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HOUSE OF REPRESENTATIVES

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WEDNESDAY, APRIL 21, 2021
8:03 A.M.

PRESENTATION ON
PRO-LIFE/ABORTION, PART II -
PROVIDERS AND ALTERNATIVES

BEFORE:

HONORABLE KATHY L. RAPP, HOUSE MAJORITY CHAIRMAN
HONORABLE DAN FRANKEL, HOUSE MINORITY CHAIRMAN
HONORABLE AARON BERNSTINE
HONORABLE TIMOTHY R. BONNER
HONORABLE STEPHANIE BOROWICZ
HONORABLE JIM COX (VIRTUAL)
HONORABLE VALERIE S. GAYDOS
HONORABLE JOHNATHAN D. HERSHEY
HONORABLE DAWN W. KEEFER
HONORABLE KATE A. KLUNK
HONORABLE ANDREW LEWIS
HONORABLE CLINT OWLETT
HONORABLE BRAD ROAE
HONORABLE PAUL SCHEMEL
HONORABLE TIM TWARDZIK
HONORABLE DAVID H. ZIMMERMAN
HONORABLE JESSICA BENHAM
HONORABLE MORGAN CEPHAS
HONORABLE ELIZABETH FIEDLER (VIRTUAL)
HONORABLE STEPHEN KINSEY
HONORABLE BRIDGET M. KOSIEROWSKI (VIRTUAL)
HONORABLE RICK KRAJEWSKI
HONORABLE SUMMER LEE
HONORABLE BENJAMIN V. SANCHEZ (VIRTUAL)

HOUSE COMMITTEE STAFF PRESENT:

WHITNEY METZLER
MAJORITY EXECUTIVE DIRECTOR
MAUREEN BEREZNAK
MAJORITY RESEARCH ANALYST
LORI CLARK
MAJORITY ADMINISTRATIVE ASSISTANT II

ERIKA FRICKE
DEMOCRATIC EXECUTIVE DIRECTOR

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Pennsylvania House Of Representatives
Commonwealth of Pennsylvania

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TESTIFIERS

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

P R O C E E D I N G S

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MAJORITY CHAIRMAN RAPP: Members, members of the public, we welcome you this morning. This is a hearing being conducted by the House Health Committee. I would ask at this time that you silence your cell phones, please, and I see that our first presenter is with us.

So while we're working on this technology, we're going to start with Chairman Frankel and have the members here introduce themselves, please.

MINORITY CHAIRMAN FRANKEL: I'm Representative Dan Frankel, 23rd District, Allegheny County, City of Pittsburgh, Minority Chair of the Health Committee.

REPRESENTATIVE SCHEMEL: Representative Paul Schemel from Franklin County.

(Audio interference)

REPRESENTATIVE BENHAM: -- representing the 36th District in Allegheny County.

REPRESENTATIVE ZIMMERMAN: Dave Zimmerman representing Northeast Lancaster County.

REPRESENTATIVE OWLETT: Clint Owlett, 68th District, all of Tioga, part of Potter, and part of Bradford County.

REPRESENTATIVE ROAE: Brad Roae, part of Crawford County and part of Erie County.

REPRESENTATIVE TWARDZIK: Tim Twardzik, the 123rd, Schuylkill County.

(Audio interference)

MAJORITY CHAIRMAN RAPP: -- abortion, DNA testing, stem cell research, medical consent, patient safety, and teen pregnancy, and telemedicine, as part of our designated issues that we are to cover legislatively. And one of the things that prompted me to have these hearings was when we received the abortion statistics and we saw that there were numbers of young girls, 12 and under, 13, who have received abortions. That was part of the reasoning for the hearings but also the fact that the current administration is -- in Washington is now changing direction and is --

UNIDENTIFIED VOICE: Good morning. Can you hear me?

MAJORITY CHAIRMAN RAPP: -- going to require that the citizens of the nation and the state pay for funding of abortions. And we know that in our state we had the unfortunate Gosnell case, and we want to make sure through our inquiries that this kind of blight does not happen in the case of Pennsylvania again.

So at this time we have four testifiers this morning in 45-minute segments.

And our first testifier is Amy Scheuring; did I

pronounce your name right?

UNIDENTIFIED VOICE: I can hear you, ma'am, but I think they're having some technical difficulties in the broadcast.

(Audio interference)

MAJORITY CHAIRMAN RAPP: Can you hear us, Amy? Do you have your microphone on, unmuted?

(Audio interference)

MAJORITY CHAIRMAN RAPP: Right. If everyone who is online with us -- and I'm sorry, I forgot to have the other members introduce themselves who are joining us virtually.

Do we want to do that quickly before the speaker -- or the testifier -- I turn to the testifier?

Representative Klunk, would you please introduce yourself.

(Audio interference)

MAJORITY CHAIRMAN RAPP: All right. I'm not getting a response from the people joining us virtually.

Amy, you are our first testifier. Can you hear me now?

MS. SCHEURING: (No audible response).

UNIDENTIFIED VOICE: We don't have audio online, Madam Chair. Sorry.

(Audio interference)

MS. SCHEURING: Can you hear me now?

MAJORITY CHAIRMAN RAPP: Yes. We can. So Ms. Scheuring, we now have rules in the House that requires that we swear you in -- people who testify.

MS. SCHEURING: Is my video and audio on?

MAJORITY CHAIRMAN RAPP: Yes. Yes, they are. Could you please raise your right hand --

MS. SCHEURING: Yes?

MAJORITY CHAIRMAN RAPP: -- to be sworn in. You can't hear us?

MS. SCHEURING: My screen is showing everyone else is muted so I'm only able to hear myself.

MAJORITY CHAIRMAN RAPP: We are trying to correct this. I know you can't hear us.

(Pause)

MAJORITY CHAIRMAN RAPP: I apologize for the technical difficulties. Hopefully, we will get this corrected as soon as possible.

(Audio interference)

MAJORITY CHAIRMAN RAPP: Yes, Whitney.

(Audio interference)

MAJORITY CHAIRMAN RAPP: Ms. Scheuring, can you hear me now?

MS. SCHEURING: Yes. I can. Yay.

MAJORITY CHAIRMAN RAPP: Okay.

MS. SCHEURING: Perfect.

MAJORITY CHAIRMAN RAPP: And I believe Melissa Reed, who is the President and CEO of Planned Parenthood is with us, as well, and also Genevieve Plaster.

Are you with us virtually?

MS. SCHEURING: Yes.

MS. REED: Yes.

MS. PLASTER: I am. Yes.

MAJORITY CHAIRMAN RAPP: So for the three of you who are here as of now, could you please raise your right hand to be sworn in. Thank you.

(Oath administered)

MAJORITY CHAIRMAN RAPP: Thank you.

And at this point in time, Ms. Scheuring, without further delay, please proceed.

MS. SCHEURING: Thank you very much. I appreciate being able to share a little bit. I've been with Women's Choice Network for about 35 years, and over those 35 years a lot has changed and happened, but it's been my privilege to serve in the Pittsburgh community that long. I've also been -- we're not connected with Real Alternatives but I've been a trainer for Real Alternatives. I've also spoken as a speaker at the Heartbeat Conference and Care Net, both of which are national affiliate organizations for pregnancy centers like ours. And I don't

know every single center in Pennsylvania but I believe there are over 200 centers like ours that are popping up all over Pennsylvania. I know one new one is opening in the East Liberty neighborhood in Pittsburgh on Friday; it's another medical clinic. And so keeping track of how many pregnancy centers are in Pennsylvania is difficult but I think there are over 200 of us right now.

We all share kind of the same mission, which is to empower abortion-vulnerable women to choose life. The mission has remained the same for the last 35 years but our strategies, the ways that we do that, have definitely changed. We seek to adapt to the culture, the needs of the culture, and the services that the culture requires and needs, so our services have definitely changed over the years.

And so right now, I'm sitting in one of our three medical clinics. I'm in Oakland right between Pitt and CMU campuses, and we have another center in Monroeville in a medical facility there. We have a center that is in the North Side, which is a very blighted area of Pittsburgh, and like I said, we've been serving here for just over 35 years.

One thing that has not changed that I want to address today is some of the false narrative and accusations around what we do and how we do it. And so my

hope is to provide some facts and evidence for your team today, and very respectfully help you see that the pregnancy center movement in Pennsylvania is vital, it's valuable, and it further advances families in Pennsylvania.

One of the things that I often hear over the years and it's become kind of a tired accusation is that we do not care for women, that we are in love with the fetus, that we care about babies but we don't care about women, and I want to address that because I think, you know, in 35 years of practice and knowing, literally, thousands of centers over the years, this is the furthest thing from the truth. All of us, every single one of these pregnancy centers provides resources and care in an ongoing way for women. Now, not every center is a medical clinic but every center does education and programs for women during their prenatal period and post-natal period, many of us for up to two years.

So I know at our center we have a life support program that is an educational program and a support program with mentors that -- and we, you know, seeing a woman at the point of her crisis and offering her an ultrasound, like we do right here, is just day one. That takes one day. But our work actually begins that day; it doesn't end. So we are in her life for the next two years. We might see that client or -- and her boyfriend, or her

significant partner 40, 50 times over the next two years. And if I had time today, I could list the names of clients that I've known for 10 years, for 15 years. I even have clients that we worked with in the '80s who now have grandchildren. Their baby that -- you know, that they had grew up and now is a parent themselves, so we stay in touch with these women over the long term.

And the best way to put this, folks, is that we are a transformational outreach in the community where I think -- you know, the abortion industry is largely transactional. It is treat them and street them, and in -- and sadly, in many cases, treat, street them, and repeat them, because we know that the recidivism rate with abortion and with STD is very, very high. We'll see women that have had four abortions before they -- four or five and upwards before they enter our center. So we try to be very transformational. Not one or two visits but literally over time in her life for years to come so that that child -- so that a family emerges really, so that the child is healthy and a family emerges out of that situation.

So and another issue that I'd like to cover, and I'm so short on time so that's why I'm going to just kind of ramble through some of these, one of the accusations that I hear often, and we've had had people stand in front of our center here in Oakland and accuse us of being a fake

center, and I just want to address that. We have three physicians who lead our center. All of them are medically licensed through the State Board of Medicine. All of our centers are staffed by RNs or higher. We have RDMS professionals who do our ultrasounds. These people are all trained. They're licensed through the state. We do our STD testing and treatment through the county and the state. Thank you very much for that. We appreciate that so much because STD testing is a big part of our program. All of the centers are staffed by medical professionals. There are also lay people like myself who are mentors, who work with clients in an educational kind of mode, but all of the medical services are provided by medical professionals.

Now as I said earlier, not every center is a medical clinic like the ones here in Pittsburgh. Many of them are but those who are not, they don't claim to be, first of all. And second, they may not want to replicate services that already exist. I know for us, for example, one of the things people say, well, why don't you provide prenatal care? We're literally a half mile from Magee Clinic. Why would we replicate the services that Magee is providing so well for our clients? So replicating services is not what we want to do. We really just want to provide the services that are needed. So you know, I think we have to look at this.

There's nothing fake about providing free medical services for women in communities of great need. There's nothing fake about providing women and men with ongoing education, material assistance like cribs, car seats, diapers, et cetera. There's nothing fake about meeting with women who are considering abortion and empowering them with information or resources that provide a choice.

The other part of our medical program is abortion pill reversal, which we have been doing for a couple of years. Abortion pill reversal absolutely works, and you know, I just want to give you a quick little primer on what this is and why we feel like it's so effective. You know, for so many women when they begin a chemical abortion, which is a series of pills, they experience immediate regret. Many of them that we've talked to call us and they say, you know what, I made a mistake. I have buyer's remorse. I -- it's almost like, you know, I just want to take this back. I want to turn the clock back. They have a change of heart, and naturally they're wondering at that point if there's any way that they can turn this thing around, if they can turn back the clock.

So there's a national hotline. We're part of that hotline. Our nurses are trained with APR hotline. And what's happening here is the abortion pill, the first series of pills robs the baby of vital progesterone. This

is a hormone that's naturally occurring in the first few weeks of pregnancy. It's flooding the body. And so this first pill robs the baby of that progesterone. APR is very simply restoring progesterone to the fetus. That is all -- that is what it is. We do an ultrasound. We provide progesterone into her system and within hours or days we can see an abortion reversed. It's amazing -- it's an amazing thing.

And when people say it doesn't work, I'd like to introduce you to the people and to the babies for whom it has worked because in 70 percent of the cases we're able to reverse that abortion. It is really an amazing thing and women come back and thank us. They bring their baby back and they just thank us for turning that around. You know, we really feel like at that point she still should have a choice and we're able to provide that choice. So when a woman changes her mind, we want to make sure that we're there to do that.

Progesterone, by the way, has been safely used for pregnant women since the 1950s. There is -- there are no side effects to progesterone. It is safe, it's inexpensive, it's prescribed by our OB/GYN, and it is used routinely in pregnancies -- in the early stages of pregnancy.

In the largest APR study done in 2018, it was

done with over 750 pregnant women who started the abortion pill process, and APR was successful in 70 percent of those cases. So we're very proud to provide this tremendous service in Pittsburgh, and it's being provided across the country. We're seeing great results with that. So when you hear that this is voodoo science or some kind of crazy off-label use of some -- you know, some crazy drug, really, I just wanted to give you the facts and the evidence about this that progesterone has been safely provided for women since the 1950s with no side effects. You can talk to the OB/GYNs who provide it.

Another -- one or two last things that I want to mention here is that we are really about transforming our community and making sure that families rise up. And one of the things that I can say I'm most proud of in this past couple of years is adding a men's program. You know, we look at this pregnancy holistically, so this pregnancy doesn't just involve a woman. It involves a man. And so our hope is to bring, in every case, the young man in this situation to the center. He gets to -- instead of being told to sit down, shut up, and pay, we bring him into the game. We say get off the bench; you're in the game now. And we want to know what he thinks. We want to know what his opinions are. We want to know how he feels about this and what he's thinking. So we show him an ultrasound. We

have found that the father of the baby is the most influential person in her decision. He doesn't know that and maybe she doesn't even realize that, but his temperament and his feeling about this is very, very vital.

So we bring him into the process. We bring him into the room. He sees the ultrasound, with her permission, and many times he becomes a key player. We have a program for him called DoctorDad. It is a parenting program where we're talking to these noncustodial fathers about how to raise children. What we know about young children in our culture is that fatherhood is vital for them, that increasing fatherhood will actually prevent so many ills. And you know, I could go into the studies on this, but fatherhood is a vital piece of what we should be doing in the community. So more and more centers like ours are beginning to provide these vital fatherhood program with men in the center that are able to talk with other men and really help them to find who they are as dads, so that's another program that we're really proud of.

