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REPRODUCTIVE CARE IN A POST-ROE AMERICA: BARRIERS, CHALLENGES, AND THREATS TO WOMEN'S HEALTH

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING REPRODUCTIVE CARE IN A POST-ROE AMERICA, FOCUSING ON BARRIERS, CHALLENGES, AND THREATS TO WOMEN'S HEALTH

JULY 13, 2022

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STATEMENTS

WEDNESDAY, JULY 13, 2022

REPRODUCTIVE CARE IN A POST-ROE AMERICA: BARRIERS, CHALLENGES, AND THREATS TO WOMEN'S HEALTH

Wednesday, July 13, 2022

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

The Committee met, pursuant to notice, at 10 a.m., in room 216, Hart Senate Office Building, Hon. Patty Murray, Chair of the Committee, presiding.

Present: Senators Murray [presiding], Casey, Baldwin, Murphy, Kaine, Hassan, Smith, Rosen, Hickenlooper, Cassidy, Murkowski, Braun Marshall, and Tuberville.

OPENING STATEMENT OF SENATOR MURRAY

The CHAIR. Good morning. The Senate Health, Education, Labor, and Pensions Committee will please come to order. Today we are having a hearing on reproductive care in America following the Supreme Court's devastating decision in *Dobbs* to overturn *Roe v. Wade*. I will have an opening statement followed by Senator Marshall. We will then introduce our witnesses.

After the witnesses give their testimony, Senators will each have 5 minutes for a round of questions. And while we are unable to have the hearing fully open to the public or media for in-person attendance, live video is available on our Committee website at *help.senate.gov*.

The live stream will include closed captioning. If you are in need of other accommodations, please reach out to the Committee or to the Office of Congressional Accessibility Services. Three weeks ago, the Supreme Court and the Republicans who dedicated years to swinging the court aggressively to the right, dragged our Country back 50 years. They overturned *Roe v. Wade* ended the right to abortion and upended the lives of millions of people.

The consequences have been harsh and swift. Women sobbed in clinics as they had their abortions canceled. Their personal health care decisions overruled, their futures thrown in jeopardy, and their control over their own bodies taken away. It was heartbreaking, terrifying, enraging, and barbaric.

That was just day one. Since then, the devastating repercussions of Republicans' cruelty continue to crash around us women unable to get abortions for any reason, healthcare providers unable to do

their jobs without risking prison, patients with lupus, cancer, arthritis, and more denied the medications that they need, complete uncertainty for people planning their futures as access to Plan B and IVF have been thrown into jeopardy, and Republicans' response to this devastation is to discuss how they can push even further, be even harsher, take even more power away from patients, and scare even more doctors out of their jobs.

Some Republicans are talking about a Federal ban on abortion, overruling laws in states like my home state of Washington and ripping away rights from my constituents. Republicans are talking about criminal penalties for women and healthcare providers and about making traveling to get an abortion illegal.

They are talking about everything except the actual harm they are causing. This is a health care crisis that was entirely unavoidable—or was entirely avoidable and is entirely their own creation. I have been warning for years about Republicans' attacks on reproductive rights putting lives at risk, and I am far from the only one. Women, providers, and patients across the country have all been shouting from the rooftops that overturning *Roe* would be devastating.

But Republicans refused to listen to me or to the majority of people across the country who wanted *Roe* to stand, who wanted to keep their rights and preserve women's ability to control their own bodies. Republicans are still continuing to spread disinformation about the reality that we are now facing and about the consequences of this backward agenda.

When the leaked decision came out, Republicans tried to say they weren't going to put women and doctors in jail, even as state Legislatures across the country were already moving to do just that. And they are still trying to say it won't be that bad, even when it is clearly devastating for women across the country who they are ignoring and depressing.

Well, today we are going to hear exactly what this cruelty means for women seeking abortions. Women, Republicans will force to stay pregnant when they do not want to be. Women whose bodies Republicans are taking control of without their consent and against their wishes. And this isn't just about whether people want to be parents, though let me be perfectly clear, we must do way more than Republicans have ever dreamed of doing to actually support parents, childcare, paid leave, you name it.

Republicans have blocked Democrats nonstop efforts to deliver for working families. But anyone who has given birth also knows this isn't just about whether you are ready to raise a child, pregnancy is a life changing medical procedure. It takes a physical toll. It takes a mental toll. And for too many women in our Country, it takes their life. No one should be forced to go through this against their will.

But Republicans are going to force women to stay pregnant not only when they don't want to be, but even when it could kill them. Just ask Elizabeth, who I spoke with last week in Spokane. She has been pregnant four times. All planned, all wanted. But twice she learned her pregnancy would be fatal if it was not ended. In

the first instance, she got the heartbreaking news that one of the twins that she was carrying had died.

The other could not possibly survive outside the womb, and that her life was now in grave danger. In the second instance, she was told that without immediate action, she would lose too much blood to survive the night.

As she told me and I quote, "had I lived in a state without access to safe and legal abortion, I would have died bleeding out on the side of the road, trying to make it to a state that would help me." Those are the stakes. And not just for Elizabeth, but for many patients. About 1 in 50 pregnancies in our Country are ectopic. That means they are not viable, and without medical action, they are deadly.

But in Republicans' post *Roe* world, health care providers aren't sure when or even if they will be able to treat ectopic patients without being sent to prison. Some have already been instructed to observe patients until they have unstable, vital signs before acting. Basically sit on your hands until women are at dire risk before you can do what is medically necessary. That is absolutely barbaric, and it is a policy choice that Republicans have made.

Now, some may try to suggest that patients go to another state, but if you are in the middle of a medical emergency that is dangerous or—that is dangerous or impossible. Not to mention that some Republicans are already talking about banning interstate travel. And we cannot lose sight of the fact that some—that the same patients and providers that are hurt by these restrictions are on the front lines of our Nation's maternal mortality crisis.

We have the worst maternal death rate in the developed world. And in the very states where it is the most dangerous to give birth, Republican legislators are now forcing people to give birth against their will. It doesn't take an expert to understand this is only going to get worse because of the dangerous abortion bans.

Women will be denied the care they need, the care their doctors know could save their lives. states will lose maternal health care providers who understandably don't want to live where they could be jailed for doing their job. This will be especially hard on people in rural areas, on women of color, and on women with disabilities who already have a particularly difficult time finding a provider who takes their concerns seriously and understands their health care needs.

It can be even harder still for transgender patients seeking reproductive care while facing stigma, discrimination, and bigotry. And make no mistake, this isn't just going to devastate patients in states with abortion bans. First off, I want to be very clear, Republicans have been explicit. They want to go further.

They want to pass legislation to go after people who help patients travel for an abortion, and a national abortion ban that would trample the rights of patients in Washington State. And second, even now, health clinics are being overwhelmed. I was in Spokane last week only miles from the Idaho border, and providers there are already seeing an uptick of patients and preparing for a

huge surge of patients seeking care when Idaho's extreme ban goes into effect next door.

We are talking as many as five times more people seeking abortions at our clinics. They are on the front lines of a full blown health care crisis. And let's not forget, there are so many women who cannot travel to get an abortion, who don't have the time or the resources, who face barriers to accessible travel or are too young to drive themselves. There is also the very real risk that people with no other options will turn to dangerous, even deadly misinformation that is spreading on social media.

Because, as I am warned before so many times, banning abortion doesn't stop abortions. It just stops people from getting safe abortions. And it is not only women seeking abortions who are having their lives totally upended by Republicans. It is women seeking birth control. Some Republicans have discussed going after contraception next. And Justice Thomas said the Supreme Court should overturn the right to birth control. People hoping to start a family using IVF could also be under threat.

IVF providers have serious concerns about whether parents and providers could be punished if an embryo doesn't survive being thawed for implementation or for disposing unused embryos. That isn't idle worrying because Republicans in several states have already proposed extreme bills that ban abortions starting at conception and could impact IVF and some methods of birth control.

Already, pharmacies have told patients with lupus, arthritis, and other conditions they can't fill their prescriptions due to concerns the drugs would be used for an abortion. And let's be clear, those drugs, the FDA approved as safe and effective for their condition years ago. There are also cancer patients who may be unable to start chemotherapy until they can get an abortion.

Then there are people who have a miscarriage. Abortion bans could jeopardize their health and stop them from getting the care they need to end their miscarriage. And afterwards, they could still face another nightmare, being reported by someone who thinks they got an abortion. Imagine going through the heartbreak of losing your pregnancy and then being put in prison for it.

This doesn't have to be an exercise in imagination. From 2006 to 2020, over a 1,000 women in this country were investigated, detained, or arrested because of their pregnancy outcomes. That is horrific. If it is a problem, we should be trying to solve. And instead, thanks to Republicans, it is about to get dramatically worse.

That is why people across the country are so scared and so heartbroken and so angry and I am, too, because the stakes could not possibly be higher. That is why I led Senate Democrats in pushing President Biden and his Administration to do everything they can to protect access to abortion and reproductive health care.

President Biden's Executive Order on abortion last week was a good, important step, but this fight is far from over. As we continue living through a post *Roe* health care crisis, I am still urging the President to continue to fight back.

But with limited executive authority, ultimately we need more pro-choice Senators in the Senate willing to waive the filibuster so

we can protect women. If we can get that, we can codify *Roe*, as well as put in law key protections for women. It is as simple as that. We also need to hold Republicans accountable for the harsh reality they have now created. And that is why I am holding this hearing today.

It Is why later this week, we will call for unanimous consent to pass a bill to protect women who travel to another state for abortion care, to show the stark contrast between Republicans' cruel agenda and Democrats steadfast commitment to making sure women can get the reproductive health care they need. And it is why I am going to continue standing with women and lifting up patients voices.

Anyone who thinks I am going to stop, any Republican who thinks people will forget about this in a few months, you still don't get it. How do you forget being denied your prescription because of this or being denied your birth control? How do you forget having to drive across states to end a pregnancy so you can fight for your life against cancer?

How do you forget being forced to choose between saving your patient or going to jail? How do you forget your dream of starting a family through IVF becoming a legal nightmare? How do you ever in your life forget being investigated for your miscarriage or driving your 10 year old daughter across state lines after she was raped and could not get an abortion otherwise?

How little do you have to care about women to think anyone will forget the people who are killed by this, women who can't get an abortion but need one, who turn to unsafe information because they were denied access to safe medical care. People who couldn't get a prescription filled, couldn't start chemo, or died in a maternal health care desert since doctors don't want to be treated like criminals for doing their job.

People will not forget those losses. They will sit across from that empty chair every day and they will sleep next to the empty space every night. Mark my words, they will not forget. Democrats are not going to let Republicans ignore them either.

We will not let them whistling past the graveyard they have been—spent so long digging. And we will absolutely not stop fighting with everything we have got to end this chaos, save lives, and codify the right to abortion into law.

We will never stop fighting for women's rights to control their own bodies. Never.

Senator Marshall.

OPENING STATEMENT OF SENATOR MARSHALL

Senator MARSHALL. Thank you, Chair Murray. Overturning *Roe v. Wade* was a historic occasion that signals a new beginning for millions of unborn American babies. Now the future of saving lives rests with the American people and their elected officials in the states. But this work is not finished.

Family planning opportunities need to be expanded, and mothers need greater access to services that will support them and their baby throughout and after the pregnancy. I am looking forward to

informing the American public why the Supreme Court's decision is a positive development for our Country and setting the medical sector straight in the face of non-fact based, pro-abortion fearmongering.

I appreciate Ranking Member Burr for yielding me the opportunity to lead this hearing, to use my knowledge and background as an OB-GYN who delivered a baby nearly every day for 25 years, as well as held the hands of hundreds of women suffering miscarriages, ectopic pregnancies, infertility, and life threatening obstetrical complications.

Having delivered more than 5,000 babies and started and supervised multiple family planning clinics, I would like to dispel several myths that are being heaved at the public. Myth No. 1, overturning *Roe* is a Federal ban on abortion.

No, no, that is not true. Overturning *Roe*, actually sends the issue to elected state officials, allowing the citizens of each state to address a highly emotional issue via their elected officials. Nevertheless, we will hear this false battle cry multiple times this morning. Myth two, women will not have access to abortion. That is not true.

Even The New York Times reported after overturning *Roe*, abortions will decrease by only 14 percent. It is also worth noting that after Texas passed its heartbeat law, two study showed that abortions fell around 10 percent. After *Roe,* 27 states and Washington, DC. continue to be largely unaffected, while 19 states have protected limits.

The other states will most likely fall somewhere there in between. Myth three, overturning *Roe* means health care professionals and hospitals cannot treat women with miscarriages, ectopic pregnancies, or when the mom's life is endangered. These are all scare tactics preying on the emotions of people.

Listen, every state abortion law triggered by overturning *Roe* includes an exception to save the life of the mother. Treating miscarriages and ectopic pregnancies are not the same as performing abortions. In fact, no abortion law in any state in America prevents treatment for women with ectopic pregnancies and, or other life threatening conditions.

I remember my first year in residency when we were learning about ectopic pregnancy, and our motto was to never let the sun set on an ectopic pregnancy. That model will be continued throughout America.

Every pro-life physician I know of every physician that I know of, including myself, has always and will always care for these clinical conditions, and there are no laws that prevent such. This is a total fabricated myth. Myth four, I quote Members across the aisle on this myth. Overturning *Roe* is devastating to women's health. Members will imply today carrying a baby to term is more dangerous than an abortion.

Using their logic, should we abort every baby? Should we stop all childbearing? Presenting abortion as the lifesaving solution for women facing challenging pregnancies is a warped view of health care. It denies the modern medical science that can bring both

mother and baby safely through even a high risk pregnancy. Myth five, Americans don't support limits on abortion.

A recent poll from the AP and New York Center for Public Affairs Research finds while 61 percent of Americans say abortion should be legal in most or all circumstances in the first trimester of a pregnancy, 65 percent said abortions usually be illegal in the second trimester, and 80 percent said that about the third trimester.

From a June Monmouth poll, only 36 percent of Americans support abortions as always legal, while only 30 percent believe it should be legal with limitations. Myth six, many claim that the United States fell behind our international peers on abortion access. Look, only seven nations allow abortions beyond 20 weeks, including China and North Korea. The final myth I will talk about this morning. Here is the myth, Republicans want to end contraception and family planning.

Nothing could be further from the truth. In my first year in residence, if I delivered several babies that were 13—if moms were 13 years of age, I made a commitment to make sure that there was early access to prenatal care for everybody and access to contraception as well, regardless of a woman's ability to pay in any community I practiced.

That is why I set up and volunteered at prenatal and family planning clinics and residency. And that is why I oversaw three community health centers in rural Kansas and accepted all comers to our prenatal clinic. And this is why every year we fight for robust funding for community health centers and health departments. So what does obstetrical care look like after all? We dispelled many of the myths.

Women with miscarriages and ectopic pregnancies will be treated in every state without exception. Life of the mom will continue to be honored, and Plan B remains over the counter. Republicans and Democrats must work together and continue to fight for more and earlier access to prenatal care and proper nutrition, especially in rural and urban settings, as well as childcare, and attending to all the social challenges that I have seen so many times that a young, single, or married mom faces.

This is why I co-led the Preventing Maternal Deaths Acts of 2018 and more recently worked with everyone here on this Committee to pass legislation, the Maternal Health Quality Improvement Act, which was also recently signed into law. And this is why I lead annual population letters supporting vital maternal health programs at HHS and the WIC program.

While such centers as the Stanton Center, which you will soon learn about, already outnumber abortion clinics 4 to 1 in this country, we can and will do more to help such clinics. I look forward to bipartisan cooperation, to being part of the solution to maternity issues, which have all precipitated prior to this Supreme Court decision.

Finally, we recognize family planning and access to contraception will be as important as ever. As I have in the past, I will continue to support robust funding for community health centers and county

health departments like the ones I once volunteered and oversaw. Thank you, Madam Chair, and I yield back.

The CHAIR. Thank you. We will now introduce today's witnesses. Our first witness is Dr. Kristyn Brandi. Dr. Brandi is an obstetrician gynecologist who provides abortion care in New Jersey. She also serves as Board Chair for Physicians for Reproductive Health and is an Assistant Professor at Rutgers New Jersey Medical School.

In her work as a physician and researcher, Dr. Brandi has focused on reproductive decisionmaking and racism in reproductive health care. Thank you for joining us today to share your important perspective as an abortion provider and talk about how Dobbs' decision will undermine your care for your patients.

Look forward to your testimony. Our next witness today is Dr. Jamila Taylor. Dr. Taylor is the Director of Health Care Reform and Senior Fellow at the Century Foundation and an expert in reproductive rights and maternal health.

For over two decades, Dr. Taylor has worked to champion the health and rights of women of color and other marginalized communities, and ensure access to reproductive and maternal health care, including building support for insurance coverage of abortion.

She also serves on the Board of Directors for the National Quality Forum and March for Moms on the Reproductive Freedom Leadership Council Advocates Advisory Board, a state innovation exchange, and as chairwoman of the Board of Mama Toto Village, an organization focused on promoting black maternal health.

Glad you could join us today, Dr. Taylor. Look forward to hearing from you. Our next witness is Samie Detzer. She is an abortion advocate. She has been an outspoken abortion advocate for years, sharing both the story of her own experience getting an abortion when she lived in Washington State and her mother's story seeking an abortion back in the days before *Roe v. Wade*.

She knows personally how much is at stake at this moment for many people across the country. Thank you for your courage in sharing your story today, Ms. Detzer, and speaking up on behalf of many women who are outraged to have their rights taken away. I look forward to your testimony.

Senator Marshall, if you want to introduce our final witness.

Senator MARSHALL. Thank you, Chair Murray, for the opportunity to introduce Ms. Brandi Swindell from Meridian, Idaho. Ms. Swindell is the Founder and CEO of Stanton Healthcare and Stanton Public Policy Center.

Stanton Healthcare provides medical care, women's wellness care, tangible support, and hope to pregnant women, mothers, and their families. Stanton Public Policy Center is a woman's advocacy and educational group that works on issues of human rights and justice, with the goal of empowering and inspiring women.

Ms. Swindell is a nationally known speaker and advocate for human rights and has been a passionate voice for women and the unborn. Ms. Swindell, thank you for all that you do and for being with us here today. Chair Murray.

The CHAIR. Thank you. And now we will begin with our witness testimony. Again, thank you to all of you for joining us today. Dr. Brandi, you may begin with your opening statement.

STATEMENT OF KRISTYN BRANDI, M.D., M.P.H., FACOG, BOARD CHAIR, PHYSICIANS FOR REPRODUCTIVE HEALTH, NJ

Dr. BRANDI. Thank you. Good morning, Chairman Murray, Ranking Member Marshall, and the Members of this Committee. My name is Dr. Kristyn Brandi. I use she/her/a pronouns. I am a board certified OBGYN, a complex family planning specialist, and I am here on behalf of Physicians for Reproductive Health as the Board Chair.

I have been providing comprehensive reproductive health care for over a decade, including abortion care, prenatal care, gynecologic procedures, and outpatient care. I am a proud abortion provider from the State of New Jersey.

I became an abortion provider for the same reasons that I became an OB-GYN, to help historically oppressed folks access the care they need and deserve. Obstetrics care has always been stigmatized and marginalized. It is no surprise to me that the same places that have banned abortion also have the highest rates of maternal mortality.

There are many systemic and social factors that play a role in this. I remember taking care of a patient with a desired pregnancy at 17 weeks whose fetus had not developed a brain. She decided she would end her suffering and that of her potential child by having an abortion. And her decision had become so stigmatized that I remember staff not even wanting to enter her room.

I knew then that my career would be dedicated to ensuring that no patient is shamed for making the best medical decision for them and their families. By being a full spectrum OB-GYN, I could provide the best care for my patients. I am here today to make clear that abortion is essential health care.

Abortion can be necessary to save someone's life, and it is a critical part of being an OB-GYN. National medical organizations have expressed outrage at the Dobbs v. Jackson Women's Health Decision, and National Academies of Science, Engineering, and Medicine put out a comprehensive report looking at abortion outcomes and found that abortion care has one of the highest safety records in medicine.

We know that in the United States you are 14 times more likely to die in childbirth than you are to die of an abortion. And we know from the turn away study that people denied access to abortion have a higher chance of facing poverty and having worse health outcomes compared to patients that were able to access an abortion.

I am a pro-abortion doctor, and I say pro-abortion not to be antagonistic, but to point out all the good that abortion can provide for people. Without autonomy, without decisionmaking ability, without access to abortion care, many people have challenging situations that could become even more painful or life threatening.

For those that do not want to be pregnant for any reason, the ability to have an abortion gives them the freedom to decide if and when to become pregnant. For some, abortion is liberation. There is a lot of good that comes from a people's ability to access abortion, and I want to celebrate that.

I firmly believe in the tenets of reproductive justice, that all patients have the human right to be able to decide if and when to become pregnant and to parent with children in safe and sustainable communities. I cannot separate my ability to provide care as a physician from my lived experiences.

I am a cisgendered woman who could be harmed by restrictive abortion bans. I am also a Latina, a daughter of Puerto Rican and Panamanian parents. I am also a bisexual woman and deeply identify with the LGBTQ community, a community also in deep need of timely, compassionate reproductive health care.

People of low income, bipoc folk, queer folk, people with disabilities, young people, people facing incarceration or detention, and immigrants who have faced many barriers to accessing care even before *Roe* was overturned now face bigger hurdles.

I understand deeply how restrictions on abortion and outright bans impact marginalized communities because they are my community. I am greatly concerned that abortion bans will tie health professionals hands when it comes to providing evidence based care for patients.

It is heartbreaking to consider that the skills that I have, the medicines that have been proven time and again to be incredibly safe, will be barred from patients. I took an oath to care for my patients. We are supposed to bring evidence based care to our communities. It is unconscionable to enact laws that prevent health care providers from offering the standard of care.

There are many urgent health care conditions that can arise from or be exacerbated by pregnancy for which abortion is indicated. There are already reports of having to wait for a patient become sicker and sicker before intervening.

Future health care providers may not have access to training to even learn how to provide an abortion and will be ill equipped to act in complex situations. This is not how health care should work. People are being harmed without abortion access. In conclusion, this moment is truly horrifying.

I am frightened for my patients that may be criminalized for making decisions and for health professionals that are providing high quality, evidence based care. But I won't give up. I will provide care like I provided last week, again and again. It is important because I know my patients need it.

Please remember that there are countless people in each of your states that have needed and benefited from abortion. You all love someone that has had an abortion. They deserve your consideration and protection. Thank you.

[The prepared statement of Dr. Brandi follows:]

PREPARED STATEMENT OF KRISTYN BRANDI

Good morning, Chairwoman Murray, Ranking Member Burr, and distinguished Members of the Committee. My name is Dr. Kristyn Brandi I use she/her pronouns,

and I am the Board Chair of Physicians for Reproductive Health. I am a board-certified OBGYN and have received fellowship training in the subspecialty of complex family planning. I have been providing comprehensive reproductive health care for over a decade including abortion care, prenatal care, gynecologic procedures and outpatient gynecologic care. I am a proud abortion provider from the State of New Jersey.

I became an abortion provider for the same reason that I became an OBGYN—to help historically oppressed folx access the care that they need and deserve. Obstetrics care has always been stigmatized and marginalized. It is no surprise to me that the same places that have banned abortion also have the highest rates of maternal mortality, and there are many systemic and social factors that play into these rates. I remember taking care of a patient with a desired pregnancy at 17 weeks whose fetus had not developed a brain. She decided that instead of continuing that pregnancy to term she would end her pregnancy and end what she thought was her suffering and that of her potential child. Her decision had become so stigmatized that I remember the staff did not want to enter her room. We had to call in another nurse to make sure we had enough staff to take care of her. I knew then that my career would be dedicated to ensuring no patient is shunned or shamed for making the best medical decision for them and their family. I knew that by being a full spectrum OBGYN, providing abortion care and prenatal care, I could provide the best care for my patient regardless of what they needed from me.

