dr. Verma, in your opening remarks, you described a young patient who was compelled by Georgia's law to continue an unwanted pregnancy, but was unable to access prenatal care while she was pregnant because she lived in a part of a State without sufficient doctors, without sufficient clinics and expertise. What are the risks to pregnant women in Georgia who are unable to access prenatal care?

Dr. VERMA. There are many risks to not being able to access prenatal care. Pregnancy is a time where, for many women, it is the highest risk thing that they're going to do. There are multiple complications that can come up. There are multiple issues that can come up that make that pregnancy higher risk for the patient that—or for the pregnancy itself.

And so prenatal care is incredibly important. This patient had Medicaid, so she had insurance, she had Government insurance, and there was no one in her part of the State, closeby that she could get to easily as a teenager, who took Medicaid. That is a huge shame. Right?

It—she had insurance from the Government and couldn't get prenatal care when she was forced to continue her pregnancy. I think that's also part—all of that combined has also contributed to her developing postpartum depression.

We know that mental health conditions are one of the leading causes of maternal morbidity and mortality in our State and in the country.

Mental health conditions are specifically excluded from Georgia's medical emergency exception. So Georgia, as a State, has decided mental health is not—it's good enough to count for an exception.

So if a patient is experiencing severe depression, is at risk of suicide, that does not count as an example of when we can provide care. And so this patient after this whole experience, then experienced postpartum depression, that put her life and her health and the health of her baby at risk as well. And this isn't unique. Right? We're seeing this happen again and again and again.

Chair OSSOFF. Thank you Dr. Verma.

Dr. Panakam, did I hear you correctly earlier that OB-GYN residents in States like Georgia, with extreme abortion bans, often have to travel out of State to meet their own educational requirements?

Dr. PANAKAM. That's correct, Senator. OB-GYN residents are caught in a really awkward situation where they need to receive this essential training, but they're not legally allowed to do it in the location in which they are training. This often necessitates them applying to away rotations in other States.

This is a very onerous process.

You have to do licensing again. It's expensive. You have to find alternate housing. If you have children, you have to find childcare and leave behind your family for several weeks to months at a time.

And even if you can do all of that, there's a good chance you'll be denied. Because there are not enough training spots in other States. The system only has so many slots, and right now cannot accommodate people coming up from out-of-State, across the board.

So this is going to limit many people's ability to access that training. Not everyone can travel out of State, and not everyone will be granted the opportunity. They will not even be granted a slot in order to do that. So it will restrict the training of many physicians in this country.

Chair OSSOFF. I would note, Dr. Panakam, applications for OB-GYN residency slots in Georgia decreased by almost 10 percent in the 2023-2024 application cycle. Do you believe that your peers are being deterred from applying for residency in States like Georgia because they're unable to access the training they need? They may be unable to provide the care their patients need? They may face criminal prosecution?

Dr. PANAKAM. Absolutely. As I said earlier, abortion is common. So training in abortion is a commonly sought out experience by people going into reproductive healthcare. And our training in a variety of different procedures will determine what we can do as independently practitioning physicians.

So we don't want to artificially restrict our skillset, our medical knowledge, by legal restrictions. We want to understand what the entire scope of evidence-based medicine is in OB-GYN. And at this point, just entering the field, it seems like a really tough pill to swallow, to go to a State where you won't be able to train in the entire spectrum of OB-GYN care. And as a result, many people are not coming to the South and to other restricted States when they otherwise had planned to.

Chair OSSOFF. Dr. Chandrasekaran, we just heard it firsthand from an OB-GYN intern who decided not to train in her home State. How do you expect the ban to impact recruitment and retention of OB-GYNs in Georgia?

Dr. CHANDRASEKARAN. Yes, thank you. That's a real important point. It's going to continue to negatively impact us. I think the hard part about this is you may not see that effect in 2 years, 3 years, 5 years.

You have those of us that are here a little longer, that might still be doing this. But then comes that, you know, kind of the pipeline. Right?

Who's coming behind us? Who can we bring? Who can we train? How do we build up?

That impact may not be seen again tomorrow, or in a year. But in 5, 10 years, I think this is going to be a huge impact for a State that is already struggling.

Chair OSSOFF. Dr. Verma, how about retention? We've been focused on recruitment. Retention of an OB-GYN workforce in Georgia now facing potential criminal prosecution for providing healthcare.

Dr. VERMA. Absolutely. You know, I think that some physicians in practice are thinking about leaving—I think a lot of physicians. Right? This is their home. This is their community. They have houses here. They have families here. Their kids are in school. And they aren't able to leave.

But people are also—I've talked to folks that are retiring early or that are limiting their scope of practice. And that, in addition to doctors leaving the State completely, limits patient's abilities to get care. And so we're seeing all of these things combined affecting our workforce.

As someone who mentors medical students and residents, you know, I've had many people in the same situation where they say, should I stay in Georgia for residency? This is my home. This is my community.

And I, you know, I tell my mentees, I don't think you can get the same level of training in abortion care anymore as you used to. Like, I think—I think, you know, if I was making the decision now, I would leave, get the training, and potentially come back. But also, that's unclear. Right? Like it's a scary environment to practice in.

Chair OSSOFF. And I should note that was a 10 percent reduction in residency applications across all specialties. Dr. Panakam, why did you want to be a doctor?

Dr. PANAKAM. I wanted to be a doctor, in part, because of my experiences growing up here in Georgia and seeing people not being able to access healthcare, especially in rural communities.

I studied public health in undergrad and I found medicine as an extension of that. Doctors have an incredible platform to educate, to take care of people, to directly change the course of a community. And that's the reason I decided to go through the long process of applying to medical school and complete training.

I've already been in this for about 10 years and I have at least four more to go and I would do it all over again. But I think what is challenging at this point is that we are not actually able to provide high-quality care, evidence-based medicine to a lot of our patients.

And, you know, in regards to what you had said earlier about how this might affect physician retention, we know that a lot of doctors stay to practice in the same State where they completed their training. This is well documented.

And so, if you are failing to attract physicians to come and train in your State, you are also failing to potentially fill many supervising physicians' slots in a handful of years. This is something as Dr. Verma had mentioned, and Dr. Chandrasekaran. It takes several years to see the effects, but it will come in time. And we're already starting to see some of these effects now.

Chair OSSOFF. And you wanted to help people, you've entered this field, you've worked so hard to get these qualifications, you haven't been able to come and train in your home State.

How does it make you feel as a young doctor to know that Georgia women are being forced to endure pain, risk of hemorrhage, risk of sepsis, as you laid out, that doctors in the exam room across from them have to look in their eyes and tell them that they face serious and uncertain risk of potentially fatal complications, but

that the doctor's hands are tied by politicians. How does it make you feel to know that that is the situation facing physicians and patients in your State?

Dr. PANAKAM. It is deeply demoralizing. Personally, I feel very guilty for not coming back. This is my community. I've always wanted to come back.

And I feel like I've failed a lot of people as a result. I hope to come back one day. But I think that it's difficult without changes to the existing laws here.

We want to do the right thing by our patients. You know, physicians work really hard and train for a very long time so that for every single person that walks through the door, we can counsel them appropriately. We can take their medical history into account, we can take their social circumstances into account, and offer them the best choice for them.

And by restricting abortion access, and also by restricting training in abortion as a result, you are stripping that away from thousands of physicians practicing in restricted States. And it causes a lot of distress. It is something that keeps a lot of us up at night, you know, and it's a leading reason why I think people decide to leave.

It's hard to go to work every day and realize you're not offering your patients the level of care that you would expect to, that you would hold yourself to, if you could. And the emotional consequences of all of this, I think should not be taken lightly, as well.

Chair OSSOFF. Thank you, Dr. Panakam.

Final question for each of you, beginning with you please, Dr. Verma. What do you think lawmakers should know about the impact of abortion bans like Georgia's extreme 6-week abortion ban?

Dr. VERMA. Thank you for that question and for this hearing to bring attention to this issue. I think we, as doctors, are here trying to provide the care that we can to our patients. We are trying to get people in quickly within that often impossible 6-week timeline. We are trying to do whatever care we can. We're trying to get patients out-of-State when we can't provide them care here.

And my colleagues and I, you know, we're going to continue to do what we can.

But the law has to change. It is limiting practice. It is hurting people. You know, I get that abortion is complicated for a lot of people, and it's okay to feel that complexity and to also recognize that people are the experts in their own lives and should be able to make these decisions about their healthcare and their lives. And those things can exist together.

There are so many reasons why people need abortions, and we are just in a terrible environment where we are trying to do what we can. We will keep trying to do what we can to support our patients.

But as you've heard, it is an incredibly difficult environment and people are struggling and the laws have to change. We have to get to the polls. We have to do what we can to change the laws.

Chair OSSOFF. Thank you, Dr. Verma. Dr. Chandrasekaran.

Dr. CHANDRASEKARAN. Thank you for that question. And again, thank you for this hearing and bringing attention to this. Of course, I echo what Dr. Verma said, but I want to add to that.

