My full name is Monique Chireau Wubbenhorst. I am over 18 years of age and am competent to testify. I am providing testimony in support of Ohio House Bill No. 347, Share the Health and Empower with Informed Notices (SHE WINS) legislation, which includes a 24-hour waiting period. With a reasonable degree of medical certainty, the SHE WINS legislation is clinically sound, can help to protect the health and safety of women and children, and helps to preserve women's autonomous decision-making, without stigmatizing abortion.

I am qualified to give my opinion on the Act based on my education, training, medical background, expert witness experience and publications. I am licensed to practice medicine in North Carolina (since May 21, 2000) and Indiana (since August 26, 2022). I hold specialty certifications from the American Board of Obstetrics and Gynecology (1997-present) and the National Board of Physicians and Surgeons (2023-present).

My academic background includes an A.B. in Biological Sciences from Mount Holyoke College (1981), an M.D. from Brown University Medical School (1991), and a Master's in Public Health from Harvard University (1991). I also completed a Postdoctoral Fellowship at the University of North Carolina from 2001 to 2003.

Throughout my career, over the last 35 years, I have held various academic and clinical positions, including Faculty, Division of Epidemiology and Public Health Beth Israel-Deaconess Medical Center, Department of Obstetrics and Gynecology, Boston, MA, 1995-1998; Instructor, Harvard Medical School, 1995-2000; Adjunct Clinical Assistant Professor in the Department of Obstetrics and Gynecology at University of North Carolina-Chapel Hill Medical School, 2001-2003; Assistant Professor, Duke University Medical Center Department of Obstetrics and Gynecology, 2003 - 2018; and Adjunct Clinical Professor in the Department of Obstetrics and Gynecology at Indiana University School of Medicine.

My clinical activity includes practice at St. Joseph's Regional Medical Center in Mishawaka, IN. I have actively participated in numerous academic and administrative roles, including serving on the Duke University Medical Center IRB, the Duke Medical School Admissions Committee, and as Director of the VA Gynecology Resident, Nurse Practitioner and Medical Student rotations. I have also served as a Member of the 2001 and 2002 Objective Review Committees, Expanded Medical Capacity for Community Health Centers, Bureau of Primary Health Care, Health Research and Services Administration, Washington D.C.; National Reproductive Health Working Group member, Women Veterans Health Strategic Healthcare Group, Veterans Administration Central Office, Washington, DC; Consultant to Acting Chief Consultant, Women Veterans Health Strategic Healthcare Working Group, Veterans Administration Central Office, Washington DC.; Member, National Surgical Quality Improvement Program Committee, GYN Surgery Subspecialty, for Women Veterans

Health Strategic Healthcare Working Group, and Duke University Medical Center; Chair, Cardiovascular Disease in Women and Special Populations National Committee, Clinical Council on Cardiology, American Heart Association; Reviewer, NIH Cardiovascular and Sleep Epidemiology (CASE) ad hoc study section; and Senior Public Policy Fellow, Notre Dame Institute for Ethics and Culture.

I also served as an Executive Board Member of UNICEF, and Executive Board Chair for Maternal and Newborn Health in Fragile Settings for The Partnership for Maternal, Newborn and Child Health.

My clinical career in the United States and elsewhere has been dedicated to caring for women in underserved and disadvantaged populations, especially African American, Hispanic and Native American communities, with a focus on women with medical, social, and psychiatric comorbidities and high-risk pregnancies. I have worked in multiple domestic and international contexts, including inner city Boston, rural North Carolina, the Veterans Administration, and Native American reservations in the United States; and in India, the Philippines, Kazakhstan, Ghana, South Sudan, Nepal, Cameroon, Liberia and Kenya.

My research interests and grants have primarily focused on critical areas such as postpartum hemorrhage, preeclampsia, maternal mortality, and various pregnancy outcomes. I have a substantial record of original publications in peer-reviewed journals and have delivered presentations at numerous national and international conferences, sharing my expertise on topics related to maternal and child health.

I have published more than twenty peer-reviewed publications, and have been, or am currently, a reviewer for the *Journal of General Internal Medicine*, *North Carolina Medical Journal*, *British Journal of Obstetrics and Gynecology*, *pLOS1*, *Public Health*, *Issues in Law and Medicine*, *Journal of Medical Ethics*, *Linacre Quarterly* and Cureus. My curriculum vita is attached.

I have provided expert reports for legal cases in Texas, Minnesota, Michigan, Kentucky, North Carolina, The Inter-American Court, Indiana, Kansas, Missouri and Colorado. I have also provided testimony, either at trial or by deposition, for cases in Texas, Michigan, Kentucky, North Carolina, Indiana, Kansas, Missouri and Colorado.

Informed consent is a key part of medical care, and must be obtained by the person who will perform the intervention, in such a way that it is voluntary, informed and free of coercion.