I'm here today to make clear that abortion is essential health care Abortion can be necessary to save someone's life. It is a critical part of being a an ob-gyn. National medical organizations including the American Medical Association unanimously have expressed outrage at the *Dobbs v. Jackson Women's Health* decision. The American College of Obstetricians and Gynecologists (ACOG) said in their statement about *Dobbs* "Abortion is a safe, essential part of comprehensive health care, and just like any other safe and effective medical intervention, it must be available equitably to people, no matter their race, socioeconomic status, or where they reside...Allowing states to set individual restrictive abortion policies, including restrictions and outright bans on this essential component of medical care, results in an increase in the inequities that already plague the health care system and this country." The National Academies of Sciences, Engineering, and Medicine put out a comprehensive report in 2019 looking at abortion outcomes and found that abortion care has one the highest safety records of all procedures in medicine. We know that in the United States you are 14 times more likely to die in natural childbirth than you are to die of an abortion. And we know from the Turnaway Study from the University of California at San Francisco that people denied access to abortion have a higher chance of facing poverty and having worse health outcomes in the future compared to patients that were able to access a desired abortion.

I am a pro-abortion doctor. I say pro-abortion not to be antagonistic, but to point out all of the good that abortion can provide for people. I have taken care of many people with desired pregnancies in which their abortion was a sad event for them. But without autonomy, without decisionmaking ability, without access to abortion care, there is a chance that those situations could have been even more painful or more life-threatening. And for those that do not want to be pregnant for any reason, the ability to have an abortion gives them the freedom to decide if and when to become pregnant. To have a planned pregnancy, or not, in a time that works best for them emotionally, financially, and based on their health. Abortion is liberation for some. There is a lot of good that comes from people's ability to access abortion and I want to celebrate that.

I believe firmly in the tenets of reproductive justice—that all patients have the human right to be able to choose if and when to become pregnant and to parent children in safe and sustainable communities. I cannot separate my ability to provide care as a physician from my lived experiences. I am a cis-gender woman who could be harmed by restrictive abortion bans if I happened to live in a state different than my own. I am also a Latina—the daughter of Puerto Rican and Panamanian parents. I identify as a bisexual woman and proud member of the LGBTQ+ community—a community also in deep need of timely, compassionate reproductive health care. So, I also understand deeply how restrictions on abortion and outright abortion bans impact marginalized communities because they are my community.

People with low incomes, BIPOC (Black, Indigenous and people of color) folx, LGBTQ+ people, people with disabilities, young people, people facing incarceration/detention, and immigrants, who faced many barriers to accessing care even before *Roe* was overturned, now face even bigger hurdles. After the recent Supreme Court decision, people watched as their ability to access health care changed overnight. People were able to get care the day before the decision and the next day, depending

on their zip code, their access to abortion care was gone. My biggest fear is that these people are not going to find care and will be forced to continue their pregnancies, putting their health, well-being, and security at risk. Communities of color, particularly Black women, are already at risk of high rates of maternal mortality—withholding access to abortion care will only make this dire situation worse.

I want this Committee to understand the far-reaching ripple effects of abortion bans. I remember having a patient with a ruptured ectopic pregnancy, who was talking to me in the ER quickly as we were rushing her to the operating room for surgery. It took us only 10 minutes or so from meeting her to starting her surgery. Just before we began, her blood pressure suddenly dropped dramatically—she was dying. We rushed to complete her procedure safely, finding several liters of blood in her belly along with a ruptured fallopian tube which held her 7-week pregnancy. I am so glad she came to the hospital when she did, that we identified this ectopic pregnancy so quickly, and that we were able to intervene before it was too late. In urgent situations, medical professionals need to be able to make quick decisions about the best course of care. Those seconds can make the difference in preventing life-long impacts for a person's health or whether someone survives. We have heard people question whether bans on abortion will impact care like ectopic pregnancy management even when they shouldn't or whether bans on abortion will impact care such as in vitro fertilization (IVF). Or if miscarriage management will be allowed, which uses the same medicines and procedures as abortion care. Each pregnancy is unique and as providers we need to be able to individualize care to the person in front of us.

I am greatly concerned that bans on abortion will tie health professionals' hands when it comes to providing evidence-based, quality, safe care to patients. It is heartbreaking to consider that the skills that I have, that I can physically provide, the medicine that has been proven time and again to be incredibly safe, will be barred from patients. As a doctor, I took an oath to care for my patients. I am beholden to four tenets of medical ethics—beneficence, non-maleficence, autonomy, and justice. We are supposed to bring safe evidence-based care to our patients. It is unconscionable to enact laws that prevent health care providers from offering the standard of care. There are many reasons why people need abortions. And there are many urgent health conditions that can arise from or be exacerbated by pregnancy for which abortion is indicated. There are already reports of having to wait for a patient to become sicker before intervening. Future health care providers may not have access to training to even learn how to provide abortion care and will be ill equipped to act in complex situations. This is not how health care should work. People will be harmed when they cannot access essential abortion care.

This is truly a health care crisis on top of another health care crisis. During the COVID–19 pandemic, we saw historic losses of nurses, doctors, support staff within health care because of burnout and death from COVID–19. Bans on abortion are going to have widespread repercussions. There are already not enough health care providers. There are already not enough hospitals with labor and delivery wards. Health care providers will be wary of joining communities where they cannot provide the standard of care. For states where abortion is still available, some clinics have weeks long waiting times. In pregnancy care, delays can mean that people will not be able to get abortion care. Our health care system was already struggling, and we have now added another unjust load to bear.

This moment is horrifying. I am frightened for patients that may be criminalized for making valid decisions about their health; I am concerned for health professionals committed to providing high quality evidence-based health care; I am terrified for the people that will be forced to continue an undesired pregnancy against their will. But I will not give up. I provided care last week and I will provide care next week and I will do it again the week after that. I won't give up because I know how important it is for my patients to have the care they need, when they need it, in the community they live in. Please remember that there are countless people in each of your states that have needed and benefited from abortion. You all love someone who has had an abortion. They deserve your consideration and protection.

Thank you.

[SUMMARY STATEMENT OF KRISTYN BRANDI]

Dr. Kristyn Brandi's testimony will:

- Discuss why she provides abortion care
- Explain that abortion is essential health care

- Note the support of the medical community for abortion access
- Utilize the reproductive justice framework
- Explain the impacts of abortion bans on already marginalized communities
- Discuss the relationship between abortion bans and maternal health
- Note the impacts of abortion bans on the broader health care system
- Ask the Committee to consider and protect people seeking abortion care.

The CHAIR. Thank you. Dr. Taylor. If you want to turn on your——

Ms. TAYLOR. On now?

The CHAIR. Yes.

STATEMENT OF JAMILA TAYLOR, PH.D., M.P.A., DIRECTOR OF HEALTH CARE REFORM AND SENIOR FELLOW, THE CENTURY FOUNDATION, WASHINGTON, DC

Ms. TAYLOR. Good morning, Chairwoman Murray, Ranking Member Burr, and Members of the Committee. Thank you for the opportunity to testify today on reproductive care in a post-*Roe* America.

I am Dr. Jamila Taylor and I serve as the Director of Health Care Reform and Senior Fellow at the Century Foundation, a 100 year old progressive think tank that conducts research, develops solutions, and drives policy change to make people's lives better.

I sit here before you today deeply dismayed by the U.S. Supreme Court's decision to overturn *Roe v. Wade*. Not only am I disturbed by the impact this landmark decision will have on the health and well-being of millions of women and people who want and need abortion care, I am also frightened by the impact this decision will surely have on this country's ongoing maternal health crisis.

U.S. maternal health outcomes are worsening at an alarming rate, with black women and birthing people bearing the brunt of this crisis. According to the most recent estimates released by the CDC, black women are dying of pregnancy related causes at three times the rates of their white counterparts. We are also most likely to experience severe maternal morbidity.

For black women, pregnancy and childbirth, no matter how planned out or desired, puts our lives at risks. It is always unconscionable to force the continuation of an unwanted pregnancy. But for black women and other populations who have been historically marginalized, it is particularly immoral and dangerous.

Abortion care is overwhelmingly safe. But when abortion is difficult or impossible to access, complicated health conditions can worsen and even result in death. For example, one study conducted by researchers at the University of California, San Francisco, found that women who were denied abortion care are more likely to experience high blood pressure and other serious medical conditions during the pregnancy, more likely to remain in relationships where interpersonal violence is present, more likely to experience anxiety and stress shortly after being denied care, and more likely to experience poverty.

Research also shows that states with the most restrictions on abortion are precisely those with the worst maternal health out-

comes. This is no coincidence. These states also have fewer supportive policies in place for parents and their families.

Supportive policies like universal childcare, paid leave, affordable health care, equal access to nutritious foods, and adequate funding for the wraparound services low income families and families of color desperately need. If we want to actually support women and families, then equitable access to compassionate abortion care must be paired with policies that make it possible to raise a family in the first place.

In the face of the Supreme Court's decision to overturn *Roe* and the impact it will have on the maternal health crisis in this country, there are many policy solutions that can help address these challenges.

Congress must pass the Women's Health Protection Act, critical legislation to restore the Federal right to abortion, and it must be combined with the Equal Access to Abortion Coverage and Health Insurance Act, also known as EAACH, so that abortion care is affordable and accessible to all regardless of income or source of insurance.

Last but certainly not least, Congress must pass the Black Maternal Health Omnibus Act, a comprehensive legislative package aimed at addressing various dimensions of the U.S. maternal health crisis among black women and ensure that postpartum Medicaid coverage extends to a full year for every birthing person in every state.

The twin emergencies of the maternal health crisis and lack of Federal protections for abortion will in fact harm black women the most. Both crises stem from historical and ongoing racism tied to the legacy of reproductive control and coercion.

Make no mistake, these disparities are rooted in racism, not race. This racism can be seen today in the persistence of discrimination, unequal distribution of resources, and inequitable access to care.

With our bodies and health care decisions under unprecedented attack, it is critical that we finally address the maternal health crisis while also increasing access to abortion so that every black woman and every birthing person in this country can control their reproductive lives.

Thank you again for the opportunity to testify and I look forward to your questions.

[The prepared statement of Ms. Taylor follows:]

PREPARED STATEMENT OF JAMILA K. TAYLOR

Good morning, Chairwoman Murray, Ranking Member Burr, and Members of the Committee. Thank you for the opportunity to testify today on Reproductive Care in a *Roe* America.

I'm Dr. Jamila Taylor and I serve as the director of health care reform and senior fellow at The Century Foundation, a 100-year-old progressive think tank that conducts research, develops solutions, and drives policy change to make people's lives better.

I sit here before you today, deeply dismayed by the U.S. Supreme Court's decision to overturn *Roe v. Wade*. Not only am I disturbed by the impact this landmark decision will have on the health and well-being of millions of women and people who want and need abortion care, I am also frightened by the impact this decision will surely have on this country's ongoing maternal health crisis.

U.S. maternal health outcomes are worsening at an alarming rate, with Black women and birthing people bearing the brunt of this crisis. According to the most recent estimates released by the CDC, Black women are dying of pregnancy-related causes at three times the rate of their white counterparts. We are also most likely to experience severe maternal morbidity. For Black women, pregnancy and childbirth, no matter how desired or planned out—put our lives at risk. It is always unconscionable to force the continuation of an unwanted pregnancy, but for Black women and other populations who have been historically marginalized, it is particularly immoral and dangerous.

Abortion care is overwhelmingly safe. But when abortion is difficult or impossible to access, complicated health conditions can worsen and even result in death. For example, one study conducted by researchers at the University of California San Francisco found that women who were denied abortion care are more likely to experience high blood pressure and other serious medical conditions during the pregnancy; more likely to remain in relationships where interpersonal violence is present; more likely to experience anxiety and stress shortly after being denied care; and more likely to experience poverty.

Research also shows that states with the most restrictions on abortion are precisely those with the worst maternal health outcomes. This is no coincidence: these states also have fewer supportive policies in place for parents and their families—supports like universal child care, paid leave, affordable health care, equal access to nutritious foods, and adequate funding for the wrap-around services low-income families and families of color desperately need. If we want to actually support women and families, then equitable access to compassionate abortion care must be paired with policies that make it possible to raise a family in the first place.

In the face of the Supreme Court's decision to overturn *Roe*, and the impact it will have on the maternal health crisis in this country, there are many policy solutions that can help address these challenges. Congress must pass the Women's Health Protection Act, critical legislation to restore the Federal right to abortion, and it must be combined with the Equal Access to Abortion Coverage in Health Insurance Act (also known as EACH) so that abortion care is affordable and accessible to all, regardless of income or source of insurance. Last but certainly not least, Congress must pass the Black Maternal Health Momnibus Act, a comprehensive legislative package aimed at addressing various dimensions of the U.S. maternal health crisis among Black women and ensure that postpartum Medicaid coverage extends for a full year for every birthing person in every state.

The twin emergencies of the maternal health crisis and lack of Federal protections for abortion will in fact harm Black women the most. Both crises stem from historical and ongoing racism, tied to the legacy of reproductive control and coercion. Make no mistake: these disparities are rooted in racism, not race. This racism can be seen today in the persistence of discrimination, unequal distribution of resources, and inequitable access to care. With our bodies and health care decisions under unprecedented attack, it is critical that we finally address the maternal health crisis while also increasing access to abortion, so that every Black woman and birthing person in this country can control their reproductive lives. Thank you again for the opportunity to testify.

I look forward to your questions.

[SUMMARY STATEMENT OF JAMILA K. TAYLOR]

Thank you Chair Murray, Ranking Member Burr, and Members of the Committee for the opportunity to testify today. I sit here before you deeply dismayed by the decision to overturn *Roe v. Wade*. Not only am I disturbed by the impact this decision will have on the health and well-being of millions of women and people who want and need abortion care, I am also frightened by the impact this decision will have on this country's ongoing maternal health crisis.

U.S. maternal health outcomes are worsening, with Black women and birthing people bearing the brunt of this crisis. Black women are dying of pregnancy-related causes at three times the rate of their white counterparts, and are more likely to experience severe maternal morbidity. For Black women, pregnancy and Childbirth, no matter how desired—put our lives at risk. It is always unconscionable to force the continuation of an unwanted pregnancy—but for Black women and other historically marginalized populations, it is particularly immoral and dangerous.

Abortion care is overwhelmingly safe. But when abortion is difficult or impossible to access, complicated health conditions can worsen and even result in death. For

example, one study conducted by researchers at UCSF found that women who were denied abortion care have worse economic and mental and physical health outcomes, and are more likely to remain in relationships where they experience physical violence, than women who received abortion care.

Research also shows that states with the most restrictions on abortion are precisely those with the worst maternal health outcomes. This is no coincidence: these states also have fewer supportive policies for families—supports like universal child care, paid leave, affordable health care, access to nutritious foods, and wrap-around services low-income families and families of color desperately need. If we want to support women and families, then equitable access to compassionate abortion care must be paired with policies that make it possible to raise a family.

Fortunately, there are policy solutions to address these challenges. Congress must pass the Women's Health Protection Act—critical legislation to restore the Federal right to abortion, and it must be combined with the Equal Access to Abortion Coverage in Health Insurance Act so that abortion care is affordable and accessible to all, regardless of income or source of insurance. Last but certainly not least, Congress must pass the Black Maternal Health Momnibus Act and extend postpartum Medicaid coverage for a full year in every state.

Both the maternal health crisis and abortion bans will harm Black women the most, tied to an ongoing legacy of reproductive control and coercion. These disparities are rooted in racism—seen today in the persistence of discrimination, unequal distribution of resources, and inequitable access to care. With our bodies and health care decisions under unprecedented attack, it is critical that we finally address both the maternal health and abortion access crises—so that every Black woman and birthing person can control their reproductive lives.

The CHAIR. Thank you.

Ms. Detzer.

STATEMENT OF SAMIE DETZER, PLANNED PARENTHOOD PATIENT ADVOCATE, PLANNED PARENTHOOD FEDERATION OF AMERICA, NY

Ms. DETZER. Chair Murray, Members of the Committee, thank you for inviting me to speak with you today. My name is Samie Detzer and I have two stories to share. The first is fairly simple. On May 20th, 2015, in Seattle, I had an abortion. I was 25 years old.

I was pregnant and I did not want to be. It took me 5 minutes to schedule my abortion, which was covered by Washington State's Apple Health Program. I received compassionate expert care from the providers at Planned Parenthood in my own city and in my own state. My abortion was not painful, and it was certainly not traumatic. I was not lonely or depressed or ashamed.

I can remember more about the relief than the tears, more about the feeling of freedom than of pain. I have not considered what my life would be like now if I had a child, and I have never once agonized over my decision. That story is mine alone.

No one interfered to stop me from making the best decision for myself. No one tried to take control of what was mine, my body, my freedom, or my choice. The second story is my mother's. She was 19 and living in San Francisco with my father when she got pregnant.

They were simply not ready to be the exceptional parents that they would later become. It was 1968, before the Supreme Court's decision in *Roe v. Wade* guaranteed the Constitutional right to abortion, and her doctor informed her that the only way to receive

a legal abortion in the United States was to have a team of psychotherapists deem her mentally unfit for parenthood.

She agreed to this process, was three times called officially crazy, her words, and was granted the right to have a legal abortion. And this process took just shy of 20 weeks. She received her legal abortion, finally at 5 months pregnant. Unlike my experience, my mother's procedure was needlessly painful and was physically and emotionally traumatic for her. My mother was open with her three children about her experience, but I don't know everything about it.

I don't know how in the world living across the country from her family and hiding her pregnancy from them, she was able to scrape together the money for three therapists and the abortion itself. I don't know what it was like for her to carry a pregnancy she did not want and to endure comments from strangers as she began to show. I don't know the extent of the judgment and shame my mother was subjected to. And unfortunately I can't ask her because she passed away 4 years ago.

I miss my mother every day. But I am glad that she is not here to see this terrible moment in our Country's history. I do wish that she had the chance to meet her granddaughter, my 2 year old niece, Sadie, who will devastatingly grow up with fewer rights than I had. I wish that I didn't need to share the personal details of my life, of my mother's life, with a room full of strangers.

I wish that I could feel confident that my niece would grow up with the right to make choices about her own body. And yet, here I am. I am telling these two stories because of the dual responsibility that I feel to honor both my mother and my little niece, the responsibility that I have to honor the past and fight for a better future. The Members of this Committee, the Members of the Senate have a choice.

The choice lawmakers have is how difficult you will make it for us to exercise our freedom. How much pain and trauma you will cause. How many bank accounts will be drained? And how many miles will be traveled? And how many tears will be shed? Lawmakers can decide if people in this country will be able to get the health care they deserve.

They can decide if states will be allowed to create insurmountable barriers to abortion or ban it completely. Lawmakers can decide whether our Country will look like my mother's story or mine. What they cannot do is take away our freedom to our own bodies.

No judge or justice can take away my right to decide what is best for me, my body, or my future. That freedom is ours and we will not surrender it. I hope for the sake of my mother's memory and for my niece's future, you will make the right choice. Senators, people who want or have had abortions need to know that they are not alone.

We need to know that you will continue to fight for us. I hope that you will choose to be brave alongside those of us who are telling our stories and that you will use every tool you have to protect our right to abortion care and reproductive freedom. Thank you.

[The prepared statement of Ms. Detzer follows:]

PREPARED STATEMENT OF SAMIE DETZER

Chair Murray, Members of the Committee, thank you for inviting me to speak with you today, my name is Samie Detzer, and I have two stories to share.

The first is fairly simple, on May 20, 2015, in Seattle, I had an abortion.

At 25 years old, I was pregnant and did not want to be. It took me 5 minutes to schedule my abortion, which was covered by Washington State's Apple Health program. I received compassionate, expert care from the providers at Planned Parenthood in my own city and state.

My abortion was not painful. It was certainly not traumatic. I was not lonely, or depressed, or ashamed. I can remember more about laughter than tears, more about freedom than my pain. I have not wondered what my life would be like now if I had a child. I have never once agonized over the decision.

That is my story, and it is mine alone. No one interfered to stop me from making the best decision for myself. No one tried to take control of what was mine—my body, my freedom, my choice.

The second story is my mother's.

She was 19, and living in San Francisco with my father, when she got pregnant. They were both using drugs, and were not ready to be the exceptional parents they would later become.

It was 1968, before the Supreme Court's decision in *Roe v. Wade* guaranteed the constitutional right to abortion.

Her doctor informed her that the only way to receive a legal abortion in the United States was to have a team of psychotherapists deem her mentally unfit for parenthood.

She agreed to this process, was three times called officially crazy, as she told me, and was granted the right to have a legal abortion. It took just shy of 20 weeks to navigate the process.

She received her legal abortion, finally, at 5 months pregnant. Unlike my experience, my mother's procedure was needlessly painful, and physically and emotionally traumatic for her.

My mother was open with her three children about her experience, but I don't know everything about it. I don't know how in the world, living across the country from her family and hiding her pregnancy from them, she was able to scrape together the money for three therapists and the abortion itself. I don't know what it was like for her to carry a pregnancy she did not want for five full months, to endure comments from strangers as she began to show. I don't know exactly the judgment and shame she was subjected to because the law did not honor her right to control her body. And unfortunately I can't ask her, because she passed away 4 years ago.

I miss my mother every day, but I'm glad she isn't here to see this terrible moment in our Country's history. I do wish she had a chance to meet her granddaughter, my niece Sadie, who is 2 years old—and will grow up with fewer rights than I had.

I am here today, telling these two stories, because of the dual responsibility I feel to honor both my mother, and my little niece. The responsibility I feel to honor the past and fight for a better future.

The Members of this Committee, the Members of this Senate, have a choice.

The choice lawmakers have is how difficult you make it for us to exercise our freedom—how much pain and trauma you cause, how many bank accounts will be drained, how many miles have to be traveled, and how many tears will be shed.

Lawmakers can decide if people in this country will be able to get the health care they deserve. Lawmakers will decide if states will be allowed to create insurmountable barriers to abortion or ban it completely. Lawmakers will decide whether our Country will look like my mother's story, or like mine.

What they cannot do is take away our freedom to own our own bodies. No judge or justice can take away my right to decide what is best for me, my body, and my future. That freedom is ours, and we do not surrender it.

I hope, for the sake of my mother's memory, and for my niece's future, you will make the right choice, Senators. People who want abortions or have had abortions need to know that they aren't alone, that you will continue to fight for us. I hope that you will choose to be brave along with those of us who are telling our stories, use every tool you have to protect our right to abortion care and reproductive freedom.

[SUMMARY STATEMENT OF SAMIE DETZER]

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The Members of this Committee, the Members of this Senate, have a choice. Our country can look like my mother's story, or like mine. What they cannot do is take away our freedom to own our own bodies. No judge or justice can take away my right to decide what is best for me, my body, and my future. That freedom is ours, and we do not surrender it.

I hope, for the sake of my mother's memory, and for my niece's future, you will make the right choice, Senators. People who want abortions or have had abortions need to know that they aren't alone. Choose to be brave along with those of us who are telling our stories, use every tool you have to protect our right to abortion care and reproductive freedom.

The CHAIR. Thank you very much.

Ms. Swindell.

STATEMENT OF BRANDI SWINDELL, FOUNDER AND CEO, STANTON HEALTHCARE, ID

Ms. SWINDELL. Chair Murray, Ranking Members Burr and Marshall, and Members of this Committee, thank you for giving me the opportunity to share today. My name is Brandi Swindell, and I am a fourth generation Idaho and human rights activist, and the CEO and Founder of Stanton Healthcare and Stanton Public Policy Center.

Stanton Healthcare is a women's health care provider which specializes in serving women with unexpected pregnancies by providing professional medical care, practical and emotional support, women's wellness care, and an outreach to refugee and marginalized communities.

We are based in Idaho with affiliates in the U.S. and internationally. Stanton is a part of a women's movement which has over 3,000 pregnancy resource centers and life affirming medical clinics across the Nation that outnumber abortion clinics 4 to 1.

Women who walk through our doors are treated with dignity and equality regardless of their race, political views, religion, or economic situation. After the Supreme Court overturned *Roe v. Wade* on June 24th, so many have asked the pro-life community, are you ready to support women in a post-*Roe* America?

I can say with certainty, thousands of pregnancy centers and life affirming women's medical clinics have been waiting and preparing for this moment for decades. We are ready to meet the challenge, and we are going to make sure that every woman facing an unexpected pregnancy in a post *Roe* America will have access to life affirming quality care, compassionate resources, and tangible support.

Yesterday in my home State of Idaho, Stanton Healthcare organized and led a symposium called Supporting Women in an Abortion Free Idaho. Political, faith, and community leaders, educators, and organizations all came together in a nonpartisan way to find creative and life affirming solutions as we unite to support women with unexpected pregnancies.

We are excited that other states are following Idaho's lead. In a post *Roe* America, shouldn't our Nation's goal and the goal of this Committee be to put aside divisions, anger, and partisanship, and commit ourselves to serving and helping women?