And the last thing that I'll just mention, and I'm happy to take a few questions before I have to run off, we have a staff meeting today, but we also provide post-abortion counseling. One of the things that people often accuse us of, part of this false narrative is that we're super-judgmental, and I want you to know that many of the

women who serve in our centers are post-abortive. They've had an abortion in their past. And for whatever reason, they regret that choice. They look back and say I really wish that I had been able to make a different choice, and so they want to talk with other women. And one of the things that we're really able to do is to come around people who are post-abortive and care for them through a process, and help them to find wholeness and healing and restoration, and just begin to talk about their experience in a healthy way.

We find that when we are transformational, when we reach the whole person, we're able to see her make fabulous choices going forward so that she can break out of a cycle that maybe she's been in and readdress some sexuality issues and some relational issues in a healthier way.

I think I said that was the last thing but there's so much more to say. The other thing that we've been doing for 35 years, I mean since day one, is reaching our schools. And in 2019, before COVID, we actually had a Federal Title X grant to provide education in 14 different school districts here in Pittsburgh, including Pittsburgh Public, and we were really excited to do that. We had seven certified trainers that were going into schools on a daily basis. I think we did 390-some presentations in one

school year. So that's another area where we're really trying to make sure that the community is reached in the schools and that education is provided to young students so that we can prevent these kinds of situations -- so that we can actually prevent them walking in the door for an STD test or a pregnancy test.

So sorry to -- you know, to talk so fast and try to get through it, but I wanted to help you see how valuable and how vital pregnancy ministry is across the state of Pennsylvania and why it advances families.

So I think I can take a few questions, Whitney, if that's appropriate.

MAJORITY CHAIRMAN RAPP: Thank you, Amy. This is Representative Rapp.

MS. SCHEURING: Oh. I just want to --

MAJORITY CHAIRMAN RAPP: Oh, no. That's okay. I appreciate Whitney very, very much. Believe me.

I just wanted to say that I really appreciate your testimony, and I went to your website to see everything that you were doing through the pregnancy center, and I was very impressed. You know, a lot of us who are in the pro-life community, we get accused of only being concerned about the birth but not anything thereafter, and your testimony shows that through -- and I know it's not just your pregnancy center but it's many of

the pregnancy centers throughout the state that do follow through with women, provide the needs that women need after the birth of the baby and the support that those women need. And I think that's a message that many need to hear, that it's not just we are concerned about the baby's birth but we are concerned about supporting families and fathers and getting them through not just the pregnancy, but then parenting and fatherhood. I think it's wonderful that you bring the fathers in and everything you do, and so I'm really thankful for your message. I know you have a lot of testimonies on your website, as well, and the website is Women's Choice Network, so it's a refreshing message to hear that pregnancy centers, alternative -- Real Alternatives is not just about, you know, have the baby and then we're done with you. It's a --

MS. SCHEURING: Right.

MAJORITY CHAIRMAN RAPP: -- follow-through. And I also appreciate the fact that you're counseling those who had abortions. I think there's a real sadness there for many women who do regret their decisions and so I appreciate the fact that you're taking that task on, as well.

So I'll turn to the Members, if --

Representative Frankel.

MINORITY CHAIRMAN FRANKEL: Thank you, Madam

Chair.

And thank you for testifying today, Mrs. Scheuring. I must say -- I just want to say, the use of the term abortion recidivism, you know, implies it's a crime, which it is not, and I think that that is a regrettable way to characterize this, but in the spirit of -- and by the way, 60 percent of women who get abortions are already mothers --

MS. SCHEURING: Right.

MINORITY CHAIRMAN FRANKEL: -- but you know, one of the things that the -- if you're counseling people in terms of how to avoid unwanted pregnancies, do you provide contraception to people or do you refer them to providers that do?

MS. SCHEURING: What we found, sir, is that for about 60 percent of the women we see who have chosen abortion in the past -- 60 percent of them were using birth control at the time that they got pregnant. In other words, what they've found -- what they're telling us is that I have been using birth control and it hasn't been successful in my life. In other words, if 60 percent of post-abortion women were using birth control at the time that they became pregnant, we're not really convinced that that is addressing her relational needs, so we do not provide birth control in our centers. And again,

replication of services -- many women already see a doctor. As you said, many of them are already mothers. Generally, we're seeing women at the various locations who have one, two, three children at home, and that's one of the reasons that they're considering abortion at this time, but the overwhelming majority are post-abortive and have used birth control in the past, and that abortion -- that birth control has left them down.

MINORITY CHAIRMAN FRANKEL: Well, so you do not provide --

MS. SCHEURING: No.

MINORITY CHAIRMAN FRANKEL: -- birth control or you do not refer --

MS. SCHEURING: No.

MINORITY CHAIRMAN FRANKEL: -- to providers that do. Your mission statement includes the fact that you are part of a religious outreach ministry with biblically-based teachings. How do you treat individuals who are not religiously aligned and do you offer them counseling in accordance with their own faith traditions?

MS. SCHEURING: Well, our counseling is not biblical counseling, first of all. We are -- we're really -- we're a medical clinic. We see anyone for any reason. There's absolutely no restriction on who we see. Many of the clients that we see are from various -- not

just various faith backgrounds but no faith background whatsoever, so and because we're in very diverse neighborhoods, you know, we see a large diversity of people and students. And so when we say that we are a ministry, and we are, not every center is affiliated with a faith-based ministry, but we are. And all that tells our clients is that we're going to approach this holistically. We're going to talk about the spiritual part of you, as well as the physical, emotional -- you know, the -- all of the whole. And most of our clients really value that. They really want to talk about how their spirituality affects their relationships. And we're just really -- what we're telling them is we're open to do that.

MINORITY CHAIRMAN FRANKEL: Yeah. Well, I'm looking at your mission statement and statement of principle and it's an enormous amount of religious mission to it, so I just --

MS. SCHEURING: Yes.

MINORITY CHAIRMAN FRANKEL: -- a point, I mean that -- which has not really been part of your discussion here today. Do you provide prenatal care?

MS. SCHEURING: No. We don't. And as I said, that would be a replication of services.

MINORITY CHAIRMAN FRANKEL: Uh-huh (affirmative).

MS. SCHEURING: Literally a half mile from us is

Magee Clinic. One of our doctors that is our medical director here is an OB/GYN there, so there's absolutely no reason for us to replicate the services that are literally a half mile away. Same thing in Monroeville. Same thing in North Side. Prenatal care is readily available.

MINORITY CHAIRMAN FRANKEL: So are you a medically-licensed clinic?

MS. SCHEURING: The doctors who -- there's really -- and that's kind of a false way to put it. We have medical directors who are licensed by the state. All of our medical professionals are licensed by the state. We have CLIA Waiver through the state to provide the testing and treatment that we do for STD and pregnancy, so everything that we're doing is regulated by the state. Our STD program, as I said earlier, is provided through the county and through the state. Our educational program is a federally funded program through Title X -- sorry. So I'm not sure what you mean by licensed by the state. All of the licensures that are required for a medical clinic are in place.

MINORITY CHAIRMAN FRANKEL: But you are not a medically-licensed clinic by the state. You (indiscernible - recording malfunction) so that's (indiscernible - recording malfunction) -- you are not a medically-licensed clinic, right? Correct?

MS. SCHEURING: I'm really not sure that that is a requirement of --

MINORITY CHAIRMAN FRANKEL: Okay.

MS. SCHEURING: -- of --

MINORITY CHAIRMAN FRANKEL: That's okay.

MS. SCHEURING: -- medical clinics.

MINORITY CHAIRMAN FRANKEL: That's fine. Thank you.

Thank you, Madam Chair.

MS. SCHEURING: Yeah. (Indiscernible - recording malfunction). Yeah.

MAJORITY CHAIRMAN RAPP: Thank you, Mr. Chairman.

Our next person is Representative Krajewski.

REPRESENTATIVE KRAJEWSKI: Thank you, Chair.

I thank you for your testimony. My question is in your testimony, you had stated that you have centers in blighted areas and that also in your mission statement you say you aim to empower those most vulnerable. Can you just talk a bit more about what you mean by those terms, in terms of blighted communities and also those that are most vulnerable.

MS. SCHEURING: Uh-huh (affirmative). Yeah. What we've found is that in Allegheny County, here where we are in Pittsburgh, that 40 to 45 percent of the abortions are suffered by African-American women. This creates a

social injustice like no other because African-American women comprise 13 to 14 percent of the population here, so there's a clear disparity. So when we began to open new centers, we decided to open those centers in areas where we would meet -- where we would be likely to meet those who may be underserved or in one way or another marginalized or separated from here. So that's why we've located ourselves in North Side, which is, again -- when I say blight, you know, that just means that it's an area that is kind of at this point requiring a lot of funding to get just basic needs met; Monroeville, which is largely an African-American hub; and also Oakland, which is right between the two campuses. So we've tried to locate (indiscernible - recording malfunction) strategically so that we can address that disparity. Does that help to make sense out of that statement?

REPRESENTATIVE KRAJEWSKI: It does explain your -- the thinking about it. I mean, I don't think those communities would appreciate it being described as social injustice. But as a quick follow-up question too, and what are the demographics of your staff?

MS. SCHEURING: We have a very diverse staff of men, women, old, young, Black, and White.

MINORITY CHAIRMAN FRANKEL: Okay. I ask these questions because I found a lot of that language to be

pretty problematic, to call these areas blighted, to say that it's a social injustice that these people are seeking access to abortion care. A lot of these communities have been intentionally divested from. They have not been invested into -- from -- they haven't had resources put into them for a very long time and I don't think that these communities seeking out abortion, seeking care, seeking support is something that should be described as a social injustice, so I would just recommend that you think a little bit more intentionally about the language that you use for these communities that you're aiming to serve in.

MS. SCHEURING: I appreciate your input on that, sir, and I -- you know, we're always trying to make sure that we're sensitive to the needs of the people around us. That is exactly why we are located where we are so that we can begin to invest, as you said, in the neighborhoods that we love so much.

REPRESENTATIVE KRAJEWSKI: Sorry -- one last follow-up.

MS. SCHEURING: Uh-huh (affirmative).

REPRESENTATIVE KRAJEWSKI: For these communities, what kind of -- what is the relationship that your staff has in the communities themselves? Like, do you actually do any kind of outreach? I'm curious about how your centers actually interact with the communities that --

MS. SCHEURING: Yes.

REPRESENTATIVE KRAJEWSKI: -- in your area.

MS. SCHEURING: Absolutely. Great question too because it's so vital. And it really depends on the neighborhood. So in North Side, for example, we're really integrated on the street. I mean, everybody knows us. We've been there since 2012. We're involved in all of the local festivals and outdoor activities and farmers' markets and that kind of thing. We try to be a very visible partner in the community. We also participate with the Buhl Foundation, which is investing in that area, so we go to those meetings. There's a group called One Northside that we're involved in. We try to make sure that we're in the local paper there. So that's a really easy neighborhood to join, sort of, and to become a partner in.

Oakland is a little bit more difficult so we try to make sure we're connected with the universities. So those university communities, 23,000 students live or learn right in a two-mile radius of where I'm sitting. We try to be involved in their health fairs. We try to get into dorms to do a lot of speaking.

Same thing with Monroeville. Our -- we're housed in a two medical buildings, actually, in Monroeville. We try to make sure we're building relationships with various medical providers and also rehab providers.

So -- but another real clear way is by our presence in the schools, and we've been in high schools in Pittsburgh since 1985, and have really enjoyed the presence of being with students, hopefully, as I said, long before they need to -- and maybe never need our services. So I would say that we're very, very involved (indiscernible - recording malfunction) been able to become very vital neighbors.

REPRESENTATIVE KRAJEWSKI: Thank you.

MS. SCHEURING: You bet. Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Amy.

Next we have Representative Cephas.

REPRESENTATIVE CEPHAS: Thank you, Chair.

Thank you for your --

MAJORITY CHAIRMAN RAPP: Representative, if you could just keep it to one question because we have two more --

REPRESENTATIVE CEPHAS: Okay. That's cool.

MAJORITY CHAIRMAN RAPP: -- people who -- and we're on a tight time frame. I'd really appreciate it. If we have time to come back, we will.

REPRESENTATIVE CEPHAS: I'll do one question with a long intro. So would have started with a couple of quick questions but some of the things I just wanted to highlight and as a follow-up to my colleague, Rick Krajewski's

questions, are you familiar with the Pittsburgh Gender Equity Commission and the recent Pittsburgh Inequity Across Gender And Race report that was just recently produced?

MS. SCHEURING: No. No, ma'am.

REPRESENTATIVE CEPHAS: Okay. Because it talks a lot about the racial disparities in the region that you are serving and you mentioned that -- one, that you have a diverse staff. I would be interested in hearing from a percentage perspective, broken down by race, what does that staff look like, but then also you talked about the demographics of your services that you provide. I'd also like to hear or provide information to the Committee about the racial demographic breakdown of those services that you do provide for that community.

And the reason why I raise that because based on that report, Black women in Pittsburgh are more likely to die -- are more likely to have a baby die during pregnancy than Black women in most cities across the country. So given the communities that you are serving and you speak to the point that you care for an individual up to two years past the time that they are coming into your clinic, I'd love to hear, considering that you've been in those communities for 35 years, you give your narrative and your testimony here but the data and the outcomes of Black women in these communities show a very different perspective. So

I'm interested in hearing what you feel like your role is in reversing those trends based on a study that was literally recently produced in the past three years.

MS. SCHEURING: Well, thank you for the question. And you know, it's been our hope to be effective. We are one small player. We have a staff of right now 13 people, so it is not a big giant staff. Our demographics, in terms of who we serve, pretty much 60 percent non-Caucasian, so 40 percent Caucasian, 60 percent non-Caucasian. And you know, we really try not to play the race political card at all. We're really -- we're not here to particularly right any wrongs. We're really just here for anyone who wants to see us. And we have located ourselves in places of great need but that certainly doesn't limit who comes here or it doesn't define who comes here.

We have people who come from West Virginia, from Ohio, from Erie, from the center of the state, so I understand your question and I understand the gravity of it, but I want you to know that we are just one small piece of what is happening in Allegheny County. Our mission is to reach whoever would come through our doors.

So I understand. I think on a larger scale the pregnancy movement across the state and across the country -- you know, I think we're all doing our best to advance family, to make sure that women can have a safe and

healthy pregnancy and that's why we do -- that's why we are so invested in our pre- and post-natal education programs. And they are excellent. They are excellent programs, and so why is there still a need? You know, that's a really -- that's a question that is bigger than what I can answer in the next two minutes, so it's really worthy of the discussion though so thank you for that.

REPRESENTATIVE CEPHAS: Well, I appreciate your answer but when you say your facility is not here to play the race card but the majority of your services are provided to people of color, I find that a bit challenging and would hope that you would just be a bit more intentional about understanding the underlining conditions as it relates to people of color when it comes to your services.