A cornerstone of informed consent in medicine is the requirement that the person consenting for a procedure has accurate information on a procedure's risks, benefits and

consequences in order to make an informed choice to proceed with that procedure. All procedures are associated with risks, and abortion, whether medical or surgical, is no different. Women seeking to undergo any medical intervention must give informed consent. Abortion is in fact associated with several health risks to the mother. Adequate informed consent requires that women are made aware of these risks, as well as the consequences of abortion. Informed consent and reflection periods provide critical safeguards. They ensure that women receive consistent information, that the information they receive is complete and accurate, that they have time to consider their options, and that they are protected from coercion—especially that associated with trafficking or abuse.

For example, as noted by Shah et al, "[i]nformed consent is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. . . . Informed consent is both an ethical and legal obligation of medical practitioners…Obtaining informed consent in medicine is process that should include: (1) describing the proposed intervention, (2) emphasizing the patient's role in decision-making, (3) discussing alternatives to the proposed intervention, (4) discussing the risks of the proposed intervention and (5) eliciting the patient's preference (usually by signature). Discussion of all risks is paramount to informed consent in this context. Most consent includes general risks, risks specific to the procedure, risks of no treatment, and alternatives to treatment."

Without proper informed consent, women's decision-making is impaired, and adequate informed consent cannot be said to have been given. For many people, the embryo and fetus are unborn children (and this is the context that will be used in this testimony). As a result, incomplete or inadequate informed consent. This is associated with violation of the parents' autonomy to make decisions, for themselves and their unborn child.

Consent for the abortion decision is different from any other type of informed consent. No other procedure destroys what many believe to be human life (a fact that has been noted in court cases), or has the potential to inflict pain on an unborn child without any prospect of benefit. No other elective procedure is irreversibly associated with the killing of an unborn child, and hence with short- and/or long-term maternal regret. That is why the informed consent process for the abortion procedure (whether chemical or surgical) must include accurate information, including accurate terminology. According to Thill,

"This dichotomy in terminology and the shielding of the pregnant woman from medical information [in informed consent] may unduly influence the patient's decision-making process, particularly in a time of crisis when reliance on medical counsel is high…In Gonzales v. Carhart (2007), abortion providers noted that pertinent medical information about the abortion procedures was not typically disclosed to patients. In the majority

opinion, Justice Kennedy noted that the omission of information necessitates government involvement: “It is, however, precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State…The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know… (IV.A) [emphasis added]” (quoting Gonzales v. Carhart, 550 U. S. 124, 160 (2007)48”.

Underlying the importance of detailed accurate informed consent for abortion is the concept of choice – the choice to keep what many consider to be one’s baby, or to abort him or her. It is paternalistic to deprive women of knowledge that could better inform their choice to undergo or not undergo an abortion. If women receive information that causes them to change their mind regarding abortion, this is empowering them to exercise autonomous decision-making. To not disclose detailed information is not only dishonest and unethical, it curtails a woman’s right to fully understand the consequences of her decision and to choose accordingly.

As noted above, during the informed consent process, it is of paramount importance that a woman meet with the physician who is performing her abortion (whether surgical or chemical). This is standard medical practice, and every hospital where I have worked required that a patient meet the physician performing her procedure prior to surgery. In many states, physicians have been held liable for their delegates not providing adequate informed consent, or for not obtaining consent themselves. The person doing the procedure should obtain consent, as required by the Act.

In Ohio, women and girls can access abortion at 10 abortion clinics across the state (https://www.acluohio.org/app/uploads/2025/02/kyr_abortion_250220.pdf) and by mail (see, for example https://www.plancpills.org/abortion-pill/ohio). Abortionists may provide abortion pills via telemedicine, that is, without an in-person visit. The latter 2 options are highly problematic.

Chemical abortion (as well as surgical abortion) is associated with physical and mental health risks

First trimester abortion is always lethal to a developing human and is associated with risks to the mother. Niinimaki et al used data from Finland’s health service administrative database, which included all women in Finland undergoing abortion from 2000 to 2006 (42,619 women) and collected follow up data for 42 days post abortion (Niinimäki M, Pouta A, MD, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heikinheimo O. Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. Obstet

Gynecol 2009;114:795–804). 52.5% of women underwent chemical abortion and 47.5% underwent surgical abortion. For women undergoing chemical abortion, 20% of women in the medical-abortion group and 5.6% of women in the surgical-abortion group had at least one type of adverse event. In this study, women undergoing medical abortion had 8 times the risk for hemorrhage from medical abortion compared to those undergoing surgical abortion. They had 5.4 times the risk for incomplete abortion (i.e. retained fetal and placental parts), and 3.6 times the risk for incomplete abortion. The authors concluded that "Because medical abortion is being used increasingly in several countries, it is likely to result in an elevated incidence of overall morbidity related to termination of pregnancy".

In a study by Ireland et al comparing complication rates among women undergoing chemical versus surgical abortion (Ireland LD, Gatter M, Chen AY. Medical compared with surgical abortion for effective pregnancy termination in the first trimester. Obstet Gynecol 2015;126:22–8), the risk of abortion failure was four times higher for women undergoing chemical abortion compared with surgical abortion. medical abortion had a four times higher risk of abortion failure than those undergoing surgical abortion. Persistent pain and/or bleeding were the most common reasons for a second abortion procedure after chemical abortion.

