TESTIMONY OF CATHY K. DRATMAN, MD, FACOG

before the

PENNSYLVANIA HOUSE JUDICIARY COMMITTEE

HOUSE BILL 1979

OCTOBER 13, 1989

INTRODUCTION

I am a Board-Certified Obstetrician Gynecologist. I am a graduate of Hahneman Medical College and served an internship and residency at Pennsylvania Hospital in Philadelphia. Pennsylvania Hospital is one of the busiest high risk obstetrical centers in the State. During these years I provided care to many women, including those with severe medical problems, and those with wanted but genetically or developmentally abnormal pregnancies. During that time I also performed many first and second-trimester abortions. I have had a private obstetrical and gynecological practice, and I am presently the Medical Director of Planned Parenthood of Southeastern Pennsylvania and of Chester County Planned Parenthood. Both organizations provide reproductive health services, including pregnancy testing, options counseling, sexually transmitted disease services and contraception. Planned Parenthood of Southeastern Pennsylvania also operates a surgical center for first trimester abortions. Many of our clients are working single parents who earn too much for medical assistance and whose marginal jobs do not provide insurance.

I appreciate this opportunity to explain the impact House Bill 1979 will have on women such as those I have cared for, and on practicing physicians. I ask you to consider the effect this legislation will have in the real world of doctors and their patients. With that understanding, I hope that you will protect the lives and health of Pennsylvania's women and children by recommending defeat of this bill.

I have carefully analyzed the bill and I am deeply troubled by many of its provisions. Before addressing each of my concerns in specific terms, however, I would first like to emphasize that there is no doubt that the effect of the combined burdens imposed by this bill will be to seriously endanger the lives and health of women seeking abortions in Pennsylvania. Many of the provisions will cause delays in the obtaining of a medically safe abortion. Such delays will make the procedure more hazardous for women: for each week of delay after the 12th week of gestation, there is a 15-30% increase in complications from the procedure, and a 50% increase in the chance of maternal death. In effect, this bill will cause later, less safe abortions to be performed.

Other provisions will interfere with my ability as a physician to exercise my clinical discretion so as to provide the safest care possible for the pregnant woman. The bill will discourage doctors from performing abortions by expanding the liability of doctors who perform abortions, and imposing unnecessary informational and investigatory requirements upon them. Finally, new obstacles such as spousal notice, coupled with the likely decrease in the availability of legal abortions, will make it likely that some Pennsylvania women will resort to illegal, unsafe means to obtain the abortions they need. The lives and health of these women - tragically and unnecessarily - will be placed in serious jeopardy.

SPECIFIC PROVISIONS

Section 3211 (prohibition of abortions after 24 weeks):

I would like to begin with Section 3211 because it is most disturbing to me. This section prohibits physicians from performing an abortion after 24 weeks gestational age except where necessary to prevent the death of the mother. In addition, those abortions after 24 weeks that are permissible cannot be performed unless, among other things, two other physicians concur and the abortion is performed in the manner which provides the "best opportunity for the unborn child to survive".

This section is apparently motivated by the mistaken belief that abortions are frequently and cavalierly performed in the late stages of pregnancy. In fact, only a very small number of abortions in Pennsylvania are performed at this time of gestation. Indeed, 94% of abortions in Pennsylvania take place in the first trimester of pregnancy. Nationally, fewer than .01% (less than 100) abortions are performed per year after 24 weeks gestation. In Pennsylvania in 1988 only one abortion was performed after 26 weeks. These abortions are necessary when (a) a woman is suffering from a serious pre-existing health problem, such as lupus, kidney disease or diabetes, and the pregnancy has exacerbated that problem, endangering her health or life; (b) when the woman experiences pregnancy-related health problems such as toxemia, which is seriously jeopardizing her life or health; or (c) when the fetus has severe anomalies. In each of these instances, women have done everything possible to maintain the pregnancy. In many cases, the women have risked their lives and their health in an attempt to have a baby. The decision to abort at this juncture is a terribly difficult one, but one that must

be made by the woman and her physician, in light of all of the attendant circumstances.

This section places dangerous limitations on my clinical discretion. First, abortion is only allowed in order to avert maternal death. I have no discretion to terminate the pregnancy in order to avoid serious injury to the woman's health; indeed, the act provides that I will be prosecuted as a felon if I do so. This is unacceptable, forced malpractice. Physicians must be able to protect maternal health as well as maternal life. Many serious conditions may arise during late pregnancy, which may not cause death, but may pose a serious threat to a woman's health. For a preeclamptic patient at 24 weeks gestation, continuing a pregnancy means probable kidney damage and seizures. For a diabetic whose blood sugars have become dangerously high and uncontrollable, continuing a pregnancy may mean increasing eye and kidney damage as long as that pregnancy continues. These patients probably will not die from continuing their pregnancies but will unnecessarily be made very, very ill. This section also forbids me from providing an abortion for a suicidal patient. This limitation is incomprehensible to me. If a woman commits suicide, she is just as dead as a woman dying from a cardiac complication, and so is her fetus.

