Coons QFRs for Parker_final

1. **Physicians in other parts of the country have reported an increase in the number of women who arrive at doctors' offices having previously tried to self-abort—which we know can lead to death—have you seen a similar increase in your practice?**

Thankfully I have not seen many women who have attempted to self-abort as I primarily see women who make it to the clinic where I practice. I did have one patient, a 34 year old pediatric nurse from the local academic hospital who presented after obtaining what she thought was the abortion pill online and self administering it. She had already determined that the purported medication did not work and was 8 weeks when she presented for care. We determined that she had no deleterious effects from the self-medication, but she was totally intimidated at having to present to the clinic through a throng of protesters, fearful of being recognized as well as having to wait for the mandated delay to elapse. I have seen do –it-yourself instructions on the internet, and while this patient was not harmed, I worry about women trying to accomplish this goal in a safe manner outside of healthcare supervision. This highly educated Mississippi woman demonstrates that women here are no less desperate for abortion access and will take the extreme measures that they deem necessary when they need abortion and it is not available.

2. **You are the sole abortion provider for Mississippi but live in Alabama, two states with some of the highest poverty rates in the country. None of the doctors who live in Mississippi are willing to provide abortion services and 94% of Alabama's counties do not have abortion providers. Looking around the country, I am struck that the most restrictive statutory regimes exist in those states with the highest rates of poverty. How have these abortion restriction impacted the level of access women have to reproductive care and family planning service, and in particular poor and minority women**?

As noted by the demographic characteristics for both of these states, these burdensome laws encumber women with the greatest need for safe, compassionate abortion services. The things you cite correlate tightly with limited access to contraception, medically accurate sex education, and comprehensive primary care, the lacks of which lead to unplanned, unwanted pregnancies or wanted but lethally flawed ones, which is where abortions come from. Abortions do not come from locations of clinics near impoverished communities of color, a preposterous notion. Nor do they occur due to selfish women being indifferent to motherhood, as is sometimes alleged by abortion opponents. Many women who have abortions are already mothers. The lack of the reproductive health determinants that I mentioned create the lived reality of the women I see, women of color and/or poor, despite women of all backgrounds being at risk for needing abortion services. Ironically, my home regional states have not resolved the disparities that are driving the need for the care that I provide, but opponents against abortion have been very effective at putting barriers in the way of women that need the services the most.

3. Both Alabama and Mississippi, like many other states, have enacted laws that require doctors to force women to have ultrasounds. Some laws prevent doctors from using telemedicine to provide care to women. Others have required doctors to use outdated and medically unsafe medical protocols which are all designed to target abortion. How have these restrictions interfered in the doctor-patient relationship?

All of these things interfere greatly with the therapeutic relationship that I have with my patients by forcing both them and me to interact with considerations that have nothing to do with the patient's care. As her physician, my primary responsibility to my patient is to make recommendations and provide services that focus solely on her need and wellbeing. Being prohibited from using technology to facilitate her care in a largely rural state like MS or AL places abortion beyond the reach of women who live in a county without a provider. Forced use of diagnostic modalities that do not add anything to medical decision-making serves the purpose of coercion, and being restricted from prescribing medications in a way that reflect my best medical judgment, interfere with my ability to provide the care that women deserve. None of these laws are evidence based and all serve as means for abortion opponents to abuse regulatory authority.

Questions for the Record
Senate Judiciary Committee
Women's Health Protection Act Hearing
Senator Richard Blumenthal

QUESTIONS FOR DR. WILLIE PARKER:

Dr. Parker, your perspective as a practicing physician, as a doctor who provides reproductive health care for underserved populations, and as an abortion provider in particular, is very valuable to the ongoing debate about abortion rights in this country. Many legislators who enact abortion laws, and sometimes very harmful laws, have never seen the inside of a clinic. Indeed, many of them will never personally face the question of whether or not to have an abortion, since most are men. Real world experiences like your work providing care to thousands of individual women should carry great weight in today's abortion debates.

1. **In your experience as a medical provider, are there cases that demonstrate the problems with the pretextual restrictions the Women's Health Protection Act guards against? If so, can you please describe a few of them?**

   The types of laws that the WHPA seeks to prevent often work synergistically to greatly encumber women accessing abortion services, assuming that they don't put them beyond their reach altogether. I have seen women miss their opportunity to have an abortion in Mississippi simply because of these laws. I recently had a 23 year old woman with 2 children from the Delta region, a couple of hours away and abjectly poor, who found herself pregnant with the third. She had been forced to delay her appointment to the clinic due to financial challenges, child care, and as a non-driver, her inability to get a ride down to Jackson where we are located. When she finally made it to the mandated counseling visit, her ultrasound showed her to be 16 weeks 0 days, the absolute cutoff for legal abortion at our facility. We apprised her of the gestational age and offered referral to the closest clinic, in Tuscaloosa, AL, 230 miles away. She indicated that she would not be able to travel to the next state, and very sullenly returned to the Delta to continue the pregnancy. If there were no waiting period, I could have done her procedure the day that

she presented. In addition, without the mandatory face to face counseling, the patient could have possibly gotten in earlier for a counseling visit prior to the next session where a doctor would be present. If she had seen me in Washington DC, these would not have been issues.