In a study by Aultman et al, FDA adverse event reports data related to the use of mifepristone from September 2000 to February 2019 were analyzed (Aultman A, Cirucci C, Francis C, Beran B, Lockwood M, Seiler S. Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019. Issues in Law & Medicine, Volume 36, Number 1, 2021). This analysis brought to light serious concerns about the safety of mifepristone abortion. The authors noted that "Significant morbidity and mortality have occurred with the use of mifepristone as an abortifacient, including at least 24 US deaths reported by the FDA from September 2000 to February 2019". These researchers also noted a significant number of ectopic pregnancies diagnosed in women after they had undergone chemical abortion; "Of the 75 reported ectopic pregnancies in the FDA AERs we analyzed, over a third were known to be ruptured including one death". The second concerning trend was hemorrhage requiring transfusion. The authors note that "Four hundred and eighty-one patients required blood transfusion following medical abortions". The third was infection with unusual bacterial infections, including a specific organism called *Clostridium sordelii*, which causes rapidly-fatal infections.

A UK-based research organization based in the United Kingdom, Percuity, noted in 2021 that "Ranbaxy (UK) Limited is the manufacturer of Medabon, the mifepristone/misoprostol combination treatment provided by BPAS [the British Pregnancy Advisory Service] to its pills-by-post [mail-order abortion] clients. In its SmPC (summaries of product

characteristics), Ranbaxy states that…'The non-negligible risk of failure…makes the follow-up visit mandatory in order to check that abortion is complete."

In addition, Percuity found that "complications arising from the failure of medical abortion treatment result in 590 women presenting at the emergency department of their local NHS hospital in England every month", and that in both 2022 and 2023 "more than ten thousand women were treated at an NHS hospital for complications arising from an abortion". Percuity found that "the treatment failure rate is 5.9%, 1-in-17".

Percuity also cites NHS data showing that "emergency ambulance responses for complications arising after a medical abortion are three times higher for women using pills-by-post at home [mail-order abortion], compared to those who have their medical abortion in a clinic. In 2018, prior to NHS' rollout of the "pills by post" program (where abortion pills are mailed to women without them seeing a physician). The "pills by post" program began in 2019, and between 2018 and 2020, the percent of abortions carried out at home increased from 0% to 34% to 67%". These findings clearly demonstrate why it is mandatory that women undergoing abortion – whether chemical or surgical – must meet with the physician performing the procedure.

Liu et al performed a study using Canadian data comparing first trimester abortion morbidity with mifepristone-misoprostol vs. surgical abortion (Liu N and Ray JG. Short-term adverse outcomes after mifepristone–misoprostol versus procedural induced abortion. Ann Intern Med. 2023;176:145-153). They noted that "Within a universal health care system, there was a slightly higher risk for SAEs [serious adverse events] up to 42 days after an IA [induced abortion] with mifepristone–misoprostol compared with outpatient procedural IA in the first 14 weeks of pregnancy…On comparing mifepristone–misoprostol with ambulatory procedural IA done in hospital up to an estimated 9 weeks' gestation, the risk for SAEs did not differ, but mifepristone–misoprostol was associated with a higher risk for any adverse outcome, ED [emergency department] use, and subsequent procedural IA".

First trimester surgical abortion carries immediate risks of hemorrhage, infection, continuing pregnancy, death, perforation of the uterus, damage to organs including hysterectomy. These complications, and the need to discuss them in counseling for informed consent, are described in the National Abortion Federation 2024 Clinical Policy Guidelines for Abortion Care. First trimester chemical abortion is associated with risk for hemorrhage, infection, continuing pregnancy, need for surgery for retained fetal and/or placental parts, and death.

Rates of complications associated with second trimester abortion are higher than for first trimester abortion. For example, Turok et al (Turok D, Gurtcheff SE, Esplina MS, Shahb M,

Simonsena SE, Trausch-Van Horn J, Silvera RM. Second trimester termination of pregnancy: a review by site and procedure type. Contraception 77 (2008), pp. 155–161) studied differences in complications between second trimester abortions performed in 475 women, in hospitals vs. free-standing clinics. The authors found that major complications (defined as death, uterine perforation, hysterectomy, transfusion, clotting disorders, deep venous thrombosis, pulmonary embolus, stroke or heart attack, need for exploratory surgery, and prolonged hospitalization) occurred in 11% of women undergoing hospital D&E, 10% of women undergoing hospital induction of abortion, and 1% of women undergoing abortion in clinics.

Other complications included: need for readmission, need for curettage after abortion for retained placenta and/or fetal parts, infection of the fetal membranes after initiation of the procedure, and uterine infection. The authors also note that complications may have been underreported due to loss to follow-up.