MAJORITY CHAIRMAN RAPP: Representative, I think Amy has tried her best to answer your questions. This is really about providing services to women, no matter what their race, creed, anything. They are reaching out, doing the best, and that's all any of us can do is to do the best that we can do. But thank you.

And if there's time, I'll go to Representative Schemel.

REPRESENTATIVE SCHEMEL: Thank you, Madam Chair.

And thank you so much for the beautiful work that

you do at the Women's Choice Network. It's sometimes centers like yours are accused of actually providing less choice or limiting choice so I would ask you, in your experience based upon your years of working there, do you ever or have you ever had women come who aren't aware that they can get abortions or where they could get abortions; have you ever had women that come that aren't aware that they can get contraceptives or where they can get contraceptives; and in contrast, you know, you offer a choice that women have instead of getting abortions or maybe of having counseling on natural family planning. So in your experience, do women leave your clinic having more choices or fewer choices?

MS. SCHEURING: I love that question. One of the reasons that I walked into this ministry 35 years ago is what I was hearing, and I continue to hear today -- is women who say I had no choice. I had to get an abortion. I had no choice. And you know, that was a challenge to me because I felt like, you know, every woman should have a choice. And I -- so what we really set out to do was to make sure that people could find a choice for life and that has been our tag line, where the choice is life.

So we are intentional about making sure that when a woman leaves our center she definitely is empowered with all of the options that are in front of her, not just the

ones she's willing to consider. So we take time with her and talk about parenting. We take time with her and talk about adoption. We definitely go over the abortion procedures, what that means, what that will look like because that is one of her options.

I have never met a woman -- and let me just say, within recent history -- in the last 15 years, let's just say, who has not known where to get an abortion. As a matter of fact, many of the women who visit us for an ultrasound already have an abortion appointment scheduled. She knows where to get birth control. As I said earlier, about 70 percent of the women that we see are using birth control when they walk in our door. This is not about a lack of services. It is about a lack of choice.

And so when she enters our doors, we want to make sure that she is empowered with all of the choices, even the ones that she isn't willing to sit down and consider right now. And that's what we tell her. Let's just take 10 minutes and talk about the things -- you know, all of the choices that are in front of you, and let's see how we can empower you so that you are absolutely confident that you have looked at every single choice and you have made the one that's right for you. And I've got to be honest with you, 80 percent of the women who view their ultrasound, who go through our care, choose life, and we're

really happy about that. But 20 percent of them don't and they go on and choose abortion and we offer to them a post-abortion care offering if they're willing -- you know, if they're -- if they would like to do that.

So we are very open with all of our clients about who we are and what we do and why we're here, and you know, the overwhelming feeling that they have is wow. Somebody listened to me. Somebody cared about me. Somebody followed up with me. And yes, you know, even somebody talked about my faith, talked about my emotions, talked about my relationships. The question that we -- we ask a lot of questions and many of our clients will say wow, no one has ever asked me that question before. And so what we're trying to do is really reach people in a holistic way to provide all of the choices, not just one, so that she feels completely empowered and informed.

And doesn't every woman -- I mean, doesn't every woman deserve that? And the added bonus is that the young gentleman who's in her life, maybe he's part of her relationships, maybe not, but he's the father of this child. He also gets the benefit of understanding the options that are in front of this woman. Instead of just, well, do whatever you want to do and I'll pay for it, he actually has a voice and he actually gets to -- you know, gets to begin to talk about what his deal is, and we love

that. And honestly, I've got to say, that eclipses everything, in my opinion, is that we are able to honestly see a person walk out the door and say thank you very much. I'm not going to do what you said to do but you know what, thank you for opening up the conversation. And when a person calls us back and says you know what, I had an abortion but you guys really cared for me and I appreciate that. You know what? That's gold for me.

Yes. We love to see babies born and we love to see moms choose life, but I'll tell you what, what we really love is to know that we are impacting lives, that we are transforming families, and that we're not just a transactional relationship.

So thank you so much for that question.

MAJORITY CHAIRMAN RAPP: Thank you, Amy. Our last question from the Members who are here is from Representative Benham.

And we have Members who are here virtually. If you have questions and if you want to send them through email or chat to Whitney or to Erika, we can get those to Amy and we will try and get the answers to your questions.

At this time, we have time for -- we really don't have time for one more question but Representative Benham's been on the list, so Representative Benham, one question, please.

REPRESENTATIVE BENHAM: Thank you, Chairwoman. I appreciate it.

And thank you, Amy, for your testimony, as well. I notice here in your statement of principle, the Women's Choice Network does not discriminate in providing services because of race, creed, color, national origin, age, or marital status of its clients. I'm noting -- noticing a few missing protected classes like gender, for example, or disability, or health status. And you are aware, I'm certain, that there are women whose disability or whose health status would make carrying a pregnancy to term very dangerous or potentially fatal. I am, in fact, one of those women. And you let Representative Frankel know that you do not recommend, provide, or refer clients for contraceptives. So I'm wondering how you would counsel a woman who needs to avoid pregnancy. Thank you.

MS. SCHEURING: Yes. Thank you. Yes. And to just clarify, we see a lot of those who have -- who are on the LGBTQ+ spectrum. We're very happy to meet with them and honestly, you know, you can look on Google. One of the reviews that we love is, you know, they don't judge you there, and we don't. We really accept people however -- when they walk in the door we're loving them exactly as they come in the door, and that includes, of course, any type of disability. All of our centers are handicap-

accessible, first of all. We make sure that that is -- that that's a high priority.

And for those women who are coming to us for that kind of need, you know, that's a little outside of our scope of services. Right away, that would be an instant referral to either a high-risk doctor if she is concerned about pregnancy, and if it's an STD test and we're just talking to her about health and safety and just healthy relationships, again, that would be a referral. We are not at all, you know, opposed to referring her back to either her PCP or to a clinic or somewhere she can go, but it is a -- we are not diagnosing pregnancy issues or -- we are really here to do pregnancy testing, ultrasound. We walk through those things, and if there's anything that falls outside of our scope it immediately goes to one of the three medical directors.

REPRESENTATIVE BENHAM: So just to clarify, when a woman is seeking contraceptives, you do refer.

MS. SCHEURING: Well, naturally, we refer her back to her OB/GYN for prenatal care. And if she's seeking -- if somebody is calling and saying, you know, do you provide birth control at your clinic, we would say no, we don't. So I mean, I think if a person were just seeking that, they -- we would probably not make an appointment here. We would say we simply do not provide that service.

So we have a scope of services that we can provide and so we just simply tell her that's not within our scope of services.

REPRESENTATIVE BENHAM: So you do not (indiscernible - recording malfunction)?

MS. SCHEURING: Right. As I said, we do not provide birth control or abortion.

REPRESENTATIVE BENHAM: That was not my --

MS. SCHEURING: Okay.

REPRESENTATIVE BENHAM: -- my question.

MAJORITY CHAIRMAN RAPP: Representative, we're really out of time and we have to move on. And I think Amy has answered the question.

But Amy, I want to thank you for your testimony today. We are time-limited in this hearing today, so I want to thank you very much and if we receive some emails I'm hoping that we can send those to you and then that you could reply.

And if Representative Benham wants to follow up with a question, you're more than welcome to do that, as well.

So thank you so very much for your time today. We truly appreciate it.

And at this point in time, we're going to move directly to Melissa Reed, who is with us virtually, who is

the President and CEO of Planned Parenthood Keystone. And Ms. Reed, if you would like to proceed, if you're unmuted, go right ahead, ma'am.

MS. REED: Good morning. And thank you Chairwoman Rapp. I am Melissa Reed, President and CEO of Planned Parenthood Keystone. I want to thank the House Health Committee and its chairs for giving me the opportunity to speak at today's hearing.

PP Keystone is a proud affiliate of the nation's largest and leading provider of sexual and reproductive healthcare, the Planned Parenthood Federation of America. And Planned Parenthood Keystone has nine health centers throughout central and eastern Pennsylvania and serves over 22,000 patients each year in 37 counties in the Commonwealth.

We are a part of the state's social safety net, providing care and education, no matter what. In fact, at least one in five women has relied on Planned Parenthood health centers for care in her lifetime. Planned Parenthood leads the country with the most up-to-date medical standards and guidelines for reproductive healthcare and uses clinical research to advance healthcare delivery to reach people in need of care, and for many people Planned Parenthood is their only source of care, making our health centers an irreplaceable component of the

country's healthcare system.

And as experts in reproductive healthcare, Planned Parenthood health centers often provide family planning services that other safety net providers simply do not offer. We offer the full range of sexual and reproductive healthcare, like HIV testing, PrEP and PEP medications for HIV prevention, cancer screenings, gender-affirming care, and annual visits, in addition to contraceptives and abortion care.

We also offer sexuality education using an award-winning and evidence-based curriculum to help youth and adults understand their bodies and make informed decisions about their health. Our LGBTQ+ programs provide a safe place for LGBTQ+ youth to find peace and solace with each other, and we offer counseling, support, and education. And though we offer the full range of sexual and reproductive healthcare and education, the reality of accessing care is different for many people.

Access to sexual and reproductive healthcare can be difficult for Pennsylvanians, and especially so for the most vulnerable people in our communities, such as people of color, those with low incomes, people living in rural areas, and immigrants. The COVID-19 pandemic has exacerbated these challenges and put basic healthcare including reproductive healthcare out of reach for some

patients.

Further restrictions to abortion and sexual and reproductive healthcare will severely limit access and do grave damage to the health of Pennsylvanians. Those who already face barriers to accessing healthcare will be hurt the most. Any erosion of access to abortion jeopardizes the health of pregnant people, their families, and the state, as a whole, and quite frankly, it's unpopular. Sixty-three percent of Pennsylvanians believe abortion should be legal in almost all cases and abortion is one of the safest medical procedures performed in the United States.

Data including from the CDC shows that abortion has over a 99 percent safety record. And yet, here we are today, day two of three hearings already scheduled, wasting taxpayers' time and money by focusing on banning abortion and restricting access to reproductive healthcare. It's seriously misguided when we are currently grappling with a deadly pandemic. Moreover, given Pennsylvania's high rate of maternal and infant mortality, high rate of opioid addiction, and low vaccine rates in communities of color, it's time to focus on increasing access to preventive care, not on working to restrict access to healthcare.

But don't take my word for it. Hear from a patient. This is Linda's story. I will always be grateful

for the kind and compassionate care I received from Planned Parenthood when I decided to terminate my pregnancy. I am standing here today with a career, a safe home, and a healthy marriage because I had access to healthcare that enabled me to make the family planning choices that were best for me. Linda's very personal experience turned into advocacy and though hers is just one story, there are more like her.

Further attempts to restrict access to abortion, like the bills already introduced this session, aren't about protecting patients like Linda or keeping others like her safe and healthy. Instead, they are another attempt to exert control over bodies and cruelly to limit healthcare for the most disadvantaged groups of people.

I appreciate the opportunity to address the Committee this morning and I am here to provide you with facts to destigmatize abortion and to remind you that the decisions you make have repercussions for the bodies of our patients. Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, President Reed. You made a statement here. You've made several that I obviously disagree with. You say these hearings are a waste of taxpayer money. If you heard my opening statement, I stated that one of the reasons we're having these hearings is because taxpayers will now be under the

Biden administration. This administration wants taxpayers to pay for all abortion, even those of us who believe that it is wrong to have abortions, and many people do not believe that we should be paying for abortions with our tax money. So even though you think it's a waste of taxpayer money, this Committee, one of our legislative issues is abortion and it is our duty to make sure that these procedures are done in a lawful way.

So that being said, could you walk us through the process of how an abortion takes place and what happens when someone steps in your door, and how does it -- how does surgical abortion differ from a chemical abortion?

MS. REED: Well, to answer your question, first let me just say that the Hyde Amendment, which is currently in place, restricts access to abortion by banning public funding of abortion except for the cases of rape, incest or life endangerment, and that's still in place. And yes, the Biden administration would like to abolish the Hyde Amendment, which Planned Parenthood supports because, quite frankly, we believe that access to abortion shouldn't depend on your income.

But to go further with regard to your question about how a patient would access an abortion at Planned Parenthood, if a person comes to Planned Parenthood who is pregnant, we provide all their options (indiscernible -

recording malfunction) them in a very compassionate way that really explores the concerns that that patient has. We talk about the risks with all the different options, and then we furnish that to the patient to make sure that they have the information they need to make the decision that's best for them.

And regarding your question regarding surgical in-clinic abortion and medical abortion, I'm not a doctor. I can't go into the specifics of the medical procedure but what I can share with you is that medical abortion is a series of two medicines, mifepristone and misoprostol. Those medicines have been used safely in the United States for over 20 years now, and the majority of patients who come to Planned Parenthood now request that method for abortion care, if that's what they're choosing. And that is safely administrated up to 11 weeks from a person's last menstrual cycle.

Then for an in-clinic abortion at our affiliates, we're able to provide that at several of our health centers and for that we can go to 13 weeks 6 days post-last menstrual period.

MAJORITY CHAIRMAN RAPP: Thank you. What kind of information do you give to someone who would walk into the door as far as their options and choices when they come to you seeking an abortion? What's the information that you

give?

MS. REED: Well, we provide counseling on all their options, whether it's parenting, whether it's adoption, or abortion, and we refer out for OB care if a person chooses parenting or adoption because we know that it's important for prenatal care to start as early as possible in a pregnancy so that the person can have the healthy pregnancy and healthy baby. If they want an abortion, they are counseled on the procedure, how it's performed, and the risks and benefits of that procedure.

MAJORITY CHAIRMAN RAPP: Thank you. There's information from the Department of Health; is that given out to the person seeking abortion?

MS. REED: Yes. There's certainly -- Planned Parenthood follows all the Pennsylvania laws (indiscernible) in accordance with the law, and so Pennsylvania has many requirements, one being a 24-hour mandated informed consent, and all of our patients are required to have that informed consent at least 24 hours prior to the procedure.

MAJORITY CHAIRMAN RAPP: Thank you.

Our next question is from Representative Roae.

REPRESENTATIVE ROAE: Thank you, Madam Chairwoman.

And thank you for your testimony. You had said

that abortions -- you said something to the effect that 99 percent of them are safe, and I'm just wondering, you know, how can a medical procedure be safe if the result is always a dead baby. I mean, usually with a medical procedure, if you end up with a death that's considered to be unsafe, not safe.

MS. REED: What I can share with you is the way you stated your question was really inflammatory as you -- as I know you know. Abortion is a very safe medical procedure. In fact, one in three women in the United States have an abortion at some point in her lifetime. And it's critical and it's protected by the Supreme Court's decision in Roe v. Wade, that that is an option available to all pregnant people in the United States, if that's what they choose.