Another patient experienced unnecessary anguish due to mandated counseling requirements that I provide all patients in Mississippi seeking abortion with the medically false information that they are at increased risk for breast cancer if they have an abortion. The patient was a 35year old woman with a first pregnancy whose mother had a history of breast cancer. Although she had demographic characteristics that increase breast cancer risk, I had to reassure the patient that despite my being required to cover this information, her decision to end her pregnancy would not adversely affect her cancer risk in any way. Having to provide medically inaccurate information to my patients creates the ethical conflict of potentially causing psychological harm to my patients in order to meet the requirements of such laws.

2. How would the Women's Health Protection Act affect your patients?

The WHPA would prevent the regulatory abuse that is making it increasingly difficult for my patients to access abortion care. By challenging regulations that parade as safety and preventing the rules that function as barriers to my patients, such as long waiting times, burdensome consent processes, and exposure to medically inaccurate information, my patient when freed from such concerns can focus on getting into care in a timely manner, make sound medical decisions in privacy and consultation with me as their provider, and remain healthy for the benefit of herself and her family.

The recent hearing on the Women's Health Protection Act devoted significant attention to state requirements that abortion providers have hospital admitting privileges. As mentioned in some testimony provided during the hearing, admitting privileges can serve important purposes. Hospitals often review a doctor's educational background, licenses, and experience before granting membership. Such review processes can help ensure that only appropriately qualified doctors provide care. Yet even physicians without admitting privileges, including some abortion providers, must adhere to regulations regarding medical licensing and ensuring patient health and safety. In addition, federal law requires hospital emergency rooms to treat any patient with an emergency condition until the

condition is stabilized. In other words, all patients are entitled to equal access to emergency hospital care, irrespective of whether their treating clinician has admitting privileges. Dr. Parker, can you share your perspective as a reproductive health care physician and explain the challenges you have faced with obtaining admitting privileges in Mississippi?

There is no doubt that regulation of medical practice can play a significant role in assuring the quality of care that a patient receives by making sure that physicians are licensed to provide medical care, and this is usually done by all state medical boards without regard to specialty. Board certification as a secondary criterion for quality assurance also can play a role, but targeted regulations of abortion providers does nothing to enhance the safety of an already extremely safe procedure. Safety standards in outpatient settings should not be higher for abortion clinics than any other clinical setting. Medical boards are best positioned to determined licensing criteria, not hospitals. Hospitals determine staff eligibility based on whether or not a physician's presence on staff will result in admissions to the facility, a fiscal consideration, not a medical one. Admitting privileges, when they are difficult to obtain largely on the basis of politicized perception of abortion care, become an insurmountable barrier to women because doctors are prevented from providing that much needed care. Licensed in the state of Mississippi as well as several other states, to date, I have been unable to secure admitting privileges at hospitals in the vicinity of the clinic where I practice, my effort to comply with recent regulations covering abortion facilities there. Of the hospitals we applied to, several did not respond to our request for application and the ones that did indicated that their decision to not proceed with the application was based on their conclusion that my presence on the staff would be a disruption to the internal and external politics of the institution. I have never had difficulty securing privileges at previous facilities in other states where I have practiced.

While I applied for privileges to be in compliance with the recent regulatory changes, I know both admitting privileges and board specialty requirements to be medically unnecessary and irrelevant to the safety of abortion services. Licensed health care professionals of all specialties can be and are trained to competency in abortion care to meet that need for their patients, and abortion providers and facilities already maintain extremely high standards to insure quality services for the women who need them.

The irrelevance of admitting privileges is based on the fact that in the rare event that an emergent situation arises in a clinic or ambulatory care setting, standard of care irrespective of specialty or type of problem would dictate transferring that patient to the nearest facility that can address that patient's need. As you rightly implied, the Emergency Medical Treatment and Labor Act (EMTALA) creates this expectation, thus patient transfer would happen regardless of whether or not the transferring physician held admitting privileges at the nearest facility and care has to be provided to that patient. Transfer agreements, which most clinics have in place, already facilitate such a situation. Abortion, whether medical or surgical, requires hospitalization 0.3% of the cases, all gestational ages combined, making clear that a hospital admitting privileges requirement proves only to be excessive and burdensome. Transfer agreements with hospitals or physicians have proven more than adequate to get patients to the next level of care when the need arises. Abortion care itself is the safety measure for pregnant women in this country, not the problem.