Edlow et al. (Edlow AG, Hour MY, Maurer R, Benson C, Delli-Bovi L, Goldberg A. Uterine evacuation for second-trimester fetal death and maternal morbidity. Obstetrics and Gynecology 2011;117:307–16) noted that "[higher] gestational age was significantly associated with maternal morbidity", with women undergoing abortion at > 20 weeks' being 2 ½ times more likely to suffer a complication than women undergoing abortion at < 20 weeks' gestation.

Bartlett et al found that the risk of a woman dying from abortion increased exponentially by 38% for each week of gestational age (Bartlett L, Berg C, Shulman H, Zane S, Green X, Whitehead S, Atrash H. Risk Factors for Legal Induced Abortion–Related Mortality in the United States. Obstet Gynecol 2004;103:ka9 –37). Abortions performed between 16 and 20 weeks had a mortality risk 30 times greater than abortions performed in the first trimester. Abortions performed at or after 21 weeks had a mortality rate 76 times greater than abortions done in the first trimester. In Ohio, 12.2% of abortions – more than 1 in 10 – were performed in the second trimester (at 13 – 21 weeks).

Undiagnosed ectopic pregnancy is a risk in both chemical and surgical abortions. In fact, a young Ohio woman, Tia Parks, died in 2019 from a ruptured ectopic pregnancy the day after undergoing a first trimester abortion at Preterm abortion clinic in Cleveland, OH (see attached autopsy report). In 2014, another Ohio woman, Lakisha Wilson, died at Preterm abortion clinic from hemorrhage after an abortion performed at 19 weeks' gestation.

Abortion also has long-term consequences for women's health. Two recent meta-analyses have confirmed the association between abortion and preterm birth (Saccone G, Perriera L, Berghella V. Prior uterine evacuation of pregnancy as independent risk factor for preterm

birth: a systematic review and metaanalysis. Am J Obstet Gynecol. 2016;214(5):572–591; Lemmers M, Verschoor MA, Hooker AB, et al. Dilatation and curettage increases the risk of subsequent preterm birth: a systematic review and metaanalysis. Hum Reprod. 2016;31(1):34–45).

Quoting AAPLOG's Practice Guideline #11 PB-5-Overview-of-Abortion-and-PTB.pdf (aaplog.org), "PTB [preterm birth] is defined as delivery before term, i.e. before 37 weeks and affects about one in ten deliveries in the United States. The majority (70%) of babies born before 37 weeks are born at 34 to 36 weeks. About 10% of PTB (1-2% of all U.S. deliveries) occur before 32 weeks and are termed "very preterm births." Very preterm births pose greater risks to the neonate and greater costs to the family and system." From my experience, preterm birth is heartbreaking to families and takes an enormous toll on them, as well as on clinical professionals.

ACOG's Practice Bulletin #234 (2001) also states that "A history of dilation and curettage (D&C) [used to perform surgical abortion] has been associated with an increased risk of preterm birth in some, but not all, studies. A meta-analysis of 21 studies including almost 2 million women found an association between subsequent preterm birth and history of D&C (odds ratio [OR], 1.29; 95% CI, 1.17–1.42), with slightly greater odds after multiple D&C procedures compared with no procedures (OR, 1.74; 95% CI, 1.10–2.76)". These studies indicate that women undergoing abortion are at increased risk for preterm birth. In Ohio, the preterm birth rate in 2023 was 10.7%, and in Cleveland it was 15.6%, second in the United States only to Detroit, MI (https://www.marchofdimes.org/peristats/reports/united-states/report-card).

Future pregnancy complications other than preterm birth may be caused by surgical abortion-related uterine damage. Baldwin et al (2018) found that uterine curettage (as occurs with surgical abortion) doubled the risk of abnormal placental attachment, which is associated with catastrophic hemorrhage at delivery. (Baldwin H, Patterson J, Nippita T, Torvaldsen S, Ibiebele I, Simpson T, Ford J. 2018. Antecedents of abnormally invasive placenta in primiparous women. Obstet Gynecol 131(2):227-233). While the evidence on preterm birth after chemical abortion is still evolving, some research suggests that women who require dilation and curettage for retained fetal and placental parts after failed chemical abortion may be at increased risk for future preterm birth (Calhoun B. Medication Abortion and Preterm Birth. Issues in Law & Medicine, Volume 38, Number 2, 2023).

Abortion is associated with increases in the risk of long-term and less direct causes of death. Risk of death associated with abortion increases over time (due to substance abuse, cancer, pregnancy complications, suicide) while risk of death following term pregnancy is lower. A US study spanning 8 years in California found in 2002 a 62% increase in all cause

deaths, 154% increased risk in suicide (Reardon DC, Cougle J, Ney PG, Scheuren F, Coleman PK, Strahan T. Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study. Southern Medical Journal 2002;95:834-41).

A Finnish study in 1997 found death rates 4 times higher after abortion compared to childbirth up to 1 year. (Gissler M, Kauppila R, Merilainen J, Toukomaa H, Hemminki E. Pregnancy associated deaths in Finland 1987-1994: Definition problems and benefits of record linkage. Acta Obstetricia et Gynecologia Scandinavica 1997;76:651-57). Subsequent studies in Finland showed maternal mortality-childbirth 28.2/100,000, while abortion mortality was 83.1/100,000 or 3 times higher (Gissler M, Ber C, Bouvier-Coll M, Buekins P. Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland 1987-2000). The risk of suicide was 6 times higher following abortion.

