Senate Judiciary Committee
SB 2150
January 16, 2023

Good afternoon, Chair Larson and members of the Committee. My name is Dr Ana Tobiasz, MD and I am a Maternal Fetal Medicine physician in Bismarck. Thank you for the opportunity to testify in favor of SB 2150. I am asking the committee to give this bill a Do Pass recommendation provided amendments can be granted.

My medical training and expertise is in caring for women during high risk pregnancies. I was born and raised in Munich, ND and completed my undergraduate and medical school training at the University of North Dakota. After medical school I completed a 4-year residency training in Obstetrics and Gynecology followed by a 3-year fellowship training in Maternal Fetal Medicine. I have worked as a maternal fetal medicine specialist in Bismarck since July 2017. I am one of 5 of my specialty throughout the entire state.

After completing my out-of-state residency training and fellowship training, I returned to my home state so that I could improve access to high quality obstetric care for many reasons. Partly because I had a high-risk pregnancy with my first and did not receive appropriate care planning for my son who would be born with a congenital anomaly and I expect better for women and families in this state. Also, because I don't think pregnant women should have to travel out of state to access high quality and safe obstetric care and state of the art fetal diagnosis and delivery care planning.

I have been a leader in the state for helping to initiate and be involved in programs that would improve quality and safety of obstetric care in this state, including the perinatal quality collaborative, maternal mortality committee, and the ND Medical Association Leadership Council.

I spend my days getting women and their fetuses safely through pregnancy. This includes women with severe heart conditions, lung conditions, cancer, and complications that arise in pregnancy including preeclampsia (high blood pressure and risk of organ injury in pregnancy), membrane rupture and hundreds of others. It also includes diagnosing fetal conditions which require in utero procedures for the fetus to survive and care planning for babies that will require surgery after birth in order to survive.

Despite the fact that most of my days are spent making sure women get as far as they can safely in the pregnancy with a plan of care for their fetus/neonate, sometimes medical conditions will necessitate delivery prior to the point the

fetus can survive if delivered. These are heartbreaking scenarios for everyone involved. The patient, the family, the doctors making these diagnoses and having to give these recommendations, as well as the nurses caring for the patients. These are not “elective” terminations by any means and for that matter, there are no non-medically indicated terminations that occur in this state at any of the medical facilities which provide obstetric care.

For this reason, I can only support SB 2150 if amendments in the definition of medical emergency exceptions are made. If not, it will threaten my ability to practice in this state without fear of criminal prosecution for providing what is the standard of care medical practice.

While I have concerns about multiple aspects of this law, I support SB 2150 insofar as it is an improvement on the restrictions on abortion that were provided by the “trigger law,” which effectively bans abortions in all circumstances with limited exceptions and severely limits the ability of obstetricians and health care professionals who provide care to pregnant women only with the support of an affirmative defense.

SB 2150 eliminates the affirmative defenses in the trigger law and this is a respectable change to minimize the impact these laws will have on practicing physicians who care for pregnant women experiencing medical complications in North Dakota.

I do have concerns with SB 2150 as it stands and would request amendments to include several exceptions.

- First and foremost, the exceptions deemed a medical emergency are not sufficient to allow for care for the most common medical conditions in pregnancy that would necessitate an abortion, including pre viable membrane rupture and pre viable preeclampsia. The language of concern includes an exception for preventing “her death or substantial and irreversible physical impairment of a major bodily function, not including any psychological or emotional condition.” A simple amendment to change this language to “substantial OR irreversible physical impairment of a major bodily function” would allow for the majority of these medical conditions to be cared for as standard medical practice would dictate. If this change is not allowed, most of these patients will require transfer out of state for their medical care or their physicians will be potentially open to criminal charges. The requirement of an irreversible physical impairment is too specific and does not account for the range of scenarios that would require an abortion as the only feasible option to improve the health and condition of the mother without threatening her life or resulting in serious

conditions such as sepsis, organ failure, hysterectomy, among others.

An example of this would include a pregnant woman who experiences membrane rupture prior to fetal viability who develops an in utero infection. At the time this is diagnosed, she may not be experiencing irreversible effects related to the infection. Waiting until the time point she has organ injury will delay her care and will put her at risk of sepsis, further organ injury, and death. These women can go from looking generally not that sick to very ill in a matter of minutes and the minute we suspect these infections we need to act. Effecting delivery of the fetus and placenta and treating with antibiotics will not leave her with an irreversible condition. The question still stands: when is this condition irreversible and at what point can I act without risking committing a crime? *Ideally physicians would act well before their patients are at risk for irreversible harm as with any other medical condition. Complications of pregnancy are a medical condition that should receive the same respect.*

- I also have concerns that we do not allow for pregnancy termination for lethal fetal anomalies. These decisions are no different than making the decision to make a family member with end stage cancer “do not resuscitate” or to take a family member off life support if no brain stem activity is present that would sustain life. Forcing these women to carry these pregnancies to term poses a risk to their health. The risk of continuing pregnancy to term makes it 14 times more likely the woman will die as a result of pregnancy as compared to abortion. I would respectfully ask that consideration be given for an amendment that would allow for these families to stay in state and have an in-hospital labor induction at the time these conditions are diagnosed rather than having to travel out of state.

  An example of this would be a fetal diagnosis of anencephaly, which is an anomaly that results in the fetus having an absent skull covering the brain. This is a universally lethal condition and the majority of these infants will not survive more than minutes or hours after birth. If the family chooses to carry to term they receive ongoing prenatal care and making plans for palliative care of the infant after birth. My ask is that these families not be forced to carry to term with these types of uniformly lethal diagnoses. The majority of families who receive a lethal fetal diagnosis during pregnancy will opt for pregnancy termination and 100% of these currently travel out of state to receive the same compassionate care that they should be able to receive close to home. These are end of life decisions. They can have the same palliative care experience with their infant at 20 weeks and in fact would improve the chances they would be able to see their infant

born alive and spend those precious moments with them. We wouldn't expect forcing the prolongation of any other life limiting condition so how is this different, especially when it poses a risk to maternal life.

- My last concern is related to the rape and incest exception. Proof of rape and incest will be difficult to obtain and the law does not make it clear what documentation would be required as proof. Will a police report need to be filed and provided by the patient? Additionally, limiting this exception to 6 weeks gestation effectively makes it impossible for the majority of individuals in these horrific circumstances to seek abortion care. If the legislature is serious about making this an exception, the gestational age needs to be extended as the majority of pregnancies are not diagnosed until after 6 weeks gestation and therefore this exception will not allow for termination for the majority of individuals who have just undergone a traumatic experience.

In summary, I ask for a do pass for SB 2150, as amended, allowing for the medical emergencies to read "substantial OR irreversible physical impairment of a bodily function."

I would also ask for consideration of amendments to include an exception for termination for lethal fetal anomalies and to clarify the documentation needed to prove rape and incest to allow for an abortion without the health care professional facing criminal charges for performing an illegal abortion, as well as to extend the gestational age to later than 6 weeks gestation.

Dr Ana Tobiasz, MD
Maternal Fetal Medicine Physician