Written testimony of Christina Francis, MD

Senate Finance Committee hearing "Chaos and Control: How Trump Criminalized Women's Health Care"

September 24, 2024

Chairman Wyden, Ranking Member Crapo and Members of the Committee,

Thank you for the opportunity to submit testimony on behalf of myself, as a board-certified OB/GYN, and on behalf of the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), a professional medical organization with thousands of members across the country, for which I serve as CEO. I thank you for the chance to offer my expert analysis that induced abortions are not necessary for women's health as well as how physicians can provide the same excellent and compassionate care to our patients now as we could before the *Dobbs* decision.

The title of this hearing is yet another attempt to redirect the public's attention away from the true danger to women's health – unregulated and dangerous abortions that not only ended the lives of over 1 million human beings last year in this country alone, but also are harming and killing women. The "chaos" that exists is because of the unconscionable lies and misinformation that are being peddled by the media, pro-abortion politicians, and abortion activists—not the laws meant to protect the citizens of various states from the harms of induced abortion.

These laws provide wide latitude for physicians, like myself, to act in an expeditious and evidence-based fashion to care for women in potentially life-threatening situations. Saying otherwise endangers our patients and serves only the abortion industry.

The CDC, our national public health agency, defines induced abortion as "an intervention performed by a licensed clinician…that is intended to terminate a suspected or known ongoing intrauterine pregnancy and that *does not result in a live birth*." They also note that this definition "*excludes* management of intrauterine fetal death, early pregnancy failure/loss, ectopic pregnancy, or retained products of conception[1]." (Emphasis mine) The intent of an induced abortion is intentional feticide (i.e. to produce a dead baby).

In contrast, a medically-indicated maternal fetal separation is defined as a procedure done to prevent the mother's death or immediate, irreversible bodily harm, which cannot be mitigated in any other way. It is preferably done in a way that does not directly induce fetal death and respects the fetus' bodily integrity (unless doing so would further endanger the life of the mother)[2].

[1] https://www.cdc.gov/reproductive-health/data-statistics/abortion-surveillance-system.html

[2] Glossary of Medical Terms for Life-Affirming Medical Professionals, 2023. American Association of Prolife Obstetricians and Gynecologists. https://aaplog.org/wp-content/uploads/2023/06/Glossary-of-Medical-Terms_20230615_7.pdf

State prolife protections are aimed at preventing the elective intentional killing of fetal human beings. All state laws allow for maternal fetal separations to be done (through whatever means necessary) in order to save the life of the mother and many, including Georgia, allow them to prevent permanent physical impairment.

This means that in EVERY state in this country, women can receive immediate care for miscarriage, ectopic pregnancy, post-abortion complications and life-threatening conditions in pregnancy. **Let me make this perfectly clear** – dilation and curettage (D&C) procedures and dilation and evacuation (D&E) procedures in and of themselves are NOT illegal anywhere in this country. They are only illegal in states with prolife protections if they are done with the intent of ending the life of the preborn human being. In fact, in the state of Texas in 2023, 62 pregnancy terminations were done for medical emergencies or to preserve the health of the pregnant mother – 7 of these were D&C's and 4 were D&E's[3].

How to care for women in emergency situations is not confusing to physicians. We knew how to do it before the *Dobbs* decision and we know how to do it now. When faced with a complex patient, we assess their clinical status using our reasonable medical judgment and then proceed with the appropriate treatment based on standards of care and our clinical expertise as well as shared decision making with the patient. We know how to detect early signs of potentially life-threatening conditions and when to intervene in order to prevent that condition from progressing to where the patient is on the brink of death.

The only cause of confusion is dangerous political rhetoric.

This rhetoric:

- falsely tells women they could be prosecuted if they go to the hospital for complications after an abortion when in fact prolife laws hold women harmless;

- falsely tells doctors D&Cs are banned, when in fact D&Cs for every indication other than to induce an abortion are not prohibited;

- falsely tells doctors they can't provide miscarriage care or treat ectopic pregnancy, when they actually can and should;

- falsely tells doctors they can't act until women are actively dying when no state laws require this;

- falsely tells women abortion drugs are safer than Tylenol when we have clear evidence they are dangerous and can be deadly.

It is not the laws to blame but rather the pro-abortion politicians and the media who have created deadly confusion as well as the professional associations who have failed to inform and train physicians and other hospital staff accurately.

[3] https://www.hhs.texas.gov/about/records-statistics/data-statistics/itop-statistics

Statements that prolife laws prevent life-saving care are **lies**.

These statements don't just cause confusion. They are dangerous because they sow confusion and fear among physicians and patients. In fact, they can have deadly consequences.

Last week (the week of September 16th), we learned of two women from Georgia who tragically died in 2022 after taking the abortion drug mifepristone along with misoprostol. Not only did these abortion drugs end the lives of their children but they led to the deaths of Amber Thurman and Candi Miller as well.

