Thank you, Senator Ossoff and the members of the Subcommittee, for allowing me to speak today.

I am a board-certified, fellowship trained obstetrician/gynecologist and complex family planning specialist. I am a member of the American College of Obstetricians and Gynecologists and the Society of Family Planning. I have provided comprehensive OBGYN and reproductive health care in Georgia for 23 years. I am director of a fellowship and a resident training program in family planning (including abortion and contraceptive care). I have a master in public health degree in Epidemiology. And I have conducted research on the impact of Georgia's restrictive abortion ban on individuals as well as on the state. My views expressed in my testimony today are my own and do not necessarily represent the views of my employer, Emory University.

I have observed firsthand how patients have been adversely impacted by this ban. Although the volume of patients served has decreased since the ban came into effect, abortion is not rare. That is because doctors and clinics in our state recognize the need to continue to provide abortion care within the confines of the legislation. Following safe, evidence-based practices, we work to see patients as early as possible in their pregnancy. As with any other medical decision, we provide patient-centered counseling to each person who presents for abortion care, providing factual information, benefits, and risks for each option, to help them make their own decision based on their personal values and needs.

We began to hear a common theme. People tell us that time is limited by the ban; they feel under the gun to make a decision whether to abort their pregnancy. We want to continue to allow people the time they need after finding out they are pregnant, to think and decide what to do about their pregnancy, like they would with any other important medical decision but the decision is always theirs to make.

I continue to see pregnant women who have a high-risk medical condition, develop a pregnancy-related complication, or discover their fetus has a congenital defect. Make no mistake. This restrictive ban has increased maternal mortality and poor health outcomes.

In Georgia and other restrictive states, we have learned of case after case of pregnant women being turned away or experiencing delays in their care. Within this ban, legislators with no medical expertise have created limited definitions that simply are not used in the practice of medicine. Complex medical situations cannot be distilled into a law with strict limitations, especially when it does not make medical sense. I have talked to many physicians throughout the state who are confused by the language in the law. In large part, this is due to new rules that don't fit the reality of what people experience in pregnancy, and the harsh criminal penalties physicians face if a prosecutor, judge, or jury doesn't agree with their medical judgement. When is something an emergency? When is a pregnancy "futile?" When do the exceptions apply? Physicians, hospitals, and clinics work to understand the ban's language to determine whether they can provide the standard of care within the confines of the law. Medical care is put on hold as we search for legal clarity. As a result, patients may be denied timely, effective care.

In Atlanta, physicians, myself included, have seen patients in the ICU, with sepsis, with renal failure, needing tube feeding, with hemorrhage, needing blood transfusions or a hysterectomy, who would not have been in those positions if we had been able to offer then care to avoid further harm. It is the standard of care to offer a termination of pregnancy to patients experiencing a complication early in pregnancy because it is the safer option for them. These outcomes would not happen if their providers were able to practice medicine in an ethical and evidence-based manner. As physicians, we are trained to identify when a patient is at high risk, so we can provide care to prevent them harm. If we need to wait until harm is already occurring, we are often too late to prevent the consequences. Deciding when to intervene in an emergency involves many aspects that often have nothing to do with the presence of fetal cardiac activity, and yet the law sets an arbitrary limit to the care we can provide.

For example, sometimes I see a pregnant woman in the midst of a miscarriage, but with a fetus that still has cardiac activity. Even when cardiac activity is present, if this is happening very early in pregnancy, sadly, she will not be able to deliver a baby that will survive. The standard of care is to offer expectant management when possible, but also termination of pregnancy when needed. In this case, terminating a pregnancy that was already in the process of ending in medically considered miscarriage management. But if fetal cardiac activity is present, Georgia's ban defines this care as abortion and limits the care I can provide. The ban does not adequately address how to care for a patient with an early pregnancy complication in which fetal cardiac activity is still present, but an emergency has not yet occurred. And so, delays in care occur as hospitals, physicians, and clinics are unsure how to proceed.

In addition, the term "medical futility" is not a medical definition, but a legal definition. So, what does "futility" mean? What does it mean for a fetus to be "incapable of sustaining life?" That they will die at birth? In 2 days? In 1 year? That there is zero chance of survival? What if there is a 10% chance? Sometimes I see a pregnant woman after her ultrasound identifies a life-limiting birth defect in her fetus. Birth defects can have a range of possible anatomic or functional abnormalities that may or may not all be apparent by ultrasound. Women in this situation have seven times the risk of pregnancy complications as well as the high chance their baby may not survive. We counsel them on the details of their baby's condition, estimating the impact on the baby's life and health, so they have the information they need to decide whether or not to continue the pregnancy. Medical risk is rarely discussed in black and white or with certainty, and yet, women ultimately make the decision that is best for them and their families, according to their values and beliefs. The ban does not adequately address how to care for a patient like this with a life-limiting birth defect. The law puts these patients all in the same category, regardless of their individual circumstances.

The exception for rape or incest also sets arbitrary limits that do not address the needs of sexual assault survivors. Only 20% of survivors file a police report for sexual assault. A police report does not change the medical care they need. It is not a medically necessary step. A physician may ask a patient if they filed a police report to provide advice (are they still in danger? do they need any assistance in contacting the police?), but not because it improves their health care.

Forcing a physician to ask a patient to involve law enforcement as a condition of their receiving medical care undermines patient trust, ultimately harming their health.

Sexual assault survivors also often delay care because of the trauma of their experience. For that and other reasons, they are more likely to present late for care. And yet the ban only allows for abortion before the "post-fertilization" age of 20 weeks. Post-fertilization pregnancy dating is another legal term created by the ban, as I noted that pregnancies are dated post-last menstrual period. This has created additional confusion for physicians, hospitals, and patients in their understanding of the law. Once again, the ban does not adequately address how to care for a patient like this after an assault when we need to consider the trauma they have experienced while providing the health care they need.

In sum, because of Georgia's abortion ban, clinics and physicians have no choice but to turn away patients in need of essential health care. Every day that it is in effect, Georgians suffer an assault to their autonomy and needless risks to their health and lives.