I think, again, biology, human systems, a pregnancy, literally all the physiologic changes a maternal body and a new being, a fetal being growing inside that body does to your body, is not a machine.

It's not black and white. It varies. And putting laws on a system that is extremely volatile and changeable and not identifiable as yes-no, black-white, it is only going to lead to tragedy.

And so, this is not a situation where law can cover all the factors and the facets that we need to cover. That's why this is medicine and it's not law.

Chair OSSOFF. Dr. Panakam.

Dr. PANAKAM. I think I want to end simply by saying, abortion is healthcare. And healthcare should be determined by doctors, not by legislators.

There is a body of evidence that we follow, you know, decades of research, of advocacy, that have gone into why we think the way we do, why we offer certain procedures at certain times, and not in other scenarios.

And I think it was incredibly concerning that people without medical knowledge are now restricting our ability to provide evidence-based care. They're not speaking from a place of knowledge.

And as a result, real people are affected. Real people are getting sick. Real people are having unwanted pregnancies. And real people are dying.

And in order for all of this to change, we, as Georgians, and as you know, all residents in this country, you have to make it known that this is not—this is not something we will stand for. This is not acceptable. And that we should leave reproductive healthcare in the hands of physicians who have worked very hard and very long to achieve the level of knowledge needed to make those decisions.

Chair OSSOFF. Thank you, Dr. Panakam.

I want to thank each of you for not just participating in today's hearing, but also for dedicating your careers to the health of your pregnant patients.

And I have a sense of just how hard you've worked and how many extraordinarily long call shifts you've endured, and how many 3 a.m. trips to the hospital to ensure that a laboring patient has a safe delivery you've made, and just how much of your lives you've invested in helping people.

And on behalf of all Georgians, I'm extremely grateful to you—and grateful to you for lending your expertise today. Because, as I said at the opening of the hearing, there's a lot of political voices weighing in on this issue. The public needs to hear from the doctors, who are providing care every day, what this is really doing to pregnant women in Georgia.

And we've heard extremely concerning reports today from leading OB-GYNs in Georgia, and a resident who was deterred from coming to practice in her home State because of this extreme abortion ban.

We've heard about women who struggle to get the healthcare they need at critical moments when their health's at risk, when they're experiencing a miscarriage and turned away from the doctor, about extremely worrying and high-risk medical scenarios that haven't yet reached some vague state of sufficient emergency ac-

cording to politicians who haven't practiced a day of medicine in their life.

And we've heard about how Georgia's law is driving doctors out of our State—when we already face a dire shortage of OB-GYNs—that for years has been negatively impacting the health and lives of women in Georgia, including worsening the access to prenatal care in our State.

Well, I'm grateful to all of you for illustrating what this really means for healthcare providers and for your patients.

I would note for you, and for members of the public, that the hearing record will remain open for 1 week for statements to be submitted into the record.

We welcome contributions from the public.

Questions for the record for our witnesses may be submitted by other Senators by 5 p.m. on Tuesday, July 30th.

I want to restate my gratitude to Mayor Garrett and the city of Decatur for hosting us today. It's great to be in Decatur.

And thank you, again, and the hearing is adjourned.

[Whereupon, at 10:50 a.m., the hearing was adjourned.]

[Additional material submitted for the record follows.]

Testimony of Dr. Suchitra Chandrasekaran, MD MSCE, FACOG
Member, Health Policy and Advocacy Committee for the Society of Maternal Fetal Medicine
Before Senate Subcommittee on Human Rights and Law
"Health Impacts of Abortion Ban on Georgia Women"
July 23rd, 2024

Good morning, Senator Ossoff and distinguished members of the Subcommittee on Human Rights and Law. My name is Dr. Suchitra Chandrasekaran. I am a board-certified and fellowship trained maternal-fetal medicine subspecialist. I am here today as a member of the Society for Maternal-Fetal Medicine, or SMFM, to describe the harmful effect restrictions on reproductive health have on patients, their families, and the clinicians that care for them.

As a maternal-fetal medicine subspecialist, I provide obstetric care for pregnant persons who are diagnosed with conditions or experience complications that make their pregnancies high-risk. I proudly take care of pregnancies affected by maternal health issues ranging from hypertension and diabetes to cancer and complex life-threatening heart disease. Throughout this care, I perform ultrasound imaging and provide genetic testing to assess fetal well-being.

I am the child of a first-generation immigrant family from India that grew up in small towns in Southern Ohio and Eastern Tennessee. I have had the opportunity to train and practice in varied geographic regions of our country including the Midwest, East, and Pacific Northwest, and in a full circle now practice and provide care in the South in the state of Georgia. I have cared for pregnant people from all backgrounds, races and ethnicities. I speak here today as an individual who has the absolute privilege and honor to have conversations with patients and families as they experience one of the most emotional, social and physically challenging times in their lives.

As an MFM specialist practicing in Georgia, what I want to tell Congress is that the Georgia abortion ban limits the ability of myself and my colleagues to provide evidence-based care and counseling and significantly puts the well-being and lives of our patients at unnecessary risk. Having previously practiced in states where I could provide full scope evidence-based care and counseling, I am horrified and deeply saddened by the situation and lack of choices our patients are given to prevent further damage to their health and lives. While I live and see these stories every day in my practice, I will be highlighting a few of these disturbing stories here. Furthermore, while I am using the word stories in this testimony, for my patients, these are not stories-these are nightmares and tragedies.

During my early years as an MFM, I practiced in the state of Washington at the University of Washington. The university covered care for pregnant persons in five different states -- Washington, Wyoming, Alaska, Montana, and Idaho. Patients came to us from small islands in Alaska, taking a boat, seaplane, then commercial flight to get to Seattle. Others traveled treacherous mountain passes from Eastern Washington. Much of these regions were obstetric deserts, or regions with suboptimal number of providers for obstetric care, meaning that these patients were not just a few hours away from home by car, but many hours away from home by flight and other sources of transportation. This greatly affected how they made decisions regarding their pregnancy.

Around 1 AM during a call shift on labor and delivery, I received a call from Alaska about an individual in her second trimester who presented experiencing shortness of breath and was subsequently diagnosed with a pre-existing heart condition. Due to inadequate healthcare coverage, this was the first time the condition had been identified. Pregnancy has huge effects on how the heart works and, for patients who may not have had care before, pregnancy is often how their existing heart conditions are diagnosed. Once it was clear this Alaskan patient had a very severe heart condition, she was transferred to UW. Sadly, this was not a unique transfer or scenario for us -- just another normal night, another normal transfer.

We received her in the early hours of the morning. She was tired, scared, had been in transit for hours. Her partner was not able to be with her as he could not miss work. This was her first pregnancy and had been her dream -- to go through pregnancy and to be a mother. Now she was facing her nightmare with a new heart condition diagnosis, scared for her health and her baby's health. She had no support because of regional conditions and the need for income. She was alone. My team spoke with her in detail about her prognosis and options. Because of Washington state's protective abortion laws, I was able to offer abortion as one of those options. We had her partner on the phone during our discussions. Her pain and her partner's pain were heartbreaking. After a couple of days of managing her heart condition and weighing her risks, she made the gut-wrenching and challenging decision to terminate her pregnancy to focus on taking care of her heart condition. I held her hand and shared tears with her as she made this decision.

While I thought about her risks, her emotional health and supporting her through the process, I never imagined that I would be practicing in an environment where I couldn't even offer her freedom to make decisions regarding her body, her life, her pregnancy—but if that case had occurred today, in Georgia, that's exactly what would happen. Because I was able to provide an abortion, this patient specifically had the opportunity to get her heart condition fixed and I had the personal joy and privilege of delivering her baby in her next pregnancy. I had held her dead fetus with her wrapped in a knitted blanket in the first pregnancy and cried with her; I had held her beautiful baby boy in the second pregnancy and cried tears of joy with her. I never expected as obstetric providers we would be living a nightmare where that choice for her to make the best decisions for her health would no longer be possible. I never thought I wouldn't be able to provide safe, evidence based, full scope obstetric care.

Fast forward 7 years. The dreaded morning of June 24, 2022 when the United States Supreme Coard released its decision in *Dobbs*. Right as we heard the news and were trying to process the gun-wrenching realization that practice would never be the same and frantically wondering what this would mean, my sonographer brought my next ultrasound me to review. This ultrasound was for a woman who had not had access to insurance and care until the early second trimester and had come for her first ultrasound a few weeks later. Access to healthcare is a major issue in the state of Georgia which is burdened by the presence of obstetric deserts, or regions with limited medical access. She had to move before she could access obstetric care and have her ultrasound.

