

Chair Merrin, Vice Chair Manning, Ranking Member Boyd and Health Committee Members, thank you for allowing me to testify here today on Senate Bill 23. My name is Maria Phillis, I am an obstetrician-gynecology resident physician practicing here in Ohio. I am testifying in opposition to Senate Bill 23 and respectfully request that you vote no on the proposed bill.

I begin by noting that I am not speaking on behalf of my university, residency or workplace but on behalf of myself as a citizen of and physician working in Ohio.

I have multiple concerns with the proposed bill and I hope to use the time you have granted me to explain why I, as a physician who is dedicated to providing care for women and their families, and hope to do so in Ohio for the remainder of my career, am very concerned about this bill.

I have three main concerns about this bill. First, I am concerned about the impact this will have on patient care here in Ohio. Second, I am concerned about the impact this will have on physician's ability to practice effectively and in line with nationally recognized guidelines of care. Finally, I am concerned about the effect this bill will have in attracting and retaining current and future obstetrician-gynecologists to Ohio to practice.

First in regard to my concerns about patient care: SB 23 attempts to limit access to abortion care once a heartbeat is detected. This will have a negative impact on patient care here in Ohio. There are a number of ways this will happen.

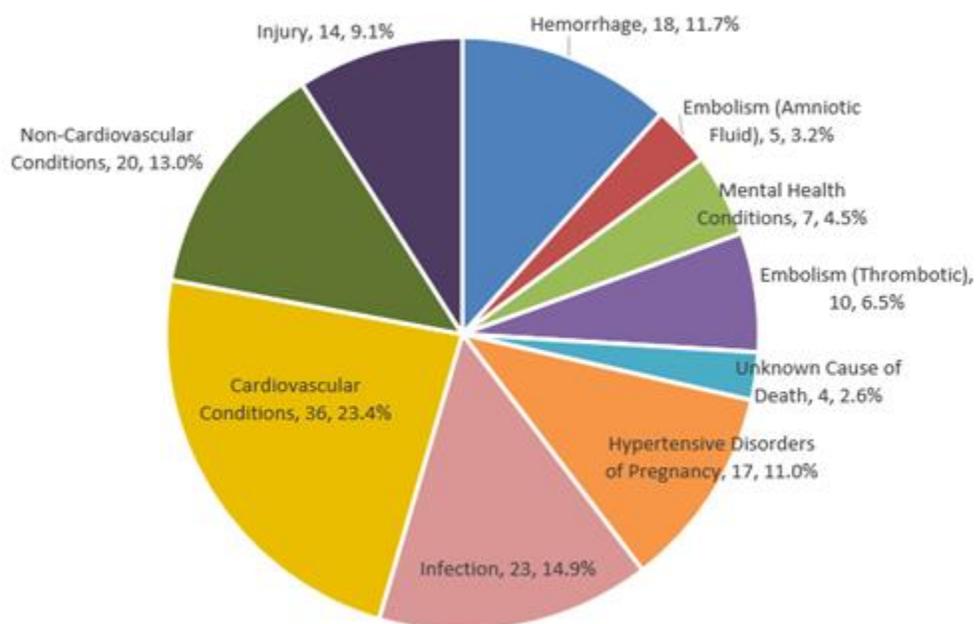
Access to safe, legal abortion services is an essential component of women's health care.¹ American College of Obstetricians and Gynecologists (ACOG), is the largest organization of obstetricians and gynecologists in the country, i.e. the experts in women's health care and they support this standard of care nationally for all women. When access to abortion care is limited, women suffer.

I have treated many women with a multitude of medical conditions that make pregnancy a threat to their lives. Pregnancy, when it goes right, results in a happy, healthy mom, a happy, healthy baby and an intact family, which we all celebrate. When pregnancy goes wrong, it can leave children without a mother. Pregnancy is a strain on a woman's body. Even healthy women sometimes die or are left ill. Women who start off with a heart that doesn't pump well, or kidneys that don't let them filter their blood are at a high risk of the pregnancy itself killing them. Pregnancy carries with it complications such as preeclampsia, which is a condition in which blood pressure rises uncontrollably and sometimes results in seizures, organ failure and death if uncontrolled. Placental abruption, when the placenta peels away from the uterus wall or placenta accreta, where the uterus attaches itself to the uterus and can't be removed can result in a woman bleeding to death. Some women are at greater risk of these complications and may choose not to proceed with a pregnancy that may kill them. They deserve the right to avoid these risks to their lives. Pregnancy, on average, carries with it a 14-fold higher risk of death

¹ ACOG Committee Opinion No. 613: Increasing access to abortion. *Obstet Gynecol.* 2014 Nov;124(5):1060-5. doi: 10.1097/01.AOG.0000456326.88857.31.

than that of abortion.² When women choose to avoid that risk to their lives, we need to honor that choice. I can't think of any other area of medicine in which physicians have to fight so hard to avoid their patient's facing a higher risk of death despite the patient's own wishes. Especially where maternal mortality in the US is on the rise.³

Ohio Pregnancy-Related Deaths by CDC Maternal Mortality Cause of Death Category (2008-2014)



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Many of the proponents have presented arguments about the meaningfulness of a heartbeat in a pregnancy, largely noting its emotional resonance. I have been in the room or performed an ultrasound for a new mother when she hears the heartbeat for the first time, and I agree that it is an emotional moment. I love celebrating that milestone with my patients. I mourn with my patients who desire pregnancy very much and don't hear that heartbeat and face the reality of a miscarriage. I don't dispute its emotional meaning. However, as a physician, I know that the viability of a pregnancy is so much more than a heartbeat. I know that from the time a heartbeat is detected to the time the lungs develop enough to be able to take a breath (around viability about 22-24 weeks, but this varies with each pregnancy⁵), that if a pregnancy is delivered and the lungs can't accept and accommodate air there is nothing I can do to keep that heartbeat

² Id.