REPRESENTATIVE ROAE: Now, in the event that there's an abortion taking place and the baby is accidentally born alive, I assume you don't kill the baby. That's happened at some abortion clinics over the years where babies were killed after they were born. I assume you do not kill the baby if they're accidentally born alive. But my question is five minutes earlier you were going to kill the baby when it was inside the mom, but now that it's outside the mom, I assume you would not kill the baby. Could you explain the thought process for that?

MS. REED: What you're describing, sir, is called infanticide, and it's a crime.

REPRESENTATIVE ROAE: Right.

MS. REED: And that is not anything that a Planned Parenthood affiliate or any abortion provider would be involved with. In fact, medical doctors and other healthcare practitioners are required by their oath and their medical standards and guidelines to care for a pregnant person and an infant in an emergency situation like the one that you're describing.

REPRESENTATIVE ROAE: But one minute prior to that it's okay to kill the baby when it's still inside the mom, but once it's outside the mom it's not okay to kill the baby?

MS. REED: What I'm telling you is that when a -- in a very unlikely event that an infant is delivered, then medical doctors will do whatever they can to provide the emergency care necessary for a patient and the infant.

REPRESENTATIVE ROAE: Well, I'm going to hope that there's a lot of accidental births as abortions are taking place because I'd like to see as few abortions as possible, but thank you.

MAJORITY CHAIRMAN RAPP: Representative Owlett.

REPRESENTATIVE OWLETT: Thank you, Madam Chair.

And thank you for your testimony. I've heard you

talk at times about licensed abortion sites and health centers. What's the difference between the two and are both licensed in the state of Pennsylvania?

MS. REED: So thank you for your questions. So abortion is highly regulated in the state of Pennsylvania and the -- when we want to license a center to provide abortion care, then we're required to make an application to the Department of Health in Pennsylvania. Trained folks from the Department of Health come and look at our site, make sure that the facility meets the standards put in place by the Abortion Control Act. They look at the licensing of our staff and they look at all of our equipment and facility.

REPRESENTATIVE OWLETT: And procedures, everything?

MS. REED: And procedures, and when we have -- and they look at our patient protocols. And once that they have signed off on that, the Department of Health will provide a license to us so that we can begin to offer abortion care. Going forward, then the Department of Health comes to our clinic on an annual basis for an inspection and not only is that inspection quite rigorous, but they also come regularly for surprise inspections. And so I can say that, you know, centers that provide abortion care are very heavily regulated and monitored by the

Department of Health in this state.

REPRESENTATIVE OWLETT: So I've got a question for you. When specifically did Planned Parenthood Keystone adopt the policy to provide telemedicine abortions?

MS. REED: We provide -- started providing telemedicine abortions -- I believe it was about a year and a half ago. And that was very important additions of service delivery for our patients because, quite frankly, Pennsylvania has very few counties where abortion is provided and as you know, we have a large geography and many of our patients are from very rural areas with limited access to transportation. So that allowed us to really provide care that was necessary and to remove some barriers for our patients.

REPRESENTATIVE OWLETT: So the Department of Health is well aware that you've been providing telemedicine abortions for a year and a half?

MS. REED: Oh, yes. Absolutely. Uh-huh (affirmative).

REPRESENTATIVE OWLETT: So --

MS. REED: They reviewed our protocol and signed off on it before we ever started delivering care in that manner.

REPRESENTATIVE OWLETT: So Department of Health at our last hearing on April 8th, they were quoted as

saying at this time they do require face-to-face appointments, I believe. I don't believe we allow telemedicine abortions. I would have to double-check on that. I believe that this was a piece of legislation or policy that the Department was interested in but I don't believe that this is allowed at this time.

So my question is -- and then you were quoted in a video saying, we're also very excited to be able to offer this vital service to patients. Somebody from your staff said PP Keystone proudly provides abortion through telemedicine.

MS. REED: Uh-huh (affirmative).

REPRESENTATIVE OWLETT: So you've been doing it for a year and a half. The Department of Health is saying that it's not legal at this time. So the FDA also, prior to -- as most recently a couple of days ago, it was not allowed by FDA, that they were requiring a face-to-face in-person visit, so do you follow the FDA's guidelines or do you follow the statute and the guidance from DOH? Because it seems like there's a conflict here.

MS. REED: I appreciate your question and I can see where there's some misunderstanding in the way we're talking about this provision of care. So one, the Department of Health, as you know, the person who was testifying was new to their position and might not have been aware of all that

was being provided in the state.

But secondly, let me explain. When we began providing telemedicine abortion, we were required by the Department of Health to have a licensed provider sitting in a licensed facility, which we did, and the patient would come to another site and be connected to the doctor via a live video, right? Like Zoom, right? But this was a medically protected video conferencing service and the patient was sitting with a clinician in one of our other health centers having a live discussion with the doctor over Zoom.

REPRESENTATIVE OWLETT: So --

MS. REED: And (indiscernible - simultaneous speech) --

REPRESENTATIVE OWLETT: -- a physician is not in the room with the patient?

MS. REED: They're on video with the patient and have access to that patient's medical record. That patient's already had their required lab work. That patient's already had their informed consent. They've already confirmed their pregnancy and then the doctor is in real time having a discussion with the patient just like telemedicine that I'm sure you've probably received over the past year where you're receiving excellent quality care but through a live video feed.

REPRESENTATIVE OWLETT: So what type of training does the clinician have?

MS. REED: Well, our clinicians are licensed by the state and through their licensing organization. They go through rigorous training with Planned Parenthood at the highest levels of clinical standards and safety, and then they're, of course evaluated on a regular basis and provide excellent, excellent quality care.

REPRESENTATIVE OWLETT: So after our hearing, I did not hear any clarification from DOH that they are allowing telemedicine abortions. Did they reach out to anybody else at Planned Parenthood to clarify that with you? Because they haven't reached out to the Committee, that I'm aware of?

MS. REED: No. There was no need for them because we were certainly in accordance with Pennsylvania law on the provision of telemedicine abortion.

REPRESENTATIVE OWLETT: But not the FDA's guidance at the time?

MS. REED: That's not true. So the FDA's guidance said that the medicine, misoprostol, had to be given at the guidance of a physician and provided by the physician, and that is exactly what Planned Parenthood is doing.

REPRESENTATIVE OWLETT: So if I may, Madam Chair,

one more question?

In 2010, there were nine complications in 6,600 medical and chemical abortions. In 2019, the report said that there were 172 complications in 13,845 medical chemical abortions. When I look at the complications and procedures, medical chemical and abortions is three times higher than the next highest level, and since 2010, we've seen almost a 900 percent increase in complications in medical and chemical abortions. One of the contributing factors is the fact that we're doing medical and chemical abortions past 10 weeks, in contrast to what's recommended. Does Planned Parenthood Keystone provide medical chemical abortions after 10 weeks?

MS. REED: We provide medical abortions up to 11 weeks, which is standard practice and is certainly within accordance to instructions in the provision of safe abortion care.

REPRESENTATIVE OWLETT: Could you help us understand, the Committee, and you could do this either now or later, there's 117 past 11 weeks in the report of medical chemical abortions? So if that didn't happen at Planned Parenthood, where -- could you help us understand where that possibly could have happened?

MS. REED: I certainly cannot. I'm not familiar with those reports and could not comment on them.

REPRESENTATIVE OWLETT: Okay. We'll dig into it and figure it out.

Thank you, Madam Chair.

MAJORITY CHAIRMAN RAPP: Thank you, Representative Owlett.

Representative Frankel.

MINORITY CHAIRMAN FRANKEL: Thank you, Madam Chair.

Just for some clarification, Ms. Reed, you mentioned lab work.

MS. REED: Uh-huh (affirmative).

MINORITY CHAIRMAN FRANKEL: Do patients have to have their blood drawn --

MS. REED: They do.

MINORITY CHAIRMAN FRANKEL: -- for -- and they have -- do they have to see a provider for that?

MS. REED: Well, they can either go to a lab of their choosing or but most usually they come in and their blood is drawn by one of our medical center assistants.

MINORITY CHAIRMAN FRANKEL: So that's a prerequisite for this -- there is an interaction with a provider prior to a telemedicine prescription of medication for abortion -- medical abortion?

MS. REED: Oh, yes. They have a series of tests that are required, both blood work and urinalysis, in

addition to the informed consent that's required.

MINORITY CHAIRMAN FRANKEL: Thank you. Let me -- you know, I want to also ask you a couple of questions about privacy. Can you describe the privacy Planned Parenthood provides to patients?

MS. REED: Sure. Well, as a medical provider, we are required to abide by the HIPAA guidelines and we take it very, very seriously because our patients trust us to provide them care in a nonjudgmental confidential environment, and in fact, we require our entire staff, from my position to our administrative staff to our medical center staff, to take HIPAA training on an annual basis to make sure that our guidelines are very strict and tight.

MINORITY CHAIRMAN FRANKEL: All right. And to your knowledge, are unlicensed providers, like the ones we just heard from -- are they required to protect the privacy of patients and HIPAA, if they're unlicensed?

MINORITY CHAIRMAN FRANKEL: No. They are not. Those patients who -- or actually just say those people because they're not actually patients when they go to one of those crisis pregnancy centers, their confidentiality could be at risk.

MINORITY CHAIRMAN FRANKEL: And finally, let me ask you because, you know, obviously access is an important thing and -- what has happened to access recently and is

there enough abortion care availability in the state of Pennsylvania?

MS. REED: Well, Representative Frankel, like many healthcare providers, COVID-19 created huge challenges for the provision of care in our state and for our patients. And with the pandemic, on top of the loss of Title X funding for Planned Parenthood affiliates, access to care was severely diminished over the past few years and it has been especially difficult, again, for communities of color, for people who live in rural communities, and it's incumbent on us as people who care about the health and well-being of the Commonwealth to fully fund Medicaid to increase access to public funding and to restore family planning services for low income patients.

MINORITY CHAIRMAN FRANKEL: Thank you. Finally, I just want to note that in your opening remarks, you know, obviously we are in a pandemic, but the fact of the matter is we're in a number of different pandemics, whether it's STDs, whether it's maternal mortality. I mean, these are things, I think, that I wish our Health Committee was focusing on, and as I note, you do focus on those things because 97 percent of the services that you provide are not abortion care. They relate to many of these other issues that we're facing as multiple pandemics in our community, so I want to thank you for the work that Planned Parenthood

does in our Commonwealth.

MS. REED: Thank you so much.

MAJORITY CHAIRMAN RAPP: Thank you, Representative Frankel.

I'd like to remind the Members that we have had hearings on vaccines and the pandemic, and I'd also like to remind members of the public and the Members that during the emergency shutdowns the governor decided that abortion facilities were essential when many of our businesses and hospital procedures for other patients were deemed nonessential, so I think there was -- I don't think Planned Parenthood facilities were ignored during the pandemic. But this Committee looks at many issues during the pandemic, and we will continue to do so.

Representative Klunk, I think you are next on the list, Representative.

REPRESENTATIVE KLUNK: Thank you, Madam Chair.

And thank you, Ms. Reed, for joining us this morning. I have some questions surrounding the use of ultrasounds and sonography, which are very frequently used and quoted in the National Abortion Federation's standards. So could you walk us through when ultrasounds are used, how often they're used kind of in the course of the continuum of a pregnancy, and with a patient who might come in to seek your care?

MS. REED: Well, ultrasounds are an important diagnostic tool and we can use those ultrasounds for a variety of reasons. One is to date pregnancy. One is to rule out an ectopic pregnancy. And so we provide that tool and that information to a patient as part of the process of giving them the care that they need and require.

REPRESENTATIVE KLUNK: And so throughout the continuum of pregnancy, when are those time markers when you would be using an ultrasound in the course of care?

MS. REED: Well Representative, so Planned Parenthood affiliates in this state do not provide prenatal care. So once a pregnant patient has come in and explored options with us and made a decision to continue their pregnancy, we refer them out to, you know, an OB/GYN for prenatal care and then that kind of follow-up and ongoing review of the development would be in the hands of that provider.

REPRESENTATIVE KLUNK: So if a woman would seek your care for an abortion and that would be after, say, 14 weeks, does Planned Parenthood perform an ultrasound at that time, because that is part of the NAF standards?

MS. REED: So our affiliate does not provide abortion after 14 weeks, so you know -- so that doesn't really fall within the scope of my affiliate.

REPRESENTATIVE KLUNK: Okay. Thank you so much.

Appreciate that.

MAJORITY CHAIRMAN RAPP: Thank you, Representative.

Representative Benham.

REPRESENTATIVE BENHAM: Thank you Chairwoman.

And thank you, as well, for testifying. I'm wondering if you can talk a little bit -- you know, we're currently living in a pandemic within several pandemics. I think here about rising STIs, STDs, the maternal mortality crisis, the ongoing crisis that we see around substance use, as well. What do you see as solutions to these ongoing pandemics, particularly as it relates to care for pregnant people?

MS. REED: Well, thank you for that question. And there are a number of different pathways we can take to try to reduce STI transmission and that pandemic and to improve health outcomes for people throughout the Commonwealth. So one thing that I think is really important that we do is fully fund sexual and reproductive healthcare. That includes providers of abortion care because, as you heard from the testimony this morning, there are alternative programs that receive millions of dollars in state funds that do not provide birth control, do not counsel people according to medical standards and guidelines on how to prevent STI transmission and

treatment. And so the important thing that I think for you to know is that that funding needs to be restored to providers of comprehensive sexual and reproductive health.

Secondly, I think it's important that this Legislature look at passing comprehensive sex education legislation. In this state, there is not a mandate for sexuality education. And what we have found is when young people get age-appropriate sex education throughout their learning years that they are better prepared to make healthy informed decisions throughout their lifetime, and that's really critical.

Another area that I really want to share with you is the importance of fully funding the Medicaid budget requested. As you know, during the pandemic millions of Pennsylvanians have lost their jobs and access to insurance, and in fact our (indiscernible - recording malfunction). And so we are finding that (indiscernible - recording malfunction) are having to pay out of pocket and we are trying to get them enrolled onto the Medicaid program so there is more of a need for that safety net for the state of Pennsylvania to provide for patients to make sure that they get care that they need to lead healthy lives, they're able to take care of health concerns immediately instead of putting them off until they have reached a level that is more serious.

REPRESENTATIVE BENHAM: Thank you. I appreciate that. I'll highlight too that I do have a bill requiring comprehensive sex education, and I would encourage members of this Committee to cosponsor it. Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Members.

Ms. Reed, you're welcome to stay if we have time for following questions.

We are going to move on to Dr. Sarah Gutman.

And Representative Bernstine, you will have the first question, sir, for Dr. Gutman.