She was a young woman, excited for this pregnancy and eager to "see her baby" in this first ultrasound. I, however, saw a fetus with a significant cardiac defect. Although the baby would be born alive—meaning that the case did not fit within Georgia's exception for medically futile pregnancies—the prognosis and quality of life after birth would be extremely limited. Even after

multiple surgeries, the long-term outlook for this kind of a heart defect was questionable requiring more surgeries, hospitalizations, and higher-level resources for daily living. 10 minutes ago, I would have counseled this woman about what carrying the pregnancy would look like and what we would do; I would have also counseled her that given the risks of this pregnancy to the fetus and ultimately her health, such as significant cardiac issues or fetal demise, termination of the pregnancy is also an option. 10 minutes later, I could no longer counsel on that option. 10 minutes later, I walked into her room, shell shocked at how the only practice and counseling methods I had known for 15 plus years had been impacted and spoke to her about how my concerns for this fetus and what the cardiac defect would mean for this infant when born. As a doctor, my job is to support whatever decision a pregnant person wants to make, whether it's to continue a challenging, high-risk pregnancy or terminate the pregnancy. As a doctor, my job is to inform of all the risks and outcomes. But now, as a doctor, my ability to counsel was limited and I could not, and did not, provide comprehensive counseling on her options. My patient was in tears, knowing the law had just gone into effect. I had no words to share with her at that moment; we both knew there was only one path forward regardless of if that was the path she wanted; I too only had tears to share with her at that moment. The nightmare had begun.

Even before the *Dobbs* decision, the high maternal morbidity and mortality rates affecting the state of Georgia were well known. One of the largest drivers of this rate is maternal cardiac disease. Yet Georgia's ban forces women with very high-risk maternal cardiac conditions to carry their pregnancies to term, regardless of the dangers to the mother's health. For example, I had a patient in early 2023. She had a disease process called Lupus—a disease that can be mild or severe. In its severe form, it can significantly affect a pregnancy and threaten maternal and fetal health including kidney and heart damage for mom and very preterm delivery for fetus. This patient had the severe version with significant heart issues. She was in her late first trimester when she found out about her pregnancy. She was scared, knowing the risks of her becoming very sick, her heart facing serious issues including heart failure or death, or having a very preterm baby that could have long term health issues was extremely real. But now, even though she was only in the late first trimester, I couldn't provide full spectrum reproductive healthcare and offer her the option of a termination. My hands are tied as a provider. I am limited and stuck. She doesn't have resources to obtain care elsewhere. She is limited and stuck. The system has limited her reproductive rights and ultimately negatively impacted her long-term health and life.

As my patient's case illustrates, in a state where maternal morbidity and mortality are extremely high with cardiac issues driving this factor, the abortion ban can only worsen this issue. In a state where maternal mental health conditions are another key contributor to morbidity and mortality, it is needless to say the trauma of being stripped of autonomy to make critical personal health decisions is real and long lasting. It's not just the now we have affected; we are detrimentally impacting the future health, wellness and quality of life for pregnant people by this restriction on reproductive rights. We have detrimentally impacted long term maternal morbidity and mortality in a state that is already having high rates.

I am committed to remaining in Georgia and providing the best possible care for my patients in this challenging environment. However, in a state where health care access is an issue, and the need for obstetricians is crucial for basic prenatal care, the abortion ban hurts the state's ability to

recruit excellent obstetricians as physicians do not want to practice in environments where providing full spectrum evidence based reproductive care including abortion is not an option.

I have provided stories above. I have demonstrated what success can look like when full scope care can be provided. I have shown the aftermath of not being able to provide that care. High risk pregnancies are unexpected, life-threatening, emotionally traumatizing and life changing for all involved. The current abortion ban in Georgia limits our ability to provide the compassionate and full spectrum reproductive counseling and choices to our patients and the aftermath of these tragic stories will only continue to worsen the overall future health of pregnant persons in Georgia.

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

Senator Lindsey O. Graham
Questions for the Record
"Health Impacts of Abortion Ban on Georgia Women"
July 23, 2024

Questions for Dr. Suchitra Chandrasekaran

1. The best social science evidence suggests that there are 10,000 abortions annually performed at the stage where the baby could live outside his or her mother's body.[1] Do you support any restrictions on purely elective abortions after viability that are not performed due to rape, incest, or to protect the life or safety of the mother?
    a. What about after 28 weeks? Do you support any restrictions on purely elective abortions after 28 weeks, when the neonatal survival rate is 98%?
    b. What about after 32 weeks? Do you support any restrictions on purely elective abortions after 32 weeks, when the neonatal survival rate is 98.1%?
    c. What about after 35 weeks? Do you support any restrictions on purely elective abortions after 35 weeks, when the neonatal survival rate is 100%?
    d. Do you support any limitations on purely elective abortion at any stage of gestation?
    e. Even assuming that the figures cited above are incorrect, would you support any limitation on a woman's right to receive an abortion after 35 weeks?

2. As a physician, what in your medical training or expertise qualifies you to:
    a. Resolve philosophical questions of when human life begins?
    b. Resolve questions of whether and to what extent state protections on human life should extend to unborn life?
    c. Resolve questions of how the people of individual states should determine democratically their own protections on unborn life?
    d. Resolve questions of whether the proper subject of lawmaking is at the federal or state government level?

3. Eloisa Lopez, Executive Director of Pro Choice Arizona and the Arizona Abortion Fund, testified as a witness in a recent Senate Judiciary Committee field hearing in Arizona on abortion restrictions post-*Dobbs*. She stated that "I have had four

[1] According to the Guttmacher Institute, approximately 1,037,000 abortions occurred in the formal healthcare system in 2023. *Despite Bans, Number of Abortions in the United States Increased in 2023*, GUTTMACHER INSTITUTE (May 10, 2024), https://www.guttmacher.org/2024/03/despite-bans-number-abortions-united-states-increased-2023. The CDC estimates that, as of 2019, roughly 1% of abortions are performed after viability (i.e., when a child can often survive if separated from his or her mother). *Abortion Surveillance – United States, 2019*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Nov. 26, 2021), https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm#T11_down. This suggests that roughly 10,000 late-term abortions are occurring each year.

abortions; neither of them was due to sexual assault or an emergent medical threat. I simply did not want to be pregnant in that moment and time."[2]

a. Do you agree that this is a valid justification for an abortion?
b. What about during the third trimester?

4. In your opinion, what if any restrictions should a federal or state government be allowed to impose on abortions after the beginning of fetal viability?

5. Michael Stokes Paulsen has noted, "Trait-selection bans throw down a gauntlet: Does the Constitution really confer a right to abortion when the sole reason is the race, or sex, or disability of the unborn human child? Is there a constitutional right to kill a living human fetus *because* he or she is a child of color, because he or she has Down syndrome, or because (in a perverse reversal of a traditional expression of joy) 'it's a girl!'?"[3]
   a. In your opinion, should federal or state governments be permitted to restrict abortions that are conducted because the baby is a particular sex?
   b. In your opinion, should federal or state governments be permitted to place restrictions on abortions that are conducted because the baby is a particular race?
   c. Dr. Warren Hern's research further shows that of second- and third-trimester abortions performed because the baby had an abnormality, abortions because the baby had Down Syndrome composed the largest group. In your opinion, should federal or state governments be permitted to place any restrictions on abortions that are conducted because the baby has a non-life threatening disability, such as Down's Syndrome?

6. In your opinion, should doctors with conscientious objections to abortion be permitted to refuse to provide abortion procedures to patients?
   a. The Accreditation Council for Graduate Medical Education (ACGME) requires that "Residents who have a religious or moral objection may opt out and must not be required to participate in training in or performing induced abortions."[4] Do you agree that the ACGME should provide this exception?

7. In your opinion, should federal tax dollars be permitted to be used to fund abortions or abortion providers, for instance, through the Medicaid program?

---

[2] Eloisa Lopez, Responses to Sen. Lindsey O. Graham Questions for the Record, SENATE JUDICIARY COMMITTEE, *available at* https://www.judiciary.senate.gov/imo/media/doc/2024-06-25_-_qfr_responses_-_lopez.pdf.
[3] Michael Stokes Paulsen, *Abortion as an Instrument of Eugenics*, HARVARD LAW REVIEW, Vol. 134, Issue 7 (May 2021), *available at* https://harvardlawreview.org/forum/vol-134/abortion-as-an-instrument-of-eugenics/.
[4] ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology, IV.C.7.a).(4)(a), *available at* https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_2023.pdf (last accessed July 30, 2024).

8. Mifepristone is a drug that is used for abortion during the early weeks of pregnancy, along with another drug called misoprostol.
    a. In your opinion, should mifepristone, misoprostol, or other abortion-inducing drugs be available to patients without a medical professional's prescription?

9. Please answer the following questions with a Yes or No response, without divulging patient-specific information:
    a. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients for the purpose of inducing an abortion?
    b. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients that you not have not met with personally, but rather only:
        i. By email?
        ii. By phone call?
        iii. By virtual meeting, e.g., Microsoft Teams or Zoom?
        iv. On the basis of a patient's answers to an online informational form?
    c. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients for use in states where the drug is regulated or banned?
    d. Many women seeking abortion do so as a result of coercion, including from sex traffickers. In your opinion, should a doctor be allowed to remotely prescribe these drugs, without a patient visit in-person, to patients in jurisdictions where the drug is regulated or banned?
    e. "Abortion-pill reversal" is a procedure that involves the administration of progesterone to a pregnant women who has taken mifepristone but not misoprostol. Have you ever presented abortion-pill reversal as an option to any of your patients as a component of informed consent, shared decision-making, and respect for patient autonomy?

