

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.