As political leaders and Members of this Committee, you can support women with unexpected pregnancies by passing legislation that would provide better prenatal and medical care for the marginalized and women from communities of color. Paid maternity leave and childcare are steps in the right direction.

Since May 2d, there have been over 60 attacks on centers like Stanton Healthcare. These attacks are unconscionable and ultimately threaten the women who attempt to walk through our doors seeking access to our services.

Because of this, Stanton has had to hire private security, a private security firm which has cost our organization thousands of dollars. For those who disagree with the Supreme Court's decision on *Roe*, directing revenge and retaliation on centers like Stanton Healthcare is misguided, it is hateful, anti-women, and must be condemned and stopped immediately.

Today, I am calling on all Members of this Committee to personally and publicly condemn the firebombing, violent attacks, and threats against life affirming charitable women's clinics. Congress and the Biden Administration should be a part of the solution and not cast blame on centers like ours.

It is also deeply troubling members of the press, politicians, and media outlets refer to centers like Stanton as fake clinics. First, we are attacked with physical violence. Next, we are attacked with the violence of lies, disinformation, slander, and falsehoods.

To diminish Stanton Healthcare in this way insults our medical directors who are highly regarded MDs, our physician assistants,

nurses, stenographers, and others on our medical team who have worked so hard to receive, achieve, and maintain their medical credentials. But most of all, it insults the thousands of women and their children who have been helped by our clinics.

They do not receive fake medical care or fake baby formula during a nationwide shortage or fake baby supplies, fake financial support, or fake counseling, and so much more when they walk through our doors. We should not be attacking clinics like Stanton or proposing anti-woman legislation, but rather we should be standing with these women who seek our services.

It is important for this Committee to note, since 1980, the abortion rate has fallen by more than 50 percent. During the same time, women have succeeded on a variety of educational and economic metrics. If women are gaining educationally and economically at a time when abortion rates are falling, it is pretty clear that women do not need to rely on abortion to succeed.

The overturning of *Roe* on June 24th sent shockwaves through our Nation that will take us months and perhaps even years to process. However, if we are truly committed to justice and women's rights, we can come together as a Nation and find creative solutions to empower and stand with women in a post *Roe* America.

Once again, thank you for the invitation to share about the critical work of Stanton Healthcare and the amazing women we serve. Thank you.

[The prepared statement of Ms. Swindell follows:]

PREPARED STATEMENT OF BRANDI SWINDELL

Dear Chair Murray, Senator Burr, and Members of this Committee, thank you for giving me the opportunity to share today.

My name is Brandi Swindell, and I am a fourth-generation Idahoan, human rights activist, and CEO and Founder of Stanton Healthcare and Stanton Public Policy Center.

Stanton Healthcare is a women's healthcare provider which specializes in serving women with unexpected pregnancies by providing professional medical care, practical and emotional support, women's wellness care, and an outreach to refugee and marginalized communities. We are based in Idaho, with affiliates in the U.S. and internationally.

Stanton is part of a women's movement which has over 3,000 pregnancy resource centers and life-affirming medical clinics across the Nation that outnumber abortion clinics by four to one. Women who walk through our doors are treated with dignity and equality regardless of their race, political views, religion, or economic situation.

After the Supreme Court overturned *Roe v. Wade* on June 24, so many have asked the pro-life community, "Are you ready to support women in a post-*Roe* America?" I can say with certainty, thousands of pregnancy resource centers and life-affirming women's medical clinics have been waiting and preparing for this moment for decades.

We are ready to meet the challenge and we are going to make sure that every woman facing an unexpected pregnancy in a post-*Roe* America will have access to life-affirming quality care, compassionate resources, and tangible support.

Yesterday in my home State of Idaho, Stanton Healthcare organized and led a symposium called, "Supporting Women in an Abortion-Free Idaho." Political, faith, and community leaders, and organizations came together in a non-partisan way to find creative and life-affirming solutions as we unite to support women with unexpected pregnancies. We are excited that other states are following Idaho's lead.

In a post-*Roe* America, shouldn't our Nation's goal, and the goal of this Committee, be to put aside divisions, anger, and partisanship...and commit ourselves to serving and helping women?

As political leaders and Members of this Committee, you can support women with unexpected pregnancies by passing legislation that will provide better prenatal and medical care for the marginalized and women from communities of color. Paid maternity leave and child care are steps in the right direction.

Since May 2, there have been over 60 attacks on centers like Stanton Healthcare. These attacks are unconscionable and ultimately threaten the women who attempt to walk through our doors seeking access to our services. Because of this, Stanton has had to hire a private security firm which has cost our organization over $6,000 to date.

For those who disagree with the Supreme Court's decision on *Roe*, directing revenge and retaliation on centers like Stanton Healthcare is misguided, hateful, anti-women, and must be condemned and stopped immediately.

Today, I'm calling on all Members of this Committee to personally and publicly condemn the fire-bombing, violent attacks, and threats against life-affirming charitable women's clinics. Congress and the Biden Administration should be part of the solution and not cast blame on our centers.

It is also deeply troubling for the press, politicians, and media outlets to refer to centers like Stanton as "fake clinics." First, we are attacked with physical violence. Next, we are attacked with the violence of lies, disinformation, slander, and falsehoods.

To diminish Stanton Healthcare in this way insults our medical directors who are highly regarded MD's, our physician assistants, nurses, sonographers and others on our medical team who have worked so hard to achieve and maintain their professional credentials.

But most of all, it insults the thousands of women and their children who have been helped by our clinics. They did not receive "fake" medical care, or "fake" baby formula during the nationwide shortage, or "fake" baby supplies, "fake" financial support, or "fake" counseling and so much more when they walked through our doors. We should not be attacking clinics like Stanton or proposing anti-woman legislation. Rather, we should all be standing with these women who seek our services.

The overturning of *Roe* on June 24 sent shockwaves through our Nation that will take us months and perhaps even years to process. However, if we are truly committed to justice and women's rights, we can come together as a nation and find creative solutions to empower and stand with women in a post-*Roe* America.

Once again, thank you for the invitation to share about the critical work of Stanton Healthcare and the amazing women we serve.

[SUMMARY STATEMENT OF BRANDI SWINDELL]

Ms. Swindell will describe the work of Stanton Healthcare which operates life-affirming women's healthcare clinics providing a wide range of services to women with unexpected pregnancies including professional medical care and practical and emotional support. Stanton Healthcare also offers women's wellness services and an outreach to refugee and marginalized communities.

Stanton is part of a women's movement which has over 3,000 pregnancy resource centers across the nation—outnumbering abortion clinics by four to one.

In addition, Ms. Swindell will:

Discuss how the pro-life movement is ready to meet the challenge to ensure every woman facing an unexpected pregnancy in a post-*Roe* America will have access to life-affirming quality care, compassionate resources, and tangible support.

Address the violence and attacks against life-affirming clinics; calling on all Members of this Committee to personally and publicly condemn the fire-bombing, violent attacks, and threats against life-affirming women's clinics. Congress and the Biden Administration should be part of the solution and not cast blame on our centers.

Draw attention to the damaging effects of labeling life-affirming centers "fake clinics." Doing so insults the thousands of women and their children who have been helped by our clinics. The women served did not receive "fake" medical care, or "fake" baby formula during the nationwide shortage, or "fake" baby supplies, financial support, counseling and so much more. We should not be attacking clinics like Stanton or proposing anti-women legislation. Rather, we should all be standing with them.

Let's come together as a nation and find creative solutions to empower and stand with women in a post-*Roe* America.

About Stanton Healthcare

Stanton International is a life-affirming movement of women's healthcare clinics founded in 2006 and based in Idaho's Treasure Valley with affiliate locations in the U.S. and internationally. Stanton exists to ensure women facing unexpected pregnancies have access to quality medical care and compassionate alternatives to abortion.

Stanton Healthcare never discriminates in providing services based on race, creed, color, national origin, age, marital or financial status of its clients. We provide our services to a diverse demographic that includes; the refugee community, those struggling with economic challenges, and the marginalized. All services are provided at no charge to women, children, and families.

Stanton Healthcare's flagship operates three licensed clinics in Idaho—in Boise, Meridian, and a mobile medical clinic. Every Stanton clinic adheres to the highest medical standards under the supervision of a board-certified OB/GYN and Physician Assistant.

Stanton provides a vast array of services to the community at no charge, including:

- Early detection pregnancy testing
- Ultrasound/pregnancy verification
- Options counseling
- Abortion Pill Reversal (APR)
- Wellness care
- STD/STI testing and treatment
- After-abortion exams and support
- Advocacy appointments
- Maternity and baby supplies
- Lactation support
- Pre-and post-natal education
- Massage therapy
- Refugee assistance and support
- Breast cancer screening awareness and partnership with local mammography mobile clinics
- Fatherhood mentoring
- Mobile clinic outreach to underserved and rural communities
- Referrals for OB/GYN care, housing, legal assistance, and adoption

A few vital statistics about Stanton Healthcare's clients:

- In 2021, 73 percent of the women we served at Stanton Healthcare in Idaho were considering or seeking an abortion.
- 90 percent of these women reported feeling pressured to have an abortion by someone they trust.
- 170 Stanton Babies were born in the past year.
- 187 Stanton Babies are currently due to be born.
- More than 90 percent of women choose life at Stanton Healthcare after seeing their baby on ultrasound, talking with a trained advocate and medical professional, and receiving quality resources and support.

In a 2021 snapshot of just one of our Stanton Healthcare clinics (in Meridian, Idaho) Stanton provided over $429,000 in life-affirming services at no charge to clients, including:

- $174,000 in baby clothing and supplies, along with 18 months of wellness support through our StantonCare individualized program for moms and babies.
- 348 Lab-grade pregnancy tests valued at $22,620
- 618 Ultrasound exams valued at $194,670
- 283 Follow-up visits valued at $31,395
- 36 STD tests and follow-up care valued at $7,308

Abortion Pill Reversal In response to the increased push of chemical abortions via the "abortion pill," Stanton Healthcare offers Abortion Pill Reversal to moms who

feel the sting of regret after taking the first abortion pill. So far, Stanton has had three babies born after successful reversals. Stanton provides this life-saving medical care because no woman should ever feel forced to complete an abortion when she has a change of heart.

Contrary to claims Abortion Pill Reversal is unsafe or medically unsound, the only valid criticism that should be offered of Abortion Pill Reversal is that it is a relatively new technique yet to be exhaustively validated. Credible studies have shown that the oral treatment with progesterone (which is what Stanton administers) has a successful reversal rate of 68 percent. The conclusion of one such study: "The reversal of the effects of mifepristone using progesterone is safe and effective." [1] This is consistent with Stanton's own experience, as babies have made it to full term in good health using this method.

Funding and Resources

In sharp contrast to abortion businesses such as Planned Parenthood which receive hundreds of millions of taxpayer dollars every year, Stanton Healthcare exists solely through the generous financial support of individuals, churches, and community organizations. In addition to our highly qualified medical and client care team, Stanton's personnel includes trained volunteers who in 2021 contributed 13,202 hours—totaling $369,656 in donated time.

Community Impact

For over 15 years, Stanton Healthcare has been a powerful force for good in Idaho's Treasure Valley. Stanton's clinics have provided quality care at no charge to women seeking physical, emotional and practical support during an unexpected pregnancy, resulting in stronger families and stronger communities. Stanton clients consistently rate their experience with glowing reviews, regularly referring friends and family for services. Because of Stanton's incredible impact, support has come from all corners of the state and the nation—lawmakers, community leaders, clergy, political figures, and other prominent leaders have expressed their unwavering public endorsement of Stanton Healthcare. With confidence in our mission, Stanton Healthcare will continue to provide hope and help to women and their families across the U.S. and internationally.

Stanton Healthcare Client Testimonials:

Jacey

"I was in a very bad place in my life when I decided to get an abortion. My mom told me she wouldn't have anything to do with my baby. My boyfriend was a drug addict and causing abuse in my life and left me, and I was diagnosed with having severe panic attacks and hyperemesis at just 5 weeks into my pregnancy. I was so sick I would throw up 20–30 times a day and had to get IV fluids. I thought there was no way I could do this. I was so sick I felt like I could die. I already had one daughter and didn't think anyone would love me with two. I thought my only option to have a future was to abort my baby.

I drove to Planned Parenthood and saw Stanton Healthcare across the parking lot. I had heard about them and thought to myself, "I'm going to go in there and if they can help me and can change my mind about getting an abortion, then so be it. And if not, I'm going across the parking lot to Planned Parenthood to get an abortion."

I went to Stanton Healthcare and found that they are a real clinic that helped me with everything I needed. They loved me and showed me I wasn't alone, gave me things I needed for my baby, counseling to get out of my life-threatening abusive relationship, encouraged me I could make it through having hyperemesis, encouraged me that I could have a life with this baby, encouraged me to find a church I was loved after having been hurt elsewhere, and gave me ultrasounds to see my baby. Seeing my daughter's heartbeat made me stop feeling the panic attacks that made me want to abort and stop feeling the horrible nausea and see my baby was a real

[1] Delgado G, Condly SJ, Davenport M, Tinnakornsrisuphap T, Mack J, Khauv V, Zhou PS. A case series detailing the successful reversal of the effects of mifepristone using progesterone. Issues Law Med. 2018 Spring;33(1):21–31. PMID: 30831017. *https://pubmed.ncbi.nlm.nih.gov/30831017* (retrieved July 7, 2022)

person that I couldn't kill. It instantly made me feel attached to my baby and love her.

Not only did Stanton help me decide not to abort, but they helped me turn my life back to God. When I lost my job after my baby was born, I was able to pray because the people at Stanton loved me in a way that turned my heart back to God. I felt led to start my own business and for the first time in my life, I can provide for my children on my own and have more than enough. They impacted my whole future and my children's future.

I look at my baby and feel ashamed that I ever was going to abort her. I'm so glad she is in this world now and in my life forever because I was able to choose to keep her with Stanton's help. I thank God that Stanton helped me get out of fear and choose life.

Now everyone loves my daughter. My mother is in her life and happy I had her. It impacted her, as well. My daughter has a sister and I found a man that loves all of us. All my fears were lies and had I aborted my little girl, I know it would have caused me to carry shame and depression.

Thank you, Stanton, from me and my baby. She has a future to live because of you."

Audrey

"Throughout my pregnancy and postpartum experience, Stanton Healthcare has made it a priority to provide me and my family with quality care. From the moment we walked in, we felt taken care of by everyone.

Stanton did an ultrasound of my now 3-month-old daughter and brought me so much peace during a stressful season. They provided me with all the resources I needed to get signed up with Medicaid, they recommended my OB (who I now recommend to other expecting mothers), and they provided me with lots of information about pregnancy because it was my first. Stanton made my pregnancy experience so smooth. I was in need of a lot of help and I am so happy that I decided to go to Stanton first.

During my postpartum period, Stanton has provided me with countless resources, including diapers, classes, and clothes. I feel incredibly supported and feel I have even developed a friendship with some of the women at Stanton. I know they are an essential resource in our community and hope to give back in any way I can."

Jennifer (Abortion Pill Reversal)

"Finding out I was pregnant was a big surprise. I'm married, almost 40, and we had six other children.

While I've always felt like people shouldn't get abortions, my husband was adamant in telling me we shouldn't have more babies.

When we went to Planned Parenthood, they showed me a video about the abortion pill. Over and over, the video says after taking the pill, women feel a huge sense of relief. But before even taking the pill, I was extremely upset. In fact, I was sobbing uncontrollably.

I've thought back on that so many times. Can you imagine a medical professional sitting in front of you while you are sobbing and not saying something like, "Ma'am, I don't think now is the time for you to take this pill. You seem like you have not decided this is the best thing for you."

But no one said that. No one even asked if I was okay.

After my husband filled out paperwork, I was instructed to take the first pill in front of the doctor. When he handed me the pill, I had a feeling of intimidation and vulnerability, but I took it.

I kept thinking, "I'm going to feel relief soon." Their video had assured me I would, but I didn't feel anything close to relief. So then I felt crazy and out of my head. Having an abortion was not something I wanted. I was forcing myself and believing the lie that I was going to feel relief.

Planned Parenthood left me with the impression that they are a business, and their product is abortion, and it is just a money game. It wasn't to support me or help me make the best decision, or make sure that I was okay after I left, or anything like that.

Before we left, we had paid over $1,000 for the ultrasound and the pills.

That night, I couldn't sleep, so around 2 a.m. I googled: 'If I don't take the second set of pills, will the baby be okay? Did I cause damage or defects?'

That's when a phone number came up about Abortion Pill Reversal, which I'd never heard of, so I started texting it. And someone responded right away.

Within a couple of hours, I knew I was going to be connected with a place that would try to help my baby and me. That same morning I walked into Stanton Healthcare and met the incredible people there. They did an ultrasound and my baby still had a heartbeat! They started me on a protocol to help protect my baby from the effects of the abortion pill, and they continued to provide me with caring support through the whole pregnancy, and beyond.

My son is now 5 months old—completely healthy—and we could never imagine our lives without him! I'm super grateful for Stanton meeting me early in the morning on a Saturday to save my son. And I'm so grateful to everyone who supports Stanton so women like me can know this option exists and have access to it. It gave me the opportunity to change my mind. I would have missed out on life with my son and I would have regretted that decision forever.'"

Stanton Healthcare's legal counsel, Michelle Adams, responds to claims of Stanton being a "fake clinic."

The interpretation of the word "fake" is not a matter of opinion. It means 'not true, real, or genuine.'

However, Stanton Healthcare is recognized by the State of Idaho as a fully licensed medical clinic, operating under all state laws and the licensing of its Medical Director, with all proper CLIA waivers, maintaining documentation of proper licensing from all its medical staff and volunteers, with a medical advisory team, and continuing education in best practices. Stanton is listed by the Idaho Department of Health and Welfare as a recognized provider in this field. Ultimately, Stanton meets or exceeds the licensing requirements of healthcare clinics in Idaho and has certification and standards of excellence beyond that of abortion providers in the state.

It is irrational to suggest that because abortion clinics and pregnancy medical clinics serve a similar population—pregnant women—they must, therefore, offer the same set of services. It is presumptuous to declare which services ought to be offered at every establishment serving pregnant women. Stanton Healthcare offers many services that abortion clinics do not, but it would be illogical to therefore conclude that the abortion clinics are "fake clinics."

The reality is that Stanton, and many of those of its type, fill a critical niche in our Nation that would not be served otherwise. Many served by Stanton are low-income and vulnerable women who would not receive sufficient practical or emotional assistance elsewhere. When politicians and media outlets cast disparaging suspicion on our clinics, you are steering women away from some of the places where they might receive such support.

The CHAIR. Thank you. We will now begin a round of 5 minute questions and I ask my colleagues to please stay—keep track of your clock and stay within those 5 minutes. Dr. Brandi, I am going to start with you. Across the country, states that protect abortion rights are preparing for a surge in patients coming from states where they no longer have the right to access the care that they need.

Researchers estimate that 36 million women of reproductive age will now live under abortion restrictions and bans. In my home State of Washington, clinics are expecting to see five times as many out of state patients. And this is really a full blown health care crisis that is going to cost women their lives and their health because they can't access the care they need from their own doctors in their own states.

I want to thank you for providing such incredibly important care because the work you do is essential, and it saves lives. Talk to us about how abortion bans in other states impact your work as a provider in New Jersey and the care that your patients receive.

Dr. BRANDI. Thank you so much, Senator, for the question. You are right. There is going to be millions of people that hopefully will be able to access care, and unfortunately will be leaving their homes and their communities in order to do so. I am very fortunate to practice in New Jersey, where our Governor and legislators have passed proactive laws to help protect the care in our state.

Unfortunately, that is not the case elsewhere. And many people across the country will be leaving their communities to get that care. What that looks like is delays in care, which leads to patients presenting often later in pregnancy.

It means patients may not be able to get to us because all of the logistics of travel like childcare, like making sure people have days off of work, they have gas so they can get to their appointments, all lead to people not being able to access the care. And we know that disproportionally impacts people of color and other people that are marginalized.

People that live in states that the care is protected often—are anticipating enough flow and people. People are going to be having to wait that live in those communities for weeks. And we are already seeing that in certain communities that appointments are taking two, 3 weeks to be able to get that appointment.

Unfortunately, in pregnancy care, weeks matter. And that may create further barriers to people being able to access the care that they need and deserve.

The CHAIR. Thank you. Ms. Detzer, thank you for sharing your story and your mom's. I know it takes a lot of courage to speak out about a personal situation, and I am really grateful that you were willing to do that today.

You spoke really powerfully about your mom's experience before *Roe* and what happened to her, and your experience in what you—happened in a world where we had *Roe*. Talk to me a little bit about what abortion rights means in your life.

Ms. DETZER. Thank you, once again, for the opportunity to share my story, Senator. The first thing that comes to mind for me is that what a person does with their life after they have an abortion need not be exceptional for that abortion to be necessary.

What they do with their life after that should be the same as the choice to have an abortion, entirely up to them. However, in my case, I am pretty proud of the things that I have done in my life after having an abortion. Most importantly to me, having an abortion allowed me to be a support system for my brother and my sister when they became parents, when they chose to become parents.

I would say probably most importantly to me, that having an abortion allowed me the time and resources to care for my mother as she got sick with cancer and eventually died. And so I am deeply grateful for the abortion that I had that allowed me to live my life as I wanted it to.

The CHAIR. Thank you. Dr. Taylor, as you mentioned, this crisis is not being felt equally. Black and Native American women, for example, continue to experience disproportionately higher rates of death related to pregnancy or childbirth. How will the overturning of *Roe* exacerbate the maternal mortality crisis in our Country?

Ms. TAYLOR. Thank you for the question, Senator Murray. You know, it is going to greatly exacerbate our maternal mortality crisis in this country. You know, based on research that was conducted not too long ago, we know that the fall of *Roe* will cause our overall maternal mortality rate to go—to increase by 20 percent. For black women, it will increase by 40 percent.

I think it is important to talk about the maternal mortality issue in this context, because it is bigger than even the conversation we are having today. Black women disproportionately are impacted not only by the maternal mortality crisis, but also unable to access abortion even before *Roe*.

These challenges are going to be basically insurmountable in a lot of ways. But as I mentioned in my testimony, there are solutions that can be implemented to address the issue.

The CHAIR. Thank you very much. My time is up.

Senator Marshall.

Senator MARSHALL. Thank you again, Chair Murray. You may hear the abortion lobby say that maternal mortality is up to 14 times more for carrying a pregnancy to term as opposed to an abortion. But in absolute terms, the chances of dying from pregnancy is approximately 0.024 percent, which, let me be very clear, is unacceptable. It is too high of a rate. Before Dobbs or after Dobbs, it is too high.

Let me also point out that more women ages 20 to 44 die each year from trauma, cancer, heart disease, suicide, homicide, liver disease, diabetes, and stroke than pregnancy related complication. Finally, this, please realize that HHS does not require actual reporting of abortion complications.

While the abortion industry is quick to claim that eradicating all protections from the only—from the unborn is the only way to lower maternal mortality rates, abortion is not the solution to this crisis. Rather, the Nation should focus on addressing the underlying causes that lead to maternal mortality.

Here in our Nation's capital, for example, has the fewest laws protecting life in the womb compared to the other 50 states, but its mortality rate of 36 per 100,000 means that women in D.C. are 50 percent more likely to die from pregnancy related causes as women in the rest of the Nation.

For black mothers, the situation is even worse. And according to maternal mortality report of 2019, black women accounted for 90 percent of all pregnancy related deaths in the districts. The maternal mortality rate for black mothers in D.C. is 71 per 100,000, dwarfing, tripling the national average.

It is especially a problem here in D.C. Ward 7 and 8. If I describe this particular geographical area, they have no hospitals with birth wards. They only have three grocery stores and drastically fewer

pharmacies than the other wards. These are issues we can and must address.

Each time we spend taxpayer dollars funding the abortion industry, we take away money and resources from providing real solutions for mothers and our Nation's most valuable resource, our children.

Ms. Swindell, if you had a clinic in D.C., in this high mortality rate, how could you impact the maternal mortality rate?

Ms. SWINDELL. Oh, we would definitely have an impact. Thank you for that question. You know, Stanton Healthcare, we are a nonprofit, life affirming women's medical clinic. We don't charge for any of the services that we provide.

We have a very high focus on pre and post-natal education, a very high focus on quality prenatal care, and then also putting together an individualized care plan for every woman who walks through our doors. And so we make sure that she has a solid support system, that she has all of the resources that she needs, that there is a plan in place.