Doctor, are you with us virtually?

DR. GUTMAN: I am. Can everyone hear and see me?

MAJORITY CHAIRMAN RAPP: Yes. And if you would please raise your right hand to be sworn in.

DR. GUTMAN: Sure.

(Oath administered)

MAJORITY CHAIRMAN RAPP: Okay. And you may proceed. If you could keep --

DR. GUTMAN: Thank you.

MAJORITY CHAIRMAN RAPP: -- a little bit of your introduction, we would like more time (indiscernible - voice lowered). We have a long list of questioners and -- or if you could be brief we'd really appreciate it.

DR. GUTMAN: Absolutely. I have very brief remarks. I did just want to say good morning both to the

House Health Committee and to people across the Commonwealth who are tuning in today. Just quickly, before I introduce myself, I wanted to thank Chairman Dan Frankel, as well as yourself, Chairwoman Kathy Rapp for allowing me to provide testimony today.

My name is Sarah Gutman. I am an obstetrician/gynecologist. I'm currently in a complex family planning fellowship at the University of Pennsylvania. I completed a Master of Science in Public Health at the Johns Hopkins Bloomberg School of Public Health in 2012, and a residency in Obstetrics and Gynecology at the University of Pennsylvania in 2020. I'm currently a member of ACOG, the American College of OB and GYN. I'm here to share with you my clinical expertise and my knowledge around abortion access and the care I provide to women in Pennsylvania.

The testimony I'm providing today, it is my own. It's not on behalf of the University of Pennsylvania nor am I speaking to institutional policies or practices. I'm here today because I believe that all people deserve access to the full range of sexual reproductive healthcare options, which includes abortion care. I provide abortion care because as an OB/GYN I see daily how deeply personal decisions are about reproductive health and pregnancy. I know it's my job to help my patients understand and access

all of their options.

Whether my patients are ready to build a family, already parenting, striving to make ends meet, or focused on their education or career, my patients share something in common. They are making thoughtful, sometimes difficult decisions about their health, well-being, and future. What is sometimes hard to fathom is that while I have the honor and privilege of providing quality and essential sexual reproductive healthcare for many, there are people throughout the state who face barriers that make accessing care extremely difficult or downright impossible. Systemic barriers including income, lack of access to transportation, they disproportionately affect Black, indigenous, people of color, the LGBTQ+ community, people with low incomes, and young people. Legislation that puts an additional barrier between myself and my patients does not protect them or their families.

I really appreciate the opportunity to speak with everyone today and I welcome any questions that you have.

MAJORITY CHAIRMAN RAPP: Thank you, Doctor, and we're going to go down the list from the previous testifier.

And the first question will go to Representative Bernstine.

DR. GUTMAN: Absolutely.

REPRESENTATIVE BERNSTINE: Thank you, Doctor, and thank you for taking time out of your schedule to be here today. A couple quick questions for you. Number one, do you -- what date do you provide abortions up to?

DR. GUTMAN: Sure. I provide abortions up through the gestational age limit in Pennsylvania, which is to -- through 23 weeks and 6 days.

REPRESENTATIVE BERNSTINE: Okay. Can you describe specifically what happens, and I would assume that's a D&E, right?

DR. GUTMAN: Yeah.

REPRESENTATIVE BERNSTINE: Okay. Can you describe that specific process for me?

DR. GUTMAN: Sure. Absolutely. So a D&E is a surgical procedure that's typically done in the second trimester of the pregnancy. Our patients, they come in. They see us in the office. We first have an in-depth counseling session with them, so we talk to them about all of their options including adoption and parenting. We talk to them about the risks and the benefits of the procedure. The procedure itself is typically done in an operating room. The patient receives anesthesia. We help to open the patient's cervix. Then we remove all the products of conception and the pregnancy.

REPRESENTATIVE BERNSTINE: Okay. So then you go

in and then how do you get the fetus out? How does that work?

DR. GUTMAN: I'm sorry. There's a little bit of feedback on your microphone.

REPRESENTATIVE BERNSTINE: Yeah. Sorry. They give me the bad microphone, so. That's how the Chairwoman shuts me up. Is that better?

DR. GUTMAN: That's a little better.

REPRESENTATIVE BERNSTINE: All right. So how do you get the fetus out?

DR. GUTMAN: So we use various instruments to remove the fetus.

REPRESENTATIVE BERNSTINE: Such as what?

DR. GUTMAN: We use forceps, typically, but there's different types of those, as well.

REPRESENTATIVE BERNSTINE: All right. So you take those; you stick it up there; you pull it apart, suck it out; is that kind of the process?

DR. GUTMAN: I certainly wouldn't describe it in that language. I think that --

REPRESENTATIVE BERNSTINE: How would you describe it?

DR. GUTMAN: So I would tell the patient that we -- after opening her cervix, that we use instruments including a combination of the forceps and the suction to

remove the pregnancy. We always handle pregnancy tissue with a lot of respect.

REPRESENTATIVE BERNSTINE: Wow. So you go up there; you pull it out. Does it come out limb by limb? Does it come out all in one piece? How's that come out?

DR. GUTMAN: It typically comes out in pieces, fragmented.

REPRESENTATIVE BERNSTINE: In pieces, okay. Any particular part -- right arm, left arm, all of it together? Some of them are crunchied in the -- I mean how's this?

DR. GUTMAN: I really disagree with the way that you're characterizing it?

REPRESENTATIVE BERNSTINE: I'm just -- I'm trying to understand.

DR. GUTMAN: Yeah. I am happy to talk to you about the medical aspects of it, but I feel like you're describing it in a way that's intentionally meant to provide an image that isn't medically accurate. We do --

REPRESENTATIVE BERNSTINE: But I'm asking you to provide the image. I'm asking you to --

DR. GUTMAN: Sure.

REPRESENTATIVE BERNSTINE: -- share --

DR. GUTMAN: Sure.

REPRESENTATIVE BERNSTINE: -- with me the image.

DR. GUTMAN: Absolutely. So we use instruments

under ultrasound guidance so that we can see that we're being safe, that we're taking great care, and as we remove the pregnancy it does come out in parts but it -- every procedure is different.

REPRESENTATIVE BERNSTINE: Okay. Well, thanks. What I'm also going to do is I assume we'll have your email address on here or I'm sure I can get it online. And you said that you bring them in and you talk about the options for abortion, parenting, and adoption; is that correct?

DR. GUTMAN: That's correct.

REPRESENTATIVE BERNSTINE: Okay.

DR. GUTMAN: We talk about all pregnancy options.

REPRESENTATIVE BERNSTINE: Fantastic. So I'm going to send you my personal email address later and I'm going to copy my wife in on the email, and I'm going to tell you right now, if you have somebody that wants to give their child up for adoption, is looking for something, we'll take it. So you'll receive an email from me in the next 24 hours. You'll have all of our information including my cell phone number, and you can reach out to us at any time or if there is anyone else that is even considering that I will personally and we will personally find parents for these kids that want to be put up for adoption.

DR. GUTMAN: Well, I appreciate having your

contact information.

REPRESENTATIVE BERNSTINE: Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Representative.

Representative Borowicz.

REPRESENTATIVE BOROWICZ: I waive off. That -- my question was for Planned Parenthood before.

MAJORITY CHAIRMAN RAPP: That's okay. You can go ahead.

REPRESENTATIVE BOROWICZ: Okay. So they have state inspections also?

UNIDENTIFIED VOICE: (No audible response).

REPRESENTATIVE BOROWICZ: Okay.

Could you please walk us through the inspection process that you go through by the state?

DR. GUTMAN: As a clinician, I don't think I'm the best person to walk you through that but I'm happy to have you get in touch with the administration at our clinic if that would be helpful to you.

REPRESENTATIVE BOROWICZ: Okay.

MAJORITY CHAIRMAN RAPP: We'll hold you, Representative, if we have time (indiscernible - simultaneous speech).

REPRESENTATIVE BOROWICZ: Okay. Yeah, because it was specific to Planned Parenthood.

MAJORITY CHAIRMAN RAPP: I'll just take your time then and ask.

I do have the article that you wrote in regard to Representative Ryan's bill, and I'm just going to quickly ask one question. This would --

DR. GUTMAN: Sure.

MAJORITY CHAIRMAN RAPP: -- this is a bill and it's been stated by others that these bills are a waste of time and -- but this bill particularly, that you wrote an opinion on was Representative Frank Ryan's fetal remains bill where, simply, the bill said that if the parents choose and request the remains of their unborn child that they should have the ability to have the remains of that child and you wrote an article disagreeing, obviously, with the bill. So could you describe to me how you dispose of remains? If --

DR. GUTMAN: (Indiscernible - simultaneous speech) --

MAJORITY CHAIRMAN RAPP: -- if you don't want the parents to have the remains, what is the procedure to dispose of remains?

DR. GUTMAN: Well, just to clarify, I'm absolutely not in opposition of the parents having the remains if that's what they would wish. What I'm in opposition to is to mandate or to legislate that we have to

do the same process for all products of conception, regardless of gestational age.

MAJORITY CHAIRMAN RAPP: And that was not -- that is not the content of the bill. The bill says that if the parents choose to have the remains that they have the right to request and --

DR. GUTMAN: Which they already have.

MAJORITY CHAIRMAN RAPP: -- their request should be given. But -- so I'm asking you if the parents can't have the remains, what do you do with fetal remains; how are they disposed of?

DR. GUTMAN: Sure. So parents can absolutely have fetal remains. We have this conversation with our patients all of the time. It is part of our practice to help patients, to help parents feel like they are being taken care of and that we are meeting all of their needs including with fetal remains disposal. There already are legislative practices in place in Pennsylvania about how fetal remains are disposed so that can be done through the hospital or can be done through a private burial service, if that's what the parents prefer, but that's something that's already in practice in our -- within our clinic.

MAJORITY CHAIRMAN RAPP: Okay. It's actually not through legislation but -- so a lot of hospitals will just have the remains picked up by a medical waste company. But

what would most hospitals, what would most abortion providers do with the remains; how are they disposed of?

DR. GUTMAN: I don't know that I can speak for all abortion providers but I do know that at the -- our hospital it depends a little bit on the gestational age but that the parents are always -- or the patient is always involved in the decision-making process and most of my patients opt to have the hospital dispose of the remains and they do not want the extra emotional burden of having to make that decision.

MAJORITY CHAIRMAN RAPP: Do you -- at this time, do you sell any fetal tissue to any medical researchers?

DR. GUTMAN: We never sell any fetal tissue. There are -- is medical research that goes on.

MAJORITY CHAIRMAN RAPP: And how do you -- do you have to obtain consent from the mother?

DR. GUTMAN: Of course.

MAJORITY CHAIRMAN RAPP: What's the process?

DR. GUTMAN: So there are research coordinators who are deeply involved in that process. The patients are approached and discussed what the study is. They provide informed consent and they are able to decide if they would like to participate.

MAJORITY CHAIRMAN RAPP: Thank you.

Representative Cephas. Make sure I'm reading the

name correctly.

REPRESENTATIVE CEPHAS: Thank you Chairman -- Chairwoman, sorry.

And thank you, Doctor, for your testimony today. I just want to follow up on some of my other colleagues' lines of questioning in reference to the multiple pandemics that we are experiencing right now. So it's been made mention the pandemic of COVID-19, the opioid pandemic, as well as maternal mortality, which we know is all trending in the wrong direction. Data shows, and this was mentioned during some previous testimony during this process -- the data has shown that facilities that offer abortion care and access are on a downward trend. Over, you know, a decade or two, we've gone from 145 clinics down to 17, while crisis pregnancy centers are on the rise.

Again, during these hearings, one of the previous testifiers mentioned in other states like Texas, there's been a direct correlation between decrease in abortion care and access to contraceptives to a rise in the maternal mortality rates. Can you talk broadly about the adverse health effects to maternal health as it relates to the decrease in this type of access and care?

DR. GUTMAN: Yeah. Absolutely. Thank you for that question. It is absolutely factual. It is just 100 percent indisputable that decreasing access to abortion

care and to comprehensive reproductive healthcare increases maternal mortality and increases bad outcomes for patients, for women. So it's incredibly important that patients have this available, and I agree with you, it is something we need to pay close attention to because as access decreases in Pennsylvania, I think we will see that maternal morbidity/mortality, that unfortunate outcomes go up.

REPRESENTATIVE CEPHAS: Thank you for that. And several other providers mentioned that 97 percent of the care that they do provide are outside of the realm of abortion, and you know, one of the things that remains critical as we see our maternal mortality rates increase -- it's increased by 21 percent over a five-year period, it's critical to note that some of the correlations to those deaths have been limited access to prenatal care, limited access to contraceptive care, and as we look to reverse, again, this pandemic that we're dealing with currently, it's essential that providers, like yourself, are both supportive but then also that you are protecting life in a holistic way. So I appreciate all the services that you provide, not just for that one moment in time with a difficult decision but the holistic care that you provide for families, so thank you again.

DR. GUTMAN: Thank you.

MAJORITY CHAIRMAN RAPP: Thank you,

Representative.

Representative Frankel?

MINORITY CHAIRMAN FRANKEL: Thank you, Dr. Gutman. Really greatly appreciate you being here and offering your testimony and perspective. One of the things that we had heard about earlier this morning and in our previous hearing is of the practice of abortion reversal. Can you talk a little bit about the science and the medical data around that issue and that treatment?

DR. GUTMAN: Absolutely. And thank you for bringing it back up because I would love to clarify some things that were said earlier. The practice of abortion reversal, it is not scientifically credited in any way. There are no clinical trials demonstrating that it is safe or effective. The medication abortion process, it involves two medications, as has previously been stated, mifepristone and misoprostol. There is no data that providing progesterone after administration of mifepristone will reduce abortion rates or will help protect women and I think providing women with that as an option are sort of giving people a false premise that that could -- is something that might work for them is bad medical information and puts women at risk.

MINORITY CHAIRMAN FRANKEL: (Indiscernible - audio interference) you. Here -- let me -- one quick other

question that Erika asked me to look into. You know, we've -- medical abortions -- we've heard medical abortions having greater complications. My understanding is that some remaining placenta may be both common in both medical abortion and pregnancy, and doctors aren't clear that this is likely a complication. Can you comment?

DR. GUTMAN: Yes. I definitely agree with that. So whenever -- I'm sorry, there's some noise in my background. Whenever we talk to a patient about the informed consent process of a medication abortion, we review with them that there is a small chance that there may be some (indiscernible - audio interference) tissue that would require a second procedure. It is always discussed with them at the beginning. It is uncommon but they know that it can happen and typically it is something that is quickly resolved.

MINORITY CHAIRMAN FRANKEL: Thank you, Dr. Gutman. Appreciate it.

DR. GUTMAN: Thank you.