³ CDC, Severe Maternal Mortality and Morbidity in the United States, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

⁴ Ohio Department of Health, Pregnancy Associated Mortality Review (PAMR) Data, <https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/pregnancy-associated-mortality-review/resources/PAMR-Data>

⁵ B.D. Kamath-Rayne & A.H. Jobe, Creasy & Resnik's Maternal-Fetal Medicine: Principles and Practice, 8th ed. Fetal Lung Development and Surfactant, 6, 223-234.e2

going. Without the ability to get oxygen through the lungs, the heart can't get oxygen and can't continue to beat, so medically the focus on a heartbeat is misplaced. And, even at that cusp of viability there are a smattering of things that can go wrong. So, the focus on the heartbeat instead of a more holistic discussion of viability is not medically or scientifically based and does not give women the best information about the viability of a particular pregnancy.

Second, I am concerned about the impact this will have on physician's ability to practice effectively and in line with nationally recognized guidelines of care. As physicians, we take very seriously our dedication to our patients and our ethical requirements to provide the care that we think is the safest and most effective, to provide all safe evidence based alternatives to patients

The American Medical Association (AMA) publishes recommended code of ethics for physicians, and I want to draw the committee's attention to Section 1.1.3 of the code that speaks of patient's rights in the physician-patient relationship, namely that they have the right *"To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment."*⁶

To limit our ability to provide care that is safe and nationally the standard of care among physicians in the US is to infringe on the ability of physicians to act in line with these ethical guidelines.

Additionally, we have amazing research institutions in Cleveland, Columbus and Cincinnati working on the cutting edge of fetal viability, fetal therapies and interventions to help women intervene on very wanted pregnancies. We have patients in Ohio, as well as patients traveling from other states to obtain interventions on very wanted pregnancies here in Ohio, that carry with it some risk to those pregnancies, but also potential benefits to make a difference in otherwise lethal or life limiting conditions. If and when these procedures fail, patients need to know that we are able to care for them in any eventuality, whether that is inducing labor early for their own safety, terminating a pregnancy that has gone wrong, or otherwise caring for them. Limitations on the ability to intervene to end a pregnancy may impact the ability of Ohio to be a leader in fetal interventions, to serve patients from around the country in their care, and to make a difference in heartbreaking fetal abnormalities so that we can actually protect very wanted pregnancies.

Finally, I am concerned about the effect that this bill will have on the ability of Ohio to attract the best and brightest future obstetrician-gynecologists to Ohio to practice and the ability of those who do practice here to have the skills necessary to provide care to their patients. Ohio like most of the rest of the country faces a predicted shortage of obstetrician-

⁶ AMA Code of Medical Ethics Opinions on Patient-Physician Relationships

gynecologists⁷, specifically a recent study reported that Cincinnati is one of 15 metropolitan areas around the country that have the greatest percentages of obstetrician-gynecologists over 55 yrs old, which means that as they near retirement age, the workforce that will replace them is not as robust.⁸

Recent data suggests that training in a state is a predictor of whether you will remain there to practice.⁹ I have personally participated for the last two years in my residency's recruitment program and have had very honest and direct conversations with medical students interested in our program and our state, but afraid that if they train in Ohio that their ability to provide appropriate medical care to their patients will be affected. I shared their concerns when I made my decisions about where to train. I want to be able to provide the full scope of care to my patients as an obstetrician-gynecologist. Part of that care is abortion care. I never want to have to look my patient in the eye and tell her that I know what will help her, I think it's safe for her and appropriate care that is standard of care throughout the country, but I cannot provide it for her here, I have to send her away and hope that someone else will care for her as well as myself and my colleagues do.

I'm a native Ohioan, born and raised in Northeast Ohio, attended high school and college here, my family's here, my husband's family is here, Ohio is my home. I want nothing more than to continue to be able to provide care for your constituents here in Ohio in the most safe, effective and evidence-based manner possible. I hope that you will allow me to remain here and allow me to provide the full scope of obstetric and gynecologic care for my patients and your constituents.

Thank you very much for your time and attention. I respectfully request you vote no on SB 23.

⁷ American Congress of Obstetricians and Gynecologists. The Obstetrician–Gynecologist Workforce in the United States 2017. Washington, DC: American Congress of Obstetricians and Gynecologists; 2017. <https://www.acog.org/Resources-And-Publications/The-Ob-Gyn-Workforce/The-Obstetrician-Gynecologist-Workforce-in-theUnited-States>.

⁸ OB-GYN Workload & Potential Shortages: The Coming U.S. Women's Health Crisis, Doximity, July 2017

⁹ Koehler TJ, Goodfellow J, Davis AT, Spybrook J, vanSchagen JE, Schuh L. Predicting In-State Workforce Retention After Graduate Medical Education Training. *J Grad Med Educ*. 2017 Feb;9(1):73-78. doi: 10.4300/JGME-D-16-00278.1.