Our program runs the duration, not—its 9 months of pregnancy, whatever that point is that she comes to our center, and then a minimum of 9 months after that. So it is an 18 month program, and it even goes beyond that. We have moms that come in that their children, their babies, they're Stanton babies, as we call them, are 10 years old now, 5 years old.

They still come in and we are that support and resource for them. So we are seeing very good results through our individualized care program. Again, it is that focus on pre and post-natal education and good prenatal care.

Senator MARSHALL. Yes, thank you for that answer. I want to keep on this topic of this ill-conceived concept about abortion being safer than pregnancy. You know, first of all, stating the obvious, the mortality rate for the unborn baby is almost 100 percent and abortions and very low in childbirth.

We also believe that continuing pregnancy is very protective of the mother and child, particularly when we think about suicide rates of women that have had babies versus the abortion, women that have had abortions.

We think about even higher incidences of trauma and murder for women have had abortions as opposed to women who have bore their pregnancy and had children. Do you see many problems with that post-abortion syndrome, emotional distress, suicidal because of the abortion?

Ms. SWINDELL. Thank you, Senator. Yes, we do. In fact, Stanton Healthcare runs an after abortion care program, and that support program is always full. We have women that walk through our doors that are very traumatized after having abortion. Most women experience both short term and long term physical and emotional challenges after an abortion.

In fact, studies show that one in four women that undergo an abortion express feelings of depression, anxiety, regrets, things that follow along with that, substance abuse to try and numb the pain, hallucinations of their child, nightmares. Women experience things

like being very stressed out at a certain time on the clock because that is when the baby—when the abortion happened, and the baby was killed.

My own mother suffered from the pain of a past abortion. In fact, she only became suicidal after she had an abortion. She was never suicidal before that. She also, may she rest in peace, passed away in 2016.

But she always regretted her abortion, and she became a very big supporter of Stanton Healthcare so that other women wouldn't have to go through the same experience she did.

Senator MARSHALL. Thank you so much. I yield back.

The CHAIR. Senator Hassan.

Senator HASSAN. Thank you, Chair Murray and Ranking Member Marshall. I want to thank all of our witnesses for being here today. We know that the end of *Roe* is not the final goal of anti-choice extremists. Their ultimate objective is to ban abortion nationwide. We have to hold the line against any efforts to enact a nationwide abortion ban and keep fighting to protect a woman's fundamental freedom.

This is, after all, about whether women are allowed to make their own complex life and health decisions. Dr. Brandi, in the wake of the Supreme Court's decision, we are hearing extremely concerning reports about women experiencing difficulty getting critical emergency care related to pregnancy.

As Senator Murray mentioned in her opening statement, 1 in 50 women experience an ectopic pregnancy, a life threatening condition. Doctor, can you walk through what an ectopic pregnancy is, how it develops, and how it is treated, please?

Dr. BRANDI. Absolutely. Thank you for the question. As you stated, ectopic pregnancy affects about 2 percent of all pregnancies, and an ectopic pregnancy is a pregnancy that is implanted outside of the uterus, most often in the fallopian tubes. But it can be in the ovaries, it can be in the abdomen.

This condition will never continue on to a normal pregnancy, and often it is life threatening for the person that has that condition. I will tell a quick story that I had a patient recently in the ER with an ectopic pregnancy, and minutes are critical in that—in the ability to take care of that person.

I talked to them in the ER, they were walking around a couple of minutes, and then 20 minutes later by the time we are in the operating room, they were critical. Their vitals were dropping. We had to emergency do their surgery to in order to save their life. I am really glad that we were able to provide that care in such a quick fashion. But we have seen a chilling effect in other states.

It was reported in the New England Journal of Medicine how providers in Texas after SB–8 were confused. They didn't know what was safe, they didn't know what was—they had to make decisions about whether or not to follow their oath or protect themselves against potential litigation and criminal action.

It is really heartbreaking to consider as a physician that I would have to hold back what I know is evidence based care to intervene

right at that moment because I am worried about calling my lawyer and making sure that I can do that before I intervene.

Senator HASSAN. Right. And it is—so as you point out, it is both the uncertainty created along with the reality that seconds count when you are caring for a patient with an ectopic pregnancy.

Dr. BRANDI. Exactly right.

Senator HASSAN. Well, it is clearly—a treatment for an ectopic pregnancy is clearly lifesaving medical care. And politicians have no place in the doctor's office or in the operating room where a doctor should be able to provide care quickly and safely based on best medical guidance.

One more question for you, Dr. Brandi. The Supreme Court's decision created countless legal questions that have brought uncertainty into hospitals and clinics, as you have just pointed out.

Reports indicate that confusion has interfered with treatment for a number of conditions, ranging from rheumatoid arthritis and IUD insertions to miscarriages. Dr. Brandi, could you outline why this confusion is harmful in a medical setting?

Dr. BRANDI. Sure. We spend years and years of our lives as physicians training on the right management for the right condition, to be able to diagnose and intervene right at the minute that patient needs that care. Medications are complicated and can treat multiple disease processes.

For example, as you mentioned, methotrexate, which is a medication we use to treat ectopic pregnancies, and back in the day used to use for abortion care, also treat things like rheumatoid arthritis and lupus, which disproportionately impact women. And so there is confusion now between providers or pharmacists about what medications they can provide for patients.

There is a lot of overlap, for example, on miscarriage management. It is the exact same medicines, the exact same procedure as abortion care. And so it is unclear if providers can provide that care under these very confusing regulations.

Senator HASSAN. Thank you very much. And thank you, Madam Chair. I think it is clear that these decisions are best left to women and their health care providers. Thank you.

The CHAIR. Thank you.

Senator Cassidy.

Senator CASSIDY. Thank you all. It is kind of with—you know, I am a physician, and it is kind of with grief that I come to this because there is so much misinformation put out. But let me first say that we have a lot of common ground here. A lot of common ground.

First, let me just say, what has actually been accomplished are things that I personally I have been involved with. I have lived in has been signed into law the John Lewis National Institute on Minority Health and Health Disparities Research Endowment Vitalization Act, and Maternal Health Quality Improvement Act.

Two things designed to address disparity. Working on legislation called the Connected Mom. Allowing a woman on Medicaid to be

at home and have her vital signs measured remotely as opposed to perhaps taking public transportation to and from the physician.

We have worked—we have worked significantly on what to do about addiction services, knowing that many women who die a year, within a year after a pregnancy die of addiction. Working on—we just passed a major suicide bill, a mental health bill, which, again, since many women who die post pregnancy die of suicide. So, but we there is more to do. I emphasize that because there is common ground, and the common ground gets kind of lost in the midst of a cloud of misinformation.

Now, again, I am going to speak as a physician because I found that when patients came to me in a panic, the first thing I had to do was kind of dispel their fears that were not the case, and to try instill facts where there was instead this kind of, oh, my gosh.

First, I think Dr. Marshall did a wonderful job of pointing out that he as a pro-life physician, takes care of patients with ectopic pregnancies, period, end of story. So we hear dialog that somehow a woman with an ectopic pregnancy will not get her care. It is just not true. Can we dispel that? And when folks say, oh, those states that have the highest—the most restrictive abortion have the highest maternal mortality.

No one speaks of Washington, DC, which has the highest maternal mortality and has absolutely no limit upon abortion access, up to the point of parturition. The baby can be coming through the birth canal here in Washington, DC. and can be aborted.

Five minutes, it would be a child in someone's arms, and instead 5 minutes early is dismembered, his skull crushed, and they have the highest maternal mortality in the Nation. And my gosh, if there is anything to fear, Ms. Swindell, in my home state, I happened to visit one of the crisis pregnancy centers.

It is amazing the good work they do. And people come there voluntarily. They can leave at any time. They elect to stay. And when I went there, they had a whole closet full of clothing and formula. I said, well, this is—I thought you were prenatal. And they said, no, we continue to care for the family of the child after the child is born, and we have all these that are here for that family.

Now, there is Federal legislation being introduced that would shut down crisis pregnancy centers, that would say, Ms. Swindell, no matter what your good work, Washington, DC. is going to shut you down. I will also say, my gosh,

there is all this kind of implication that Washington, DC. is bearing down on people's lives. There is Federal legislation to ban crisis pregnancy.

Democrats want to force pro-life physicians and nurses to either do abortions or lose their license or have—face civil penalties. Dr. Marshall, you are pro-life. If you decided, no, the heavy hand of Washington, DC. is going to come in and snatch your license away or subject you to civil penalties.

That is concerning. Can anyone—now next, can anyone name a state in which there is a law saying that if the life of the mother is at risk, the woman does not have a right to an abortion? You can't because there is no state. Every state allows an exception for the life of the mother.

There is this kind of, frankly, misinformation that is not the case. I am going to speak as a physician. There is a lot of common ground. Let's do something about maternal mortality. But let's don't hide our efforts in a cloud of misinformation, suggesting for a fact that aborting every baby is the way to protect mamas' lives.

When we see here in Washington, DC, with the most liberal law in abortion in the Nation having the highest rate of maternal mortality. Now, let's suggests that a mama is going to have her life placed at risk because of these or because of an ectopic pregnancy, she can't have her abortion addressed. And the richest was a transgender are somehow going to be affected.

There is not a law out there related to abortion that also relates to transgender. I usually ask questions, but here I just had to say, let's all think like doctors who really want to lower maternal mortality, but also calm everybody down with facts, not with misinformation. With that, I yield.

The CHAIR. Senator Smith.

Senator SMITH. Thank you, Madam Chair, Ranking Member Marshall. Dr. Taylor, I want to just turn to you quickly. Could you quickly respond to this myth, of course, about post-abortion trauma and suicidal thoughts? Maybe also just quickly address some of the systemic causes for the vast disparities in maternal mortality in this country.

Ms. TAYLOR. Sure. Absolutely. You know, based on how I talk about maternal mortality, I center around black women in the work that I do. And the maternal health crisis is the root of that is racism. How we see structural racism not only show up in the health care system, but I think also broader society.

We know that racism, particularly the experience of it for black people, causes us to be more susceptible to disease, mental health challenges, in addition to physical health challenges. And so we do see that show up sometimes in the context of the care that pregnant women may be undergoing.

I think a part of it is to black women also have reported experiencing not being listened to by their health care providers. So when they express pain or discomfort in some of their exchanges with physicians, that is sometimes ignored.

We even saw Serena Williams share her own story of what happened to her and not being listened to shortly after having her daughter. And so to me, those are some of the root causes of the maternal mortality crisis.

Look, I recognize that pregnancy in and of itself, no matter how you decide to move forward, that is the decision based on the woman and her family in consultation with her physician.

That can spark some challenges for her mentally because it is a difficult decision. But I don't think that it is true to say that for the most part, women who stand firm in their decision to have abortion are regretting that or experiencing mental health challenges because of that.

Senator SMITH. It is fundamentally a question of who has the decision and the ability to control your own decisions in your own life

is really what this is about, it seems to me. I would like to turn to you, Dr. Brandi, and turn to the question of medication abortion.

Medication abortion has been a safe and effective way of terminating a pregnancy in the first 10 weeks. For nearly 20 years, a provider can safely prescribe medication abortion through telehealth in most cases, and it can be delivered to the male also. Slightly over half of abortions in this country are done with medication now.

But now that the Supreme Court has overturned *Roe*, this medication will be a crucial access point for many women. We cannot allow Republican politicians to spread misinformation about this medication, which is happening, or to erect unnecessary hurdles, unnecessary hurdles to stop women from access.

Dr. Brandi, can you just tell us, is medication abortion safe and effective for women to use in the first 10 weeks of pregnancy?

Dr. BRANDI. Senator. That is an easy one. Absolutely.

Senator SMITH. Thank you. And can you just walk through a little bit of the process for how providers determine whether medication abortion is effective for a person?

Dr. BRANDI. Sure. When I see a patient that is seeking abortion, I always go through all the options and talk about risks and benefits.

Particularly around medication abortion, there are very rare contraindications to receiving medication abortion, but generally it is incredibly safe. It is anywhere between 95 and 99 percent effective in ending a pregnancy up to 10 weeks. And it is something that requires very few interventions from the health care system.

Many people can determine based on their last menstrual period when they became pregnant, and based on that and their symptoms, a patient can be provided this medication over the phone via telehealth.

Senator SMITH. It is not medically necessary for a person to be prescribed this medication by a physician in an office?

Dr. BRANDI. Not in an office setting, no.

Senator SMITH. Thank you. I want to just be clear about this. Medication abortion cannot alone undo the damage done by Republican politicians who are taking away women's freedom. And today, we know that there are states that are undermining the capacity of people to access medication abortion, but it is an important access point to protect access where we can and to actively fight this misinformation, I think, is an important thing for us to do here.

I am sorry that I am out of time here, but I want to just follow-up briefly on the question, the line of questions that Senator Hassan asked, which was to really—really to illustrate the chaos that is ensuing around this country as a result of this extremist Supreme Court decision to take away this fundamental freedom of people.

What we see from Republican lawmakers determined to control the decisions that women want to make based on where you live, the right and freedom of women to get an abortion, to manage their

miscarriages, to treat an ectopic pregnancy is now severely compromised.

This legal chaos, which has ensued, means that your doctor may not even believe that they have the autonomy to decide and to make it into practice based on what their best medical information is and what they believe is best for their patient. So let's be clear. Let's be clear. Republicans are responsible for this chaos.

They created this health care crisis because they believe they know better than women whose lives and stories they will never know. They believe that they know better. They believe that they should control.

That is what we are now faced with. That is what we are now working to fix. We will not stop working until women's freedom can be exercised equally in all parts of this country. Thank you, Madam Chair.

The CHAIR. Senator Braun.

Senator BRAUN. Thank you, Madam Chair. Listening to Senator Smith's point of view there, I think as we do give it, this is a topic that I think for 49 years has been in one place. It has now come to another. I think we have got to be careful that we don't get too caustic in either point of view.

Right now, the Supreme Court says it is back with the states. I have been a believer on this issue from the get-go. You do not demonize the folks you disagree with, and you make sure that in this case, when we have returned this to the people, we make the right decisions at the state level. I am going to have the same question and I am going to start with Ms. Detzer.

You were quoted on September 17th, '21 on Fox 13, Seattle News that you have not looked back except in celebration and deep appreciation for your choice. And again, respect that. I would like to ask you, though, when it comes to, when your state grapples with it, at what age do you think gestationally it is no longer appropriate to have an abortion.

Just a simple question. I think that any of us, if we are out here talking about the issue, especially in states where it may go beyond where it is commonly accepted, I would like to know your opinion.

Ms. DETZER. Sorry, Senator, could you repeat your question, please?

Senator BRAUN. You and your—some of the organizations you support, support abortion, I believe, up until the moment of birth. I would like to give you the chance to clarify that if you think that is still where it should be, or if there is an age beyond which you would not be comfortable with an abortion.

Ms. DETZER. I am not a medical provider. I have no standing to make any statements about medical limits. What I am here to do is to share with you all my personal story of abortion access and to highlight how my mother story of abortion access was so very different, and how much changed in just one generation between us.

Senator BRAUN. Putting a medical issue aside and assuming there was none, is there an age beyond which you would be uncomfortable with an abortion?

Ms. DETZER. I am sorry. Are you asking me to consider an abortion not a medical procedure? Because I believe that it is. It is health care.

Senator BRAUN. Taking the inherent risks of an abortion aside, and if it is minimal, do you think there is an age beyond which you would be uncomfortable with it?

Ms. DETZER. I am sorry. Could you please repeat that question? I am not sure how to separate health care from an abortion.

Senator BRAUN. You are making that point, and I will let you rest on it. I will go to Ms. Brandi with the same question.

Dr. BRANDI. Excuse me, Senator. Are you asking me a question or——?

Senator BRAUN. Same question I asked Ms. Detzer.

Dr. BRANDI. I apologize. I was confused. I am Dr. Brandi. Thank you. I think what you are trying to bring up is abortion care later in pregnancy. I understand people have very different opinions about what that looks like and how they feel comfortable regarding different gestational age limits.

But I think talking about these hypothetical scenarios doesn't actually respect the pregnant people that I take care of every day that have varying circumstances. And as a physician, I think the most prudent thing is to listen to their stories, assess their own medical risks, depending on where they are in pregnancy, and help them decide what's best for them.

I think bans based on a gestational age, whatever that gestational age is, just create barriers to care and don't actually improve the safety of care, which is what I care about most for my patients.

Senator BRAUN. You know, being a doctor, I think you may have a better way to answer the question in the sense that I know there is medical risk in doing anything. At the point you can't eliminate risk, but were—say there would be as little as you could determine at the time, do you still think it is appropriate for someone to choose an abortion up to the point of birth?

Dr. BRANDI. Senator. Again, that hypothetical that I think is brought up quite a bit actually is not what abortion care looks like on a day to day basis. Abortion care after 20 weeks is about 1 percent of pregnancy. I think by focusing on that, you de-legitimize and you disrespect a lot of the patients that are seeking this care for very legitimate and important reasons.

Senator BRAUN. Ms. Swindell, would you like to weigh in?

Ms. SWINDELL. Sure. I believe in what all the medical textbooks say. I am not a medical professional, but life begins at the beginning. And there is an amazing spark that occurs when the sperm and the egg meet, and a new embryo is formed.

I believe in respecting all stages of life and development. I think that is an important part of human rights and also women's health care. And so I believe in what the medical textbooks say. I believe in biology. I believe in science. And frankly, it is not rocket science.

Life begins at the beginning. And abortions at any stage take the life of an innocent human being, and that is a grave human rights

violation. I was born after 1973. I was born in 1976, aging myself here. I was open prey in my mother's womb.

My Government decided that I had no Constitutional rights or human rights or civil rights. And it is a new day, and it is a new era. And pre-born children, their humanity is being respected. And it is a great thing.

Senator BRAUN. Thank you. I respect all of your opinions and ask the question because of how difficult it is to answer. And why they should be left with the states, with the people within the states to make that decision. When you look at——

The CHAIR. Senator Braun, your time——

Senator BRAUN. Yes, and I will finish up here in just a moment, with that diversity of opinion. So thank you for your answers.

The CHAIR. Senator Hickenlooper.

Senator HICKENLOOPER. Thank you, Madam Chair. I thank all of you for your service and your willingness to come here today. You know, I grew up—I was born in 1952 so the issues around abortion were of intense discussion, obviously, in those days. And my mother was a single mother, raised four kids by herself and we discussed frequently the issues surrounding abortion.

This was kitchen table discussions. It was my mother's—no matter how lean our household budget may have been, she tried to give every year some donation to Planned Parenthood.

Some years it was $10. But she felt that a woman who was forced to carry a child to birth, that they were not ready for, that they didn't intend, was being forced to give up part of their life and to have challenges and obstacles that would make their achievements in life far, far more difficult and oftentimes would lead to devastating results.

Colorado State where we are—we proudly support a woman's right to access, the right of access to health care. But we are surrounded by states on three sides that have either or are going to or are expected to enact abortion bans. And we will certainly see a large influx of patients. I think this can stretch the providers in Colorado and other states that are already quite thin.

It is going to impact access not just to abortion, but to other reproductive services. Dr. Brandi, I will start with you. How are these abortion bans impacting access to other reproductive health services like contraceptive care, cancer screening, etcetera?

Dr. BRANDI. Thank you, Senator, for the question. You are right that while abortion bans on face value just impact abortion, they impact so much of reproductive health care and care that is entirely unrelated to reproductive health care.

Things like, we mentioned earlier different immunologic diseases can be impacted because treatments are very similar. Or, for example, cancer cases where people may get delays in their care or may have contraindications to certain types of birth control that may not be accessible to them.

There are so many ways that this is impacted, ways that medical physicians and other health care professionals knew about, and we are seeing through Texas. But every day I am hearing a new report

about a different medication, a different patient scenario, because every patient is unique.

Every patient is an individual. And we in medicine have to be creative sometimes when we take care of patients, find new ways to treat different diseases. And when our hands are tied, when there are certain bands that just create a law without thinking about the people that it impacts, it is really challenging for physicians to be able to meet that individuality of patients and give them the appropriate care that they need.

Senator HICKENLOOPER. All right. Thank you very much. Dr. Taylor, I wanted to ask you also, in your opinion, what does this notion of Government mandated pregnancy or enforced pregnancy, what kind of outcomes is that going to lead to and what kind of health outcomes is that going to lead to for women?

Ms. TAYLOR. Absolutely. Thank you for the question, Senator. First of all any time we are forcing a person to continue with a pregnancy that they would like to terminate, it could impose various issues for that individual, whether it is stress, anxiety, mental health challenges.

I think in addition to that, if we put this in the context of the maternal health crisis in this country, it could mean that individual may not keep up with their prenatal care appointments. They may also struggle financially if they have to continue with a forced pregnancy.

We also know that even if you look at something like higher education we know that for a woman who can access an abortion, a college age woman, that she is more likely to finish school. And so it really has an impact on the broader consequences of that person. I think another point I will add too is that about 60 percent of people who have abortions are already parents.

Not having the opportunity to terminate a pregnancy for a woman and her family could mean that she is unable to care for and support the children that she already has. It could impose additional economic challenges for the broader family, and it could even lead to health challenges for the children that she already has.

It really is a broader issue that can impact various aspects of a woman's life.

Senator HICKENLOOPER. All right. Thank you very much. And just one last very brief question, if I can. I saw a number, heard a number last week that almost half of all pregnancies in America are accidental or unintended. Is that true? Do any of you have that accurate number on that?

Dr. BRANDI. I can speak to that. Yes, about 45 percent of pregnancies are unintended and about 40 or about half of them end in abortion. And so even though we talked earlier about percentages being very small, if you think about percentages on the broader sense, like the 14 percent of people, that is actually equitable to thousands of people that can become pregnant in our Country. And so that is a huge impact for people across our Country.

Senator HICKENLOOPER. Right. Thank you all. Thank you.

The CHAIR. Thank you.

Senator Murkowski.

Senator MURKOWSKI. Madam Chairman, thank you for the hearing today. And to our witnesses, thank you. I have had an opportunity to read your stories in your testimony that you have provided to the Committee.

I have heard many stories from Alaskans, most notably in this past couple of weeks, from women who are really very distraught about the Supreme Court ruling in the Dobbs case.

But the stories that you have shared from a personal decision to terminate a pregnancy and to the challenges that parents or family members face in accessing care, to the stories that women who visited clinics such as Stanton and decided to continue a pregnancy, I think they all demonstrate how these are very deeply, deeply personal, deeply complicated and of course, incredibly challenging decisions that far too many women face each year, and clearly that Americans hold deep and conflicting convictions over.

When it comes to decisions that are so personal, that are so complex, and have such an impact on a person's lives, I think that choice must ultimately be in the hands of the individual and not in the Government.

That is where I came down on vaccine mandates. It is where I come down on abortion. But I think that like so many other areas there, there are nuances, there are gray areas. Many Americans, myself included, believe that it is reasonable to not require those who are firmly opposed to abortion to support it with their tax dollars, and that providers who do not wish to be involved in abortion should not be forced to be.

What I would hope that we can agree on is that it is in the best interests of everyone to create a system where fewer women face this choice in the first place because everybody has adequate access to and knowledge about contraceptives and because women and families have the support that they need.

But ultimately, I believe in limited Government, individual liberty. I support a woman's right to make her own health care decisions and that means reproductive health care. I am working with a small bipartisan group to ensure that the rights that women have relied on for the last 50 years as established in *Roe* and in Casey and in Griswold, that these are protected.

I hope that at a minimum our legislation will demonstrate that there is a majority in the U.S. Senate that supports these basic rights. I know that folks are all like, well, how are we going to get this legislation passed? And so kind of the knee jerk response here is to take on the filibuster.

I want to just raise this because I think that it is tempting to call for the removal of the filibuster so that we can do something. But I would ask my colleagues to take the longer view and think about what elimination of the filibuster would mean for both sides and for our Country in the future.

In the recent years, the filibuster has been used multiple times to block attempts to restrict access to reproductive health care. Three times, in 2015, 2018, and then again in 2020, pro-choice Senators used the filibuster to block a 20 week abortion ban. It was

used to stop a blanket ban on funding for Planned Parenthood in 2015.

There were numerous other times to prevent the erosion of reproductive rights. I think we have got to look at this again down the road. The balance of power in Congress moves back and forth. Without the filibuster, do we really think, do we really believe that a different majority would not seek a nationwide ban on abortion and find a way to succeed in enacting it?