I am also troubled by the fact that this section may be based on the assumption that 24 weeks gestation, in fact, equals viability. This is totally incorrect. It is not just gestational age that determines the viability of a given fetus; its genetic make-up, its condition in utero and at delivery, its

mother's medical condition, her use of drugs, the reason for the delivery, the site of the delivery (community vs high risk hospital), the mother's prenatal care, fetal size and placental function for gestational age, presence or absence of infection or of fetal abnormalities, all are at least as important as gestational age in determining true viability, especially in the late second trimester, before 28 weeks. This section, therefore, forbids abortions in instances where the fetus, in fact, may not be viable and continuing the pregnancy will cause serious injury to the woman.

I am also deeply troubled by the requirement that where abortions can occur after 24 weeks, they be done in the manner most likely to produce fetal survival. This provision, for example, would seem to require me to perform a caesarean section for a genetically nonviable fetus such as an anencephalic or for a marginally viable, infected 24 week fetus, even if operative delivery is the worst possible option for the woman. And who defines what steps constitutes "all reasonable steps necessary to preserve the child's life and health"? This statute is so vague as to invite harassment cases by zealots. By forcing physicians to choose the method most likely to produce live birth the bill in effect requires them to jeopardize women's health. I believe that this section as drafted with its criminal penalties for exercising clinical judgment will drive some obstetricians out of practice.

Finally, the requirements for additional physicians' concurrence with clinical judgment and for the presence of an

additional physician at delivery even in the case of a marginally viable (or genetically nonviable) fetus may force unnecessary, dangerous delays in required treatment, and turn a marginal medical situation into a true emergency, especially in small hospitals, where these additional physicians may not be available.

Section 3205: I am also very concerned by Section 3205. First, the bill requires that women wait 24 hours between the time their physicians provide information leading to informed consent and the abortion procedure. While on its face this requirement sounds innocuous, in fact, it is not. Most clinics do not perform abortions on a daily basis, some only once a week; therefore, the waiting period will necessarily result in a delay far greater than 24 hours. As I have already stated, delay in the performance of the abortion increases the risks to the woman. This additional burden of delay may needlessly require some women to require second trimester procedures, whose risks and costs are considerably greater. In addition, it is important for you to understand that in Pennsylvania many women must travel great distances to get an abortion. The waiting period will require them to travel this distance on two separate occasions or pay the cost of staying in a strange city away from family and friends for at least one additional night. Furthermore, since most women have already made up their minds about the procedure by the time they make the appointment, the requirement serves no purpose other than to delay and to increase the cost and risks of the abortion decision.

The new informed consent requirements of Section 3205 are also problematic. I believe that women with unwanted pregnancies should be provided with sufficient information to enable them to make informed and deliberate decisions regarding their options. Medical standards require physicians or their agents to provide informed consent and we do so as a matter of routine. The requirements in the bill, however, are unacceptable.

First, Section 3205 (a)(i) as drafted fails to permit a physician to designate an agent to provide the information required by that section. This is unreasonable. Standard practice is that the physician delegates the informed consent and counseling functions to trained counseling staff. This reduces the cost of abortion and results in better patient preparation because these trained personnel are better equipped to provide the patient with supportive counseling and the women have more opportunity to discuss their options and their feelings about the procedure with counselors. Physicians should therefore continue to be permitted to delegate the responsibility to trained staff.

I am also troubled by the informed consent provision because it limits the physician's discretion by requiring that the patient be given specific information that might often be irrelevant, misleading and confusing to the patient. For example, in instances where a woman is the victim of rape or incest, and has decided that continuing the pregnancy is not an option, a discussion of the medical risks of continuing to term is obviously inappropriate and cruel.

Section 3205(a)(2) requires that the woman he told that she has a right to review printed material published by the Department of Health which describe the unborn child and include pictures representing the development of unborn children at two-week gestation increments. This information has no medical relevance and can only serve to create anxiety or guilt in a woman faced with an already stressful decision.

Section 3205(a)(2)(i) also requires that the woman be told that the Department of Health publishes a list of agencies offering alternatives to abortion. Again, this information is certainly not appropriate in all instances. Where it is appropriate, it should be offered in options counseling, not in preabortion information. Planned Parenthood offers this information during options counseling; the organizations listed are screened by Planned Parenthood for adequacy of services and quality of care provided. There is no mandate for such screening or regulation by the Department of Health.

Will the list include such agencies as the Montgomery County Center in which a pregnancy test client was physically restrained and forced to watch an anti-abortion film before her test would be performed?

Will the list include the Philadelphia "agency" promising postpartum assistance and delivering only one case of formula and one box of diapers?

Will the list also include the real-world information that there are few adoptive homes for nonwhite, handicapped, AIDs-or drug-affected, or older-than-newborn children?

The informed consent provision also requires that the patient be given information about the availability of medical assistance benefits and the liability of the father to assist in child support. This is totally inappropriate. The information bears no relationship to the medical risks of abortion. Moreover, this is complex, legal information which is beyond the scope of a physician or counselor's expertise, and certainly far beyond the scope of simple printed materials. An abbreviated presentation of this information may confuse and mislead the patient.