10. When answering questions during the hearing, you stated, "in a field like OB . . . you're dealing with two basically living organisms working kind of symbiotically with each other."
    a. Stedman's Medical Dictionary defines "symbiosis" as, among other things, "[t]he mutual cooperation or interdependence of two people, such as mother and infant . . . ." Do you agree with that definition?
    b. Stedman's Medical Dictionary further defines "organism" as "any living individual, whether plant or animal, considered as a whole." Do you agree with that definition?
    c. Do you agree that a pregnancy (the subject of obstetrics) involves a mutual interdependence of two living individual people, i.e., a mother and child?
    d. How do you account for the interests of the child when making decisions regarding abortion?

11. Former president of Planned Parenthood, Alan Guttmacher, has written, "A facet that makes the obstetrician's burden unique in the whole field of medicine is his double obligation; he simultaneously cares for two patients, the mother and the infant."[5]
    a. Do you agree with that statement?
    b. How does this inform your approach to abortion?

12. In your testimony, you used the term "evidence-based" to refer to abortion, but states that collect data on the reason women undergo abortion report that more than 95% of abortions are performed in healthy mothers with healthy babies. There is therefore no medical reason or indication for abortion in these women, and no evidence whatsoever that such an abortion provides any therapeutic benefit. In addition, the abortion kills a human being.
        i. Given these facts, do you agree that abortion performed in healthy mothers with healthy babies is "evidence-based"?

[5] Alan Guttmacher, *Pregnancy and Birth: A Book for Expectant Parents*, New American Library, Revised Edition (January 1, 1962).

Testimony of Dr. Aisvarya Panakam, MD
Before the Senate Judiciary Subcommittee on Human Rights and the Law
"Health Impacts of Abortion Ban on Georgia Women"
July 23rd, 2024

Good morning, Senator Ossoff and distinguished members of the Human Rights and the Law Judiciary Subcommittee. My name is Dr. Aisvarya Panakam and I use she/her pronouns. I am a recent graduate of Harvard Medical School and a current Resident Physician in Obstetrics & Gynecology at an academic medical center in Pennsylvania. I'm testifying today in my personal capacity and thank you for this opportunity.

I grew up in Georgia and am a proud Southerner. After spending the past decade of my life studying in other parts of the country, I was eager to return home to complete my medical training. Yet, I am here today to explain why I chose not to pursue OBGYN residency in the South. I was halfway through medical school when the Dobbs decision ended the constitutional right to access abortion. Immediately, trigger bans were initiated across the country, including here in Georgia.

Over the next two years, every single southern state instituted either a total ban or a prohibitively early gestational age ban on abortion. When it came time to apply for residency, many applicants into OBGYN, including myself, prioritized programs that offered training in full spectrum reproductive care including abortion and miscarriage management. It was a bitter day when I realized that I would not be able to receive training to the same extent in any state in the South, including Georgia. Ultimately, I prioritized programs in other regions of the country.

To contextualize why I made this choice, I would like to share a few key facts. First, abortion is common. Prior to the Dobbs decision, one in four women of reproductive age in the United States was predicted to have an abortion by age 45.[1] Second, abortion is safe. Surgical abortion remains one of the safest medical procedures a person can undergo.[2] For abortion to remain accessible and safe, reproductive health physicians like myself must receive this essential training.

This need for comprehensive training is recognized by accrediting bodies. The Accreditation Council on Graduate Medical Education (ACGME) requires that all OBGYN residency programs provide their residents with comprehensive clinical experience in abortion.[3] However, since the Dobbs decision, an OBGYN resident in the South now faces a myriad of uncertainties and often has more questions than answers. Will I have sufficient case volume? Will I learn to manage complex cases? Would I be able to confidently perform this procedure by myself?

---

[1] Jones RK. An estimate of lifetime incidence of abortion in the United States using the 2021–2022 Abortion Patient Survey. *Contraception*. 2024;135. doi:10.1016/j.contraception.2024.110445
[2] Upadhyay UD, Desai S, Zlidar V, et al. Incidence of Emergency Department Visits and Complications After Abortion. *Obstetrics & Gynecology*. 2015;125(1). https://journals.lww.com/greenjournal/fulltext/2015/01000/incidence_of_emergency_department_visits_and.29.aspx
[3] ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology. Published online July 1, 2023. https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_2023.pdf

Residency is a difficult process in and of itself. Additional roadblocks to obtaining necessary training will continue to dissuade talented physicians from practicing in states with abortion restrictions.

It is important to recognize that abortion training gives OBGYNs an additional skillset that they can apply to diverse scenarios, especially during medical emergencies. Even if a OBGYN chooses not to perform abortions, if they are trained in procedural abortion, they will be better equipped to manage conditions such as miscarriage, hemorrhage, and infection. Training in abortion makes for a capable obstetrician-gynecologist.

Georgia must prioritize the development of OBGYNs because its maternal health outcomes are among the worst in the country.[4] Half of Georgia's counties lack a single OBGYN, leaving one in three women without access to essential maternal care.[5,6] The sad truth is that Georgia desperately needs more OBGYNs, yet it is failing to attract them. In 2022-2023, applications to OBGYN residency in restricted states decreased by 5.6%.[7] A recent survey of medical students applying into OBGYN sheds light on a major reason: 73% of survey respondents reported that the Dobbs decision affected which programs they applied to.[8]

I am deeply concerned about the dangers that Georgia's six-week abortion ban creates for women. As a medical student, I helped care for a Georgia women whose fetus was diagnosed with severe genetic anomalies. She was not allowed to receive an abortion in Georgia and by the time she arrived at our clinic in Massachusetts, her fetus had been dead for several days. She was admitted to the Intensive Care Unit for a life-threatening clotting disorder called disseminated intravascular coagulation (DIC) as well as massive immune dysregulation in the form of sepsis. Georgia's abortion ban jeopardized her life by delaying her access to care. This case reaffirmed my commitment to train in a place where abortions can be accessed by women who need them.

I speak on behalf of the tens of thousands of medical students and physicians who are currently in the training pipeline and who will make up the future healthcare workforce of this country. States that severely restrict abortion access will struggle to attract and retain OBGYN physicians, causing shortages to their physician workforce. I made the difficult decision to not return home for my residency training. Many of my peers have also made this choice. With the support of our lawmakers, we can expand abortion access which will also help reverse this exodus of students,

---

[4] Maternal Mortality Rate by State 2024. World Population Review. 2024. Accessed July 18, 2024. https://worldpopulationreview.com/state-rankings/maternal-mortality-rate-by-state.
[5] Physicians by Specialty by County, 2020. Number, Rate, and Rank. file:///Users/ashpanakam/Downloads/2020_Rate%20and%20Rank%20(4).pdf
[6] Maternity Care Desert: Georgia, 2021. March of Dimes | PeriStats. Accessed July 18, 2024. https://www.marchofdimes.org/peristats/data?reg=99&top=23&stop=641&lev=1&slev=4&obj=9&sreg=13
[7] Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health. Research and Action Institute. doi:10.15766/rai_2rw8fvba
[8] Frame B, Vrooman H, Beckham AJ. Effect of Dobbs v. Jackson Women's Health on Obstetrics and Gynecology Residency Applicants [ID 2683390]. *Obstetrics & Gynecology*. 2024;143(5S). https://journals.lww.com/greenjournal/fulltext/2024/05001/effect_of_dobbs_v__jackson_women_s_health_on.11.aspx

doctors, and health professionals leaving restricted states. Thank you for having me today. I look forward to your questions.

Senator Lindsey O. Graham
Questions for the Record
"Health Impacts of Abortion Ban on Georgia Women"
July 23, 2024

Questions for Dr. Aisvarya Panakam

1. The best social science evidence suggests that there are 10,000 abortions annually performed at the stage where the baby could live outside his or her mother's body.[1] Do you support any restrictions on purely elective abortions after viability that are not performed due to rape, incest, or to protect the life or safety of the mother?
    a. What about after 28 weeks? Do you support any restrictions on purely elective abortions after 28 weeks, when the neonatal survival rate is 98%?
    b. What about after 32 weeks? Do you support any restrictions on purely elective abortions after 32 weeks, when the neonatal survival rate is 98.1%?
    c. What about after 35 weeks? Do you support any restrictions on purely elective abortions after 35 weeks. when the neonatal survival rate is 100%?
    d. Do you support any limitations on purely elective abortion at any stage of gestation?
    e. Even assuming that the figures cited above are incorrect, would you support any limitation on a woman's right to receive an abortion after 35 weeks?

