Senate Judiciary Committee

SB 2150

Monday January 16, 2023

Chair Larson and Committee Members, I am Dr Collette Lessard, a board-certified physician in Obstetrics and Gynecology practicing in Grand Forks, North Dakota. I have been practicing as an OBGYN physician for nearly ten years.

I am here in support of SB 2150, with a few critical amendments. We support and appreciate that this bill, compared to the trigger law, removes the affirmative defenses, and outlines the ability for us OBGYN physicians to treat ectopic pregnancies. We are thankful that you heard our concerns about those issues.

As stated by the North Dakota Medical Association, we are requesting an amendment to SB 2150 regarding the medical emergency language. The requested amendment is to replace "and" with "or" on page 2, line 6 and to replace "and" with "or" also on page 5, line 31. These amendments are critical to patient safety. The amendments are necessary so that OBGYN physicians can provide safe care for our patients locally when unexpected and serious pregnancy complications arise.

In the current bill, the wording is "to prevent her death or substantial AND irreversible physical impairment of a major bodily function". There are many examples of serious pregnancy complications that can occur prior to viability of the pregnancy. By viability, I mean the gestation at which a baby has a chance, with neonatal intensive care support, to survive outside of the uterus. Many of these pregnancy conditions pose significant increased risks to the mother. Treatment of these conditions in a timely manner, can prevent further harm and risk to the mother's health. In giving patients these difficult diagnoses, we counsel patients on risks and benefits to immediate treatment (induction of labor/termination of the pregnancy) versus expectant management (continuing the pregnancy) and the prognosis for their baby. In many of these scenarios, the prognosis for their baby is very poor due to the early gestation in pregnancy when these complications are occurring. When women choose expectant management in these conditions, they are risking serious health complications. It should be a patient's choice in these scenarios to make individualized and informed decisions with their healthcare team. If the wording is left as it currently is, "substantial AND irreversible physical impairment of a major bodily function", a pregnant woman would be forced to continue a pregnancy until they are becoming critically ill. This is not the standard of care in medicine.

I will give a specific example of one of these medical conditions, preeclampsia. Preeclampsia is a disorder of pregnancy in which a woman develops high blood pressure unexpectedly. Preeclampsia is responsible for an estimated 16% of maternal deaths. This condition can

present any time after approximately 20 weeks in the pregnancy. Most frequently it occurs later in the third trimester and near term in the pregnancy. However, it can occur prior to viability as well. Preeclampsia with severe features is the most dangerous form of this condition. Patients with preeclampsia with severe features tend to have very high blood pressures, putting them at risk of stroke. There are also many other acute (sudden) and long-term complications affecting other organs in the body that can occur with preeclampsia with severe features. These complications can include seizures, kidney and liver failure, pulmonary edema (fluid on the lungs), myocardial infarction (heart attack), acute respiratory distress syndrome (lung failure), coagulopathy (the body's clotting factors are consumed and spontaneous, life-threatening bleeding occurs), and liver rupture. The ultimate treatment for preeclampsia is delivery of the baby and placenta. Initially upon diagnosis, blood pressure treatment and other medications are started. This can stabilize the disease temporarily. But with preeclampsia with severe features, progression to the complications above will eventually occur without delivery. These complications can occur within days or a week or two of diagnosis. The other difficult factor is that you cannot predict when a patient's clinical status will deteriorate, and it can be sudden and rapid. I have had some of these patients doing very well and stable, and yet within hours have sudden-onset chest pain and blood pressures approaching 200 mmHg, or develop kidney failure or coagulopathy overnight. The risk of stroke is significantly increased in pregnant women when blood pressures exceed 160 mmHg systolic (the top number). When this disease develops at 20 or 21 weeks, for example, expectant management is very risky and unlikely to reach the gestational age of viability.

The above is just one example of an obstetric scenario in which women are faced with a grim prognosis for themselves and their baby. The requested amendment (to replace "and" with "or" on page 2, line 6 and to replace "and" with "or" also on page 5, line 31) would allow the patient to make an informed medical decision in these devastating circumstances, given the substantial risks to them and the poor prognosis for their child. The way the line is currently written in SB 2150 with "substantial AND irreversible physical impairment" makes it so that we are not allowed to treat these women until they are experiencing the most serious complications, putting their lives at unnecessary risk. We should be able to offer delivery before they develop coagulopathy or organ failure. If this amendment is not made, all of these patients will need to be sent out of state. This poses unnecessary and significant challenges, along with emotional and financial burdens for them.

The second requested amendment is in section 3b, regarding the gestational age limits on pregnancies conceived by sexual assault. The reality is that most women who are pregnant via sexual assault may not even know that they are pregnant until much farther along in the first trimester. It also puts unnecessary pressure on these women to be rushed into making a decision, in already devastating and emotional circumstances.

A third amendment requested is to allow for abortion for lethal fetal anomalies in this state. These diagnoses bring forth unimaginable pain and devastation to families. They are unexpected and not often known about until 20 weeks, at the standard time of an anatomy scan. Deciding to continue a pregnancy or not after receiving the diagnosis of a lethal fetal

anomaly is making an end-of-life decision for their child. Pregnancy comes with risks, even in the healthiest women. We should allow these families to make these decisions for their child while in the uterus, just like they are allowed to make decisions about withdrawing care or providing supportive care for their child after birth. This also allows the patient and her family to consider the risks to her with delivering the baby in the second trimester for example, compared to carrying to full-term. These are heartbreaking and painful decisions for families. They should be able to receive this compassionate care in state with their OBGYN physician and their families close by, rather than needing to travel out of state for care.

The complexity of obstetrics is very challenging to convey and, unfortunately, it often underestimated and not fully understood by the public. Before becoming an OBGYN, I did not understand any of this either. I want to finish my testimony by sharing my background, so you all understand what I mean by this.

My family farms just outside of Grafton, North Dakota, where I was born and raised. I grew up with Catholic and conservative values. When graduating high school and throughout college, my feelings on abortion were simple and "black and white". I felt that abortion was wrong under all circumstances. It was not until medical school that I began to recognize that the world of pregnancy and obstetrics was much more complicated than I had known. During medical school and OBGYN residency I finally understood why abortion is a medically necessary part of reproductive care.

Let me clarify, I have never performed an elective abortion. I did not attend a residency with those services. However, in residency I learned that abortion is much more than a woman ending her pregnancy because she does not want to be pregnant. Abortion sometimes is choosing to induce labor at 18 or 20 weeks gestation because severe complications in the pregnancy have arose, or because your baby has a lethal birth defect and will not survive outside the uterus. These are unexpected, heart-wrenching, and devastating decisions. Abortion in some of these circumstances is a woman choosing an end-of-life care decision for her baby during the pregnancy. OBGYN physicians, our nurses and team members provide diligent and compassionate care to these families during these times.

Chair Larson and Committee Members, I truly had no idea the scope of what abortion was, or the complexities of pregnancy, before I became an OBGYN. Likewise, I recognize that you all may not fully realize the seriousness and dangers of these situations either. I care so deeply about the patients I serve. I am hoping that you hear what we are trying to explain. We are the only physicians in the state caring for these women in these circumstances. We already having a shortage of OBGYN doctors. Restricting our ability to care for them in these circumstances will make it worse. Please seriously consider these suggested amendments – changing "and" to "or" in the medical emergency language, removing the six week gestation limit for abortions in pregnancies from sexual assault, and allowing for abortions for lethal anomalies in state. Thank you for the opportunity to testify today. I would be happy to answer any questions.

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