Morgan et al in UK found that there were 8.1/1,000 suicide attempts in patients undergoing abortion versus 1.9/1,000 suicide attempts in those giving birth (Morgan C, Evans M, Peters JR. Suicides after pregnancy: Mental health may deteriorate as a direct effect of induced abortion. Br Med J 1997;314:902) .

Large record-based studies show that women who have undergone abortion have an increased death rate due to accidents, compared to women who were not pregnant and compared to women who carried a pregnancy to term (Reardon DC, Ney PG, Scheuren FJ, Cougle JR, Coleman PK, Strahan T. Deaths associated with pregnancy outcome: A record linkage study of low income women. Southern Medical Journal. 2002;95:834).

The above data show that abortion is not a low-risk procedure. Many deaths from abortion have been documented, as noted, even at early gestational ages. Further, there are no comprehensive data on abortion complications. In part, this is because rates of follow up after abortion are low. The American College of Obstetrician-Gynecologists Current Commentary: Routine Follow up Visits After First-Trimester Induced Abortion (2004) noted that “In practice, attendance at abortion follow up visits is usually low, generally about 50%. Studies of first trimester aspiration abortion complications observing consecutive series of patients show follow-up proportions from 35% to 60%, although a few series report proportions as high as 80-90%”. Most women with complications from abortion seek help at emergency departments, not at abortion clinics, which are not open 24 hours.

Deaths have occurred in association with the abortion pill, deaths associated with abortion are more common in African American women, and there are significant racial-ethnic disparities in abortion rates

The risk of complications and death is not evenly distributed among ethnic groups. Racial-ethnic disparities in abortion mortality rates indicate that the procedure is markedly more

dangerous for African American than for European American women. Bartlett et al (2007) found that "The second most significant risk factor for death [from abortion, after gestational age] overall was race. Women of black and other races were 2.4 times as likely as white women to die of complications of abortion…At all gestational ages, women of black and other races had higher case mortality rates than white women." Finding that "women of black and other races tend to have abortions at later gestational ages", the authors used statistical methods to account for this difference and found that women of African American and other races-ethnicities were still twice as likely as European American women to die from abortion at any gestational age. Zane et al also reported that the abortion "mortality rate was 0.4 for non-Hispanic white women, 0.5 for Hispanic women, 1.1 for black women and 0.7 for women of all other races…Black women have a risk of abortion-related death that is three times greater than that for white women".

These ethnic disparities in abortion-related deaths point to even more remarkable disparities in abortion rates. In Ohio, African Americans comprise 13.6% of the population, but 42.3% of abortions occur in black women https://www.census.gov/quickfacts/fact/table/OH/PST045224; Induced Abortions in Ohio, 2024 [attached]). Yet despite the fact that African American women undergo abortion at more than three times the rate of white women, the maternal mortality rate is twice as high for black women. Black women should have the lowest rates of maternal mortality, if it were true that abortion reduces maternal mortality (https://childrenandyouth.ohio.gov/for-providers/maternal-infant-clinical-initiatives/pregnancy-associated-mortality-review/pregnancy-associated-mortality-review)

Below are listed some reported deaths from chemical abortion have been reported, which are likely only the tip of the iceberg.

- In 2022, a 19 year old Canadian girl died of septic shock after taking the abortion pill (https://run-with-life.blogspot.com/2023/01/medical-abortion-is-fatal-for-19-year.html).
- In 2022 Candi Miller Candi Miller (GA), 41 years old, died after taking mifepristone-misoprostol obtained online https://www.liveaction.org/news/autopsy-report-candi-miller-abortion-pill-questions.
- Also in 2022, Amber Nicole Thurman died of complications following chemical abortion https://www.nationalreview.com/corner/media-mislead-on-tragic-death-of-amber-thurman/.
- Alyona Dixon also died in 2022 following chemical abortion (https://abortiondocs.org/wp-content/uploads/AlyonaDixonAutopsy-searchable.pdf).

Ms. Thurman's tragic death from pills obtained online underscores the need for physicians to meet patients in person prior to performing an abortion.

The complications listed in Section 2317.58(A) of the Act are known to be associated with abortion, and adequate informed consent cannot be obtained from a woman or girl seeking abortion without those complications being disclosed

From the literature cited, and from my clinical experience over the last 35 years, the complications listed in Section 2317.58(A) are known to be associated with either chemical or surgical abortion. These complications are well documented, are inherent to the abortion procedure, and may be serious. I have encountered many of them in my clinical practice. Informed consent must include full disclosure of all of these potential complications, just as it must in any intervention performed by a physician. Informed consent cannot be said to have been obtained from the girl or woman unless these complications are fully disclosed to her in terms that she can understand.

Telemedicine and self-administered abortion are unsafe and endanger women.