MAJORITY CHAIRMAN RAPP: I'm going to go to Representative Lewis.

But I just wanted to ask a quick question, especially when we're seeing the chemical abortions because in Abortion Control Act, it does specifically request -- or under the law, a pathological exam of abortions so that the

woman, the doctor can feel confident that all the contents of the womb have been emptied. So I do have a question on how -- how does that happen during a chemical abortion, a pathological exam? It doesn't seem like too many women are going to want to be bringing in their aborted unborn child for a pathological exam.

DR. GUTMAN: So typically the process for a medication abortion is that the patient comes in for either a telehealth or for an in-person exam following a termination and so they have a physical exam or they have a description with a physician of the process.

MAJORITY CHAIRMAN RAPP: Thank you.

Representative Lewis.

REPRESENTATIVE LEWIS: Thank you, Madam Chair.

Thank you, Dr. Gutman, for taking the time this morning to testify. I have -- I just want to switch gears a little bit here and talk about minors who are seeking abortions and what measures are being taken in the profession right now to protect minors. And specifically, at the prior hearing we had heard testimony about girls as young as 12 seeking abortions in Pennsylvania, and our research actually shows this is an annual reoccurring problem with sometimes as many as 10 girls in a given year under 12 -- or 12 or under having abortions in the Commonwealth. Since this is clearly a crime -- I mean,

these are children, there's no way to -- there's no way whatsoever to give consent, could you tell us what your practice -- what you do to protect these victims, these minors.

DR. GUTMAN: Sure. Absolutely. And this is clearly something that's very important to us, to myself as a physician and as a mother. We take many steps to protect these patients. It is already legislated in Pennsylvania that a minor needs to have parental consent or judicial bypass in order to obtain a termination procedure, which we adhere to. We also, if there is any concern at all for sexual abuse or trauma, that gets reported. We're mandated reporters to the ChildLine Service.

REPRESENTATIVE LEWIS: Thank you. And I assume then, and can you just confirm that if a 12-, 13-, 14-year-old girl comes in for an abortion procedure, they are automatically presumed to be victims of a crime and therefore a report happens?

DR. GUTMAN: It is always investigated, so I would say we always talk to that patient. We always get the full information. If there is any doubt or any concern then a report happens.

REPRESENTATIVE LEWIS: Okay. Would -- question for you, just for your opinion, would you support legislation that requires a showing of a report to law

enforcement or ChildLine that corresponds with each abortion on a child that's 12, 13, or 14 years old?

DR. GUTMAN: No. I don't believe I would support that legislation. I think that it adds additional barriers to people providing care and it might inhibit people from seeking out care that they needed.

REPRESENTATIVE LEWIS: Okay. Do you have an internal, let's call it a red flag system, to indicate concerning behavior and specifically we're talking about a lot of these children are victims of human trafficking and that's kind of the big issue that many times when these reoccurring cases happen where a child is seeking an abortion, this is clearly a victim of human trafficking. Are there any red flag systems that to you indicate concerning behavior that would show that they're possibly victims of crimes, like human trafficking or incest or something along those lines?

DR. GUTMAN: Well, it is something that we certainly talk about, we receive training in. We definitely are aware of the potential risk of human trafficking and if we have concerns we absolutely report them.

REPRESENTATIVE LEWIS: Thank you. Would you be supportive of legislation and/or do you have any thoughts for us, because obviously we're looking at this issue

holistically and trying to find good public policy to advance, and so would you support legislation or have any thoughts on requiring a system to help identify and protect these little girls from these behaviors which are resulting in the unintended and unwanted pregnancies in the first place?

DR. GUTMAN: I think I would need to know a lot more about the legislation before I'd be able to tell you if I could support it or not.

REPRESENTATIVE LEWIS: Fair enough. And do you have any professional thoughts on this as far as, hey, here's some suggestions for the Committee on legislation we may want to look at as far as helping providers identify when -- I mean, to me it's a no-brainer. If someone's 14 and they're seeking an abortion, clearly they're a victim of a crime and some report has to be made and some intervention has to take place to protect them from another crime happening to them. But do you have any thoughts on this, as a provider, saying, hey, here's some ideas for the Committee. And if you don't -- and I know I'm putting you on the spot, so can you maybe think about that and provide us with some suggestions on how to help these victims who clearly are the victim of a crime?

DR. GUTMAN: I would be very happy to collaborate that -- on that and to think about it, and I'm happy to

provide my contact information after the hearing so that we could be in touch.

REPRESENTATIVE LEWIS: Thank you, Doctor.

And Madam Chair, I have no further questions. Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Representative.

Representative Krajewski.

REPRESENTATIVE KRAJEWSKI: Thank you, Madam Chair.

Thank you, Dr. Gutman, for providing your testimony and for providing safe and accessible reproductive healthcare. This is particularly important to me because University of Pennsylvania is in the 188th District, so I thank you for providing care to our community. My question is -- you know, there's been a lot of focus in the lines of questioning so far about the risks of terminating a pregnancy, but could you speak more about the dangers and risks associated with restricting abortion access, whether that's physical risk to health, mental health, or even any other socioeconomic or social-determinate risks to restricting abortion access?

DR. GUTMAN: Yeah. Absolutely. I think that it has been shown over and over again that legislation that restricts access to abortion is ineffective and actually

just increases harm to patients. Restricting abortion does not decrease abortion but it makes it less safe. It means that there's delays to when women can access abortion care and they access it later in pregnancy. So I completely agree with you, there are a lot of harms that can come from making it more difficult for women to access safe and legal abortion, which is what people need.

REPRESENTATIVE KRAJEWSKI: So thank you. I just want to read off a few other stats that I have here, which women denied an abortion had four times as many odds of having a household income below the federal poverty level and three times greater odds of being unemployed. I've also read studies about increased mental health issues, depression, anxiety, so I think this is something that we really need to be thinking about when we talk about these issues.

And then my quick other follow-up for you is what do you think are the most challenging issues facing the patients that you see that seek abortion care?

DR. GUTMAN: Yeah. It's a really good question. So the patients that come to me, they are mothers. Many of them are already mothers. They are patients who are facing financial constraints. They are facing difficult decisions in the era of a -- particularly in the era of a pandemic. They are trying to make the best decisions they can for

themselves and for their families. There's lots of studies that show women who seek abortion, they don't do it because they're selfish. They do it because they're selfless and they're trying to do what is right for their families. So I think that they -- every woman is unique and they -- and every pregnant person is unique and they face all sorts of barriers but in the end they are making a really thoughtful decision about what is best for their families.

REPRESENTATIVE KRAJEWSKI: Thank you, Doctor. Just in closing, I'll say if all of these, just to raise the points and statistics raised by my colleague, Rep. Cephas, Black women are always the most impacted and most affected by these issues, and we should always be thinking about this when we talk about these policies. Thank you.

DR. GUTMAN: Absolutely. Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Doctor.

Representative Bonner.

REPRESENTATIVE BONNER: Thank you, Madam Chair.

Thank you, Doctor, for your time and your testimony today. My first question, at what point in time do you believe that the fetus will feel pain?

DR. GUTMAN: Thank you for the question. I know that this was brought up in the prior hearing, as well. I think that the science and the data that we have available tells us that a fetus cannot feel pain until late into the

third trimester, so I do not believe that these procedures cause a fetus any pain.

REPRESENTATIVE BONNER: I'm sorry, you said late in which trimester?

DR. GUTMAN: The third trimester.

REPRESENTATIVE BONNER: Third trimester? So you feel there's no pain felt by the fetus prior to that time?

DR. GUTMAN: Correct.

REPRESENTATIVE BONNER: How would you know that?

DR. GUTMAN: So there are some -- I'm not a maternal fetal medicine specialist but I do know that you had one who was able to testify previously, so I'm sure that they were able to provide more details than I can, but I do know that there are animal models -- that there are models looking into this, and there's an understanding of fetal development and the development of nerves in the brain cortex that tell us that it's not possible.

REPRESENTATIVE BONNER: If you felt that the fetus was detecting pain at the time of the performance of your procedure, what could you do to address that pain issue?

DR. GUTMAN: I think that that question is difficult to answer because I just don't believe the premise is true. I don't believe that fetuses feel that pain.

REPRESENTATIVE BONNER: Why not err on the side of addressing pain, even if there's a slight potential?

DR. GUTMAN: I certainly hear you in that if there was a potential, sure, we should err on being cautious, but I disagree that there is that potential.

REPRESENTATIVE BONNER: Okay. The procedure that you have described, and I don't mean in any way to be aggressive or distasteful, but is there any other way to approach this procedure by having the fetus not experiencing life or life sensations prior to what you're doing?

DR. GUTMAN: I'm not entirely sure what you mean by life or life sensations.

REPRESENTATIVE BONNER: Is there any way to totally desensitize the fetus prior to the procedure that you're performing?

DR. GUTMAN: I -- at this point in their gestational age, the fetus -- it's not sensing so I think that that's unnecessary.

REPRESENTATIVE BONNER: Okay. My final question, under what circumstances would you not report a pregnancy to ChildLine or a child that was 12 or 13, 14 years of age?

DR. GUTMAN: I think that is a really difficult hypothetical answer -- question, but I can just reiterate that we take issues of possible sexual abuse and possible

rape incredibly seriously. I -- like I said, I myself am a mother. I care about these issues. If there is any concern, we certainly report it.

REPRESENTATIVE BONNER: Wouldn't you have a concern automatically with --

DR. GUTMAN: Of course.

REPRESENTATIVE BONNER: -- a child 12 to 14 years of age?

DR. GUTMAN: Of course. It's always part of the conversation that we have and it's always part of the informed consent process, regardless of the patient's age, to determine that intercourse was consensual and that a patient is not in any danger.

REPRESENTATIVE BONNER: I've been a prosecutor for nearly 20 years, and I'm trying to think of any circumstance where the law would not require you to report the pregnancy of a 12- to 14-year-old child, and I just can't think of one. I was just hopeful you could give me one example where you would not report it to ChildLine?

DR. GUTMAN: I think it is difficult to come up with hypotheticals but I can tell you that of the patients that I have seen, the -- we take a lot of care into talking to them, to getting their full history, to understanding their lives. If there are concerns, we absolutely report them. But I think, as you can probably understand as a

prosecutor, it would be dishonest of me to ever say never -- 100 percent, things don't happen (indiscernible audio interference).

REPRESENTATIVE BONNER: So there --

DR. GUTMAN: But I --

REPRESENTATIVE BONNER: -- so there are occasions where you have not reported the pregnancy of 12- to 14-year-olds?

DR. GUTMAN: I don't know of any specific examples of that in my practice, but I just can reiterate again that we take this seriously and that we absolutely have our patients' best interest, and we report anything that we find concerning.

REPRESENTATIVE BONNER: Thank you, Doctor. Appreciate your time and testimony.

DR. GUTMAN: Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Doctor.

And we'll be going to Representative Owlett.

REPRESENTATIVE OWLETT: Thank you, Doctor. And thank you for your testimony and being here today. Do you -- I asked Planned Parenthood Keystone if they are doing medical chemical abortions past 10 weeks and they said they were not. Are you doing or providing medical chemical abortions past 10 weeks?

DR. GUTMAN: We provide medical abortions through

70 days of gestation. I think the terminology is a little challenging because there are times when we might provide an induction for a patient who desires it, but that's typically not the same procedure that you're describing.

REPRESENTATIVE OWLETT: Okay. So help me understand the 177 -- or 117 past 10 weeks. Where is that happening? How does that happen? Why is it considered a medical chemical abortion and why are we doing them past 10 weeks?

DR. GUTMAN: You know, I'm not sure. I'm not -- I heard you mention that statistic, but I can only speak for my own practice so I'm not sure what that was categorized as or what those specific examples were.

REPRESENTATIVE OWLETT: But you would support not doing them past 10 weeks?

DR. GUTMAN: So I would -- I want to be careful in saying that there's a medication termination with mifepristone and misoprostol is what I would consider a medication abortion and that is through 70 days of gestation and we -- or there is a lot of data showing that it is safe past that but that's typically what we use. And then there are other procedures further along in gestation that would be with different medications.

REPRESENTATIVE OWLETT: And do you do telemedicine abortions?

DR. GUTMAN: We use telemedicine as part of our provision of abortion care.

REPRESENTATIVE OWLETT: How long have you been doing those?

DR. GUTMAN: I believe that it has been happening since the beginning of the COVID-19 pandemic --

REPRESENTATIVE OWLETT: So --

DR. GUTMAN: -- to provide patients with a sort of safer way to access care.

REPRESENTATIVE OWLETT: -- so prior to that you were not doing any telemedicine abortions?

DR. GUTMAN: I believe that's --

REPRESENTATIVE OWLETT: So a little over a year ago -- March-ish, last year?

DR. GUTMAN: I believe that's correct. I would have to look into -- or ask the clinic administration to be sure that's right.

REPRESENTATIVE OWLETT: That would be great if you could let us know.

And my last question is you talked about ongoing studies about pain and it must be there's some sort of a conflict here as to whether or not -- and we heard it in our last hearing. Some are saying it's possible. Some are saying it's not possible. Why would we not want to error on the side of caution here and make sure that these

fetuses are not experiencing pain? Why would we -- I mean, wouldn't that be a horrific feeling as somebody who's providing these abortions that to -- that it's even possible that we are -- we have studies going on?

DR. GUTMAN: I don't want to spend a lot of time sort of belaboring a point that was discussed in a prior hearing and that's -- as a -- I'm not a maternal fetal medicine specialist, but as I said before, all of the data that I personally have seen and all of the information that I feel comfortable with and understand is that there is no perception of pain during these procedures.

REPRESENTATIVE OWLETT: So if one of these studies comes out and shows that they do, that would change your perspective on it?

DR. GUTMAN: I would certainly want to look at the data and understand the research better.

REPRESENTATIVE OWLETT: Okay.

I appreciate the time and I think this will probably be my last line of questioning, Madam Chair, but I -- just in closing, I -- there's really -- we would be approaching these conversations in completely different ways. One side sees it as a human being and a life and one side doesn't, and that's the conflict that we're dealing with because if we all saw it as a life we would probably be approaching everything a little bit differently, at

least I hope we would. And I personally see this as a life. It's a human being that needs to be valued and that's my perspective and I think it's important to recognize that that's the struggle that we are having here in these hearings and these conversations. But I personally see it as a human being, as a life, that deserves value and respect and honor.

And I appreciate you taking the time to be here, and I really do appreciate the Chairman providing an opportunity to have these hearings where we can really highlight the importance of life and what is really going on, specifically, in these reports that have a lot of us very concerned.

But thank you Madam Chair.

And thank you for being here, Doctor.

DR. GUTMAN: Thank you.

MAJORITY CHAIRMAN RAPP: Representative Schemel.