AAPLOG has been educating our members, patients and the public for years about the very dangers of these drugs that we are illustrated in the tragic deaths of Amber and Candi. Around the same time, another young woman, Alyona Dixon, died days after taking the abortion drugs. This time, it was in Nevada, which has very permissive abortion laws. And yet her outcome was the same. We warned this would happen – and now that it has, abortion advocates are trying to blame prolife laws.

These women, like so many others, deserved to know the risks associated with these drugs. Risks like infection, which is the leading cause of death after taking mifepristone, known to be an immunosuppressant and to cause an increased risk of sepsis[4]. Amber and Alyona both died from sepsis due to retained fetal tissue from an incomplete abortion. These complications would have likely been diagnosed well before they turned fatal if the FDA had not removed the requirement for the abortion drug provider to have in-person follow-up office visits with women after they take the drugs.

Per the FDA's own label, about 1 in 25 women will go to the emergency room after taking mifepristone and misoprostol to induce an abortion. Abortion advocates have tried to downplay women's trips to the ER by saying these women just didn't know what adverse reactions were normal. But a recent study of emergency department visits among Medicaid eligible women showed that the number of emergency visits were higher for chemical abortion than for surgical abortion or live birth. In fact, the frequency of an emergency room visit after a chemical abortion was twice the rate after a live birth and the visits were significantly more likely to have an acuity rating of severe or critical[5].

Claims that incomplete abortions after taking abortion drugs are rare are also false. Amber Thurman was 9 weeks pregnant with twins when she took these drugs. Nearly 10% of women who start a chemical abortion at 9 weeks will require surgery to complete their abortions due to retained tissue[6]. Did anyone warn her of that risk?

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[4] Miech RP. Pathophysiology of mifepristone-induced septic shock due to Clostridium sordellii. Ann Pharmacother. 2005 Sep;39(9):1483-8. doi: 10.1345/aph.1G189. Epub 2005 Jul 26. PMID: 16046483.

[5] James Studnicki, John W. Fisher, Tessa Longbons Cox, Ingrid Skop, Donna J. Harrison, Christina A. Cirucci, David C. Reardon, Christopher Craver. (2024) "Comparative Acuity of Emergency Department Visits Following Pregnancy Outcomes Among Medicaid Eligible Women, 2004-2015". International Journal of Epidemiology and Public Health Research, 5(2); DOI: 10.61148/2836-2810/IJEPHR/075

[6] Maarit J. Mentula, Maarit Niinimäki, Satu Suhonen, Elina Hemminki, Mika Gissler, Oskari Heikinheimo, Immediate adverse events after second trimester medical termination of pregnancy: results of a nationwide registry study, *Human Reproduction*, Volume 26, Issue 4, April 2011, Pages 927–932, https://doi.org/10.1093/humrep/der016

That risk increases to nearly 40% even early in the second trimester. Due to the Food and Drug Administration's (FDA) reckless removal of the in-person dispensing requirement in 2021, women like Candi Miller and others in states where induced abortion is legal can obtain these drugs online with no confirmation whatsoever of their gestational age (how far along their pregnancy is). The risks of these drugs (including heavy bleeding, need for blood transfusion, retained tissue, sepsis and death) increase exponentially with increasing gestational age.

Not knowing exactly how far along a woman is in her pregnancy destroys any chance of giving her accurate information about her individual risks for an induced abortion – something that is central to truly informed consent. Additionally, women cannot be adequately screened for ectopic pregnancy, a potentially lethal condition that occurs in 1 in 50 pregnancies, without an in-person visit. Undiagnosed ectopic pregnancies have led to the deaths of several women (that we know of) who took abortion drugs[7].

Rather than being honest about what actually led to Amber and Candi's deaths, the abortion industry and its allies (including Vice President Harris) are shamelessly claiming that their deaths are the result of Georgia's abortion law - despite the fact that there is zero evidence to support this claim.

As of September 20th, if you google "Can you get a D&C in Georgia", the first thing you find are the ProPublica articles falsely stating that a D&C, even for treatment of an incomplete abortion, is a felony. This is a dangerous lie.

Given the fact that women who take these drugs, whether they get them online or from an abortion facility, are being told to just go to their local emergency room if they have complications, it is especially dangerous if they are told that the hospital won't care for them. Where does that leave them?

These lies are not in the service of our patients but rather of extreme political agendas that cannot articulate ANY limit or regulation of induced abortion they would tolerate.