The filibuster is really one of the few mechanisms that protects the rights of the minority. I raise this because I think we need to be looking long term at this. Now, this hearing is about reproductive care in a post *Roe* world. I want to ask you, Dr. Taylor, what does this mean?

What are the downstream impacts that we should expect on access to care outside of abortions, even in states where the Dobbs decision will not have an effect? In Alaska, our courts have held that our state Constitution protects access to abortion. But at the end of May, Planned Parenthood clinic in Soldotna closed its doors.

They do not provide abortions. The Dobbs decision again is not going to impact our state. But what we heard was a Planned Parenthood spokesman said that the closure was a result of review by Planned Parenthood that led to the closure of five clinics nationwide. They are basically looking to reduce their budget to prepare for changes in states with trigger laws. We don't have one of those.

Now, the closest Planned Parenthood location to Soldotna is in Anchorage, it is 3 hours away. The closest source of Title X comprehensive reproductive care is Homer, 2 hours away. So we are seeing changes like this in a state like Alaska that is supposedly not going to be impacted because of our Constitutional provision.

But you have got trigger laws in states like Kentucky and Idaho that are driving a reduction of access to birth control and reproductive care as far away as a state like Alaska. I haven't allowed much time for the response here. But it is a concern to me that the reduction to access in care is going to result in more and not fewer unplanned pregnancies.

The CHAIR. Senator Murkowski——

Senator MURKOWSKI. I ask the question of Dr. Taylor——

The CHAIR. Dr. Taylor has left momentarily. She will be right back. We can ask her for a response in writing or attempt Dr. Brandi.

Senator MURKOWSKI. Maybe Dr. Brandi can address that. Thank you. I didn't realize that she had vacated the Chair there.

Dr. BRANDI. Sure. Thank you for the question and happy to answer. You are absolutely right that there will be downstream effects, and we will not know truly all of the effects that will impact things like maternal morbidity and mortality, unplanned pregnancy rates for—we won't know that for years to come.

But I think it is important to name that we have a health crisis on top of already, a health crisis through COVID. That many labor and delivery wards across the country, for example, have closed because they were unable to keep their doors open.

Thinking about an influx of people that may be seeking maternity care, do we have the support systems? Abortion and maternity care are not mutually exclusive. And I am an OBGYN. I take care of both patients.

Not often patients are the same patient. And so it is important to recognize that things like maternity care, labor and delivery, and having access to nearby clinics in the communities that are needed are both issues that need addressing and will have long term impacts.

The CHAIR. We have gone way over time on Senator Murkowski, so I am going to move on to then——

Senator MURKOWSKI. Thank you, Madam Chair.

The CHAIR. Thank you.

Senator Rosen.

Senator ROSEN. Thank you, Chair Murray. You know, this hearing really comes at a critical time. I appreciate the thoughtfulness of the Senator from Alaska, how she is working on a bipartisan way to help us move forward on this.

Thank you. But nonetheless, the Supreme Court's decision to overturn *Roe v. Wade,* it does take away a woman's right over her own body and it is going to hand it to anti-choice politicians. In states like Nevada, access to reproductive care, it remains—to health care remains protected. But the threat of a nationwide ban is real. And it will have, it will have dire consequences.

It is why I am going to continue to call on President Biden to take all executive actions he can to protect reproductive rights, to protect women's lives, and it is why we need to ensure a total ban on abortion never becomes Federal law. And so all of us here have been discussing extreme abortion bans and anti-choice politicians rolling out these rigid bans across the country, forcing women to carry pregnancies against their will.

We have seen some laws so extreme they don't even have exceptions for rape or incest. I know we are at the end of a—toward the end of a long hearing, and I have a few questions.

Dr. Brandi, maybe we will just have a discussion about how the lack of, total lack of exceptions, these very rigid state laws, how it is harmful to women, how it creates a unique burden on someone like you, an OBGYN, the patient and the doctor, waiting until somebody is moments, perhaps from death in order to take care of them.

Can you just speak a little bit about that? I have a few other questions on this. I thought we maybe have a discussion.

Dr. BRANDI. Thank you, Senator. I would love to have a discussion on this. I think it is—it was mentioned before that there are exceptions for the life of a mother. And so, of course that is okay.

That is great for our patients, make sure that they are safe. But the problem with the very few restrictions, or the very—sorry, the very few allowances for being able to provide abortion care is that it doesn't take into account the individual circumstances of that person.

What we are seeing across the country now in places where abortion is banned, except for life of the mother clauses, is that people don't know what that means on the ground. Doctors don't know what that mean.

Ideally, as a physician, if I have a patient that has an illness, a condition, I want to be able to treat her right then and there. I don't want to wait a couple of hours or a couple of days for conditions to get worse. And many doctors across the country are asking, how bad does it have to be?

Senator ROSEN. Where is this thin line? And where is the thin line between life and death for both, for both the mother and the fetus? You talk about this. What about in cases of severe anomaly where someone is forced to carry a pregnancy? Can you talk about that and what—how you are going to deal with that? Fetuses with a severe fetal anomaly, pregnancy isn't viable, and it is really a threat to the physical and mental health of the woman.

Dr. BRANDI. Sure. I think you bring up a good point around viability, which is a very common conversation about having gestational age bans, for example. That every pregnancy is different. Some pregnancies may be viable at certain gestational ages. Some pregnancies where the fetus has some type of anomaly may never be viable.

I have patients that have that situation where they have a fetus with anomalies, it is always a nuanced conversation about what are their goals for this pregnancy and what are their goals for their potential child? Do they want to continue a pregnancy and deliver and go through a labor process and watch that fetus when it is delivered, watch their baby die shortly after?

Or do they want to have an abortion and end the pregnancy earlier? I think that decision should be that individual person's decision. I don't think I am able to make that decision for them. I am hopeful that people outside of their families, people like politicians, won't be able to make that decision for them either.

Senator ROSEN. Again, it is about individual liberties and right to privacy. But sadly, in some states, women can face jail time, steep financial penalties, possibly the physicians, the nurses, friends or neighbors or family members who may help you. So, what impact do you think these threats of jail time on everyone are going to impose on people?

Dr. BRANDI. Thank you for that question. I think—I assume that most doctors didn't go to medical school to wait to take care of patients, to delay care. All of us want to provide the standard of care. We want to provide evidence based medicine and help our patients with whatever care that they need.

Now physicians are being put in an impossible situation where they have to decide whether or not they want to follow their oath, to do no harm, to protect our patients, or protect ourselves and protect our families and protect our licenses. That is an impossible decision.

Doctors care so deeply for our patients. I know I care so deeply for my patients. And it is incredibly hard to think about being in that position where I can't intervene because I have to call my law-

yer force to make sure that it is okay, or that I am going to wait and wait and wait until someone gets sicker and sicker because I don't know what that law means.

We are seeing that across the country. I am hearing stories from all over, from physicians that are withholding lifesaving care because they don't want to go to jail. And that is really not how health care should work.

Senator ROSEN. An incredible burden on, you are right, for the physicians and health care providers who care so deeply, and of course, for a woman and her family's right to privacy in these choices. Thank you, Madam Chair.

The CHAIR. Thank you.

Senator Murphy.

Senator MURPHY. Thank you very much, Madam Chair. Thank you all for your testimony today. And thank you for this hearing. In states across this country that have imposed trigger laws and some of the most intense restrictions on abortion, there also tend to be the fewest services available for women and families.

Run through the list of states that are in the midst of criminalizing abortion and you will run into states that have refused to expand Medicaid under the Affordable Care Act, leaving women and families without access to the basic health care that is necessary to raise a child today.

Survey the states that have had on the books these trigger laws and you will find states that have not passed any meaningful family leave or medical leave legislation, leaving parents with no option but to have a baby and to immediately go back to work, to be able to afford that health care that isn't being paid for because of the lack of Medicaid expansion.

Dr. Taylor, could you just talk for a second about the consequence of a policy of forced pregnancy in states that provide no meaningful access to health care and parental leave. The kind of policies that you would think states that are so interested in more pregnancies would have invested in. What is the consequence of that?

Ms. TAYLOR. Sure. Absolutely. I think the consequences that we leave moms and their families out to dry. You know, as you have mentioned, it is so essential for a family to have access to affordable childcare, affordable health care access to nutritious foods. I mean, we can run down the list.

And unfortunately, in these states that are also banning abortion, they don't have those supports available to these families. I think another point to lift up here, too, is that these are all situations that are going to disproportionately impact women of color and who are already experiencing challenges, whether it is in terms of their financial outlook, housing, insecurity, poverty.

I think the conversation around providing services or providing diapers or maybe even formula, if you can get your hands on it in this moment temporarily, is not going to do anything to support those families over the long term.

Senator MURPHY. Dr. Brandi, I wanted to talk to you about another issue, an issue that the Senate may take up later this week.

Listen, this is all about putting Government in a position of control over women and their bodies.

But apparently it is not enough to tell women when they can bear a child. It is not enough to dictate to women when and how they can access health care. Now, we are going to also dictate to women where they can travel to get health care.

Because all throughout the country there are state Legislatures getting ready to take up pieces of legislation that would eliminate the ability of individuals, in this case women, to be able to travel where they want for health care in this country, just another mechanism of controlling the decisions that women make, Government being in charge.

One piece of legislation in Missouri contemplates legal liability for anyone involved in interstate health care travel, including the person who works at the call center to help set up your appointment would now be legally liable, would potentially be dragged into court after higher up lawyers in order to protect themselves. So I am interested in your perspective as a provider, right.

This world that we are entering into in which all of a sudden not only are you not going to be able to travel across state lines to obtain health care, but that everybody in the business of health care is now going to have to shut their doors to people who simply want to travel ten miles from one state to another in order to get health care. What does that world look like?

Ms. TAYLOR. Thank you for the question, Senator. I think it is a really scary world, what that potentially will look like. We are already seeing now that people are trying to travel to get care. I don't want to be checking people's licenses to confirm their address and know where they come from before I can intervene.

Doctors, health care providers just want to do our jobs. We just want to take care of people, whoever shows up at our door. But at the same time, we want to make sure that our clinics and our staff are protected from these arbitrary laws that are trying to chill our ability to provide health care to people.

I am also just heartbroken that people have to leave their communities to get the care that they need, not just for those people that are traveling thousands of miles, if they can even travel at all, but also for my friends, my colleagues that are out of jobs right now, that are—that have the skills, they have the medicines to be able to take care of people in their communities and are not allowed to. All of that is heartbreaking. And that is all not how health care should work.

Senator MURPHY. Thank you, Madam Chair.

The CHAIR. Thank you.

Senator Baldwin.

Senator BALDWIN. Thank you, Madam Chair. I would like to use some of my time this morning to highlight the words of Dr. Christine Lyerly, who is a board certified OB-GYN and abortion care provider in Green Bay, Wisconsin.

She says, imagine sitting in an exam room with your doctor explaining a very personal problem that is affecting every aspect of your life. And your doctor looks you in the eye and says, I know

how to help you, but I can't because the politicians in our state won't let me.

Physicians in Wisconsin have been forced to stop practicing medicine because of our state's restrictive abortion ban. It was signed into law in 1849. You didn't hear me wrong, 1849. That was 70 years before women even had the right to vote.

Instead of providing care to patients, they have to turn patients away or consult with their lawyers, delaying critical care and wasting precious time. Dr. Brandi, what is the impact of delaying care in these critical situations?

Dr. BRANDI. Thank you for the question. Delaying people's ability to access that care or delaying interventions in life saving situations can be the line between life and death for some people.

As stated earlier, it is very unclear what these laws mean for providers on a day to day basis. For example, and I apologize for getting too technical, but let's use the example of someone breaks their water at 18 weeks, 19 weeks. It is very unlikely that pregnancy will continue to term or will have a good fetal outcome.

But it is unclear based on this law with protections for the life of the mother, when are we allowed to intervene? Is it at that moment when typically I would have a conversation about—with that patient about what they want to do? Is it when that broken water creates an infection?

Is it when that patient becomes septic, when they are in the ICU in shock? It is not written down anywhere what we do because we want to follow the standard of care, and that would be to intervene at that moment. But these laws don't really specify, and it is very confusing for the people on the ground.

They are trying to figure out, well, when can I intervene? And while waiting, this patient is getting sicker and sicker when they don't have to. That is not evidence based care, and that is a scenario that many doctors are in right now.

Senator BALDWIN. Thank you. Dr. Taylor, can you describe how barring physicians from providing abortion care impacts access to other sexual and reproductive health care services? So, for example, how does this affect families and affect those who are pregnant or looking to become pregnant?

Ms. TAYLOR. Sure. Absolutely. You know, what comes to mind with this question is you do have some providers that are in situations where they are providing maternity care as well as abortion care. And so if they have to shutter, that means that the women in that community will not have access to the prenatal care that they need. You know, we have seen this at the Century Foundation in particular.

You know, we work with community based organizations that are actually run and led by you know, women of color serving the community on the front lines. And some of those organizations are providing services on both for abortion and maternity care.

Facility that has to shutter its doors, that is going to impact the comprehensive set of services that are available to folks in those communities.

Senator BALDWIN. Thank you. Dr. Brandi, this is for you again. Wisconsin's law provides that when an abortion is necessary to save a patient's life, this decision must be signed off on by two additional physicians. I will add that in Wisconsin, not even a cancer diagnosis or treatment for cancer falls under the exception for saving the life of the mother.

That means in Wisconsin, three physicians have to come together, possibly in an emergency situation, to decide if a woman's life is worth saving because it is now required by the Legislature in the State of Wisconsin.

On Monday, the Biden Administration released updated guidance on the Emergency Medical Treatment and Act of Labor Act, or EMTALA, reminding doctors that they must terminate a pregnancy if doing so is necessary to stabilize a patient in an emergency medical situation.

I want to thank the Administration for this guidance, but I know that it is not a complete solution for the political interference that doctors are experiencing, and we need legislation for that. Dr. Brandi, can you explain why burdensome requirements to administer emergency care are so harmful?

Dr. BRANDI. Thank you for the question. And just to briefly explain, EMTALA protects patients from being turned away from hospitals and emergency care settings, historically to protect people that were unable to pay.

The requirement requires emergency physicians to be able to assess a patient and potentially stabilize that patient if it is an emergency situation or transfer, if that patient is unable to be get the proper care in that setting.

The problem with EMTALA and its use right now within the abortion bans that exist is one, religious hospitals that may not provide abortion care can refuse and do not fall under the restrictions of EMTALA.

Many people seek care in these facilities. And even if they have a life threatening situation like breaking water early, hemorrhage, they don't necessarily have to fall under those rules.

The other thing with EMTALA is that, again, we are in the scenario that doctors are going to have to figure out among themselves, and it may be different depending on what hospital you are in, what is the stabilizing condition, how sick does someone have to be to consider that—if they fall under EMTALA or not?

There are going to be different scenarios, just like you are explaining, that many doctors would have to come to together and decide and figure that out. But it is unclear if we will be protected. Like how will we know if we are making the wrong choice?

The CHAIR. Senator Kaine.

Senator KAINE. Thank you, Chair, and thank you to each of the witnesses. Sharing your own personal experiences and stories is very important. I want to share a story. I won't do as good a job as you because this is a Virginian story, but it is not mine. But I want to share it. It was a news article. Madam Chair, I would like to ask to be introduced in the record from NBC News last week.

The CHAIR. Without objection.

[The following information can be found on page 68 in Additional Material.:]

Senator KAINE. Jamie Abrams, and I will read an excerpt from this. What moving from Kentucky to Virginia after I was diagnosed with cancer reveals about *Roe*.

After teaching *Roe v. Wade* as a family law professor, I experienced the stunningly painful irony of reading the leaked Supreme Court opinion in Dobbs on the day I was diagnosed with invasive breast cancer.

Overnight at age 44, I became a person who would need an abortion if pregnant because cancer treatments would compromise a healthy birth and delay needed cancer care. I also became someone like other hormone positive breast cancer patients who was advised to discontinue hormonal contraception because it could stimulate the growth of cancer cells.

In the aftermath of *Roe*'s being overturned, supporters of the move want to pretend that abortion access can be surgically extracted from women's health care decisionmaking as a whole.

Nothing can be further from the truth. Since the Dobbs' leak, which has made it clear what the conservative leaning court was poised to do, I have switched gears rapidly between being a reproductive rights scholar and a breast cancer patient. I also switched employment from Kentucky to Virginia at a time when a woman's Constitutional right to bodily autonomy has been stripped away.

This move across state lines and into a different area of women's health care has revealed a searing reality. We now live in a world of vastly divergent health care systems for women. When I was diagnosed with cancer, the last thing on my mind were pregnancy, birth control, and abortion.

Yet nearly all of my medical appointments, tests, and surgery itself were predicated on controlling reproduction and being able to terminate a pregnancy if needed. Cancer care also requires that I share my reproductive medical history about prior pregnancies, the number of live births I have had, the medications I have taken, what surgical procedures I have had, and who my other providers are.

I answered honestly, not worried now whether my answers are under surveillance by regulators or law enforcement. As a breast cancer patient in Northern Virginia, I have thankfully found unbounded compassion, empathy, dignity, privacy, and vital rising human connection.

But according to Kentucky's trigger law banning abortion, I would lose all decisionmaking autonomy and be subject to a doctor's discretion about whether an abortion was necessary to prevent the substantial risk of death. Is stage one breast cancer enough?

Stage two? What relevance are my two children for whom I desperately seek the best prognosis and longevity for myself? Does the law require me to endure the state for compelled progression of cancer?

The answers to these questions would be entirely unclear. In reality, doctors would treat me under an amorphous cloud of state

imposed liability because the Kentucky law makes it a Class D felony to provide abortions outside these exceptions.

I would like to ask you, Dr. Brandi, this—I was very, very struck by this. And it strikes me that this is probably not an unusual concern or case.

Dr. BRANDI. Thank you, Senator, for the question. And you are absolutely right, that I think many people before all of this happened didn't really understand the full impact of how this is going to radically change health care and put our health care system potentially into chaos.

I know as a doctor, I live in the gray, meaning that patients don't read the textbook. They don't come in with a very clear cut answer as far as what to do. All of our care is tailored to that individual person, and conditions like cancer have a unique treatment based on that individual person.

That involves a conversation about pregnancy options and whether or not to delay pregnancy, or whether or not a patient should terminate a pregnancy if they are diagnosed with cancer or wait several months to get treatment.

Senator KAINE. The notion that we would say to someone with a cancer diagnosis, hey just move to another state. I mean, just move to another state. This author could do that. A lot of people can't. People of low income can't. People of color would have a harder time doing that.

The notion of the court in Dobbs that we will just rely on your state Legislatures, state Legislatures, that where women are dramatically underrepresented, where people of color dramatically underrepresented. In Congress right now, 26 percent of Congress is women. That ranks us 76th in the world.

We are below the global average of women in Congress. So the notion to tell somebody who is politically less powerful, oh, just rely on your Legislature. Well, that is not going to give you comfort. That is why the 14th Amendment was passed to protect people who the majority would not protect.

Equal protection, even if the majority won't give it to you in a Legislature, you are entitled to it. Protection of your liberty. Even if the Legislature won't give it to you, as an American, you are entitled to it.

I can't imagine a scenario where we are just going to be casually telling cancer patients and those with other conditions, they just have to lump it and move to another state.

The CHAIR. Senator Casey.

Senator CASEY. Chair Murray, thanks very much. Thank you and the Ranking Member for the hearing. I know we are out of time because the—are getting close to the time the vote has expired so I will be very brief.

Dr. Taylor, I wanted to start with you and in particular wanted to cite directly from your testimony. In the third paragraph of your written testimony you say, and I am quoting, "black women are dying of pregnancy related causes at three times the rate of their white counterparts.

We are also most likely to experience severe maternal morbidity." That is what you said in those two sentences. How are these Americans impacted by the Dobbs decision?

Ms. TAYLOR. Thank you for the question, Senator Casey. You know, black women are, as you mentioned from those stats, more likely to experience maternal health challenges in this country.

I think the Dobbs decision is only going to exacerbate that. You know, for black women who may choose to terminate a pregnancy, they may be living in states where abortion is banned, and they are not able to do that.

If you think about that in the context of the fact that they are also more likely to die from pregnancy related causes this decision is going to be incredibly dangerous for them, and not only for them, but also for their families.

Another thing that I mentioned earlier today in the hearing is the fact that 60 percent of people who have abortions are already parents. Many of these women are already parents. And so this also has implications for their families.

We also know that when a woman in the postpartum period, when she is able to access the health care that she needs, prenatal care that she needs she is also more likely to have healthy children and healthy infants.

This is really something that is going to impact the black family overall, any other family who may be in a situation where they would have chosen to terminate a pregnancy, but they are forced to continue on with that pregnancy.

Senator CASEY. Thank you, doctor. I will maybe submit a question for the record for Dr. Brandi regarding miscarriage management and how this decision will affect your ability to treat the people that you treat. In particular, the relationship with your patients, including for pregnancy related care. If you want to respond briefly, but you can certainly amplify it for the record in writing if you want.

Dr. BRANDI. Sure. Happy to respond now or in writing. I will briefly say that, again, the management for miscarriage is the exact same management for induced abortion, same medicines, same procedure.

If there are restrictions about what type of procedure to offer or what type of medication is allowed, it just—it doesn't impact just induced abortion. It impacts all kinds of pregnancy care. I want to be able to offer the standard of care, the evidence based treatment that my patients deserve.

I don't think that legislation should be able to interfere with that, because that is what our patients need.

Senator CASEY. Thank you, doctor.

The CHAIR. Senator Marshall, do you have any closing comments or questions?

Senator MARSHALL. Yes, I would like to ask a couple more questions, if I could. Thank you so much, Madam Chair. Ms. Swindell, for years Planned Parenthood has claimed that they are not focused on abortion but provide a slate of services for women.

Why then has Planned Parenthood closed a clinic in your home State of Idaho and has plans to do so in other states that have passed laws or planned to pass laws to prohibit abortions?

Ms. SWINDELL. Great question, Senator. Yes, I think there has been at least 60 Planned Parenthood and abortion clinics nationwide that have closed since the overturning of *Roe v. Wade,* which is interesting when you hear the argument that they are all about helping women and providing all these other services and abortion is just less than 3 percent of what they do.

Well, then why are they closing all their clinics down? Wouldn't you want to stay open to help women, whatever they are going through with an unexpected pregnancy and to help navigate the current climate or perhaps provide all those other services that you claim to provide? So the reality is they are in the abortion business. That is what they want women to choose.

I think that is being exposed right now. My home State of Idaho, yes, the Planned Parenthood in Boise, right next door to one of our Stanton Healthcare clinics closed down. I do want to say that in Idaho, we have eight pregnancy resource centers and life affirming clinics throughout the State of Idaho.

Now there are two Planned Parenthoods and I think maybe one other abortion clinic. So if anybody would like some helpful advice on how to have enough accessibility for women facing unexpected pregnancies, you can look to the pregnancy care center movement and centers like Stanton.

Again, nationwide, we outnumber abortion clinics 4 to 1. So if you want accessibility look to us, look to what we are providing. And also, it makes the charges against our centers and wanting to shut us down—I think Senator Elizabeth Warren said, let's go after clinics like Stanton Healthcare with $100,000 fines to shut down what we are doing.

How can you want more care for women in one breath, abortion care, and explain all these scenarios where women are underserved and marginalized, and then go after the exact clinics that are providing those services very well in our Nation.

Senator MARSHALL. That is great. Ms. Swindell my job is to be a voice for Kansans. And one of your jobs today is to be a voice for your patients.

Ms. SWINDELL. Yes.

Senator MARSHALL. What would you like to share, that if your patients were here today, what would you share with us that you would think it would be important for Senators to know?

Ms. SWINDELL. Well, I would like to share with you, if I may, one of our client stories. She gave it to me, and I said I would do my best to share it. You have it in your written testimony that I submitted. I just highlighted a few parts to save time. But if I may, this comes from a Stanton client, J.C.

I was in a very bad place in my life when I decided to get an abortion. My mom told me she wouldn't have anything to do with my baby. My boyfriend was a drug addict and causing abuse in my life and left me. I was diagnosed with having severe panic attacks.

I drove to Planned Parenthood and saw Stanton Healthcare across the parking lot.

I went to Stanton Healthcare and found that they are a real clinic that helped me with everything I needed. They loved me and showed me I wasn't alone, gave me things I needed for my baby, counseling to get out of my life threatening, abusive relationship, and encouraged me that I could have a life with this baby.