REPRESENTATIVE SCHEMEL: Thank you, Madam Chair.

Thank you, Doctor. Doctor, you -- one of the things I really get from your testimony today is the amount of time that it sounds as though you spend with patients counseling them. You're certainly in a unique position to do that. You describe the process of women choosing to terminate their children. You say it is hard. It is gut-wrenching. You also describe the fact that you treat the

product -- what you term the product of conception or fetal tissue during the abortion with respect. And interestingly, during Representative Bonner's questioning, you indicated that if there were proof that a fetus could feel pain during an abortion that you believe that is something that should be addressed. So given that, I would --

DR. GUTMAN: Uh-huh (affirmative).

REPRESENTATIVE SCHEMEL: -- say that you must recognize or acknowledge there's something unique about the fetus as opposed to perhaps the product of other -- other tissue within the body, like an appendix if -- during an appendectomy. So with that, I mean, what do you believe that uniqueness of the fetus is? Why are these decisions hard and gut-wrenching? Why would we treat the fetus with pain if we believe that the fetus -- you know, could feel pain? Why do we treat fetal remains with respect? As a physician who counsels women in these matters, you know, why do we do that and what do you believe that means?

DR. GUTMAN: So I appreciate your question and I think it is a really complex one that it is important to think about -- excuse me, as a provider. I want to just state that this decision is not always gut-wrenching and difficult; sometimes it is. But every woman is different, and I think in the end what matters is the patient -- the

pregnant person who is in front of me and their health, their well-being, and their desires to continue a pregnancy or not, and I'm here to support them and not to impose my own personal belief system onto that person.

REPRESENTATIVE SCHEMEL: Okay. So when you say that you treat the product of the conception as you're aborting -- performing the abortion with respect, you're doing that just out of deference to the patient in the event that the patient is having -- believes this to be a difficult decision that they're making?

DR. GUTMAN: I think that's a difficult question to answer. I think that it is both, coming from myself and for the patient's perspective, but I think that the end result is that this is up -- this is the patient's life and the patient's decision, and it's my job to sort of help them reach all of their options, and I feel completely comfortable with the work that I am doing.

REPRESENTATIVE SCHEMEL: Okay. And one last question, and I acknowledge this is a bit philosophical but you're a physician and you're involved in this industry. When do you believe that life actually begins? And this is not entirely philosophical because you are actually engaged in terminating a pregnancy, but when do you believe that life actually does begin and when should we recognize the personhood of the product of conception?

DR. GUTMAN: I agree with you, that is a philosophical question and I'm here today to sort of speak as a physician and as a scientist. But my overarching answer is that it's very complicated and that there are a lot of different factors, but I do not believe that it's our job to impose what we believe life begins onto other people. I think --

REPRESENTATIVE SCHEMEL: Sure. You perform abortions up to 23-1/2 weeks, so I presume that you do not believe that life begins before 23-1/2 weeks?

DR. GUTMAN: I don't think I can answer that because I think every single situation --

REPRESENTATIVE SCHEMEL: You're a physician that -- you're a physician. You're a very knowledgeable woman. You're a physician. You perform abortions up to 23-1/2 weeks. I -- you are knowledgeable about the product of conception and the fetal development of the child up to 23-1/2 weeks because you physically see it when you perform the abortions and reassemble the body parts following the abortion, so I assume that you must not consider a fetus at age 23-1/2 weeks to be a person and that to be a life?

DR. GUTMAN: I think that every individual circumstance is unique and I think it is impossible to paint every person with one brush, and I think that there are --

REPRESENTATIVE SCHEMEL: So if someone -- if say, the mother, since you put the decision entirely upon the mother, if the mother considers that to be a life and the life of this individual -- that this perhaps this proto-person, you might say, is determined by someone else, by the mother, makes the determination as to whether the unborn child or the product of conception or fetal tissue is a life or is not a life? You're saying as a doctor you don't make that determination?

DR. GUTMAN: I'm saying as a doctor that I provide an essential service which is abortion care up through the legal gestational age limit in Pennsylvania. And I think that we can all agree that our -- the end goal of this Committee and of myself is to provide women with safe access to medical care, and that's what I'm doing.

REPRESENTATIVE SCHEMEL: Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Representative.

Representative Borowicz.

REPRESENTATIVE BOROWICZ: Yes. Thank you, Doctor.

Thank you, Chairwoman.

I know you explained, as Representative Schemel just talked about, which sounded like a dismemberment abortion, which is, you know, horrifying to me up to 23

weeks. We know that many 21-week babies have made it and lived, and I agree with Representative Owlett. You know, from the moment of conception we believe there's life. And so I just -- my question is and, you know, I listened to -- sorry, I wanted to add one more thing -- Abby Johnson, who worked in the abortion industry and walked away after witnessing one of these procedures that you explained, which is pretty horrifying if we lay it out there how it happens.

And I just wanted to know because I just want to expose things that go on, you know, that people in America really don't -- you know, we've turned a blind eye to 61 million babies -- 61 million lives, and we've turned a blind eye to it for many years now. So I just wanted people to know what's the process of disposing the remains of that child?

DR. GUTMAN: So I think that what you're asking is what is the current process in place for fetal remains disposals?

REPRESENTATIVE BOROWICZ: Correct.

DR. GUTMAN: Correct, which I have answered before, which is that the pregnant person is always involved in the decision, that they are offered the chance to have a private burial or to have the remains released to them if they would like. If not, they are offered a

service through the hospital for a cremation.

REPRESENTATIVE BOROWICZ: Okay. And if they choose not to have those, then how do you dispose of that life?

DR. GUTMAN: The hospital helps to arrange a cremation with a service.

REPRESENTATIVE BOROWICZ: Okay.

MAJORITY CHAIRMAN RAPP: Thank you, Representative.

Representative Frankel, I believe you have some ending remarks --

MINORITY CHAIRMAN FRANKEL: I want to --

MAJORITY CHAIRMAN RAPP: -- for Dr. Gutman.

MINORITY CHAIRMAN FRANKEL: -- I have -- I just want to clarify one area that was discussed earlier. So the idea of fetal anesthesia, we heard from a surgeon in the last hearing that -- if something like that were to be used would cause tremendous risk for the mother. So I'm wondering, is it ever appropriate to take that type of risk on a hypothetical with respect to pain?

DR. GUTMAN: No. It's not. And I agree with you and with the testimony that was previously provided, both by the fetal surgeon and by the maternal fetal medicine specialist that not only is the risk not worth it, it's also not indicated based on all of the science, all of the

data that we have.

MINORITY CHAIRMAN FRANKEL: Okay. Thank you, Dr. Gutman. I really appreciate your thoughtful and patient testimony and response to our questions today. Thanks so much.

DR. GUTMAN: Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Representative Frankel.

And Dr. Gutman, and I know you've had some tough questions today and I appreciate you coming to this Committee, and we know in this Committee that we deal with some tough issues. We try to be as respectful as we can, but that's always, you know, everybody's -- the perception.

I do have one last question for you, and it does regard the commentary on Representative Ryan's bill. You seem to have a concern that the bill -- how the bill defines and the term unborn child. When -- are you aware that the term unborn child is used throughout the Abortion Control Act and the term unborn child has withstood court challenges previously and why do you think that that term should be changed? Because the term unborn child has been -- the Abortion Control Act has withstood the test of Supreme Court challenges, so I have some concerns of why you would be -- are you opposed to the term unborn child? Just your comments, because that is used in the Abortion

Control Act throughout.

DR. GUTMAN: Sure. Yeah. And I am very aware of the Abortion Control Act and the use of the term. I think that the term is not a medical term. It's not -- it can be misleading. I think that it is intended to prevent people from seeking access to safe abortion care. I think that in the context, especially the Fetal Remains Bill, it's used to describe any product of conception, which I think is just overreaching and doesn't describe the full depth of what happens in pregnancy.

MAJORITY CHAIRMAN RAPP: So if we were talking about animals and a dog was pregnant with puppies, would you say that they're pregnant with unborn puppies? What term would you use for unborn puppies?

DR. GUTMAN: I'm not a veterinarian. I'm an obstetrician. So I think that is a difficult question for me to answer. I certainly wouldn't refer to somebody's life-threatening ectopic pregnancy as an unborn child so I think there is a lot of nuance that using that term just does not give justice to.

MAJORITY CHAIRMAN RAPP: Well, I do know that the Supreme Court has disagreed with you and that was back in 1980s. So again, Dr. Gutman, I do appreciate -- I know these are difficult questions. You've answered honestly and I very much appreciate that. If you would like to stay

for the next testifier, you're more than welcome to if we have any further questions.

And so thank you so much. I know you have a very busy schedule and if we have further questions we will try and email them to you, as we have with our other testifiers and we can get more answers from you, hopefully. Thank you so much for being here today.

DR. GUTMAN: I'm happy to be a resource and to be available.

MAJORITY CHAIRMAN RAPP: Thank you.

So at this time, Members, our next testifier is Genevieve Plaster, who is the Deputy Director for Policy and Administration with the Charlotte Lozier Institute.

Ms. Plaster, you may go ahead, give us a little bit of background, what you do, and then we will follow up with some questions, and thank you so much for being here today.

MS. PLASTER: Thank you so much for having me. Good morning to distinguished chairs and honored Members of the Committee. Thank you again for having me testify at today's hearing. My name is Genevieve Plaster, and so I'm the Deputy Director of the Charlotte Lozier Institute, which is a research institute and our mission is really to provide the science and statistics for life. In doing that, we've analyzed the national abortion trends over

decades, and that includes looking at data published by the country's largest abortion business, Planned Parenthood. I did have prepared testimony but I think maybe in the interests of time, yours as well, I might just share some research that addresses previous statements and hope that can be helpful for you all, and then return to the previous testimony if there's time.

So first, on chemical abortion and medication abortion, I know we had spent a long time talking about the process of two abortion pills and reporting for that. I just wanted to share in response to some statements previously about the safety of chemical abortion. I'd like to cite and refer to two robust studies, just really to rebut previous statements about safety.

So first, there's a 2009 Niinimaki, et al. paper in which the researchers reviewed record linkage data of about 42,000 abortions and found that complications were four times more frequent for chemical abortions than for surgical abortions, so that is a major very robust study that again looks at records, linkage data, and not just adverse events that are voluntary.

And the second study I'd like to reference on safety is a recent one, a peer-reviewed published study from this year by Aultman, et al., a group of OB/GYNs reviewed FDA adverse events that were the result of a FOIA

request, and essentially looking through all of the adverse events that are unique to the United States from September 2000, when mifepristone was first approved by the FDA to February 2019, when the actual study commenced. This found that about 15 percent of all of those FDA adverse event reports were not codable, meaning that there was very brief and insufficient information reported to the FDA.

An important factor in all of this FDA adverse event reporting for chemical abortion is that in the U.S., reporting of abortion is voluntary and sporadic, so for example, the State of California which has a lot of abortions, and we know that from estimates of the Guttmacher Institute, they don't actually publish or report abortion data to the CDC so that is actually not calculated within the United States abortion statistics.

So it's really not possible to calculate a national complication rate for mifepristone and misoprostol abortions based solely on the adverse event reports to the FDA. A second consideration about (indiscernible - recording malfunction) while we're having this discussion on chemical abortion and the abortion industry's push to expand it is that in March 2016, the FDA did change the prescribing requirements so that only deaths are required to be reported, and again, that's just to stress that other adverse events such as hemorrhaging or follow-up abortions

and really severe life-threatening events would not be required to be reported.

So just I can send this along as well (indiscernible - recording malfunction) follow-up prepared testimony but wanted to just refer to those two. In the Dr. Aultman testimony in Dr. Aultman, et al, this FDA research study, they found that 74 percent of the FDA adverse event reports were codable as severe; over 20 percent of the adverse events were life-threatening or ended in death; and then 70 percent of those adverse events required follow-up surgery including total hysterectomy.

One additional finding that I thought would be good to include for the record is that abortion providers did not handle most of the complications for their patients but rather the women found care at the emergency room on their own separately, and again, that's data from the FDA adverse reports that were results of a FOIA request.

So Planned Parenthood is part of a coalition calling for this extreme protocol of no-test chemical abortion where women who are seeking a chemical abortion do not need to receive any sort of physical or in-person tests that would rule out if they're able to undergo it, essentially their eligibility and the safety of undergoing chemical abortion.

Recently, as you already know, the FDA issued a

statement that has temporarily lifted its regulations, allowing mail-order dispensing of chemical abortion through mifepristone. And Planned Parenthood centers are and have been prime partners in a study of mail-order chemical abortion drugs and that was (indiscernible - recording malfunction) intentionally circumvent previously enforced FDA safety regulations. The study that's registered at chemicaltrials.gov is also recruiting girls as young as 10 years old.

And for my own work at the Charlotte Lozier Institute, I've attended other state hearings on chemical abortion this year and thought I would offer here a personal testimony from a woman who shared her story of a chemical abortion by Planned Parenthood in Montana. And she described having an incomplete abortion, meaning there were still parts of the unborn baby in her that she did not expel. She had a need for follow-up surgical abortion, and by the end of the process she suffered seven infections. What made it worse in her case, she described in her own words, that the informed consent process by the Planned Parenthood office for going over the possible risks of chemical abortion is, quote, a minute-long counseling session, end quote, where the doctor, quote, briefly read off side effects and had her sign a paper. So in her words she shared that "I felt rushed by Planned Parenthood." And

further, another state legislator asked her if Planned Parenthood had offered any information on options when she arrived for her abortion, and she just answered simply no. So one could wonder how many more women will experience something similar to this as the abortion industry and Planned Parenthood advocates for an expansion of chemical abortion.

Part of my work too at CLI has been monitoring chemical abortion in abortion centers and specifically with Planned Parenthood across the country, looking at their locations and services provided. Fifty percent of all Planned Parenthood abortion centers are centers that only do chemical abortions, so again, that's easy on the end of a provider. The woman would go to a center, take the first drug, mifepristone, and then be able to go home or elsewhere to handle the rest on her own. And so in Pennsylvania, these centers that are chemical abortion only include the Harrisburg, Norristown, and Wilkes-Barre centers. And since chemical abortions generally are only initiated at the center and completed elsewhere, as I just mentioned, it would be important for the understanding of public health (indiscernible - recording malfunction) to get a clarification on how chemical abortions are reported in the state. So for example, I know Pennsylvania puts out quarterly facility reports and if there is additional

information about how chemical abortions are captured in the facility report, I think that would be interesting from the public health and tracking aspect of it.

Of note, at the national level, our institute estimates that 41 percent of total abortions in 2018 are chemical already and that's increasing. Planned Parenthood, however, has not reported how many of its total 355,000 abortions across the country -- how many of those are chemically induced. I know some affiliates do report that in their affiliate annual reports but not at the national total level.