And this extreme abortion agenda is out of step with how the vast majority of OB/GYN's practice day in and day out. Three surveys done before the *Dobbs* decision showed that 76-93% of OB/GYN's did NOT perform induced abortions[8,9,10]. And yet I think it would be safe to say that nearly, if not all of them were treating ectopic pregnancies, miscarriages and life-threatening complications of pregnancy. The only physicians who needed to change their practices after the

[7] Aultman K, Cirucci CA, Harrison DJ, Beran BD, Lockwood MD, Seiler S. Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019. Issues Law Med. 2021 Spring;36(1):3-26. PMID: 33939340

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

[9] Stulberg DB, Dude AM, Dahlquist I, Curlin FA. Abortion provision among practicing obstetrician-gynecologists. Obstet Gynecol. 2011 Sep;118(3):609-614. doi: 10.1097/AOG.0b013e31822ad973. PMID: 21860290; PMCID: PMC3170127

[10] Grossman D, Grindlay K, Altshuler AL, Schulkin J. Induced Abortion Provision Among a National Sample of Obstetrician-Gynecologists. Obstet Gynecol. 2019 Mar;133(3):477-483. doi: 10.1097/AOG.0000000000003110. PMID: 30741798.

Dobbs decision were those doing elective induced abortions – less than a quarter of all OB's in the country.

I have had the honor and privilege to practice as an obstetrician/gynecologist for nearly two decades and for the last 8 years I have practiced as an OB Hospitalist. This means I work exclusively in the hospital – delivering babies, caring for women hospitalized with high-risk pregnancies, and seeing patients in the emergency department with OB or GYN emergencies. I went into this field of medicine because I love walking with women through all phases of their life – through times of extreme joy as well as through very difficult circumstances. I have the unique challenge of caring for not just one, but two patients at once when I'm caring for a pregnant woman – my fetal patient as well as my maternal patient. Much of what we do in obstetrics involves maximizing the health of both throughout the pregnancy.

I have delivered thousands of babies in my career and treated countless pregnancy complications during pregnancy, at delivery and in the postpartum period – both here in the US and in rural Kenya for 3 years. I have treated hundreds of women experiencing miscarriage and ectopic pregnancy. I have had extremely difficult conversations with patients who, despite being too early in their pregnancy for their baby to survive, were showing signs of conditions that, if left untreated, could progress to a life-threatening condition. I have had to tell them that it was too dangerous to continue their pregnancy and we had no choice but to deliver them early. And yet in all of these circumstances and throughout the course of my career, I have never had to intentionally end the life of my fetal patient in order to save the life of my maternal patient. Maternal fetal separations intend to save the life of the mother – not to end the life of her child.

Intent is key to many things we do in medicine – if my intent in performing a c-section is to expedite a delivery when the fetus is showing signs of distress, that is acceptable and medically indicated. If my intent in doing a c-section is to expedite the delivery so that I can go home sooner, that is not. Though this may seem to be a flippant example, it illustrates that though it may be the same procedure, it is the intent that makes it an appropriate intervention versus potential malpractice.

I practice in Indiana, a state that currently outlaws all abortions with exceptions for rape/incest, life-limiting fetal anomalies, and life of the mother. I have always provided excellent healthcare to all of my patients, including pre-viable maternal fetal separations when necessary, and my practice did not change at all after our law went into effect. In fact, the official guidance from my hospital system to all of its physicians was that none of our practices needed to change (other than paperwork required for the state) – we would continue to provide the same care to our patients that we always had. And we do not delay treatment in cases like Amber's. We provide immediate, appropriate and indicated care for any woman who walks through our doors – as can any hospital across the country, regardless of their state's laws on abortion.

My patients, and all women across this country, deserve better medical care than the "care" that abortion advocates are peddling. Women deserve to have in person counseling from a competent physician – not some invisible and inaccessible "provider" who will simply dispense the drugs

that they are profiting off of and tell women to just go to their local emergency room if they experience complications.

I have cared for several women in just this situation, as have many of our members. In fact, once when I went down to our emergency room to see a patient for chemical abortion complications who needed a blood transfusion, IV antibiotics and a D&C due to retained tissue, one of the emergency physicians pulled me aside and asked me if something had changed with these drugs because he was seeing so many more women come in with these complications. I informed him that in fact, something had just changed. The FDA had removed the requirement that women have an in-person evaluation and counseling before getting the drugs – opening the door for online dispensing with little to no evaluation or counseling. The disgusted shake of his head said it all.

It is imperative that women, especially when they are in the midst of the crisis of an unplanned pregnancy, receive accurate information – not only about their state laws but also about the risks of induced abortion. Women and their children (born or preborn) deserve excellent healthcare. Fear mongering with lies and misdirection does nothing to accomplish these things. In fact, it actively harms my patients.

AAPLOG is leading the way in showing how to care for patients not only in a life-affirming way but also educating physicians on the care that they can, and should, provide if they are practicing in a state with prolife laws. We have invited other medical organizations to join us (even those that disagree with us on the issue of induced abortion) and we would hope that if their goal really is to ensure the health and safety of all of our patients that they will be willing to collaborate with us on this.

Education based on the facts about state laws and long understood principles in medicine is absolutely imperative right now and should be the focus of our resources. It is time to put political rhetoric aside, speak with truth and clarity, and put the care of our patients (all our patients) first.