The inclusion of this information is particularly offensive to me in light of the cold reality that the child support and medical assistance available to poor women is inadequate at best. If you see fit to further restrict abortion, you MUST provide better benefits for the poor women who will be bearing children they would not otherwise have had. City hospitals are considering closing their OB clinic services because the cost of providing that care is totally beyond the State's allocation. There is currently NO State funding for contraception; we must have funds to PREVENT unwanted pregnancies as well. There is also no provision for increasing child care benefits to realistic levels, or for increasing allocations for the social services these mothers and children require. This bill is written as if life ends at delivery.

Section 3209: The new requirement of notice to the spouse is very disturbing. In most cases women involve their husbands in the abortion decision anyway. In certain troubled marriages,

however, women have good reasons for not involving their husbands. There is no justification for the state to force these women to choose between notifying their husbands and admitting infidelity or that they are rape victims in signed statements which may remain in the medical chart. As a physician, I am also very concerned that many women will simply choose to hide their marital status from me. The provision will, therefore, interfere with the honest communication that is critical to the doctor-patient relationship. I am also concerned about what obligations this section places on the physician. In what circumstances will we be subject to license suspension or revocation for violating this Section? Have I violated it if I perform an abortion without getting a statement where the person claims not to be married, but in fact is married? How much proof of alleged marital or non-marital status must I demand before performing an abortion? This Section will undoubtedly have a chilling effect on the willingness of doctors to perform abortions.

Section 3210: This section requires that physicians make a determination of gestational age before performing an abortion. The requirement is apparently applicable throughout pregnancy. I am troubled by this provision because it invades our discretion by requiring physicians to perform those tests and examinations necessary to make an "accurate diagnosis" of gestational age. What is an "accurate diagnosis"? How accurate is accurate? For whose purposes? What determinations are required? Does "accurate" imply "ultrasound" in all cases? If so, this would add unnecessary delay and extremely unnecessary cost to the cost

of a first trimester abortion. The cost of a first trimester abortion is now approximately $240; an ultrasound costs approximately $140. Ultrasound is a sophisticated, expensive test not required medically in many cases. Performing it only in order to comply with this statute is clearly harassment and interference with clinical judgment. Finally, once again, this Section like Section 3211, seems to be based on the false assumption that gestational age alone determines viability. As I have explained, this is wrong.

Section 3204: This Section limits a physician's discretion in determining whether an abortion is "medically necessary" by prohibiting the abortion if it is sought solely because of the sex of the fetus. In considering this section you should be aware that there are approximately 200 x related chromosone diseases. This means that only males have the disease. Where couples have a family history of these diseases, current medical practice provides the option of chorionic villus sampling or amniocentesis to diagnosis male fetuses so as to provide the family with the option of abortion in order to avoid the birth of a child with devastating physical or mental conditions. I am afraid that this proposal will have the adverse consequence of chilling this practice.

Section 3216: This section bans the use of tissue from an aborted fetus for research or experimentation purposes and also prohibits the performance of non-therapeutic medical procedures on the fetus for experimentation purposes. This provision is

very dangerous; its inclusion in a bill ostensibly designed to protect children is particularly ironic.

In considering this provision you must recognize that many of the therapies which now save neonatal lives began as experiments. There is no clear difference in terms of medical practice among experimenting, testing and treating. Every medical test or treatment that is now standard began as an experiment that became standard through a gradual process of observing the results, confirming the benefits and modifying the technique.

In Philadelphia presently researchers are trying a new technique of fluid breathing on fetuses whom they know will not survive. The purpose of this research is to develop a technique which, when perfected, will improve the chances of survival for premature babies with immature lungs. Under this bill, such procedures might be banned, and with them, the possible later salvage of other neonates.

Experimentation with human fetal tissue was essential to the development of the Salk polio vaccine (for which the 1954 Nobel Prize in Medicine was bestowed), the understanding that the Rubella vaccine virus crossed the placenta and therefore posed a risk to fetuses, and for developing techniques to identify fetuses tnat had suffered severe effects from rubella infection. Currently, fetal tissue research is essential in studying the genetics of retinoblastoma, a life-threatening disease of children; the differentiation of cells in lymphoid cancers, like

leukemia; respiratory distress syndrome; a chicken pox vaccine; transplant rejection; sickle cell anemia; and some AIDS research.

Fetal transplantation research showing promising results currently involves experimental implantation of fetal brain cells into brains of persons suffering from Parkinson's disease, and of fetal pancreatic cells into diabetics. Such fetal transplantation is the medically preferred treatment for DiGeorge's Syndrome, a congenital fatal loss of immune function.

I would ask you to think carefully before denying the people of Pennsylvania the opportunity to participate within ethical guidelines in similar important research or to benefit from techniques currently under development in the State that require fetal experimentation; denying the possibility of such research may cause the State to lose numbers of its best medical researchers and delay furtherance of their techniques and their potential benefits.

Thank you for your attention to these issues. In your deliberations, please consider the real-world impact of this proposed legislation on the health and welfare of Pennsylvanians. This legislation endangers the state's women and children. You must protect their lives and their rights; the courts can no longer be counted on to do it for you.