Seeing my daughter's heartbeat made me stop feeling the panic attacks that made me want to abort and stop feeling the horrible nausea and see my baby as a real person that I couldn't kill. I instantly—it instantly made me feel attached to my baby and love her. I felt led to start my own business.

For the first time in my life, I can provide for my children on my own and have more than enough. They impacted my whole future and my children's future. I am so glad she is in this world now and in my life forever because I was able to choose to keep her with Stanton's help.

I thank God Stanton helped me get out of fear and choose life. My mother is in her life and happy I had her. It impacted her as well. My daughter has a sister, and I found a man that loves us all. All my fears were lies. I aborted my little girl, I know it would have caused me to carry shame and depression. Thank you, Stanton, for me and my baby. She has a future life because of you.

This story to me is important. No. 1, it shows the hope that a woman found, quality care and services. But it also shows that abortion isn't the solution. She got out of an abusive relationship. She got out of an economic situation where she was lower income. She was able to start her own company.

The depression and the anxiety went away. This became a catalyst for hope in her life because she had the care and the support that she needed. 50 years of unfettered access to abortion has not solved broken systems and throwing abortion at women does not fix their problems.

What she found at Stanton Healthcare is what changed things in her life. Thank you.

Senator MARSHALL. Thank you. Madam Chair, may I have a closing remarks then?

The CHAIR. Very shortly. We have a vote and I have a closing statement.

Senator MARSHALL. All right. Well, thank you, Madam Chair, hosting this Committee. Thank you so much, Ms. Swindell, for giving us a message of hope, a message that this world greatly needs today.

Like everybody in this room, we are glad that our moms chose life. I want to publicly, No. 1, is condemn all violence, vandalism, threats, and attacks. There has been at least 40 attacks of violence and vandalism against pregnancy centers and churches, like in Kansas, in Overland Park, at the Church of Ascension.

That is certainly not the answer. Next, I want to point out my concern that last week the White House is hosting Kansas Legislatures in an attempt to interfere with the Kansas Value Them Both amendment.

The Biden White House has created enough hardships for Kansans like the price of gasoline and groceries. We don't want them forcing their radical values on the people of Kansas. I will close with this. I have spent my entire career, professional career, fighting to protect the life of moms and babies in the delivery room, in the emergency room, and in the halls of Congress.

Protecting their lives and well-being will be continue to be a priority for me, to ensure that women have access to family planning services, contraception, and birth control, to make sure that every woman has care during, before, and after the pregnancy. But we will need collaboration.

I am committed to continue to work across the aisle to provide these services and to improve our maternal mortality rates. Indeed, abortion is not the solution. Thank you, and I yield back.

The CHAIR. Thank you. You know, as we conclude this hearing, I would like to once again thank all of our witnesses for being here. But I want to make clear, we have seen attempts from Republicans to distract people from the truth.

To say that they don't want to control women's bodies even as abortions are being canceled and women are forced to stay pregnant and give birth against their will. To continue saying it won't be that bad, even as people are now losing access to lifesaving medications. And of course, Republicans are still trying to push this ridiculous, patently false notion that they aren't oppressing women, so much as leaving it to states and local officials and politicians to oppress them.

That is dishonest. They know full well many women are not able to travel. They don't have time off. They don't have childcare. And they don't have the funds. They know that these cruel bans are already creating overwhelming demand from states like mine that have the protected right to abortion.

Washington State health care clinics are already preparing to treat patients who are fleeing from states like Idaho to get the health care that they need. And what is more, Republicans are already talking about stopping those patients from traveling to get an abortion and stopping people from helping others to travel to get an abortion.

We all heard former Vice President Pence call for a Federal ban, a call that other Republicans are continuing to echo. That is not empowering local decisions when you are overwhelming and overruling states like mine.

If you want to be honest about this, about making it local, it should be local. Leave it to the patient and their health care provider. The willful ignorance of how deadly these policies are, even when these courageous witnesses today are doing everything they can to tell their story and make us listen, is not unexpected, but it is very disappointing.

You can't spin away ripping away someone's rights, taking control over their body, denying someone medication, or taking away their plans for their future. You can't spin putting someone's life in jeopardy.

That is why we have seen a lot of clumsy attempts to change the subject. And let me be perfectly clear, we are not changing the subject. Not as long as I have anything to say about it. Women should have the right to make their own health care decision with their family, their doctor, and their faith.

That is what I will continue to fight for. I would like to ask unanimous consent to add two statements to the record about the impact of Dobbs on women's health. So ordered.

[The following information can be found on pages 53 and 65 in Additional Material.:]

For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days, July 27th, 5 p.m. With that, the Committee is adjourned.

ADDITIONAL MATERIAL

AMERICAN ACADEMY OF
FAMILY PHYSICIANS (AAFP),
July 13, 2022.

Hon. PATTY MURRAY, Chair,
Hon. RICHARD BURR. Ranking Member,
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Washington, DC. 20510

DEAR CHAIR MURRAY AND RANKING MEMBER BURR..

On behalf of the American Academy of Family Physicians (AAFP) and the 127,600 family physicians and medical students we represent, I write in response to the hearing *"Reproductive Care in a Post-Roe America: Barriers, Challenges, and Threats to Women's Health"* to share the family physician perspective and the AAFP's Federal legislative recommendations.

Primary care physicians are often a patient's first point of contact with the health care system, with more than half of all office visits made to primary care physicians.[1] Family physicians are integral to the reproductive health of adolescents, teens, and adults, providing preventive health, chronic disease management, family planning, preconception counseling, pregnancy, postpartum, and menopausal care for patients across the gender spectrum throughout their reproductive years. While some patients seek care from pediatricians or obstetrician-gynecologists (OB/GYNs), in rural and underserved areas, family physicians are often the primary or sole providers of reproductive health care.[2] **The AAFP believes that pregnancy and reproductive health services are essential to general health care**.[3]

The AAFP is concerned by the Supreme Court's ruling on Dobbs v. Jackson Women's Health. This consequential ruling struck down the longstanding protections afforded by *Roe v. Wade* and Planned Parenthood v. Casey, jeopardizing the health and reproductive autonomy of patients across the country. The decision limits the ability of physicians in many states to provide safe, evidence-based medical care and erodes the patient-physician relationship. **In response to the Dobbs ruling, the AAFP joined with the American College of Obstetricians (ACOG), the American Medical Association (AMA), and 75 other health care organizations in releasing a statement unequivocally opposing legislative interference in the patient-physician relationship**.[4]

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[1] National Center for Health Statistics. National Ambulatory Medical Care Survey: 2018 National Summary Tables. *https://www.cdc.gov/nchs/data/ahcd/namcs—summary/2018-namcs-web-tables-508.pdf*

[2] Fryer GE, Green LA, Dovey SM, Phillips Jr RI. (2001). The United States Relies on Family Physicians Unlike Any Other Specialty. Am Fam Physician, 63(9): 1669. *https://www.aafp.org/pubs/afp/issues/2001/0501/p1669.html*

[3] American Academy of Family Physicians. (2022). Reproductive and Maternity Health Services. *https://www.aafp.org/about/policies/all/reproductive-maternity-health-services.html*

[4] American College of Obstetricians and Gynecologists. (2022). More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference. *https://www.acog.org/news/news-releases/2022/07/more-than-75-health-care-organizations-release-joint-statement-in-opposition-to-legislative-interference?utm—medium=social&utm—*

Continued

The AAFP's policy on reproductive and maternity health services states, **"The AAFP supports access to comprehensive pregnancy and reproductive services, including but not limited to abortion, pregnancy termination, contraception, and surgical and non-surgical management of ectopic pregnancy, and opposes nonevidence-based restrictions on medical care and the provision of such services."** [5] In the case of Dobbs v. Jackson Women's Health Organization, the AAFP joined the AMA and other leading medical societies in filing an amicus brief articulating our position that ″laws regulating abortion should be evidence-based, supported by valid medical or scientific justification, and designed to improve - not harm - women's health,″ and we maintain that position. [6]

Without the Federal protections afforded by *Roe*, numerous states have already enacted laws banning or unduly restricting access to abortion, and more are considering similar measures. **These laws jeopardize the health of our Nation and will surely worsen health disparities**. In addition to undermining patients' bodily autonomy and potentially endangering their health and well-being by precluding or delaying access to induced abortions, the Dobbs decision may also jeopardize access to certain forms of contraception and negatively affect medically necessary maternity care.

Violating the Patient-Physician Relationship and Interfering with the Practice of Medicine

Family physicians are trained to care for their patients throughout the life cycle and appreciate the challenges that adolescence, sexuality, family planning, balance of family life and career, and aging have on their patients, in addition to socioeconomic and community factors such as environmental quality, income and education level, housing availability, neighborhood safety, and social-connectedness health. Because of this, family physicians are able to provide evidence-based medical care personalized to meet each patient's unique health needs. The AAFP maintains that physicians should be free to have open and honest communication with patients about all aspects of health and safety. **The AAFP staunchly opposes legislation that infringes on the content or breadth of information exchanged within the patient-physician relationship and legislation that interferes with the provision of evidence-based medical care, either of which can harm the health of the patient, the family, and the community**. [7, 8]

While only a minority of physicians—roughly 3 percent of family physicians and 24 percent of OB/GYNs—perform abortions, **nearly every clinician who cares for patients of reproductive age and practices in a state where abortion is banned is affected by the Dobbs decision**. [9, 10] Since June 24, the AAFP and its state affiliates have received inquiries from members who are unclear about the definitions and requirements of their new or pending state laws. Below are some common topics of confusion and concern.

- **Treatment of ectopic pregnancies, pregnancies of unknown location, and complicated spontaneous abortions (i.e., miscarriages)**. Many state laws create ambiguity about whether treatment for ectopic pregnancy is considered abortion, creating physician or hospital fears of violating laws and setting the stage for disagreements in clinical judgment, which can lead to delays in critical and medically necessary care.

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source=twitter&utm—campaign=acog2022-advocacy&utm—content=joint-statement-legislative-interference

[5] American Academy of Family Physicians. (2022). Reproductive and Maternity Health Services. *https://www.aafp.org/about/policies/all/reproductive-maternity-health-services.html*

[6] American Academy of Family Physicians, et al. (2021). Amicus Brief: Dobbs v. Jackson Women's Health Organization. *https://www.aafp.org/dam/AAFP/documents/advocacy/amicus—brief/AB-DobbsVJacksonWomensHealth-092021.pdf*

[7] American Academy of Family Physicians. (2021). Infringement on Patient Physician Relationship. *https://www.aafp.org/about/policies/all/infringement-patient-physician-relationship.html*

[8] Group of Six. (2022). Legislation to Criminalize Physicians, Jeopardize Patient-Physician Relationship Have No Place in Health Care. *http://www.groupof6.org/dam/AAFP/documents/advocacy/prevention/women/ST-G6-OpposingCriminalizationOfCare-040822.pdf*

[9] Patel P, Narayana S, Summit A, et al. Abortion Provision Among Recently Graduated Family Physicians. Fam Med. 2020;52(10):724-729. *https://doi.org/10.22454/FamMed.2020.300682.*

[10] ANSIRH. (2019). More U.S. obstetrician-gynecologists are providing abortion now than in 2019. *https://www.ansirh.org/research/research/more-us-obstetrician-gynecologists-are-providing-abortion-now-2009*

- **Molar pregnancy**. This type of genetically abnormal pregnancy cannot end in fetal viability, but in some rare instances the abnormal fetus can have detectable cardiac activity, leading to confusion over whether "heartbeat laws" allow physicians to treat with a dilation and curettage (D&C).
- **Preterm premature rupture of membranes**. When membranes rupture prematurely prior to viability, the standard of care is to deliver the fetus with surgery or induce labor, which may be considered illegal in some states, even though the fetus cannot possibly survive. Failure to do so could lead to dire consequences for the patient such as intrauterine infections which could become life-threatening.
- **Cancer treatment for patient with pre-viable pregnancies**. Some cancer treatments require pregnancy termination before beginning, and others carry an increased risk of morbidity and mortality without immediate termination and surgical removal. Disagreements in clinical judgment or fears of violating laws can lead to delays in cancer care or incomplete counseling on treatment options. Abortion-ban laws and proposed bills in some states allow abortions only in severe, life-threatening emergencies. It is unclear if, under such laws, termination of a pregnancy is legal in these cases, delaying the pregnant patient's access to lifesaving treatment until after a pregnancy is carried to term.
- **Use of emergency contraception and IUDs**. Confusion over whether statutory definitions of "personhood" outlaw the use of emergency contraception, and if contraception methods which interrupt the implantation of a fertilized egg will be considered an abortion under certain state laws, is fueling misinformation and fear and limiting access to contraception. Issues so far include pharmacists refusing to dispense prescriptions for ulipristal or stock/sell over-the-counter oral emergency contraception, hospitals discontinuing provision of emergency contraception to rape victims, and physicians being unsure about or unwilling to place copper IUDs as emergency contraception.
- **Dispensing of medications to manage miscarriages or treat other conditions unrelated to pregnancy**. Pharmacists refusing to dispense or delaying filling misoprostol prescriptions can lead to additional burden for the prescribing physician and delays in needed care for patients. In addition to inducing abortion, this drug is commonly used in the treatment of ulcers, miscarriages, and post-delivery bleeding. There have also been reports of pharmacists refusing to fill or physicians stopping prescribing methotrexate, which is commonly used to treat rheumatoid arthritis and psoriasis. [11]
- **Treatment of infertility**. Patients and physicians alike are confused over whether statutory definitions of "personhood" will impact infertility treatments and assisted reproductive technology such as in vitro fertilization (IVF). Regardless of whether state laws intend to interfere with infertility care, the lack of clarity is already hindering patients' reproductive decisions. In this instance, abortion bans may have the unintended consequence of preventing patients who want to become pregnant from being able to grow their families.

In 2018, the AAFP, the American Academy of Pediatrics (AAP), ACOG, and the American College of Physicians (ACP) adopted *joint principles for protecting the patient-physician relationship* in response to the growing number of policy proposals that inappropriately interfered in the practice of medicine. [12] **Our organizations and the more than 400,000 physicians and medical students we represent call on policymakers to put patients first by taking these actions**.

1. Support participation of any qualified provider in federally and state-funded programs. Medicaid's "any willing provider" and "freedom of choice" protections are enshrined into law to ensure that an adequate number of clinicians participate in the Medicaid program to care for beneficiaries. Evidence has dem-

[11] Arthritis Foundation Statement on Methotrexate Access. (n.d.). Arthritis Foundation. Retrieved July 11, 2022, from *https://www.arthritis.org/about-us/news-and-updates/statement-on-methotrexate-access*

[12] Group of Six. (2018). Joint Principles for Protecting the Patient-Physician Relationship. *http://www.groupof6.org/dam/AAFP/documents/advocacy/legal/ST-Group6-LegislativeInterference-052318.pdf*

onstrated that restricting participation of qualified providers results in loss of access to critical care for our most vulnerable patients. [13], [14]

2. Maintain coverage of evidence-based essential health benefits such as maternity coverage and women's preventive services without cost-sharing, including contraception. Preserving access to this existing coverage is critical to ensuring that American women and families have access to the care they need.

3. Ensure that evidence-based Federal programs, including Title X and the Teen Pregnancy Prevention Program (TPPP), receive continued Federal funding and preserve evidence-based program requirements. Title X is the only Federal program exclusively dedicated to providing low-income and adolescent patients with essential family planning and preventive health services and information. Evidence-based sexuality education programs help young patients achieve their educational and professional goals by educating them about sexual health, including preventing unintended pregnancy and family planning. These and other Federal programs must continue to provide non-directive, comprehensive, medically accurate information.

4. Reject government restrictions on the information our patients can receive from their doctors. Patients expect medically accurate, comprehensive information from their physicians. This dialog is critical to ensuring the integrity of the patient-physician relationship. When outside entities restrict the information that can be given to patients of reproductive age or force physicians to provide them with medically inaccurate information, it can result in increased rates of unplanned pregnancy, pregnancy complications, and undiagnosed medical conditions.

Patient Safety Concerns

Family physicians are concerned about how overturning *Roe* will impact their practices. First and foremost, however, they are concerned about the health and safety of their patients and their patients' families. The AAFP believes that high-quality health care in family medicine is the achievement of optimal physical, mental, and behavioral health outcomes through accessible, safe, cost-effective, equitable care that is based on the best evidence; responsive to the needs and preferences of patients and populations; and respectful of patients' families, personal values, and beliefs, adapting their care to meet the unique needs of their patients and communities. [15] **Laws that unduly restrict, criminalize, or penalize the provision of safe, confidential, evidence-based medical care are a threat to patient safety**. Such laws not only interfere with the prevention, diagnosis, and treatment of health conditions but also prevent family physicians and their staff from adapting their care to meet the unique needs of their patients and communities.

Anecdotes and research on the impacts of institutional abortion restrictions offer evidence for how such restrictions put patients' health and lives at risk. [16], [17] Physicians in these settings recount cases in which abortion was medically indicated according to their clinical judgment but, because of an ethics committee's ruling, care was delayed until fetal cardiac activity was no longer detectable or in some cases the patient had to be transported to another facility. **What is clear is that the patient-physician relationship, patient safety, and patient comfort are compromised by arbitrary restrictions that force clinicians to act contrary to the medical standard of care**.

As confusion over new state abortion laws and anxiety about legal liability grow, cases such as these, in which patients experience delay or denial as they seek critical and in some cases lifesaving care, will multiply. The result will be worse health outcomes and greater health disparities nationwide.

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[13] Stevenson AJ, Flores-Vazquez IM, Allgeyer RL, Schenkkan P, Potter JE. Effect of Removal of Planned Parenthood from the Texas Women's Health Program. N Engl J Med. 2016 Mar 3;374(9):853-60. doi: 10.1056/NEJMsa1511902

[14] National Women's Law Center (2012). Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act. *http://www.nwlc.org/sites/default/files/pdfs/nwlc—2012—turningtofairness—report.pdf.*

[15] American Academy of Family Physicians. (2020). Quality Health Care in Family Medicine. *https://www.aafp.org/about/policies/all/family-medicine-quality-health-care.html*

[16] Redden M. (2016). Abortion ban linked to dangerous miscarriages at Catholic hospital, report claims. The Guardian. *https://www.theguardian.com/us-news/2016/feb/18/michigan-catholic-hospital-women-miscarriage-abortion-mercy-health-partners*

[17] Lori R. Freedman, Uta Landy, Jody Steinauer, When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals, American Journal of Public Health 98, no. 10 (October 1, 2008): pp. 1774-1778.

The AAFP *advocates* for the development and use of patient-centered, evidence-based clinical practice guidelines that adhere to principles based on the National Academy of Medicine Standards for Trustworthy Guidelines.[18] **The AAFP opposes enshrining non-evidence based medical guidelines into Federal or state law**.

Criminalization and Penalization of Medical Care

The AAFP takes all reasonable and necessary steps to ensure that evidence-based medical decisionmaking and treatment, exercised in accordance with evidence-based standards of care, does not become a violation of criminal law.[19]

Recently, the AAFP, AAP, ACOG, ACP, the American Osteopathic Association (AOA), and the American Psychiatric Association (APA) issued a statement opposing the criminalization of health care: **"We are deeply concerned that legislation and legal opinions across the country will endanger patients and clinicians by allowing private citizens and policymakers to interfere in health care decisionmaking. The patient-physician relationship, not politics, is the backbone of medicine."**[20]

In the wake of the Supreme Court's Dobbs ruling, physicians in states that restrict abortion face a perilous new legal reality. Physicians who perform abortions risk violating the law, being sued, losing their medical license, and going to jail. In some extreme instances, even counseling patients who want an abortion, including those facing pregnancy complications, could expose the physician to criminal charges.

The AAFP has heard from family physicians in states that have banned or restricted abortion, and in states that have not, that they are worried about their own legal safety. **It is clear that the criminalization and penalization of patients and clinicians disrupts and detracts from medical care**

Physicians and hospital administrators worried about the threat of lawsuits or criminal charges for violating a state's abortion ban may be inclined to practice "defensive medicine," ordering unnecessary or excessive tests or procedures in order to thoroughly demonstrate that a patient meets the narrow definition for an allowable exception to an abortion ban. Evidence suggests that defensive medicine does not make patients any healthier but can lead to increased health care costs.[21] **Family physicians have also shared concerns that having to wait on extraneous tests and second opinions can delay critical care in urgent and life-threatening situations**.

Family physicians report that they have received mixed or incomplete legal guidance from their employers in the past several weeks, leading to confusion or even confrontation among clinicians who are unsure of their standing or disagree about the best way to treat a patient while complying with new legal requirements. Small and solo physician practices do not have the luxury of in-house or contracted legal support to help them navigate rapidly changing state laws. Many of them are turning to their state and national medical societies, such as the AAFP, which typically lack state-specific legal expertise or are prohibited from offering individual legal advice.

Legal threats to the practice of medicine are also increasing physicians' administrative burden and practice expenses. As a means of proactive legal defense, many hospitals, clinics, and health systems are advising or mandating that their clinicians enhance their medical documentation for reproductive health care and related services.[22] This can mean changes to electronic medical records (EMR) systems and processes, which are costly, time-consuming, and add to physicians' administrative burden. Smaller practices rely on off-the-shelf EMR systems and can-

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[18] American Academy of Family Physicians. (2018). Clinical Practice Guidelines Policy. *https://www.aafp.org/about/policies/all/clinical-practice-guidelines-policy.html*

[19] American Academy of Family Physicians. (2022). Criminalization of the Medical Practice. *https://www.aafp.org/about/policies/all/criminalization-medical-practice.html*

[20] Group of Six. (2022). Legislation to Criminalize Physicians, Jeopardize Patient-Physician Relationship Have No Place in Health Care. *http://www.groupof6.org/dam/AAFP/documents/advocacy/prevention/women/ST-G6-OpposingCriminalizationOfCare-040822.pdf*

[21] Frakes MD, Gruber J. (2018). Defensive Medicine: Evidence from Military Immunity. National Bureau of Economic Research.

[22] Casteel K. (2022). Fetal heartbeat law leaves South Carolina doctors in dangerous limbo. Greenville News. *https://www.greenvilleonline.com/story/news/local/south-carolina/2022/07/07/fetal-heartbeat-law-leaves-sc-doctors-dangerous-limbo-abortion-roe/7759896001/*

not readily automate new documentation requirements, meaning they must spend additional time conducting manual data entry.

Additionally, physicians and hospital administrators are worried that if they opt not to provide specific care based on their understanding of state abortion restrictions, they could face liability and/or violate Federal requirements under the Emergency Medical Treatment and Labor Act (EMTALA). state laws that allow only narrow abortion exceptions when the mother is at risk of dying are at odds with the EMTALA standard, which focuses on conditions that seriously jeopardize health, bodily, or organ function.[23]

The AAFP is concerned about high rates of professional burnout among physicians in the U.S., which negatively affects the quality of patient care and can result in physicians leaving practice.[24] **The costs and anxiety associated with abortion-related legal issues are negatively impacting the well-being of family physicians and will only compound physician burnout**.[25] If not addressed, this will ultimately lead to more physicians leaving the profession or moving into non-patient-facing roles, worsening health care workforce shortages and patients' access to care.