So please someone, you can stop me if I go over, but now I'm going to return to a little bit more of the beginning of what I had prepared. So some of what our research has been, again, is tracking of national abortion trends. And in 2018/2019, the Planned Parenthood annual report did show its highest number of abortions that it has ever reported in a single year, and that's 355,000, which is an increase of over 9,200 since the previous year. In total, the business has performed more than 3.3 million abortions in the U.S. over the past decade. In terms of the various pregnancy resolution services a woman can be offered at Planned Parenthood, induced abortions account for 96 percent of those compared to 2.3 percent, which would be the prenatal services, 0.7 percent being adoption

referrals, and 0.6 percent being miscarriage care.

Looking at adoption, specifically, for every one adoption referral in 2019, Planned Parenthood performed 133 abortions. Aside from tracking the annual reports that Planned Parenthood publishes for the general public, CLI researchers have also analyzed Planned Parenthood abortion data over the past two decades and found that the business model is an aggressive one in prioritizing abortion, and by that I mean that even though the overall national abortion rate has been decreasing significantly over the past few decades, Planned Parenthood's abortions have actually increased.

In a peer-reviewed study led by our CLI Vice President of Statistics, our researchers found that when comparing Planned Parenthood abortions with the independent non-Planned Parenthood abortion businesses from 1995 to 2014, the independent businesses did reflect the national trend, which was a decrease of more than 50 percent of abortions. However, Planned Parenthood abortions, on the other hand, increased by a striking 142 percent. So part of the paper discussion is that this is a prime example of the health concept of supply-induced demand where there's a shift in demand for a service created by the provider.

Our analysis -- the statistical analysis showed that between these two decades Planned Parenthood performed

more than 3 million excess abortions, meaning abortions that would have been averted if their trends were the same as the national abortion trend. Further, on this point of abortion-forward business model of Planned Parenthood, it's not only been evident in the service data that I just referred to but it was also on national display in 2019, when organization's leadership abruptly fired then president, Dr. Leana Wen, who was the second doctor to head up the organization. In her letter to Planned Parenthood staff explaining this abrupt departure, Dr. Wen stated, quote, the new board leadership has determined that the priority of Planned Parenthood moving forward is to double down on abortion rights advocacy, end quote. After this, Dr. Wen was replaced by current president, Ms. Alexis McGill Johnson, whose background is in politics.

At the state level, looking now at Pennsylvania's latest abortion report, there were more than 31,000 abortions performed in 2019, and though the state abortion report does not incorporate the provider-specific data, the three Pennsylvania Planned Parenthood affiliates reported a total of approximately 15,400 abortion visits. And depending on whether an abortion visit represents one unique abortion procedure or not, the Planned Parenthood market share of all state abortions could be 50 percent.

In terms of a lack of transparency in business

practices, I think it is important to highlight since Planned Parenthood at the national level has about 40 percent of its total income as taxpayer funding, and so again that really -- an organization receiving that amount of millions of dollars per year should be accountable to the taxpayers. And in several instances, officials at Planned Parenthood have acknowledged intentional lack of transparency on several fronts. One of them was on chemical abortion and reporting and another on internal protocols and the medical standard guides for infants born alive during late-term abortions.

So I already talked a little bit about chemical abortions, but maybe skipping forward to the internal protocol of infants born alive during late-term abortions, in Pennsylvania we just know from the latest state abortion report that there were more than -- excuse my throat -- there were more than 460 abortions performed after 21 weeks of gestation, or more than five months. At these later stages of gestation, the risk of a baby being accidentally born alive during an abortion is increased and, for example, I'd cite a 2018 study published in Obstetrics and Gynecology, which reviewed 241 late-term abortions and reported that unless the baby was successfully killed first, more than half of them were actually born alive during the abortion. And citing recent state abortion

reports, in just four state health department abortion reports from Arizona, Florida, Minnesota, and Texas, in a single year 33 infants were reported as being born alive during late-term abortions.

So at the federal level, you might remember, several years ago Planned Parenthood officials were interviewed by a congressional team on issues related to their internal protocols about the possibility of babies being born alive, and the final report highlighted that the National Planned Parenthood Federation of America maintains its manual of medical standards and guidance, which sets the clinical practice for all of its affiliates. And the congressional final report stated that this manual of medical standards and guidance is updated every two years, and again, that's information directly from an interview with Planned Parenthood officials.

So since that was in 2016, by this time we would now have passed two likely updates of that manual of medical standards and it would be a matter of public health interest to know if there is or has been any change on how babies born alive would be treated or transferred or assessed on the off-chance that they were born during late-term abortion.

During that interview in 2016, a medical official at Planned Parenthood testified as being in charge of

writing the medical manual and did tell the congressional interviewers, quote, none of our health centers provide obstetric care. Our affiliates don't provide obstetric care so therefore they don't know how to manage a term infant or a premature infant.

Further, when the Planned Parenthood official was asked about the possibility of babies being born alive, the medical official at Planned Parenthood confirmed, quote, there's no protocol for this.

So I think I might wrap up here just with a statement on the public funding of Planned Parenthood and a little bit on the national and local side of things. During the national pandemic and public health emergency of COVID, dozens of Planned Parenthood affiliates including two from Pennsylvania applied for and received funds under the Paycheck Protection Program, which was intended to help small business stay afloat. The Treasury Department published that Planned Parenthood of Southeastern PA received somewhere between $1- to $2 million of COVID-relief funding and Planned Parenthood Keystone received between 350,000 to 1 million, somewhere in that range.

Considering that the National Planned Parenthood Federation of America is a multi-billion dollar enterprise, reporting more than 2 billion dollars in net assets in its latest report, and that it has a structured financial and

governance relationship with each affiliate, Planned Parenthood, you might remember, came under fire for this as overreach of taxpayer funds that were meant to help small businesses.

Congressional findings several years ago published that the regional affiliates do undergo a process of accreditation at the national level and abide by guidelines set by the national office, and there is a small business administration rule about affiliation that has been cited by others as pointing to the fact that these individual affiliates would not be eligible for small business loans in this regard.

According to a recent report earlier this year by the Government Accountability Office, which is an independent congressional watchdog agency, Planned Parenthood as a whole, received approximately $1.6 billion in taxpayer funds over three recent years from 2016 to 2018, primarily through Medicaid, and again, overall taxpayer funding makes up about 40 percent of all of Planned Parenthood's total revenue.

So just in conclusion, it is well known Planned Parenthood is our country's largest abortion business but in addition to that the business has demonstrated its aggressive prioritization of abortion over patient safety, all while receiving large scores of taxpayer funds, yet

Planned Parenthood has not been accountable for every -- for each business practice that I have mentioned earlier and the general public, being taxpayer funding, deserves some more information. And there is something to be said about officials at Planned Parenthood acknowledging their lack of transparency on a few fronts.

So I did omit some things but if it's helpful I can include that in my written as I send afterwards.

I really appreciate the opportunity to join in this discussion. Aside from my professional work with Charlotte Lozier Institute, I'm also -- my family's home is in Pennsylvania. I'm a first generation Philadelphian. So I was the first one in my family born in America and that was in Philadelphia, so I appreciate being allowed to testify today. Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Ms. Plaster. We do -- we are in session at 11, but we do have a couple Members who have questions.

And first is Representative Schemel.

REPRESENTATIVE SCHEMEL: Thank you, Madam Chair.

Thank you, Ms. Plaster. And you're welcome to come back to Pennsylvania too, if you've left only temporarily, I'm sure.

MS. PLASTER: Thank you.

REPRESENTATIVE SCHEMEL: Charlotte Lozier

Institute, you deal, it sounds like, primarily in statistics. Given Planned Parenthood's foundress's troubling history with race, can you give us some statistics on the percentage of abortions that Planned Parenthood performs on African-Americans and the location of Planned Parenthood clinics in or not in historically African-American communities?

MS. PLASTER: Yes. Thank you for mentioning that. You've probably seen last -- well now, I think it's this week or maybe late last week, that the current president of Planned Parenthood had a statement published in the New York Times talking about how the organization can no longer avoid this question of race and needs to own up to a historical harm that Margaret Sanger and their history and even current practices have caused minorities and people of color, so that really is a live issue and over the 100-plus years that Planned Parenthood was in existence, I feel like most recently with this whistleblower letter to the New York Times last year from abortion employees who experienced racism inside the organization, and then leadership now finally finding a way to distance themselves from that, it is still ironic though that looking at the locations of Planned Parenthood centers, many -- I don't have the numbers right in front of me, but I'm aware of a study that has looked at all of the

geographical placements of Planned Parenthood locations and they are definitely targeted in minority communities.

Here -- well here, I'm in Virginia, but in Pennsylvania, one of our researchers at CLI looking at abortion data and the race data in relation to that found that the Black abortion rate is five times that of the White abortion rate, and there definitely is a racial disparity there that's evident in the data. So I hope I answered some of your questions.

REPRESENTATIVE SCHEMEL: Yeah. I had understood that the African-American community was significantly -- outpace their percentage in the population and I would just follow with, you know, every abortion of a Black child is one less Black person in our community and we're at a loss for that. And it seems to me that abortion seems to -- whether intentionally or just by effect, to target that community. Thank you.

MS. PLASTER: Thank you.

MAJORITY CHAIRMAN RAPP: Thank you, Representative Schemel.

And Genevieve, the next question is from Chairman Frankel.

MINORITY CHAIRMAN FRANKEL: Thank you. Just a couple areas I think I need to kind of at least correct the record, and one of those issues, particularly with respect

to race and where these facilities are located, the fact of the matter is Planned Parenthood is a provider of reproductive healthcare for women, and particularly women who don't have access, don't have insurance, are underinsured, and historically, 97 percent of the services that Planned Parenthood provides don't relate to abortion care. They relate to Pap screenings, breast cancer screenings, STI, STD screenings, contraception provision, so let's be clear about that and why these are located often in urban areas where there are economically disadvantaged communities.

And since Medicaid funds are not used for abortion, thank you for pointing out that Medicaid is paying for a large percentage of the services which include the things that I just talked about. And in Pennsylvania, funds are strictly segregated and annually audited, and those funds are paying for those things like testing, STI care, contraception, HIV prevention, services like that, so I just want to correct the record.

One last thing because I think you seem to indicate that Planned Parenthood performs second trimester abortions, those are provided in hospital settings, not in Planned Parenthood clinics so I just want to go --

UNIDENTIFIED VOICE: (Indiscernible - recording malfunction).

MINORITY CHAIRMAN FRANKEL: -- hmm?

UNIDENTIFIED VOICE: (Indiscernible - recording malfunction).

MINORITY CHAIRMAN FRANKEL: Right. And the reason, as pointed out to me, my executive director -- one of the reasons for being in a hospital setting is that if there's any potential for viability, a second doctor needs to be present in our state, so I just think getting accurate information here is kind of important and these -- there's been a little bit of distortion in terms of what the reality is here. Thank you.

MAJORITY CHAIRMAN RAPP: Thank you Representative Frankel.

I think that all of our testifiers tried to testify as to the best of their ability and they were sworn in, and certainly questions from the Members, which that's what we want is to bring information before the public.

I wanted to say to Genevieve that I was quite disturbed but I've known for a long time that Margaret Sanger, the founder of Planned Parenthood, was very much a proponent of eugenics but the person who wrote the article stopped short of labeling her a racist. I certainly was hoping that that issue would not really surface today but some of our Members did bring up some of those issues.

But it is disturbing to me that -- as I've been

called a White supremacist in some articles for just having the hearing and the real White supremacist was Margaret Sanger, who is the founder of Planned Parenthood and who definitely pushed eugenics. And actually, a quote from her is that "birth control and racial betterment" was the terms that she used and it's very disturbing that the founder of Planned Parenthood -- I know there are also implications in the article that says she spoke to the Ku Klux Klan in New Jersey, and so it is disturbing when we hear that the founder of Planned Parenthood very much believed in eugenics.

Setting that aside, it is disturbing when we see the ratio of minorities versus Whites, and most of us sitting here right now believe that all life is precious and that we don't want to see any of those lives terminated because we believe in the human race, that everybody belongs to the human race.

So I thank you very much. I don't know if any of the Members had any other questions for -- oh, Representative, please.

REPRESENTATIVE TWARDZIK: Hi. Thank you very much for your testimony and for all the witnesses. It was very informative and interesting. We've done a lot of research getting ready for the hearing and one of the things we didn't have a chance to talk to Planned

Parenthood about, but as we continue to hear, 97 percent of their performance is not abortion-based, but I guess we're seeing a lot of facilities are closing in Pennsylvania and the ones that closed for Planned Parenthood are the ones that do not do abortion services. There's a list here of 16 clinics that are closed, and it seems if you're doing all the service why are the Planned Parenthood outlets closing that don't do abortion?

MS. PLASTER: If that's a -- sorry, if that's a question directed to me, I also just wanted to clarify with that 97 percent number, that that individually -- I do recall looking into the services at the national level through the Planned Parenthood annual reports and know that that 97 percent number that's -- the non-abortion services includes each and every pregnancy test that's given, even though giving one pregnancy test definitely is not at the same -- does not involve the same amount of time or care or skill or brings in the same amount of income as an abortion, so if we hear something about 3 percent of Planned Parenthood services are abortion, that's weighing an entire abortion procedure as the same thing as one pregnancy test, so the weighting is a little bit off there.

But in terms of your question of centers closing, that seems to be the pattern across the United States that I've noticed, as well, that there's a business strategy of

closing the centers that are non-abortion-performing centers and opening up -- you know, like one mega-clinic in a strategic location, so part of my testimony that I omitted for time was Planned Parenthood's opening up mega-centers in Indiana and Illinois to kind of serve a purpose of being on a border state with other states that have very life-affirming policies, life-protecting policies, and kind of being there as a hub, but closing all of the other nearby non-abortion performing centers, so there is something to that observation. And thank you for mentioning that.

REPRESENTATIVE TWARDZIK: Okay. Thank you for clarifying it.

MAJORITY CHAIRMAN RAPP: I want to thank you, Ms. Plaster, for being here today, as well as the other testifiers. We've learned a lot today from everyone who has given us testimony.

We do have a hearing tomorrow, by the way, on Down syndrome. We are going to be running a Down syndrome bill. Representative Klunk is sponsoring that bill, so we will be hearing tomorrow. That hearing is from 9 to 11.

But we truly appreciate all of your information today that you've given to us and I just want to say thank you to all the testifiers and the Members. And again, we are having another hearing tomorrow from 9 to 11. If

members of the public would choose to join us, we welcome you and thank you for being with us today.

(Hearing adjourned at 10:53 A.M.)

C E R T I F I C A T E

I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.

TERRY RUBINO
Transcriptionist
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