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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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