Disrupting Medical Education and Exacerbating Health Care Workforce Shortages

The AAFP recommends that all medical students and family medicine residents receive comprehensive training in reproductive decision-making.[26] Family medicine residency programs teach clinical skills to provide counseling, screening and diagnostic testing, treatment, and appropriate referrals provided to patients during menarche, contraception, pregnancy, lactation, and menopause. This includes performing routine gynecologic procedures, patient-centered contraceptive counseling, placement of long-acting reversible contraception (LARC), preconception counseling, diagnosis of pregnancy, counseling for unintended pregnancy, assessment and management of complications and symptoms in the first trimester, pregnancy risk-factor screening, miscarriage management and referral for surgical intervention when indicated for complicated miscarriages, D&C procedures, and assessment and management of obstetrical and other medical complications during pregnancy including consultation with obstetricians/medical subspecialists.[27],[28]

Because family physicians are trained to provide such a wide range of reproductive health services, they are well positioned to provide early abortion care to their patients in the primary care setting, which can enhance continuity of care, offer increased access for patients, and reduce stigma. **The AAFP recommends that family medicine residents have access to opt-out abortion training, to support widespread access to comprehensive training in reproductive decision-making while ensuring that no physician or health care professional is required to perform actions that violate personal beliefs**.[29] In addition to providing physicians with the critical procedural and counseling skills to care for patients who have induced abortions, abortion training also helps prepare physicians

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[23] Cornell Law School Legal Information Institute. 42 U.S. Code δ 1395dd - Examination and treatment for emergency medical conditions and women in labor. *https://www.law.cornell.edu/uscode/text/42/1395dd*

[24] American Academy of Family Physicians. (2017). Family Physician Burnout, Well-Being, and Professional Satisfaction (Position Paper). *https://www.aafp.org/about/policies/all/family-physician-burnout.html*

[25] AHRQ. (2017). Physician Burnout. *https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/ahrq-works/impact-burnout.pdf*

[26] American Academy of Family Physicians. (2022). Training in Reproductive Decisions. *https://www.aafp.org/about/policies/all/reproductive-decisions-training.html*

[27] American Academy of Family Physicians. (2018). Recommended Curriculum Guidelines for Family Medicine Residents: Women's Health and Gynecologic Care. *https://www.aafp.org/dam/AAFP/documents/medical—education—residency/program—directors/Reprint282—Women.pdf*

[28] American Academy of Family Physicians. (2018). Recommended Curriculum Guidelines for Family Medicine Residents: Maternity Care. *https://www.aafp.org/dam/AAFP/documents/medical—education—residency/program—directors/Reprint261—Maternity.pdf*

[29] American Academy of Family Physicians. (2022). Training in Reproductive Decisions. *https://www.aafp.org/about/policies/all/reproductive-decisions-training.html*

[30] Dalton VK, Harris LH, Bell JD, Schulkin J, Steinauer J, Zochowski M, Fendrick AM. Treatment of early pregnancy failure: does induced abortion training affect later practices? Am J Obstet Gynecol. 2011 Jun;204(6):493.e1-6. doi: 10.1016/j.ajog.2011.01.052.

to meet patients' other obstetric needs, such as direct counseling, uterine evacuation and miscarriage management.[30],[31]

The Society of Teachers of Family Medicine strongly opposes restrictions on educating family medicine trainees on the full scope of clinical care and advocates that Congress and federal agencies should not legislate or mandate restrictions on the educational content of training programs.[32] Such restrictions limit and adversely affect medical education. In a statement following the Supreme Court's decision to overturn *Roe*, the Association of American Medical Colleges asserts, "It is crucial that physicians have comprehensive training in the full spectrum of reproductive health care, since similar medical procedures address many health conditions."[33]

As states enact or contemplate laws banning or restricting abortion, medical schools, residency training programs, and educators are grappling with how to reconcile these laws with medical accreditation requirements. The Accreditation Council for Graduate Medical Education (ACGME) requires access to abortion training for all OB/GYN programs. While access to training is not required for Family Medicine programs, some offer integrated abortion training or local elective options, and ACGME does clearly require comprehensive reproductive health and contraception education as part of Family Medicine training.[34],[35],[36] A recent paper analyzing current OB/GYN residency programs found that around 45 percent are in states that have banned or are likely to ban abortion, and at least three family medicine residency programs offering integrated abortion training are in states that have banned the procedure in the wake of the Supreme Court's Dobbs decision.[37],[38]

In response, residency programs facing new state restrictions are considering providing their residents with access to clinical training in other jurisdictions without legal restrictions on abortion. However, **requiring or facilitating travel rotations to receive abortion training is unlikely to be feasible on a widespread scale, given the resources required and the disruptions to clinical care that resident absences cause**. Additionally, family planning clinics that often precept medical residents on rotation from other areas are already beginning to cut back

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[31] Horvath S, Turk J, Steinauer J, Ogburn T, Zite N. Increase in Obstetrics and Gynecology Resident Self-Assessed Competence in Early Pregnancy Loss Management With Routine Abortion Care Training. Obstet Gynecol. 2022 Jan 1;139(1):116-119. doi: 10.1097/AOG.0000000000004628.

[32] Society of Teachers of Family Medicine. (2022). Society of Teachers of Family Medicine Statement on the Physician-Patient Relationship and Reproductive Health Care. *https://www.stfm.org/about/governance/statements/*

[33] American Association of Medical Colleges. (2022). AAMC Statement on Supreme Court Decision in Dobbs v. Jackson Women's Health Organization. *https://www.aamc.org/news-insights/press-releases/aamc-statement-supreme-court-decision-dobbs-v-jackson-women-s-health-organization*

[34] Accreditation Council for Graduate Medical Education. (2017). Clarification on Requirements Regarding Family Planning and Contraception: Review Committee for Obstetrics and Gynecology. *https://www.acgme.org/globalassets/pfassets/programresources/220—obgyn—abortion—training—clarification.pdf*

[35] ACGME Program Requirements for Graduate Medical Education in Family Medicine. (2022). ACGME. *https://www.acgme.org/globalassets/pfassets/programrequirements/120—familymedicine—2022.pdf*

[36] Family Medicine Residencies with Abortion Training—RHEDI. (n.d.). Retrieved July 10, 2022, from *https://rhedi.org/resources/residency-training/*

[37] Vinekar, K., Karlapudi, A., Nathan, L., Turk, J. K., Rible, R., & Steinauer, J. (2022). Projected Implications of Overturning *Roe v Wade* on Abortion Training in U.S. Obstetrics and Gynecology Residency Programs. Obstetrics & Gynecology. doi: 10.1097/AOG.0000000000004832 *https://journals.lww.com/greenjournal/Fulltext/9900/Projected—Implications—of—Overturning—Roe—v—Wade.449.aspx*

[38] Family Medicine Residencies with Abortion Training—RHEDI. (n.d.). Retrieved July 10, 2022, from *https://rhedi.org/resources/residency-training/*

[39] Knox, L. (2022, July 7). Medical schools adapt to the Dobbs abortion decision. Inside Higher Ed. *https://www.insidehighered.com/news/2022/07/07/medical-schools-adapt-dobbs-abortion-decision*

[40] Anderson, N. (2022, June 30). The fall of *Roe* scrambles abortion training for universities.

on training because they are grappling with huge influxes of patients and lack the staff capacity to provide both patient care and medical education.[39],[40]

In addition to disrupting training for current medical students and residents, state abortion restrictions are likely to have a significant impact on future trainees. Students intending to provide family planning as part of their medical practice who are applying to medical school and residency programs will have to decide whether they are willing to risk being trained in a state that does not provide abortion care.[41]41 Experts predict that medical schools and residency programs in those states will see fewer applicants, whereas programs located in states that still allow abortion care will be inundated.[42] **In the short term, this will worsen the problem of unmatched medical students. Over time this will exacerbate maternity care shortages and intensify the maldistribution of physicians**.

Experts also predict that physicians in states with abortion bans will begin to leave because they do not wish to practice in a place where they are not able to provide comprehensive, patient-centered care without government intrusion. **Given the current geo-political divide in the U.S., this will worsen access to care for rural communities and increase rural health disparities**.

Jeopardizing Contraception Access

Health promotion—including screening, counseling, and vaccination—is a foundation of family medicine, and for much of their reproductive lives most women try to prevent pregnancy, which is why **the AAFP believes physicians should counsel their patients to decrease the number of unwanted pregnancies, and why the AAFP advocates for public and private health plans to provide coverage and not impose cost-sharing for all Food and Drug Administration-(FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all patients with reproductive capacity, including contraceptive methods for sale over the counter**.[43]

Confusion over whether statutory definitions of "personhood" outlaw the use of emergency contraception, and if contraception methods that interrupt the implantation of a fertilized egg will be considered an abortion under certain state laws, is fueling misinformation and fear and limiting access to contraception. In one example, the AAFP heard from a family physician who, after their state enacted its trigger law banning abortion without exception for rape or incest, saw hospitals in their city temporarily stop offering emergency contraception to rape victims, despite the fact that clinical guidelines for treating sexual assault victims call for it to be provided.

The AAFP applauds recent actions by the Administration, including the July 8 Executive Order reaffirming the Affordable Care Act's guarantee of insurance coverage for women's preventive services, including birth control and contraceptive counseling, and directing the Centers for Medicare and Medicaid Services (CMS) to ensure patient access to family planning care and protect clinicians providing family planning services.[44]

We urge Congress to pass legislation to protect and expand patients' access to FDA-approved contraception methods and comprehensive, evidence-based contraception counseling. The AAFP has endorsed the Affordability Is Access Act (*S. 4347/H.R. 7394*) and the Access to Birth Control Act (*S.*

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[38] Family Medicine Residencies with Abortion Training—RHEDI. (n.d.). Retrieved July 10, 2022, from *https://rhedi.org/resources/residency-training/*

[39] Knox, L. (2022, July 7). Medical schools adapt to the Dobbs abortion decision. Inside Higher Ed. *https://www.insidehighered.com/news/2022/07/07/medical-schools-adapt-dobbs-abortion-decision*

[40] Anderson, N. (2022, June 30). The fall of *Roe* scrambles abortion training for universities. The Washington Post. *https://www.washingtonpost.com/education/2022/06/30/abortion-training-upheaval-dobbs/*

[41] Chapman, G. (2022, July 8). It's incredibly far-reaching': medical students on the *Roe* reversal. The Guardian. *https://www.theguardian.com/us-news/2022/jul/08/roe-v-wade-reversal-medical-students*

[42] Knox, L. (2022, July 7). Medical schools adapt to the Dobbs abortion decision. Inside Higher Ed. *https://www.insidehighered.com/news/2022/07/07/medical-schools-adapt-dobbs-abortion-decision*

[43] Coverage, Patient Education, and Counseling for Family Planning, Contraceptive Methods, and Sterilization Procedures. (2020). AAFP. *https://www.aafp.org/about/policies/all/coverage—family—planning.html—Coverage,—20Patient—20Education,—20and—20Counseling—20for—20Family—20Planning,—20Contraceptive—20Methods,—20and—20Sterilization—*

3223/H.R. 6005). The AAFP also urges Congress to ensure robust and sustained Federal funding for Title X family planning programs.

Potential for Abuse of Patient Data and Violation of Patient Confidentiality

A confidential relationship between patient and physician is essential for the free exchange of information necessary for sound medical care. Only in a setting of trust can a patient share the private feelings and medical, social, and family histories that enable the physician to properly counsel, prevent, diagnose, and treat. **The AAFP believes that patient confidentiality must be protected**.[45]

The AAFP's *policy on data stewardship*, which addresses how de-identified clinical and administrative data derived from physicians' EMRs are collected and used by third parties, states that submission of data from physician practice to third parties must be voluntary, third parties must provide written policies detailing the intended uses of such data, and data storage must adhere to industry and regulatory standards for confidentiality.[46]

The Supreme Court's *Dobbs* decision has raised questions about whether and how technology companies should protect their users' data, particularly when the user is seeking reproductive health care. Experts believe that the United States' lack of strong digital privacy protections is likely to have profound implications on how state laws that ban or restrict abortion are enforced.[47] While clinicians and health care organizations must follow the Health Insurance Portability and Accountability Act (HIPAA)'s Privacy Rule, which protects against disclosures of protected health information (PHI), other entities and data that do not qualify as PHI are not bound by the same rules. Police and prosecutors could potentially obtain extremely detailed information about individuals from technology companies, including internet search histories, communications, finances, and location information and use that information to surveil or charge them for violating state abortion law. In the case of laws such as Texas' S.B. 8, which allow private citizens to sue suspected abortion patients and providers, such data could also be used to enable vigilante interference.

The AAFP applauds HHS for issuing guidance clarifying how Federal laws and regulations protect patients' PHI and the circumstances under which the HIPAA Privacy Rule permits disclosure of PHI without the patient's authorization. However, because HIPAA does not generally protect the privacy and security of individuals' personal information stored on cell phones or gathered by search engines and third-party applications, **the AAFP calls on Congress to further examine the implications of overturning Roe on patient privacy and to enact laws to protect patients from inappropriate exploitation of their data, including criminal or civil punishments for seeking medically appropriate health care**.

The AAFP has endorsed the Health and Location Data Protection Act (*S. 4408*), which prohibits data brokers from selling and transferring customers' health and location data and requires the Federal Trade Commission to promulgate rules to implement and enforce these protections.

Exacerbating Health Disparities Experienced by Marginalized Patients

The Supreme Court's decision to overturn Roe will make it even more difficult for patients to access high-quality health care in the U.S. The risks will be felt most acutely by people of color, from low-income backgrounds, and who live in rural areas.[48], [49]

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[45] Confidentiality, Patient/Physician. (2022, July). AAFP. *https://www.aafp.org/about/policies/all/confidentiality-patient—physician.html—Confidentiality,—20Patient/—20Physician*

[46] Data Stewardship. (2019). AAFP. *https://www.aafp.org/about/policies/all/data-stewardship.html*

[47] Crockford, K., & Freed Wessler, N. (2022). Impending Threat of Abortion Criminalization Brings New Urgency to the Fight for Digital Privacy. ACLU. *https://www.aclu.org/news/privacy-technology/impending-threat-of-abortion-criminalization-brings-new-urgency-to-the-fight-for-digital-privacy*

[48] Gilbert, K., Sanchez, G., & Busette, C. (2022, June 30). Dobbs, another frontline for health equity. Brookings. *https://www.brookings.edu/blog/how-we-rise/2022/06/30/dobbs-another-frontline-for-health-equity/*

[49] Zephyrin, L., & Blumenthal, D. (2022, June 24). Loss of Abortion Rights Will Send Shockwaves Through U.S. Health System. Commonwealth Fund. *https://www.commonwealthfund.org/blog/2022/loss-abortion-rights-will-send-shockwaves-through-us-health-care-system*

According to analysis by the Guttmacher Institute, nearly one in four women in the U.S. has an abortion by age 45.[50] **While the abortion rate has been declining over the past four decades, it remains a common procedure; however, abortion rates vary considerably by patient income and race and ethnicity**.[51]

Nearly half of all patients who have an abortion have incomes below the Federal poverty level, and Black and Hispanic patients have abortions at considerably higher rates than non-Hispanic white patients.[52] There are many reasons for these disparities, but studies show that Black and Hispanic patients are less likely to have access to health care—including access to high-quality contraceptive services—and are more likely to face racism and report negative experiences when they do seek health care.[53] People of color are also more likely to live in high-poverty neighborhoods and less likely to move out of poverty in adulthood than their white counterparts, due in large part to systemic racism and generational barriers.[54] Black women are three times as likely as white women to experience and unintended pregnancy, and Hispanic women are twice as likely.[55] Research has also found that low-income Black children are less likely to receive formal sex education,[56] and Black women also experience the highest rates of intimate partner and sexual violence, which can contribute to reproductive coercion.[57]

Restricting abortion without addressing geographic, economic, and cultural barriers to comprehensive health care and family planning will worsen racial health disparities and perpetuate cycles of disadvantage for women of color.[58],[59]

The United States' maternal mortality rate is alarmingly high and reveals faults that exist within the current health care system. Approximately 700 women die from pregnancy-related complications annually in the United States.[60] There are numerous factors influencing pregnancy-related mortality and morbidities, such as advanced maternal age, education attainment, and underlying health status.[61] **Large disparities in maternal health outcomes exist between women who belong to racial and ethnic minority groups and white women**. The U.S. Centers for Disease Control and Prevention's (CDC) 2019 Morbidity and Mortality Weekly Report stated that non-Hispanic Black (Black) and non-Hispanic American Indian/Alaska Native (AI/AN) women experienced higher pregnancy-related morbidity ratios (40.8 and 29.7, respectively) than all other racial/ethnic populations. (White PRMR was 12.7, Asian/ Pacific Islander PRMR was 13.5, and His-

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[50] Wind, Rebecca. (Oct. 19, 2017). Abortion is Common Experience for U.S. Women, Despite Dramatic Declines in Rates. Guttmacher Institute. *https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates*

[51] U.S. Abortion Patients. (2016). *https://www.guttmacher.org/sites/default/files/infographic—attachment/aps—demographics.pdf*

[52] Wind, Rebecca. (Oct. 19, 2017). Abortion is Common Experience for U.S. Women, Despite Dramatic Declines in Rates. Guttmacher Institute. *https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates*

[53] Cohen, S. A. (2008, August 6). Abortion and Women of Color: The Bigger Picture . Guttmacher Institute. *https://www.guttmacher.org/gpr/2008/08/abortion-and-women-color-bigger-picture*

[54] Butler, S. M., & Grabinsky, J. (2020, November 16). Tackling the legacy of persistent urban inequality and concentrated poverty. Brookings. *https://www.brookings.edu/blog/up-front/2020/11/16/tackling-the-legacy-of-persistent-urban-inequality-and-concentrated-poverty/*

[55] Cohen, S. A. (2008, August 6). Abortion and Women of Color: The Bigger Picture . Guttmacher Institute. *https://www.guttmacher.org/gpr/2008/08/abortion-and-women-color-bigger-picture*

[56] Brinkman, B. G., Garth, J., Horowitz, K. R., Marino, S., & Lockwood, K. N. (n.d.). Black Girls and Sexuality Education: Access. Equity. Justice. Retrieved July 10, 2022, from *https://www.gwensgirls.org/wp-content/uploads/2019/10/BGEA-Report2—v4.pdf*

[57] Jain, M. (2017). The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report. CDC, 2010—2012. *https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf*

[58] Dehlendorf C, Rodriguez MI, Levy K, Borrero S, Steinauer J. Disparities in family planning. Am J Obstet Gynecol. 2010 Mar;202(3):214-20. doi: 10.1016/j.ajog.2009.08.022. PMID: 20207237; PMCID: PMC2835625

[59] Tarzia, L., & Hegarty, K. (2020). Causal mechanisms of postnatal depression among women in Gondar town, Ethiopia: application of a stress-process model with generalized structural equation modeling. 18, 87. *https://doi.org/10.1186/s12978-021-01143-6*

[60] U.S. Centers for Disease Control and Prevention, May 2019 Vital Signs, Pregnancy Related Deaths Fact Sheet, accessed online: *https://www.cdc.gov/vitalsigns/maternal-deaths/index.html*

[61] Vilda, Dovile et al. Income inequality and racial disparities in pregnancy-related mortality in the U.S. SSM—population health vol. 9 100477. 28 Aug. 2019, doi:10.1016/j.ssmph.2019.100477

panic PRMR was 11.5.)[62] **Disparities for pregnancy outcomes also exist when comparing women living in rural areas with those living in urban areas**.[63]

Black and low-income patients and patients from rural communities are more likely to live in states that have banned or are likely to ban abortion since the Supreme Court overturned *Roe*. **A recent study estimating the mortality impact of a total abortion ban, due to increased deaths from unterminated pregnancies, would increase pregnancy-related deaths, most acutely for Black women**.[64]

According to the AAP, **laws that restrict access to reproductive health care also have a disproportionate impact on adolescents and teenagers, who typically do not have the resources or freedom to travel to another state to receive safe, legal health care**.[65] Family physicians are optimally trained, qualified, and experienced in evaluating and addressing the complex medical and behavioral health care needs of adolescents. The AAFP 3values the sexual health of adolescents and *advocates* for access to comprehensive medical and behavioral health care, evidence-based sex education, and increasing awareness of risks and signs of sexual abuse and trafficking, and supports a trauma-informed approach to health care. 1A[66],[67],[68] **That is why the AAFP joins the AAP in affirming strong support for adolescents and teens to receive comprehensive evidence-based reproductive health care services, including abortion**.

The AAFP recognizes sexual assault as a serious public health issue and supports the rights of survivors of sexual assault, sexual violence, and all sexual crimes.[69],[70] The AAFP calls for prioritization of the survivor's well-being, emphasizing the need for compassionate treatment, and supports a legal framework that codifies the rights of, and protections for, survivors of sexual assault.[71] Rape is a cause of many unwanted pregnancies, with an estimated one in 20 women between the ages of 12 and 45 becoming pregnant due to rape.[72] Rape is traumatic and often has long-lasting physical and psychological health consequences. **Laws that ban abortions without exception for rape and incest contradict the AAFP's policy on trauma-informed care and place rape victims at higher risk for future medical, psychological, and socioeconomic challenges**.[73]

Family physicians report that, in states with abortion bans that allow exceptions in cases of rape or incest, eligible patients still face barriers to timely access to care.

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[62] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007—2016. MMWR Morb Mortal Wkly Rep 2019;68:762—765. DOI: *http://dx.doi.org/10.15585/mmwr.mm6835a3*

[63] American College of Obstetrics and Gynecology, 2014, *https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/health-disparities-in-rural-women*

[64] Amanda Jean Stevenson; The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant. Demography 1 December 2021; 58 (6): 2019—2028. doi: *https://doi.org/10.1215/00703370-9585908*

[65] American Academy of Pediatrics. (2022). AAP Supports Adolescents' Right to Comprehensive, Confidential Reproductive Health Care. *https://www.aap.org/en/news-room/news-releases/aap/2022/aap-supports-adolescents-right-to-comprehensive-confidential-reproductive-health-care/*

[66] American Academy of Family Physicians. (2020). Adolescent Health Care, Sexuality and Contraception. *https://www.aafp.org/about/policies/all/adolescent-sexuality.html*

[67] American Academy of Family Physicians. (2017). Children's Health. *https://www.aafp.org/about/policies/all/childrens-health.html*

[68] American Academy of Family Physicians. (2021). Trauma-Informed Care. *https://www.aafp.org/about/policies/all/trauma-informed-care.html—::text=Family—20physicians—20should—20approach—20TIC,incorporate—20TIC—20into—20clinical—20practice.*

[69] American Academy of Family Physicians. (2020). Rights, Protections, and Support for Survivors of Sexual Assault. *https://www.aafp.org/about/policies/all/rights-survivors-sexual-assault.html—Rights,—20Protections,—20and—20Support—20for—20Survivors—20of—20Sexual—20Assault*

[70] American Academy of Family Physicians. (2020). Sexual Assault as a Public Health Issue. *https://www.aafp.org/about/policies/all/sexualconsent-publichealth.html—Sexual—20Consent—20as—20a—20Public—20Health—20Issue*

[71] American Academy of Family Physicians. (2020). Rights, Protections, and Support for Survivors of Sexual Assault. *https://www.aafp.org/about/policies/all/rights-survivors-sexual-assault.html—Rights,—20Protections,—20and—20Support—20for—20Survivors—20of—20Sexual—20Assault*

[72] Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. Am J Obstet Gynecol. 1996 Aug;175(2):320-4; discussion 324-5. doi: 10.1016/s0002-9378(96)70141-2. PMID: 8765248.

[73] American Academy of Family Physicians. (2021). Trauma-Informed Care. *https://www.aafp.org/about/policies/all/trauma-informed-care.html—::text=Family—20physicians—20should—20approach—20TIC,incorporate—20TIC—20into—20clinical—20practice.*

In order to qualify for an exception, patients and/or their clinician usually must provide a police report documenting the offense. Surveys indicate that fewer than a quarter of rape survivors report assault, and experts estimate the percentage is much lower for children, adolescents, and youth in foster care and juvenile systems.[74] Family physicians who care for victims of rape cite family and domestic violence and economic insecurity as possible response for non-reporting. **Requiring victims of rape and incest and their treating clinicians to jump through legal and administrative hurdles to document eligibility for a legal exception delays access to time-sensitive abortion care**.

The AAFP acknowledges that LGBTQ+ individuals, youth in foster care or the juvenile justice system, and incarcerated individuals face exceptional hardships when attempting to access health care and are at greater risk for adverse medical and mental health outcomes and recognizes that state laws banning and restricting access to abortion will undoubtably exacerbate the health disparities experienced by these vulnerable populations. We urge policymakers to study the implications of federal and state policy changes on these unique populations in order to develop appropriate solutions to mitigate the serious challenges they encounter.

Underscoring the Need for Universal Access to Health Care and Addressing Social Determinants of Health

The AAFP *recognizes health as a basic human right* for every person, regardless of social, economic or political status, race, religion, gender, or sexual orientation. The right to health includes universal access to timely, high-quality, and affordable health care services.[75] **We continue to call on Congress to pass legislation to expand access to comprehensive, affordable health care, including by expanding Medicaid and CHIP coverage to 12 months postpartum, ensuring 12 months of continuous eligibility for children enrolled in Medicaid and CHIP, closing the Medicaid expansion coverage gap, and making the American Rescue Plan's enhanced marketplace subsidies permanent**. Family physicians understand that the health of their individual patients and communities is affected by social determinants of health, which is why **the AAFP urges lawmakers to adopt a "health in all policies" approach that considers the broad health implications of policies not traditionally discussed as health care-related (such as housing and urban development, transportation, education, etc**.). Expanding health coverage and addressing social determinants of health will undoubtably reduce unintended pregnancies, improve maternal and child health outcomes, and ultimately improve the health and productivity of our nation.