Describing abortions as "purely elective" is intentionally pejorative and seeks to characterize the reason for having an abortion as either "good" or "bad." People have many legitimate reasons for not wanting to continue a pregnancy that lie outside of rape, incest, or immediate danger to their own life. For those who do seek out an abortion later in pregnancy, there is often new-found concern for fetal anomalies or new risks that develop to their health.[i] Others did not find out about their pregnancy until later in gestation or have faced systemic barriers in accessing abortion care.[ii] The Dobbs decision places extreme burden on low-income women by forcing them to find the funding, time, and support to travel outside of state lines to receive their medical care.[i] These questions also falsely insinuate that "purely elective" abortions are commonly sought out later in gestation at 28, 32, and 35 weeks.

2. As a physician, what in your medical training or expertise qualifies you to:
    a. Resolve philosophical questions of when human life begins?
    b. Resolve questions of whether and to what extent state protections on human life should extend to unborn life?
    c. Resolve questions of how the people of individual states should determine democratically their own protections on unborn life?

---

[1] According to the Guttmacher Institute, approximately 1,037,000 abortions occurred in the formal healthcare system in 2023. *Despite Bans, Number of Abortions in the United States Increased in 2023*, GUTTMACHER INSTITUTE (May 10, 2024), https://www.guttmacher.org/2024/03/despite-bans-number-abortions-united-states-increased-2023. The CDC estimates that, as of 2019, roughly 1% of abortions are performed after viability (i.e., when a child can often survive if separated from his or her mother). *Abortion Surveillance – United States, 2019*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Nov. 26, 2021), https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm#T11_down. This suggests that roughly 10,000 late-term abortions are occurring each year.

d. Resolve questions of whether the proper subject of lawmaking is at the federal or state government level?

"We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." – Justice Harry Blackmun[iii]

As a physician, my role is to counsel on safety, prognosis, and health impacts of pregnancy. It is not my role to come up with answers to complex philosophical questions for my patients. Similarly, it is not the role of legislators to impose their own conclusions to these deeply personal matters upon their constituents. Medicine and law, instead, bear the responsibility of safeguarding each individual's right to make informed and thoughtful decisions concerning their body and reproductive future. Medical expertise should inform policy decisions to ensure they are grounded in scientific understanding.

3. Eloisa Lopez, Executive Director of Pro Choice Arizona and the Arizona Abortion Fund, testified as a witness in a recent Senate Judiciary Committee field hearing in Arizona on abortion restrictions post-*Dobbs*. She stated that "I have had four abortions; neither of them was due to sexual assault or an emergent medical threat. I simply did not want to be pregnant in that moment and time."[2]
    a. Do you agree that this is a valid justification for an abortion?
    b. What about during the third trimester?

The right to make decisions about one's own body is a fundamental human right. I believe that not wanting to be pregnant is valid justification for abortion. Neither doctors nor politicians should be in the business of policing the reasons behind someone's choice to have an abortion. Moreover, it is both inflammatory and inaccurate to imply that many patients suddenly decide in the third trimester that they no longer wish to be pregnant. When third-trimester abortions do occur, they are often under heartbreaking circumstances, such as the discovery of severe fetal anomalies or significant health risks to the mother.[i]

4. In your opinion, what if any restrictions should a federal or state government be allowed to impose on abortions after the beginning of fetal viability?

"The decision [Roe v. Wade] vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician." – Justice Harry Blackmun[iii]

Federal and state governments should defer to the training and expertise of reproductive health professionals when it comes to providing options counseling – including abortion – throughout the various stages of pregnancy. Each pregnancy is unique, as is the lived experience of every

---

[2] Eloisa Lopez, Responses to Sen. Lindsey O. Graham Questions for the Record, SENATE JUDICIARY COMMITTEE, *available at* https://www.judiciary.senate.gov/imo/media/doc/2024-06-25_-_qfr_responses_-_lopez.pdf.

pregnant individual. Furthermore, fetal viability does not occur at a fixed point in gestation and can vary based on medical circumstances and available technology. No state or national law could feasibly account for the countless combinations of maternal pre-existing conditions, social circumstances, and pregnancy complications to determine an appropriate gestational age for restricting abortion. A "one-size-fits all" approach creates rigid legal restrictions which harm patients in complex medical situations.

5. Michael Stokes Paulsen has noted, "Trait-selection bans throw down a gauntlet: Does the Constitution really confer a right to abortion when the sole reason is the race, or sex, or disability of the unborn human child? Is there a constitutional right to kill a living human fetus *because* he or she is a child of color, because he or she has Down syndrome, or because (in a perverse reversal of a traditional expression of joy) 'it's a girl!'?"[3]
    a. In your opinion, should federal or state governments be permitted to restrict abortions that are conducted because the baby is a particular sex?
    b. In your opinion, should federal or state governments be permitted to place restrictions on abortions that are conducted because the baby is a particular race?
    c. Dr. Warren Hern's research further shows that of second- and third-trimester abortions performed because the baby had an abnormality, abortions because the baby had Down Syndrome composed the largest group. In your opinion, should federal or state governments be permitted to place any restrictions on abortions that are conducted because the baby has a non-life threatening disability, such as Down's Syndrome?

Sex selective and race selective abortions are uncommon in the United States and there is no data to suggest that this should be a concern. Furthermore, it is essential to recognize that these questions are deeply rooted in harmful stereotypes. For instance, the racist notion that Asian Americans are more likely to engage in sex-selective abortion, or the assumption that certain groups, such as African Americans and Latinos, are more inclined to terminate a pregnancy based on the race of the fetus.[iv] These stereotypes unjustly portray marginalized communities in a negative light, implying they are less capable of making ethical decisions or are more prone to practices like sex-selective abortion.

The decision to continue or end a pregnancy, especially when a disability is diagnosed, is deeply personal and complex, involving considerations like the parents' emotional, financial, and social resources, as well as the potential quality of life for the child. Since each family's situation is unique, government restrictions would oversimplify and undermine these nuanced decisions, failing to respect the diverse values individuals hold about disability, life, and parenting.

As a physician, my role is not to police the reasons behind a patient's decision to have an abortion. While I can understand the theoretical concerns behind these bans, I believe they are misguided, unnecessary, and harmful.

---

[3] Michael Stokes Paulsen, *Abortion as an Instrument of Eugenics*, HARVARD LAW REVIEW, Vol. 134, Issue 7 (May 2021), *available at* https://harvardlawreview.org/forum/vol-134/abortion-as-an-instrument-of-eugenics/.

6. In your opinion, should doctors with conscientious objections to abortion be permitted to refuse to provide abortion procedures to patients?
    a. The Accreditation Council for Graduate Medical Education (ACGME) requires that "Residents who have a religious or moral objection may opt out and must not be required to participate in training in or performing induced abortions."[4] Do you agree that the ACGME should provide this exception?

If a doctor conscientiously objects to abortion, they should have the freedom to decline performing a procedure they find morally distressing. However, it is incumbent upon these physicians to provide their patients with information about alternate providers or clinics where abortion services can be obtained. It is imperative that conscientious objection does not translate into an insurmountable barrier to accessing a legitimate medical procedure, thereby forcing patients into reproductive outcomes they neither desire nor choose. Furthermore, while I support the ACGME exception, it's important that all OB/GYN residents receive comprehensive training in managing pregnancy complications, which often involves the same skills used in abortion care.

7. In your opinion, should federal tax dollars be permitted to be used to fund abortions or abortion providers, for instance, through the Medicaid program?

Leading medical organizations in this country including the American Medical Association and the American College of Obstetrics & Gynecology unambiguously state that abortion is essential healthcare.[v,vi] Patients who rely on Medicaid for their health insurance should have the same access to healthcare as anyone else. Restrictions on federal funding disproportionately affect low-income patients, leading to delayed care and worse health outcomes.

8. Mifepristone is a drug that is used for abortion during the early weeks of pregnancy, along with another drug called misoprostol.
    a. In your opinion, should mifepristone, misoprostol, or other abortion-inducing drugs be available to patients without a medical professional's prescription?

The FDA has determined that "mifepristone must be dispensed by or under the supervision of a certified prescriber or by certified pharmacies for prescriptions issued by certified prescribers… mifepristone may be dispensed in-person or by mail."[vii] Mifepristone and misoprostol have excellent safety profiles when used under medical supervision. Professional guidance is necessary to screen patients for eligbility, ensure proper usage, and to provide follow up care. To increase access to these medications in a safe manner, expanding prescribing rights to nurse practitioners and pharmacists and offering telemedicine visits will be essential.

9. Please answer the following questions with a Yes or No response, without divulging patient-specific information:

---

[4] ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology, IV.C.7.a).(4)(a), *available at* https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_2023.pdf (last accessed July 30, 2024).

a. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients for the purpose of inducing an abortion?
b. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients that you not have not met with personally, but rather only:
    i. By email?
    ii. By phone call?
    iii. By virtual meeting, e.g., Microsoft Teams or Zoom?
    iv. On the basis of a patient's answers to an online informational form?
c. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients for use in states where the drug is regulated or banned?
d. Many women seeking abortion do so as a result of coercion, including from sex traffickers. In your opinion, should a doctor be allowed to remotely prescribe these drugs, without a patient visit in-person, to patients in jurisdictions where the drug is regulated or banned?
e. "Abortion-pill reversal" is a procedure that involves the administration of progesterone to a pregnant women who has taken mifepristone but not misoprostol. Have you ever presented abortion-pill reversal as an option to any of your patients as a component of informed consent, shared decision-making and respect for patient autonomy?