There are multiple reasons why telemedicine is unsafe and endangers women:

- Abortionists providing telemedicine abortion cannot assess a patient for ectopic pregnancy. It is mandatory that providers assess for ectopic pregnancy prior to abortion, to reduce the risk of this potentially fatal complication. In fact, ectopic pregnancy is a contraindication to chemical abortion.

- Abortionists providing telemedicine abortion cannot assess a patient for coercion, trafficking or abuse. As noted above, these issues may be associated with abortion because traffickers and abusers desire to hide the evidence (pregnancy in their victims) of their crimes.

- Abortionists providing telemedicine abortion cannot assess the gestational age of the unborn child, or if the mother is even pregnant. Because some of the signs of pregnancy are subtle or not easily distinguishable from normal physical signs (constipation, fatigue), it is common for women to not have an accurate idea of how far along they are in pregnancy. For example, a patient for whom I cared recently came to the hospital unaware that she was at 23 weeks' gestation. The use of chemical abortion at advanced gestational ages is associated with severe and potentially fatal outcomes.

- Abortionists providing telemedicine abortion cannot assess a patient's Rh status and administer Rhogam, a blocking antibody. Women who are Rh negative and who have an Rh positive fetus can develop antibodies which will attack and injure or kill a future Rh positive fetus in utero, if they do not receive injections of Rhogam at the time of abortion,

miscarriage, vaginal bleeding in pregnancy, and birth (all situations where the mother may be exposed to the embryo's or fetus' blood) they may become sensitized. Despite abortionists' attempts to change this longstanding medical precedent, these injections remain the standard of care (https://emedicine.medscape.com/article/252560-followup). Women who do become Rh sensitized because they did not receive Rhogam may suffer repeated early miscarriages, and their unborn children may develop severe disease or die *in utero* or soon after birth.

- Informed consent is a cornerstone of medical care, as noted, and it is essential to protecting patients and allowing them to make a fully informed decision prior to them undergoing a proposed intervention. Full informed consent, especially for an intervention such as chemical abortion that has many associated risks, cannot be safely or appropriately given virtually.

- Abortionists providing telemedicine abortion cannot supervise safe administration of the drugs, nor provide adequate follow up.

- Abortionists providing telemedicine abortion have no idea who is actually receiving the pills (disgruntled boyfriend or husband, pimp, trafficker).

- Finally, abortion pill websites provide bulk shipping, also known as "pills in advance" (https://www.plancpills.org/in-advance, https://www.nytimes.com/interactive/2023/04/13/us/abortion-pill-order-online-mifepristone.html; https://365shop2.store/products/cytotec.html?1613; https://pharmacy.amazon.com/Misoprostol-Generic-Cytotec-Oral-Tablet/dp/B084BRK72W?ref_=sr_1_1&keywords=misoprostol+tablet+bulk&crid=3IORLTAPTV7Z7&sprefix=misoprostol+tablet+bulk%2Caps%2C113&dib_tag=se&dib=eyJ2IjoiMSJ9.DnQvTi6cvz9m7eZ8dxJTIaELH0zCRvV8Z0PC304r7gZNmevCaMot9DxOcwLc5nAHJ07FFvwL3JGmWFLJX_xFQ.9omTSMI1k3Lqmb6dUg4XIrZeBMAQizdy3Oxd1_0gg3M&qid=1749134767&sr=8-1) . There is no clear reason for bulk amounts of chemical abortion drugs to be provided for direct-to-consumer sales, other than for trafficking, illegal abortion or unsupervised self-administered abortion occurring outside of a set of clinical encounters.

Abortionists providing telemedicine abortion cannot verify the quality or safety of the drugs. AAPLOG (AAPLOG Practice Guideline No. 8, February 2020) notes that "A study on obtaining abortion pills from international distributors found that no prescription or clinical information was required, the pills averaged two weeks to arrive, analysis of the medications obtained demonstrated that some misoprostol pills contained only 15% of the advertised amount of medication, the packages often arrived damaged, and no instructions were contained in any of the packages".

In a 2019 survey of abortion providers by University of Iowa researchers, published in Contraception, "Thirty-five percent of respondents had witnessed complications following self-managed abortion with misoprostol and/or mifepristone…The most frequently observed complication was incomplete abortion and retained products of conception, which comprised 34.7% of the reported types of complication, with hemorrhage following at 25.8%". (Courtney A Kerestes, Colleen K Stockdale, M Bridget Zimmerman, Abbey J Hardy-Fairbanks. Abortion Providers' Experiences and Views on Self-Managed Medication Abortion, an Exploratory Study. Contraception. 2019 August ; 100(2): 160–164. doi:10.1016/j.contraception.2019.04.006).

Other complications included ongoing pregnancy, approximately 17%; infection, approximately 8 %; sepsis, approximately 3%; preterm birth, approximately 2%; undiagnosed ectopic pregnancy, approximately 2%; and uterine rupture, approximately 1%. Significantly, 46.7% of abortion providers felt that the use of misoprostol with or without mifepristone for self-administered abortion was not safe. It is a telling admission regarding the lack of safety of self-adminstered abortion when almost half of abortionists, who might be most likely to advocate for its use, express that they feel it is unsafe.