The AAFP has called on HHS and other Federal agencies to use every available lever to protect patient safety, support family physicians and other clinicians, and strengthen timely access to reproductive health care, including medication abortion and contraception, in accordance with Federal law.[76]

We now urge Congress to take swift legislative action and utilize its Federal oversight authority to restore, protect, and improve patients' access to timely, comprehensive reproductive health care and clinicians' ability to provide evidence-based medical care.

The AAFP has endorsed the House-passed Women's Health Protection Act (*S. 4132*), and we continue to urge the Senate to pass this critical legislation to codify federal protections for reproductive health care.[77] The AAFP also supports the Ensuring Access to Abortion Act (*H.R. 8297*) which protects patients' rights to travel across state lines to seek abortion services. **Absent federal law guaranteeing all patients have the right to abortion, it is imperative that patients be able**

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[74] Kimble C. (2018). Sexual Assault Remains Dramatically Underreported. Brennan Center for Justice. *https://www.brennancenter.org/our-work/analysis-opinion/sexual-assault-remains-dramatically-underreported*

[75] American Academy of Family Physicians (2020). Health Care is a Right. *https://www.aafp.org/about/policies/all/health-care-right.html*

[76] American Academy of Family Physicians. (2022). AAFP Letter to HHS on Reproductive Health and the Patient-Physician Relationship. *https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/LT-HHS-DobbsImpact-070522.pdf*

[77] Joint Letter to Senate in Support of the Women's Health Protection Act. (2022). In Letter. *https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/LT-Senate-WHPA-051022.pdf*

to travel to seek safe, quality medical care without threat of penalty of persecution.

The AAFP stands ready to partner with the Committee to protect the patient-physician relationship and reproductive health care. Should you have any questions, please contact Erica Cischke, Director of Legislative and Regulatory Affairs at *ecischke@aafp.org*.

Sincerely,

ADA D. STEWART, M.D., FAAFP,
Board Chair,
American Academy of Family Physicians.

PREPARED STATEMENT OF NARAL PRO-CHOICE AMERICA

Thank you for the opportunity to submit a statement to the Committee on this critical issue. NARAL Pro-Choice America is a national advocacy organization dedicated to protecting and advancing reproductive freedom. For over 50 years, NARAL has fought to protect and advance reproductive freedom at the Federal and state levels—including access to abortion care, birth control, pregnancy and post-partum care, and paid family leave. Through education, organizing, and influencing public policy, NARAL and our 4 million members from every corner of the country work to guarantee every individual the freedom to make personal decisions about their lives, bodies, and futures, free from political interference. For this reason, we are submitting this statement to highlight the far-reaching public health impact of the U.S. Supreme Court decision to end the constitutional right to abortion and to call on Congress to use its authority to remedy the abortion rights and access crisis and reinstate and safeguard access to abortion care nationwide.

Abortion rights and access are facing a crisis in the United States. Despite overwhelming public support for the legal right to abortion, we're in the midst of an all-out assault on reproductive freedom. The U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* overturned *Roe v. Wade,* ending the constitutional right to abortion as we know it and signaling an ominous sign for the future of abortion rights in this country. The Court's ruling has empowered extremist state lawmakers to enforce total bans on abortion—several of which are now in place—and over half of the states in our Country are at risk of doing so.

The negative impact this cruel Supreme Court decision is inflicting cannot be overstated. This horrifying rollback of our fundamental rights is causing immediate and devastating harm to millions of people across the country who can no longer access the care they need in their own communities. Bans on abortion most harm those already marginalized at every turn by our systems and institutions, and losing *Roe* only compounds this. Women; Black, Indigenous, and other people of color; those working to make ends meet; the LGBTQ+ community; immigrants; young people; those living in rural communities; and people with disabilities are disproportionately impacted by these attacks on reproductive freedom.

This decision is set against a backdrop of increasingly cruel and draconian restrictions and bans as extremist anti-choice politicians have escalated their quest to end legal abortion. It is part of a decades-long campaign waged by the anti-choice movement and the politicians that did its bidding to end *Roe* and decimate reproductive freedom. Even before *Roe* was overturned by the Court, though it has long not been a reality for millions of people across the country, the further evisceration of abortion access had ramped up. State lawmakers seeking to advance their agenda of power and control have passed hundreds of state-level attacks on abortion access over the last decade that have made care extremely difficult, if not impossible, to access for many people across the country. According to the Guttmacher Institute, over 500 restrictions on abortion access have been introduced at the state level this year,[1] and now that *Roe* has fallen, we can expect to see even more. These systematic attacks on reproductive freedom and abortion access intentionally push access out of reach, and some go as far as criminalizing pregnant people and doctors who provide abortion care. Now, more than ever, the anti-choice movement is advancing its extremist agenda in plain sight.

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[1] Elizabeth Nash, Lauren Cross, and Joerg Dreweke, 2022 State Legislative Sessions: Abortion Bans and Restrictions on Medication Abortion Dominate, GUTTMACHER INSTITUTE, (Mar. 2022), *https://www.guttmacher.org/article/2022/03/2022-state-legislative-sessions-abortion-bans-and—restrictions-medication-abortion*

The interrogation and punishment of people who are pregnant is not far-fetched—it is already happening. People across the country are already being charged or prosecuted for pregnancy outcomes including pregnancy loss, self-managing abortion care, or even the suspicion of it.[2] Criminalizing people for having an abortion, experiencing a miscarriage or stillbirth, or any other pregnancy outcome only exacerbates racial inequities and is just one of the many ways that Black, Indigenous, and other people of color have been criminalized.

What we're seeing take place in the aftermath of the Jackson Women's Health decision is only the beginning. We know that those hostile to abortion never intended to stop with ending *Roe*—all of our most cherished rights and freedoms are also at risk. Anti-choice politicians have only been emboldened by watching the Supreme Court disregard the health and well-being of millions of Americans. Already, Republican lawmakers in Congress have floated the idea of enacting a nationwide abortion ban. Never in our Country's history has such a ban existed, and the consequences on our lives and our freedoms would be catastrophic.

The threat to our fundamental rights does not stop there. The same anti-choice, anti-freedom extremists working harder than ever to roll back abortion rights and access are also targeting our other fundamental freedoms, including birth control access, our freedom to vote, LGBTQ+ rights, civil rights, and more. There's simply no low they won't sink to in order to advance their quest for control and political gain.

We did not get here by accident. The threats that our most cherished rights and freedoms face is the result of a decades-long far-right strategy to advance a radical and out-of-touch ideological agenda. In the late 1970's, radical conservatives weaponized the formerly non-political, back-burner issue of abortion rights as political cover for their efforts to maintain white patriarchal control amidst diminishing support for racist policies like school segregation, which had previously been the backbone of their movement. In the years immediately preceding and following *Roe v. Wade,* Evangelical Christians, who now form the backbone of the GOP, were overwhelmingly indifferent on the issue of abortion. But through the carefully crafted messages of Paul Weyrich, Jerry Falwell, and other architects of the Radical Right, abortion became the political tool of choice for a movement determined to maintain control in a changing world, and the trojan horse for a far-reaching array of ideologies meant to thwart social progress.[3]

In the intervening years, opposition to abortion has become a litmus test in far-right circles for a host of political and judicial positions. In order to advance their agenda—one that has always stood in direct opposition to the values of the majority of Americans—they developed and implemented a strategy for capturing and maintaining minority rule. This strategy included pushing regressive boilerplate legislation chipping away at access to abortion through state legislatures and Congress, as well as stacking the Federal judiciary with anti-choice ideologues.

Anti-choice activists have spent decades building their influence over the Federal judiciary through well-funded, secretive networks like the Federalist Society. Conservative activists have never been shy about the fact that their takeover of the Federal judiciary is part of a broad strategy to quell the majority and cement minority rule, but the election of Donald Trump took this tactic to new heights.

In May 2016, Trump pledged to only nominate anti-choice judges, a promise he doubled down on in 2020.[4,5] And with the help of Mitch McConnell, Trump installed anti-choice Federal judges with lifetime appointments at a breakneck pace. More than a quarter of currently active Federal judges are now Trump appointees, including Supreme Court justices Neil Gorsuch, Brett Kavanaugh, and Amy Coney Barrett-tipping the balance of the Court to a supermajority unmistakably hostile to reproductive freedom.[6] Now, the work of these extremists has culminated in the end of *Roe v. Wade* and an anti-choice majority on the Court that poses a threat to all of our most fundamental freedoms.

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[2] Texas Prosecutor Drops Murder Charge Against Woman Arrested for Self-Induced Abortion, CBS NEWS, (Apr. 10, 2022), *https://www.cbsnews.com/news/lizelle-herrera-abortion-texas-murder-charge—dropped/*

[3] Randall Balmer, The Real Origins of the Religious Right, POLITICO MAGAZINE (May 27, 2014), *https://www.politico.com/magazine/story/2014/05/religious-right-real-origins—107133.*

[4] Trump Letter on Pro-Life Coalition, Sept. 2016, *https://www.sba-list.org/wp—content/uploads/2016/09/Trump-Letter-on-ProLife-Coalition.pdf.*

[5] Pro-Life Voices for Trump 2020, Sept. 3, 2020, *https://cdn.donaldjtrump.com/public—files/press—assets/pro-life-letter-potus.pdf.*

[6] John Gramlich, How Trump compares with other recent presidents in appointing Federal judges, PEW RESEARCH CENTER (Jan. 13, 2021), *https://www.pewresearch.org/fact-tank/2021/01/13/how-trump—compares-with-other-recent-presidents-in-appointing-Federal-judges/*

All people—no matter who they are or where they live—should have the freedom to make their own decisions about whether to start or grow a family, free from political interference. While the Court's egregious decision in the Jackson Women's Health case is nothing short of devastating, the fight for reproductive freedom is far from over. The vast majority of Americans are with us. Polling shows that 8 in 10 Americans support the legal right to abortion.[7] Lawmakers who interfere with our reproductive freedom do not represent the values of the overwhelming majority of people in this country.

PREPARED STATEMENT OF SENATOR RICHARD BURR, RANKING MEMBER

I have often said that being a father is the most important title I will ever have. Fatherhood—and being a grandfather—have given me a deep appreciation for the value of human life and the need to cherish and protect it. I have long believed that life begins at conception, and unborn children should be protected.

With the ruling in *Dobbs v. Jackson Women's Health Organization,* the Supreme Court rightly determined that *Roe v. Wade* lacked legitimate constitutional grounds and returned decision-making to the people and their elected representatives. The Court's responsibility under our constitution is to say what the law is, and they have done so appropriately with this decision.

We now have an opportunity. An opportunity to protect the sanctity of life and provide life-affirming support to women and their unborn children. We have an obligation to improve maternal and infant health, which this Committee has taken steps to do. And we have a challenge—to find better ways to support families with young children as Sen. Romney and I have proposed in the Family Security Act 2.0.

I am thankful for women like Brandi Swindell, and the many advocates like her, who provide support to women who find themselves facing an unexpected pregnancy. Stanton Healthcare, the organization founded by Ms. Swindell, provides pregnancy care and resources to pregnant women. Stanton Healthcare compassionately welcomes women at all stages of their pregnancy, and ensures that they are treated with dignity.

Despite Stanton's work in building stronger families and communities, pregnancy resource centers are under threat all across the country. These organizations have been targeted with intimidation, and I am deeply disturbed about past and future violence committed by radical, pro-abortion activists.

I am thankful for Senator Roger Marshall's expertise and his willingness to share both the facts and his vision for the future with the Senate HELP Committee today. I am also grateful to Ms. Brandi Swindell for being here today to provide an example of how we can provide positive, life-affirming support to women who need it, both during and after pregnancy.

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[7] Megan Brenan, Record-High 47 percent in U.S. Think Abortion Is Morally Acceptable, GALLUP, (Jun. 19, 2021), *https://news.gallup.com/poll/350756/record-high-think-abortion-morally—acceptable.aspx*

POLITICS & POLICY

What moving from Kentucky to Virginia after I was diagnosed with cancer reveals about Roe

Supporters of the end of Roe pretend that abortion access can be surgically extracted from women's health care decision-making as a whole. Nothing could be further from the truth.

TAP TO UNMUTE

House Democrat hopes to revamp bill to codify abortion rights

July 7, 2022, 9:32 PM EDT

By Jamie Abrams, law professor at American University Washington College of Law.

After years of teaching Roe v. Wade as a family law professor, I experienced the stunningly painful irony of reading the leaked Supreme Court opinion in Dobbs v. Jackson Women's Health Organization on the day I was diagnosed with invasive breast cancer. Overnight, at age 44, I became a person who would need an abortion if pregnant because cancer treatments would compromise a healthy birth and delay needed cancer care. I also became someone, like other hormone-positive breast cancer patients, who was advised to discontinue hormonal contraception because it might stimulate the growth of cancer cells.

In the aftermath of Roe's being overturned, supporters of the move want to pretend that abortion access can be surgically extracted from women's health care decision-making as a whole. Nothing could be further from the truth.

When I was diagnosed with cancer, the last things on my mind were pregnancy, birth control and abortion. Yet nearly all my medical appointments, tests and surgery itself were predicated on controlling reproduction and being able to terminate a pregnancy if needed.

Since the Dobbs leak, which had made it clear what the conservative-leaning court was poised to do, I have switched gears rapidly between being a reproductive rights scholar and a breast cancer patient. I also switched employment from Kentucky to Virginia. At a time when a woman's constitutional right to bodily autonomy has been stripped away, this move across state lines – and into a different area of women's health care – has revealed a searing reality: We now live in a world of vastly divergent health care systems for women.

As a breast cancer patient in Northern Virginia, I have thankfully found unbounded compassion, empathy, dignity, privacy and vitalizing human connection. I've been supported by patient's rights advocates, counselors, cancer patient support groups and a multitude of local health care providers. I've been buoyed by the lived experiences of survivors and their caregivers, who've catalyzed their own hardships toward walking empathetically alongside others. This support infrastructure treats me as part of a larger ecosystem that informs my decision-making.

My mind swirls with the stresses of the last two months between attending medical appointments, canceling work commitments, switching jobs and insurance plans, watching bills accumulate and organizing child care. The mere thought of traveling to another state for an MRI, a biopsy or a procedure is staggeringly unthinkable as acceptable health care. For most, it would be insurmountable because of the costs and logistics alone. But this is what health care for pregnant women choosing to terminate their pregnancies now looks like in much of America – local patient care at predictable costs for some and health care in condemned exile behind insurmountable barriers for others.

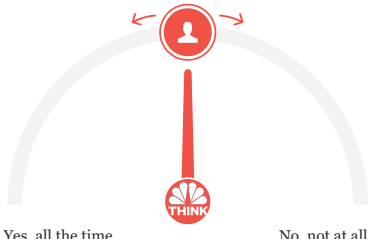
Opinion | The amendment ending slavery could be the key to securing abortion rights

While I'm at my most vulnerable and racing against the cancer clock, I've made critical decisions about how to treat this disease. I've made those choices protected by the trust of my doctors, family members, employer and insurer and – perhaps most bizarrely relevant now – my state government and my local prosecutor's office.

In its evisceration of abortion access, the court is pretending that abortion is a stand-alone issue – separate from marriage, intimacy, family planning, parenting, employment, housing and health care. The lived experiences of our mothers, sisters and daughters reveal just how fictitious that framing is.

QUICK VOTE 3470 VOTES

Do you think about how abortion bans hinder other types of care?



Yes, all the time. No, not at all.

THINK

OPINARY

When I was diagnosed with cancer, the last things on my mind were pregnancy, birth control and abortion. Yet nearly all my medical appointments, tests and surgery itself were predicated on controlling reproduction and being able to terminate a pregnancy if needed. Cancer care also requires that I share my reproductive medical history about my prior pregnancies, the number of live births I've had, the medications I've taken, what prior surgical procedures I've had and who my other providers are. I answer honestly, not worried whether my answers are under surveillance by regulators or law enforcement.

In stark contrast, how will women's health be handled comprehensively going forward in abortion-restrictive states like Kentucky? For a cancer patient facing a pregnancy or a pregnant person facing cancer in a restrictive state, the frightfully murky questions become how much cancer spread would be enough to justify a timely termination and what compilation of decision-makers holds this power (spoiler alert: It would not be me!)?

Mississippi's only abortion clinic closes

According to Kentucky's trigger law banning abortion, for example, I would lose all decision-making autonomy and be subject to a doctor's discretion about whether an abortion was necessary to prevent "the substantial risk of death" or "serious, permanent impairment of a life-sustaining organ." Is Stage 1 breast cancer enough? Stage 2? What relevance are my two children, for whom I desperately seek the best prognosis and longevity for myself? Does the law require me to endure the state-compelled progression of cancer? The answers to these questions would be entirely unclear. Doctors would have vast discretion to make decisions, largely free from accountability to pregnant patients. In reality, these doctors would treat me under an amorphous cloud of state-imposed liability, because the law makes it a class D felony to provide abortions outside those exceptions.

Come November, Kentucky will ask its voters whether the state Constitution should be amended to make it clear that it doesn't ensure a right to an abortion. Many other states, including Virginia, will have reckonings in the courts or legislatures in the coming months. It's searing to imagine cancer care, or any other health care, mired in stigmatizing government control, a surveillance state, criminalization and exile to out-of-state, out-of-pocket health care. As a society, we absolutely have the ability to ensure dignity, trust and support for women's medical decisions holistically. In treating my breast cancer, I've experienced a medical model that lives out those values and trusts my informed decision-making.

There are transformative differences between these divergent health care models in women's lives. It's the difference between exile versus empowerment, degradation versus dignity, condemnation versus consultation. Because I am trusted, valued and humanized, I make medical decisions daily to choose life for myself.

As a society, we have the capacity to build that same ecosystem for *all* of women's medical decision-making. For centuries, women across civilizations have held the weight of reproductive decision-making – and all of its complexities – with courage and rigor. Make no mistake about it, though: The stakes are an all-or-nothing framework for women's health. Either we support women's medical decision-making autonomy, or we do not. And we must.

Jamie Abrams

Jamie Abrams is a law professor at American University Washington College of Law.

THINK / OPINION

Opinion | What the supermarket employee accused of slapping

THINK / OPINION

Opinion | Tucker Carlson's greatest fear

THINK / OPINION

Opinion | Lindsey Graham's response to his Georgia subpoena is frankly disturbing

QUESTIONS AND ANSWERS

RESPONSE BY KRISTYN BRANDI TO QUESTIONS OF SENATOR LUJÀN

SENATOR LUJÀN

Question 1. Is there a relationship between restricted access to abortion services and increased maternal mortality? What does that association look like for Tribal, Hispanic, Black, rural, and other minority populations, respectively?

Answer 1. Yes, restrictions on abortion care have far reaching consequences both deepening existing health and socioeconomic inequities and worsening health outcomes for pregnant people and people giving birth. For example, women who were denied abortion care are more likely to experience high blood pressure and other serious medical conditions during the end of pregnancy; more likely to remain in relationships where interpersonal violence is present; and more likely to experience poverty. These are all factors that contribute to poor maternal health outcomes. Furthermore, research clearly shows that states with higher numbers of abortion restrictions are the same states with poorer maternal health outcomes. We also know that while most people will have healthy pregnancies, some will experience illness or conditions where pregnancy can cause serious health problems. When abortion is difficult or impossible to obtain, complicated health conditions can worsen and even result in death.

Furthermore, Black, Indigenous, Latino/a/x, people of color, folks living in geographically isolated areas, LGBTQ+ people, and people with disabilities already experience the most barriers to health care. And because of this pregnancy can be less safe for some than others. The cause of the worsening maternal mortality crises in this country is a persisting legacy of discrimination, unequal distribution of resources, and inequitable access to health care. These challenges can be mitigated by eliminating discriminatory care, moving to solve lack of resources, and providing health coverage.

Question 2. One of the greatest challenges facing patients in New Mexico is a shortage of health care providers. Of the 33 counties in New Mexico, only three are home to clinics that provide abortion services. In your experience, how has a shortage of abortion providers impacted the health of your patients? How detrimental is physical distance from abortion providers?

Answer 2. Health care shouldn't work like this. People should be able to access the care they need in their own communities without fear or discrimination. The health care provider shortage is a real threat to equitable access to care, and that is compounded when it comes to the abortion provider shortage and the uneven distribution of abortion provider density dependent upon region. There are many providers that want to provide this care to patients, but either face threats to themselves or their families in doing so or lack training in their areas—both will likely increase as a result of *Roe* being overturned.

Forcing people to travel to get care can mean the difference between being able to get the care they need or being forced to remain pregnant. When people are forced to travel for care it means

they have to take time off of work, arrange for childcare, and arrange for transportation and other accommodations, raising the costs and pushing care further and further out of reach. Lack of abortion coverage for people facing the most barriers because of restrictions like the Hyde Amendment means the cost of obtaining the procedure is already prohibitively expensive for those with the fewest resources. When we force people to travel for care what we are doing is reinforcing the two-tier system of health care in this country. We are reinforcing the stigma around abortion that it is "other" care when in fact it is routine, safe and common health care. What we are doing is denying dignity, autonomy, and well-being to those facing the most barriers because of systemic inequities.

Question 3. Do you think there is a role for the Federal Government in addressing the shortage of health care providers capable of providing abortion services?

Answer 3. Yes, the Federal Government can pass laws that protect providers abilities to do their jobs and care for their communities. The violence and harassment abortion providers across this country experience on a daily basis makes it difficult for abortion providers to care for their communities. Furthermore, hostile, anti-abortion state laws that force clinics to close also contribute to a lack of abortion providers available in any given community. Congress must pass the Women's Health Protection Act and other bold policies that would help ensure people can get the care they need. They can also remove restrictions where only physicians can provide this care—other advanced practice clinicians (APCs) are fully capable of providing safe, compassionate care and having APCs providing abortion care would increase the number of providers available to serve communities.

Question 4. In states where abortion care has been decimated, what is the impact on medical education for providers, especially in high risk patients?

Answer 4. The Supreme Court's decision allowing states to ban abortion entirely will make it difficult for many providers to learn to perform abortions, and it will also affect other forms of medical training including miscarriage management, which uses the same procedures/medicines as an abortion, counseling patients about the full scope of pregnancy options, and emergency care. Right now, nearly half of OB/GYN residency programs are located in states that have or are likely to ban abortion care. Without this training, they will be providing sub-standard types of care that goes against decades of evidence—this is not how health care should work. We are doing a deep disservice to the future generations of providers who will not have the opportunities to receive training that they deserve. And we are harming our communities by all but guaranteeing there will be some providers who do not have the skills necessary to provide the care they need.

Question 5. An alarming consequence of this war on reproductive freedom is the climate of fear that has been cultivated around accessing abortions—even in states like New Mexico where abortion services remains legal. Can you speak to the importance of combat-

ting misinformation surrounding access to abortions, especially in communities where English is not spoken as a first language?

Answer 5. Misinformation and disinformation about abortion access is a serious problem that jeopardizes people's health and well-being. Abortion care is extremely safe, and in many places across the country abortion is still legal. While we are certainly in an access crises it is imperative that people are given full, accurate information about their reproductive and sexual health care options, and that includes information being given in the language that is best for them. This means having resources for multi-lingual staff, translation services, and community-centered resources for counseling, scheduling, receiving care, and accurate information available in multiple languages online.

Question 6. As national attention turns to states, including New Mexico, that have protected a women's right to make her own health care decisions, there is a growing concern about threats to the safety of both patients accessing abortions and the health care providers working around the clock to meet the need. What resources from the Federal Government are needed to ensure that providers such as yourself are able to continue to safely provide abortions?

Answer 6. Following the Supreme Court's decision gutting the constitutional right to abortion, providers have experienced, and are preparing to continue dealing with, an uptick in violence and harassment against themselves and their patients. A report released Friday, June 24, 2022 by the National Abortion Federation found that abortion providers faced significant increases in violence and disruption to their work last year compared to the previous year including stalking, invasions, assault, and battery. Providers would benefit from additional support from the Federal Government to increase safety and security of their data, their places of work, and their personal safety. They also need Federal protection of abortion access to ensure they are able to do their jobs and care for their communities free from government interference.

[Whereupon, at 12:12 p.m., the hearing was adjourned.]

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