As a first year resident physician, I have not yet prescribed medication abortion.

Conflating reproductive access and sex trafficking is dangerous and jeopardizes the health, safety, and wellbeing of survivors. Furthermore, using telehealth services to prescribe medication abortion is effective and safe with 99.8% of patients not having any serious adverse effects.[viii]

I have not presented "abortion pill reversal" to my patients because it is not supported by science nor is it recognized by practicing physicians. It has only been suggested by a handful of small, poor-quality studies lacking approval from an Institutional Review Board thereby raising serious concerns regarding ethics and validity.[ix]

10. When answering questions during the hearing, Dr. Suchitra Chandrasekaran stated "in a field like OB . . . you're dealing with two basically living organisms working kind of symbiotically with each other." Do you agree with this description of obstetrics?
    a. Stedman's Medical Dictionary defines "symbiosis" as, among other things, "[t]he mutual cooperation or interdependence of two people, such as mother and infant . . . ." Do you agree with that definition?
    b. Stedman's Medical Dictionary further defines "organism" as "any living individual, whether plant or animal, considered as a whole." Do you agree with that definition?
    c. Do you agree that a pregnancy (the subject of obstetrics) involves a mutual interdependence of two living individual people, i.e., a mother and child?
    d. How do you account for the interests of the child when making decisions regarding abortion?

No, I would not agree that pregnancy involves a "mutual interdependence" of two living individuals. The relationship is not equal, as the fetus is entirely dependent on the pregnant woman, who bears the full physical and emotional burden of pregnancy. Furthermore, defining the fetus as an organism does not automatically confer personhood or rights equal to those of the pregnant woman.

The pregnant woman has autonomy and agency, and her well-being, health, and life circumstances must be considered paramount in any decisions related to pregnancy. The pregnant woman has the right to make decisions about her own body and future, including whether or not to continue a pregnancy.

11. Former president of Planned Parenthood, Alan Guttmacher has written, "A facet that makes the obstetrician's burden unique in the whole field of medicine is his double obligation; he simultaneously cares for two patients, the mother and the infant."[5]
    a. Do you agree with that statement?
    b. How does this inform your approach to abortion?

I believe that an obstetrician's primary duty is to the pregnant individual, their health, and their desires for their reproductive future. In pregnancies that are continued, we do consider fetal well-being alongside maternal health. However, the pregnant person's autonomy and health always remain the primary concern.

12. In your testimony, you used the term "evidence-based" to refer to abortion, but states that collect data on the reason women undergo abortion report that more than 95% of abortions are performed in healthy mothers with healthy babies. There is therefore no medical reason or indication for abortion in these women, and no evidence whatsoever that such an abortion provides any therapeutic benefit. In addition, the abortion kills a human being.
    i. Given these facts, do you agree that abortion performed in healthy mothers with healthy babies is "evidence-based"?

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." - International Conference on Population and Development, 1994[x]

The term "healthy" in this context oversimplifies the complex physical, mental, and social factors that influence reproductive decisions. Pregnancy is not a benign condition; it imposes significant physical risks to the pregnant patient. A pregnant woman is 14 times more likely to die from childbirth than from an abortion.[xi] Furthermore, the Turnaway Study demonstrated that women denied abortions experience harm. These women are more likely to fall into or

---

[5] Alan Guttmacher, *Pregnancy and Birth: A Book for Expectant Parents*, New American Library; Revised Edition (January 1, 1962).

remain in poverty, stay in abusive relationships, develop health complications, or experience worse mental health outcomes.[xii] Evidence-based medicine involves considering all aspects of a patient's health and circumstances, not just the absence of physical disease.

[i] Gomez I, Salganicoff A, Published LS. Abortions Later in Pregnancy in a Post-Dobbs Era. KFF. February 21, 2024. Accessed August 14, 2024. https://www.kff.org/womens-health-policy/issue-brief/abortions-later-in-pregnancy-in-a-post-dobbs-era/

[ii] Foster DG, Kimport K. Who Seeks Abortions at or After 20 Weeks? *Perspectives on Sexual and Reproductive Health*. 2013;45(4):210-218. doi:10.1363/4521013

[iii] Roe v. Wade, 410 U.S. 113 (1973). Justia Law. Accessed August 14, 2024. https://supreme.justia.com/cases/federal/us/410/113/

[iv] Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly | Guttmacher Institute. March 14, 2016. Accessed August 13, 2024. https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly

[v] Abortion Policy. Accessed August 11, 2024. https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy

[vi] Reproductive Health. American Medical Association. August 30, 2024. Accessed August 10, 2024. https://www.ama-assn.org/topics/reproductive-health

[vii] Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation. *FDA*. Published online March 24, 2023. Accessed August 9, 2024. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation

[viii] Upadhyay UD, Koenig LR, Meckstroth K, Ko J, Valladares ES, Biggs MA. Effectiveness and safety of telehealth medication abortion in the USA. *Nat Med*. 2024;30(4):1191-1198. doi:10.1038/s41591-024-02834-w

[ix] Medication Abortion Reversal Is Not Supported by Science. Accessed August 13, 2024. https://www.acog.org/advocacy/facts-are-important/medication-abortion-reversal-is-not-supported-by-science

[x] Health NRC (US) P on R, Tsui AO, Wasserheit JN, Haaga JG. Introduction. In: *Reproductive Health in Developing Countries: Expanding Dimensions, Building Solutions*. National Academies Press (US); 1997. Accessed August 14, 2024. https://www.ncbi.nlm.nih.gov/books/NBK233276/

[xi] Raymond EG, Grimes DA. The Comparative Safety of Legal Induced Abortion and Childbirth in the United States. *Obstetrics & Gynecology*. 2012;119(2 Part 1):215. doi:10.1097/AOG.0b013e31823fe923

[xii] UCSF Turnaway Study Shows Impact of Abortion Access on Well-Being | UC San Francisco. June 30, 2022. Accessed August 13, 2024. https://www.ucsf.edu/news/2022/06/423161/ucsf-turnaway-study-shows-impact-abortion-access

Testimony of Nisha Verma, MD, MPH FACOG
Fellow, The American College of Obstetricians and Gynecologists

Good morning Senator Ossoff. My name is Dr. Nisha Verma, and I am a board-certified, fellowship trained, obstetrician and gynecologist providing full-spectrum reproductive health care. I am a fellow with the American College of Obstetricians and Gynecologists, a non-partisan, evidence-based professional organization representing over 60,000 OBGYNs. 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 pregnant moms with worsening medical conditions 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 how abortion restrictions impact real people.

Shortly after Georgia's six-week abortion ban went into effect in 2022, I saw a high-schooler that I'll call "V" who realized after missing her period that she might be pregnant. When she came to see me, she unfortunately was just a couple days past Georgia's arbitrary cut-off, which bans most abortions after just two 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. Unfortunately, "V" was unable to find the resources and support to leave Georgia for abortion care. Because of workforce shortages in rural Georgia, where she lives, she also couldn't find a doctor in her part of the state that could care for her for many months. So, even though "V" was forced to continue her pregnancy against her will, she couldn't access the prenatal care she needed to keep herself and her pregnancy healthy.

After delivering her baby, "V" 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.

"V's" story, while heartbreaking, is not unique. Over the past couple years, I have conducted a grant-funded study to learn about the experiences of patients with high-risk pregnancies in Georgia who are attempting to access abortion care. Through this work, I have heard women describe again and again how Georgia's abortion restrictions exacerbate their suffering in already devastating situations, and leave them feeling betrayed by a government and health care system that is supposed to serve and protect them.

One participant, "M," described breaking her water at 17 weeks, when there was no chance of her baby ever developing lungs that would allow it to live outside of her. She went to the hospital but was told her doctors couldn't help her until she started bleeding or developed an infection. "M" told me that "to be denied the basic medical care I needed, to be told that I must first be at risk of dying, to be forced to relive losing my baby every day for 5 days because of Georgia's law, the trauma of that on top of my loss is devastating."

Another participant, "A," discussed how Georgia's six-week ban "rushed" her into making a decision, instead of allowing her the time to get genetic testing on her pregnancy. She shared that her older son was diagnosed with a rare genetic condition that destroyed his lungs when he was just a few years old. Now, instead of starting middle school with his peers, he is admitted to the hospital ICU and doctors have told "A" he likely has less than a year to live. "A" described the pain of seeing her son suffer, and when she found herself pregnant again, she knew that she could not have another child affected by the same genetic condition. However, because this condition does not qualify for abortion care under Georgia's very narrow exceptions and "A" could not risk leaving her son in the ICU to travel out-of-state later in pregnancy, she made the decision to get an abortion prior to Georgia's six-week cut-off, before testing on the pregnancy was possible.