To summarize the importance of the in-person requirement of the Act, AAPLOG notes (ibid) that "There are many potential negative consequences to these recommendations which ultimately demonstrate abortion advocates' disregard for the health of women. For example, underestimation of gestational age may result in higher likelihood of failed abortion. Undetected ectopic pregnancies may rupture leading to life-threatening hemorrhages. Rh negative women may not receive prophylactic Rhogam resulting in isoimmunization in future pregnancies. Potential for misuse and coercion is high when there is no way to verify who is consuming the medication and whether they are doing so willingly. Sex traffickers, incestuous abusers and coercive boyfriends will all welcome more easily available medication abortion. Catastrophic complications can occur, and emergency care may not be readily available in remote areas". The Act addresses these serious problems through the in-person requirement.

The Act's requirements, including the 24-hour requirement in Section 2317(B)(1) and the in-person requirement, are consistent with good medical practice and medical standards, and do not stigmatize abortion.

Ohio's informed consent, in-person and 24-hour requirements are necessary to help prevent coercive abortions, which are all too common in abusive relationships and sex trafficking. Coercion is a hallmark of sex trafficking, rape, domestic violence and child sex abuse. For example, the 24-hour waiting period can increase safety and support

autonomous decision-making related to abortion by increasing the likelihood that coercion will be detected.

ACOG Committee Opinion No. 554, "Reproductive and Sexual Coercion," recommends that "Because of the known link between reproductive health and violence, health care providers should screen women and adolescent girls for IPV and reproductive and sexual coercion at periodic intervals such as annual examinations, new patient visits, and during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup [emphasis added])."

Sex trafficking is a concern in Ohio, and is being aggressively addressed by state legal, criminal, youth services and other agencies. The Ohio Attorney General's Office has taken significant steps to address this problem, and has worked to build coalitions and provide resources for victims. From 2021 to the present, 1554 survivors of sex trafficking have been identified (https://data.ohio.gov/wps/portal/gov/data/view/ohio-human-trafficking-task-force-summary?visualize=true).

However, clinical professionals, especially OB/GYNs, are on the front lines of detecting sex trafficking, because they have an opportunity to interview patients privately and because reproductive health care may be one of the few interactions with a health professional that pimps, traffickers and abusers will allow. Because abortion clinics may perform abortions on women who are victims of sex trafficking, the informed consent and 24-hr waiting provisions of the Act are very important. For both chemical and surgical abortion, traffickers and abusers will often not allow their victims to meet privately with a physician because they risk disclosure of abuse, coercion or trafficking. Especially in the case of "tele-abortion", there are no safeguards whatsoever against coercion and abuse. The prescriber has no idea whether the woman seeking abortion is being threatened or coerced, how far along she is in pregnancy (or whether she is even pregnant), and whether she is being victimized by trafficking or abuse.

Research and testimony from survivors show that girls and women trapped in abuse and sex trafficking are frequently subjected to forced abortion, and that abortion is often used to cover up sex trafficking and child sexual abuse. In Laura Lederer and Christopher Wetzel's 2014 study of trafficked women, 71% of trafficked women reported at least one pregnancy while being trafficked. 21% reported having 5 or more pregnancies. 55% reported at least one abortion and 30% reported multiple abortions. 66 of the women surveyed who responded to abortion questions stated that a total of 114 abortions had been performed on them during their trafficked state. One young woman had 17 abortions. Lederer states, "Notably, the phenomenon of forced abortion as it occurs in sex trafficking transcends the political boundaries of the abortion debate, violating both the pro-life belief

that abortion takes innocent life and the pro-choice ideal of women's freedom to make their own reproductive choices" (Lederer L and Wetzel C. The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. Annals of Health Law, Vol 23(1)).

AAPLOG Committee Opinion 5: Pornography, Sex Trafficking and Abortion, July 26, 2019, discusses this issue in detail. According to this report, "Though…pro-abortion advocates proclaim abortion empowers and liberates women, it is a tool of enslavement and control for the trafficker. Victims of sex trafficking are not empowered by abortion, they are deprived of their human dignity and rights. In 2017, a survivor group undertook an informal survey of other survivors of sex trafficking, who were minors at the time. The survey was only done by and for survivors. It was not a formal survey for a specific organization. Though the survey was vast in the scope of questions, it did include some questions on who missed them, how many have had abortions as a result of their exploitation, how many were forced to be on birth control, take abortifacient drugs, and how many were minors at the time. Surveys were sent to 1123 women who identified as survivors. Of the 1123 women surveyed, 758 responded they were trafficked as children (67%). But child sexual abuse was prevalent in nearly 96% of them.

• Of the 758, nearly 90% (683) had had one abortion as a minor (ages 11-17).

• Of the 90% (683), 628 (92%) had had multiple abortions, sometimes at the same facility.

• When brought in for an abortion, none of them were separated from the traffickers or bottom who brought them in.

