**Jessica Warner**

**Proponent Testimony on Senate Bill 260**

**Senate Health, Human Services, and Medicaid Committee**

**Wednesday, February 19, 2020**

Chairman Burke, Vice Chair Huffman, Ranking Member Antonio, and members of the committee, thank you for allowing me to testify today on Senate Bill 260. My name is Jessica Warner and I am the Director of Legislative Affairs for Ohio Right to Life. Today, I speak on behalf of our board, affiliated chapters, and statewide membership in support of Senate Bill 260, the Telemedicine Abortion Ban.

For my testimony today, I will be summarizing parts of testimony written by Dr. Randall O'Bannon, Director of Research and Education at National Right to Life, who has been studying and writing on chemical abortions for over the past 25 years. His full testimony has been submitted for you, if you would like to read it in full.

From the beginning, the abortion industry has asserted that these drugs are both "safe and effective," but too many women have found otherwise.

An important government document was released on April 30, 2011 and has been updated to reflect data received as of December 31, 2018. In the "Mifepristone U.S. Postmarketing Adverse Events Summary" [1] the FDA indicated it had received almost 4,200 reports of "adverse events"(4,195) or complications associated with use of mifepristone in the U.S.

More than 1,000 women (1,042) had been hospitalized, with more than half that many (599) losing so much blood as to require transfusions. 412 women reported infections, with 69 of

[1] https://www.fda.gov/media/112118/download

those being so severe as involve hospitalization for at least 2 days, IV antibiotics for at least 24 hours, or other clinical findings or surgery.

Though official government labeling specifically says that these drugs are contraindicated for patients with confirmed or suspected ectopic pregnancies, there were still 97 known incidents of such.

These are more than just random, minor aggravations. They represent real, tangible risks clearly associated with this method. And sometimes these complications prove deadly. The FDA confirms in recent reports that it had knowledge of at least 24 deaths associated with use of these drugs. Deadly infections killed eight of the 24 in the U.S., seven of those from Clostridium Sordellii, which is rarely seen in U.S. hospitals. Undiscovered ectopic pregnancies ruptured and killed two others.

These are not simply incident reports or statistics. They are people whose lives were wrecked in their encounters with these killing drugs.

These victims aren't identified by name in the FDA report, but cases we've seen in the newspapers match up and give us more detail.

Brenda Vise was one of those who died after a ruptured ectopic pregnancy. In September of 2001, the 38-year-old pharmaceutical executive from Chattanooga went to a clinic in Knoxville, Tennessee. A test confirmed pregnancy, but technicians performing an ultrasound found nothing in the uterus and told her the baby was just too small to see. She took mifepristone there at the clinic and was given misoprostol to take later at home.

When she began to experience severe pain and bleeding, she called the clinic. They advised her symptoms were normal and routine for a chemical abortion. Calling back after her condition worsened, the clinic recommended new medications for the pain and nausea. Only after repeated phone calls did the clinic agree to see her again, but she never made it back. Vise died from a ruptured ectopic pregnancy that the clinic missed.

Vise's case shows that it is not enough to simply have the equipment to date or locate a pregnancy in the womb, but that it is essential to have someone who has the training to read an ultrasound, to do a pelvic exam, a blood test, to recognize the signs of ectopic pregnancy which these drugs will not treat.

Rebecca Tell Berg was a Swedish sixteen-year-old who took the drugs and bled to death in her boyfriend's shower in June of 2003. Manon Jones, 18, bled to death at a British emergency room in June of 2005 waiting for a transfusion after her chemical abortion.

Everyone who chemically aborts bleeds, and not just a little. A woman aborting with mifepistone generally bleeds four times as much as a woman having a simple, first trimester surgical abortion, and sometimes the bleeding goes on for days, or weeks. There are cases, however, in which the bleeding gets really out of control, and what a woman needs is not someone on the phone or a computer screen, but a doctor close by who can examine her, evaluate her condition, and provide emergency surgery if necessary.

Holly Patterson went to her local Planned Parenthood in September of 2003, signed some forms, was given and took mifepristone there at the clinic, and administered the misoprostol to herself days later. She began cramping severely, took some painkillers at the clinic's direction, and felt a bit better. Then the following day she began to bleed heavily. She went to the ER, told them of the abortion, had a pelvic exam. She was given more pain meds and sent home.