It is clear that women who need medical care, including those with high-risk pregnacies, are suffering because of Georgia's abortion restrictions. We also know that these abortion restrictions are not based in data or science – 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.

To make matters worse, doctors, overwhelmed by laws that threaten to make us criminals for providing evidence-based, life-saving care to our patients, are leaving their states. In Georgia, where already over 50% of counties have no OB/GYNs, where we have one of the highest maternal mortality rates in the country, and where women like my patient "V" struggle to access prenatal care, 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 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 urge legislators to listen to the stories of people who provide and access abortion care. I hope these stories help show how profoundly restrictions on abortion access harm all of our communities.

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

Senator Lindsey O. Graham
Questions for the Record
"Health Impacts of Abortion Ban on Georgia Women"
July 23, 2024

Questions for Dr. Nisha Verma

Senator Graham,

The below is in response to questions 1-13, shared with me following my testimony delivered during the July 23, 2024 hearing titled "Health Impacts of Abortion Ban on Georgia Women."

First, I want to acknowledge how complicated abortion care can feel for many people – doctors, patients, politicians, and other members of the public. I decided to provide abortion care as part of my medical practice knowing that abortion, for many people, can be complicated. Every time I turn on the news, I am struck by how simplistic and polarized the arguments our politicians make about abortion can be, compared to the reality of abortion care in the lives of the people and families I care for each day.

Often, when I sit and talk with real people and their loved ones making important, careful decisions about their pregnancies, the full weight of abortion's complexity hits me. Take, for example, the young woman I cared for who found out she was 14 weeks pregnant after being diagnosed with a rare, aggressive cancer. To have even a small chance of survival, she needed to start a chemotherapy regimen right away that would be toxic to her growing pregnancy.

Or consider the patient who cried with her husband in the ultrasound suite after I confirmed her water had broken at 16 weeks, and that her baby would never be able to develop lungs that would allow it to live outside of her.

Think about the mother of twin boys I saw in my clinic whose last delivery had been complicated by a dangerous pregnancy-related heart condition. Despite using her birth control correctly, she found herself 8 weeks pregnant, knowing that her chance of developing a more severe form of her heart condition with another pregnancy was too high to risk not being around for her sons.

All these people and their families made careful, conscious, informed decisions about the course of their lives. These decisions, while sometimes hard, were shaped by their unique life and health circumstances and their commitments to those that they loved. At the same time, they grieved for the loss of the potential they were carrying. As the doctor they had trusted to provide their abortion care, I respected the difficult decisions they had to make while also grieving that loss with them.

I recognize that, for many, it can be hard to exist in this "in-between" space – acknowledging both that abortion ends a potential and allows an individual to determine the course of her own life. It can be uncomfortable to hold both truths together, and so we often choose only one. But as an OB-GYN providing both labor and delivery and abortion care, I know this "in-between"

space is so much more real. It is a space where we can acknowledge the complexities of abortion without reducing it to a polarized debate and can understand the decisions people make as they try to shape their lives.

Senator Graham, you asked about my credentials to be able to provide this type of care to my patients. As a board-certified, fellowship trained OB-GYN who provides full-spectrum reproductive healthcare (everything from pap smears to gynecological surgery to delivering babies and to providing contraceptive and abortion care), I have trained for many, many years to work with patients and their families to create evidence-based care plans centered on their needs. I have had patients with incredibly high-risk pregnancies who have chosen to continue those pregnancies, and have done everything in my power to maximize the health of my patient and their pregnancy. I have also had patients who have decided that the risk of continuing such a pregnancy that threatens their heath or life is too high – they, for example, have families and other children to consider. I support these patients and their families in accessing the abortion care they need. Sometimes, my patients make decisions that are different from what I would choose – however, my job as their doctor is to center their needs and values in the evidence-based care I provide, not my own.

Senator Graham, you also ask about viability and abortion care later in pregnancy. As a doctor, I can tell you that viability varies from patient to patient and pregnancy to pregnancy. Fetal viability depends on many complex factors, of which gestational age is only one. While gestational age may be helpful in predicting the possible chance that the fetus would survive at time of delivery, many other factors also influence viability, such as sex, genetics, weight, circumstances around delivery, and availability of a neonatal intensivist health care professional. In addition, some pregnancies will never be viable. For all patients that may deliver in the periviable period, we work closely with them and their families to create the best individual care plan. These conversations may include our neonatal intensivist team, as well as other specialists. We review the familes' goals, such as optimizing survivial and minimizing suffering. We review particular factors of that pregnancy, such as fetal weight, anomalies, and chronic medical conditions. We discuss predicted outcomes, including survival and what long-term life may look like for that baby. Together with the family, we create a care plan that may include abortion, comfort care, or full resuscitation.

When we talk about abortion care later in pregnancy, it is important to remember that 90% of abortions occur in the first trimester, and less than 1% occur after 20 weeks. I can tell you, as a doctor providing both obstetric and abortion care, that when patients present for abortion care later in pregnancy, in the vast majority of cases, something has gone terribly wrong with the patient or the pregnancy. For example, I remember a patient I cared for who was so exicted to meet her baby. She and her husband had picked out a name, painted their nursery, and celebrated their baby shower. Then, on a routine ultrasound, they received the devastating news that their baby had developed a terrible condition called fetal hydrops and would not survive to birth. I counseled them about all their options, including continuing the pregnancy to term, induction of labor now, and a dilation and evacuation procedure. My patient and her husband decided that having to go through labor and vaginally deliver a baby that would not survive would only

worsen their already tremendous suffering, as would having to continue the pregnancy for many more weeks just to lose their baby. They decided to proceed with a dilation and evaluation procedure, which I provided for them with compassion and respect. I made a memory box for them with a baby blanket and footprints, and per their request, had our hospital chaplain come and do a blessing for them and the baby that they loved so deeply. This is what abortion care later in pregnancy actually looks like. In fact, misinformation about abortion care later in pregnancy and abortion care more generally is dangerous for our patients and for doctors. It contributes to stigma and confusion for my patients, who deserve accurate information about their health and lives, and also contributes to harassement and violence against doctors.

Another situation you ask about is the use of federal funding for patients that need abortion care. I can tell you that it is truly devastating that my patients who have Medicaid or are in the United States Armed Forces do not have the same access to healthcare as many patients with private insurance. Not too long ago, I took care of a young couple who were thrilled to expand their family and have a baby. Unfortunately, their pregnancy was diagnosed with a chromosomal anomaly that is incompatible with life. Together, they made the difficult decision to terminate the pregnancy. However, when they came to see me, they had no idea that their federal insurance did not cover abortion care, even in this situation. The husband told me how betrayed he felt that he risks his life to serve our country, but cannot even get the healthcare coverage he and his wife need from the federal government. This is not an uncommon situation – I see patients who need abortion care for many different reasons, but struggle to access that care because they rely on the federal government for their health insurance.

I understand that, just like abortion care can be complicated for some of our patients and members of the public, it can also be complicated for doctors. I respect the ability of doctors to opt out of providing certain medical care due to their personal beliefs, consistent with the guidance of our governing medical bodies. We as healthcare providers do have an ethical obligation to present our patients with accurate medical information and share all options with them, and refer them to care if we are unable to provide that care ourselves. As doctors, we are required to provide life-saving care for a patient that presents to us in an emergency. I also want to be clear, just as some doctors may choose not to provide abortion care based on their deeply held values, I choose to provide abortion care based on my conscience and sense of duty to my patients – that also should be protected.

You ask questions about the safety of abortion care generally and abortion care provided via telemedicine. Abortion is incredibly safe – study after study affirms the safety of abortion. Major complication rates (blood transfusion, surgery, hospital admission) are significantly less than 1%, similar or less than other medical procedures, and significantly less than childbirth. Data also demonstrate that abortion care is just as safe and effective when provided through telehealth. As stated in my testimony, the American College of Obstetricians and Gynecologists (ACOG), along with over 75 other major medical societies, identify abortion as an incredibly safe, essential health care service that requires timely access to care. ACOG and these other major medical societies, which include the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Board of

Anesthesiology, the American Board of Surgery, and the American College of Preventive Medicine, explicitly recommend the repeal of legislation that imposes barriers to access and interferes with the patient-clinician relationship, including abortion bans and other restrictions. Clearly, the overwhelming consensus in the medical community is that abortion is safe, essential healthcare. In addition, the American Board of Obstetrics and Gynecology, which is the national body that certifies all OB-GYNs in the country, has established that abortion is safe, essential healthcare, and has actually stated very clearly that spreading misinformation about abortion is medical unprofessionalism.