• None of them were asked for ID.

• All of them were given the abortion and not screened for trafficking or abuse.

• All of them were sent home with their trafficker after the abortion, with birth control or some sort of prophylactic.

• Nearly 88% of the original respondents said a Planned Parenthood facility was where they were seen.

• Nearly 85% of the original respondents were taken for some sort of STI, UTI, or reproductive issue multiple times. K. Dore, Survivor (Personal communication May 20, 2019)".

Based on these findings, there is reason to believe that abortion is common in trafficked women. Notably, each abortion in the women noted above was a failed interaction with the medical system, in many of these cases Planned Parenthood, that likely led to continued

victimization, rather than an opportunity for them to escape trafficking. Identifying trafficked women and children is a critical safety issue. In particular, abortion providers are mandated reporters.

The 24-hour waiting period provision also increases patient safety and autonomous decision-making because it helps to address two other important issues related to coercion. The literature on coercion and abortion suggests that coercion is common in women seeking abortion. Data from the National Longitudinal Survey of Adolescent to Adult Health indicated that an estimated 20% of women with a history of induced abortion stated that one or more of their abortions were coerced (Sullins DP: Affective and substance abuse disorders following abortion by pregnancy intention in the United States: a longitudinal cohort study. Medicina (Kaunas). 2019, 55:10.3390/medicina55110741). In another study of induced abortion decisions by Reardon et al., 29% of participants stated that their abortions were unwanted or coerced (Reardon D, Rafferty K, Longbons T. The Effects of Abortion Decision Rightness and Decision Type on Women's Satisfaction and Mental Health. Cureus May 11, 2023).

The authors (Reardon et al) noted that "[a] majority of women who had abortions (60%) reported they would have carried to term if they had received more support from others and/or had more financial security." These findings are consistent with the results of other investigations reporting high rates of perceived pressure to abort and ambivalence regarding abortion decisions (Moore A, Frohwirth L, Miller E. Male reproductive control of women who have experienced intimate partner violence in the United States. Soc Sci Med 2010 Jun;70(11):1737-44).

If a significant proportion of women regret their decision after abortion, as this data suggests, and might have chosen otherwise, this will be a source of ongoing psychological pain. To prevent this outcome, it is important that patients be offered the opportunity for adequate reflection. The 24-hour waiting period allows women to carefully reflect on their decision to undergo abortion, which is irreversible, as well as to potentially seek support and ways to parent if they choose to do so.

A second important social problem that could be identified is domestic violence. As noted above, coercion is a hallmark of domestic violence. A study by Glander et al. (Glander S, Moore M, Michielutte R, Parsons L. The prevalence of domestic violence among women seeking abortion. Obstetrics & Gynecology 91(6), 1002-1006, 1998) showed that, shockingly, 40% of women seeking abortion were victims of domestic abuse. Requiring that women meet with physicians alone, and requiring a 24-hr waiting period, provides a potentially important opportunity to identify women and girls trapped in sex trafficking,

domestic violence, or sexual abuse. This protects the health of these vulnerable women. And this is exactly what the Act requires.

The above research suggests that many women's decisions to undergo abortions are not autonomous, they are coerced. As noted in the Reardon study, a majority of women would prefer to parent their child if they had the financial and other support they needed to do so, and the 24-hour requirement offers them an opportunity to explore that option, if they so choose. Therefore, providing an opportunity for women to disclose coercion provides an opportunity for an abortion provider to help support a woman's autonomous decision-making, because autonomous decision-making, by definition, cannot occur in the presence of coercion.

The 24-hour waiting period is shorter than the typical preoperative process within which OB/GYNs and other physicians work, and it is a generally accepted practice in medicine that patient education, screening and informed consent occurs over a period of days or even weeks, except in an emergency. Because the preoperative process usually takes longer than 24 hours, and because of the benefits of the consent and 24-hour requirements related to possible abuse, coercion and trafficking, the requirements of the act do not stigmatize abortion. In fact, they promote autonomous decision-making on the part of the woman seeking abortion.

The challenged laws are consistent with the standard of care, help to protect women and children, and support autonomous decision-making on the part of women seeking abortion.

To summarize, informed consent is a key part of medical care, and must be obtained by the person who will perform the intervention, in such a way that it is voluntary, informed and free of coercion. Chemical abortion (as well as surgical abortion) is associated with physical and mental health risks. Deaths have occurred in association with the abortion pill, deaths associated with abortion are more common in African American women, and there are significant racial-ethnic disparities in abortion rates. The complications listed in Section 2317.58(A) of the Act are known to be associated with abortion, and must be disclosed through adequate informed consent. Telemedicine and self-administered abortion are unsafe and endanger women. The SHE WINS Act's requirements, including the 24-hour requirement in Section 2317(B)(1) and the in-person requirement, are consistent with good medical practice and medical standards, and do not stigmatize abortion. With a reasonable degree of medical certainty, the Act addresses the concerns above, helps protect the health of women and children, promotes autonomous decision-making, and does not stigmatize abortion.