Vomiting, nauseated, weak, Holly was rushed back to the ER three days later. What had been thought to be the side effects of the chemical abortion turned out to be signs of a massive reproductive infection that even the doctors missed. An investigation found that Holly had died of a deadly Clostridial infection.

These infections are supposed to be exceedingly rare, but there was a sudden rash of them once these abortion pills went on the market and, seemingly out of nowhere, several otherwise healthy women – Holly Patterson, Orianne Shevin, Chanelle Bryant, Vivian Tran – suddenly contracted this bacteria and died within about a week of their chemical abortions.

Did they have to die?

One of the major problems in all these cases is that the signs and symptoms of an ectopic pregnancy, of a hemorrhage, of a serious reproductive tract infection – that is, painful cramping, heavy bleeding, gastro-intestinal distress – also happen to be standard side effects of the chemical abortion process. They are signs that even a trained emergency room doctor, like the one who saw Holly Patterson, can easily misinterpret.

Someone who has been trained in use of the drugs, who understands the chemical abortion process, who knows and has examined the patient, really needs to be on hand to manage the situation, not some night shift nurse in the E.R. and certainly not some lowly clinic administrator who has drawn the short straw and gotten weekend phone duty.

No one is saying that every woman dies. But these women who did were, from all we can gather, in good or even perfect health before taking these abortifacients. They were, we must assume, screened and counseled and given the correct pills, but things somehow went horribly wrong and the help they needed was neither close enough nor swift enough nor capable enough to save their lives.

The folks at Planned Parenthood and their allies in the abortion industry may try and tell you that they've learned from their experience, that they've modified their protocol, that they've eliminated the problems, but women have continued to be suffer and be injured and risk death after every government warning, every protocol adjustment, every new "innovation."

The web-cam abortion is their latest innovation, one that stands to increase Planned Parenthood's reach and its revenues but does not promise to make women's lives any safer.

They claim, of course, extremely high "efficacy" rates and low rates of adverse events, but one thing you find in studies webcam abortions is a high number of "lost women," that is, women showed up for their initial appointments, got their pills, but then were "lost to follow up."

They claim high safety and efficacy rates with webcam abortions, but critical data is missing.

In Grossman's August 2011 study from the journal Obstetrics & Gynecology, 58 women, or 21% of telemedicine study participants were "lost to follow up." Nearly four times that many, 207, the report says, "declined participation" in the study or were "not invited."

This is, in fact, one of the chief problems with telemedicine abortions – not the women who dutifully check in reporting they survived their chemical ordeals – but the ones who don't, those who disappear, who go through this arduous, dangerous, bloody process without ever meeting the doctor in person who is charged with their care.

Researchers would have you ignore these lost women and calculate safety and efficacy from only those women with whom they were able to follow up. That's part of how you get a 99% "success" rate. While possible that these lost women's cases were non-problematic, it is also possible that these women turned to their own personal physicians, or to a doctor in the E.R., to handle serious problems.

Whether these other doctors would have been prepared to handle abortion related complications, or whether they would have even been told the woman was dealing with complications of a chemical abortion, is an open question. We don't know whether women in these studies were advised to keep their abortions a secret when they showed up at the E.R., but other promoters of abortion pills have told women to tell doctors they are having miscarriages, telling them the doctors can't tell the difference.

If so, they won't show up in any mortality rates or "adverse event" reports associated with the drugs, but they will be dead or injured just the same. We only know of the cases where the family came forward or a report was filed, and those accounts, as you have heard, are horrifying and tragic.

Frankly, we at National Right to Life believe that both women and their unborn children would be better off if these drugs weren't sold in the U.S. at all. But if they are going to sold, the least we can do is to make sure that the mother's life isn't going to be put at further risk for the convenience and economic benefit of the abortionist.

Even in Grosssman's 2011 study touting women's "satisfaction" with webcam abortions, a high percentage – 25% – still said they would have preferred being in the same room as the doctor.

Perhaps the industry considers a few ruptured ectopic pregnancies, hemorrhaging patients, or life-threatening infections as "statistically insignificant," as acceptable losses, as just the cost of doing business, but I don't think the rest of us do. Not when two lives hang in the balance, not when this is an entirely elective procedure, not when we can put a doctor in the room to ensure a more responsible standard of care.

On behalf of Ohio Right to Life, I urge you to pass SB 260. Protect women's health and make sure these doctors do their jobs.