One area where we often hear misinformation, as you bring up in your questions, is the idea of medication abortion "reversal," which describes a medically unproven protocol in which a high dose of progesterone is given after mifepristone has been taken. The scienfitic community actually did pursue research to look into abortion "reversal" to see if this is a treatment we can offer our patients. Members of our scientific community conducted a randomized controlled trial that had to be stopped because people were having heavy, dangerous levels of bleeding. If there was a safe possibility to reverse an abortion and I had a patient who desired this, I would be happy to provide it, but the data indicate that this regimen is potentially unsafe and is ineffective. ACOG, which publishes practice guidelines for OB-GYN care including abortion, does not recommend the practice, stating that "claims of medication abortion reversal are not supported by the body of scientific evidence, and this approach is not recommended in ACOG's clinical guidance on medication abortion." I want to emphasize again that misinformation that promotes treatments like this, like other misinformation about abortion care and healthcare, is harmful to our patients.

As a doctor, I can tell you that people need abortions for many reasons and regardless of their identities, their religious faiths, their professions, how much money they make, how many kids they have. I do abortions for young people, for grandmothers, for doctors, for people of faith – people who never thought they would be in this situation until something unexpected happened to them. In Georgia, despite who our elected officials are and the laws they have passed, I take care of Georgians every day who know that abortion is the right decision for their health care and lives. I believe that all of these people should continue to be able to access the healthcare they need. I ask people who think about abortion care in a black and white way to look at those around them, the people they love, and to understand that we are each the experts on our lives, and are able to make these decisions with consideration and compassion.

Thank you for the opportunity to answer your questions.

1. The best social science evidence suggests that there are 10,000 abortions annually performed at the stage where the baby could live outside his or her mother's body.[1] Do you support any restrictions on purely elective abortions after viability that are not performed due to rape, incest, or to protect the life or safety of the mother?
    a. What about after 28 weeks? Do you support any restrictions on purely elective abortions after 28 weeks, when the neonatal survival rate is 98%?
    b. What about after 32 weeks? Do you support any restrictions on purely elective abortions after 32 weeks, when the neonatal survival rate is 98.1%?
    c. What about after 35 weeks? Do you support any restrictions on purely elective abortions after 35 weeks, when the neonatal survival rate is 100%?
    d. Do you support any limitations on purely elective abortion at any stage of gestation?
    e. Even assuming that the figures cited above are incorrect, would you support any limitation on a woman's right to receive an abortion after 35 weeks?

2. As a physician, what in your medical training or expertise qualifies you to:
    a. Resolve philosophical questions of when human life begins?
    b. Resolve questions of whether and to what extent state protections on human life should extend to unborn life?
    c. Resolve questions of how the people of individual states should determine democratically their own protections on unborn life?
    d. Resolve questions of whether the proper subject of lawmaking is at the federal or state government level?

3. Eloisa Lopez, Executive Director of Pro Choice Arizona and the Arizona Abortion Fund, testified as a witness in a recent Senate Judiciary Committee field hearing in Arizona on abortion restrictions post-*Dobbs*. She stated that "I have had four abortions; neither of them was due to sexual assault or an emergent medical threat. I simply did not want to be pregnant in that moment and time."[2]
    a. Do you agree that this is a valid justification for an abortion?
    b. What about during the third trimester?

4. In your opinion, what if any restrictions should a federal or state government be allowed to impose on abortions after the beginning of fetal viability?

---

[1] According to the Guttmacher Institute, approximately 1,037,000 abortions occurred in the formal healthcare system in 2023. *Despite Bans, Number of Abortions in the United States Increased in 2023*, GUTTMACHER INSTITUTE (May 10, 2024), https://www.guttmacher.org/2024/03/despite-bans-number-abortions-united-states-increased-2023. The CDC estimates that, as of 2019, roughly 1% of abortions are performed after viability (i.e., when a child can often survive if separated from his or her mother). *Abortion Surveillance – United States, 2019*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Nov. 26, 2021), https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm#T11_down. This suggests that roughly 10,000 late-term abortions are occurring each year.

[2] Eloisa Lopez, Responses to Sen. Lindsey O. Graham Questions for the Record, SENATE JUDICIARY COMMITTEE, *available at* https://www.judiciary.senate.gov/imo/media/doc/2024-06-25_-_qfr_responses_-_lopez.pdf.

5. Michael Stokes Paulsen has noted, "Trait-selection bans throw down a gauntlet: Does the Constitution really confer a right to abortion when the sole reason is the race, or sex, or disability of the unborn human child? Is there a constitutional right to kill a living human fetus *because* he or she is a child of color, because he or she has Down syndrome, or because (in a perverse reversal of a traditional expression of joy) 'it's a girl!'?"[3]
    a. In your opinion, should federal or state governments be permitted to restrict abortions that are conducted because the baby is a particular sex?
    b. In your opinion, should federal or state governments be permitted to place restrictions on abortions that are conducted because the baby is a particular race?
    c. Dr. Warren Hern's research further shows that of second- and third-trimester abortions performed because the baby had an abnormality, abortions because the baby had Down Syndrome composed the largest group. In your opinion, should federal or state governments be permitted to place any restrictions on abortions that are conducted because the baby has a non-life threatening disability, such as Down's Syndrome?

6. In your opinion, should doctors with conscientious objections to abortion be permitted to refuse to provide abortion procedures to patients?
    a. The Accreditation Council for Graduate Medical Education (ACGME) requires that "Residents who have a religious or moral objection may opt out and must not be required to participate in training in or performing induced abortions."[4] Do you agree that the ACGME should provide this exception?

7. In your opinion, should federal tax dollars be permitted to be used to fund abortions or abortion providers, for instance, through the Medicaid program?

8. Mifepristone is a drug that is used for abortion during the early weeks of pregnancy, along with another drug called misoprostol.
    a. In your opinion, should mifepristone, misoprostol, or other abortion-inducing drugs be available to patients without a medical professional's prescription?

9. Please answer the following questions with a Yes or No response, without divulging patient-specific information:

---

[3] Michael Stokes Paulsen, *Abortion as an Instrument of Eugenics*, HARVARD LAW REVIEW, Vol. 134, Issue 7 (May 2021), *available at* https://harvardlawreview.org/forum/vol-134/abortion-as-an-instrument-of-eugenics/.
[4] ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology, IV.C.7.a).(4)(a), *available at* https://www.acgme.org/globalassets/pfassets/programrequirements/220_obstetricsandgynecology_2023.pdf (last accessed July 30, 2024).

a. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients for the purpose of inducing an abortion?
b. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients that you not have not met with personally, but rather only:
    i. By email?
    ii. By phone call?
    iii. By virtual meeting, e.g., Microsoft Teams or Zoom?
    iv. On the basis of a patient's answers to an online informational form?
c. Have you ever prescribed mifepristone, misoprostol, or other abortion-inducing drugs to patients for use in states where the drug is regulated or banned?
d. Many women seeking abortion do so as a result of coercion, including from sex traffickers. In your opinion, should a doctor be allowed to remotely prescribe these drugs, without a patient visit in-person, to patients in jurisdictions where the drug is regulated or banned?
e. "Abortion-pill reversal" is a procedure that involves the administration of progesterone to a pregnant women who has taken mifepristone but not misoprostol. Have you ever presented abortion-pill reversal as an option to any of your patients as a component of informed consent, shared decision-making and respect for patient autonomy?

10. When answering questions during the hearing, Dr. Suchitra Chandrasekaran stated "in a field like OB . . . you're dealing with two basically living organisms working kind of symbiotically with each other." Do you agree with this description of obstetrics?
    a. Stedman's Medical Dictionary defines "symbiosis" as, among other things, "[t]he mutual cooperation or interdependence of two people, such as mother and infant . . . ." Do you agree with that definition?
    b. Stedman's Medical Dictionary further defines "organism" as "any living individual, whether plant or animal, considered as a whole." Do you agree with that definition?
    c. Do you agree that a pregnancy (the subject of obstetrics) involves a mutual interdependence of two living individual people, i.e., a mother and child?
    d. How do you account for the interests of the child when making decisions regarding abortion?

11. Former president of Planned Parenthood, Alan Guttmacher has written, "A facet that makes the obstetrician's burden unique in the whole field of medicine is his double obligation; he simultaneously cares for two patients, the mother and the infant."[5]
    a. Do you agree with that statement?
    b. How does this inform your approach to abortion?

---

[5] Alan Guttmacher, *Pregnancy and Birth: A Book for Expectant Parents*, New American Library, Revised Edition (January 1, 1962).

12. In your testimony, you used the term "evidence-based" to refer to abortion, but states that collect data on the reason women undergo abortion report that more than 95% of abortions are performed in healthy mothers with healthy babies. There is therefore no medical reason or indication for abortion in these women, and no evidence whatsoever that such an abortion provides any therapeutic benefit. In addition, the abortion kills a human being.
    i. Given these facts, do you agree that abortion performed in healthy mothers with healthy babies is "evidence-based"?

13. You further testified that your patients experience a "sense of betrayal" regarding Georgia's abortion restrictions. Voters in states enacting abortion restrictions have elected their lawmakers, who implemented those restrictions, so lawmakers in those states have not acted independently of the will of the people. Is it your opinion that this "sense of betrayal" should override the will of the voters in these states?