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Dr. Donna Burkett Testimony Before the Vermont House Committee on Human Services – January 23, 2019

Good afternoon Chairperson Pugh, Vice Chair Haas, Ranking Member McFaun, and all members of the House Committee on Human Services. I'm grateful to all of you for the opportunity to be here today to speak in support of bill H.57, "An Act Relating to Preserving the Right to Abortion," which would codify abortion rights in Vermont law.

My name is Donna Burkett, and I'm the Medical Director of Planned Parenthood of Northern New England. I am a family physician and have been practicing medicine for over 20 years. I have been Medical Director of PPNNE for 5 years and prior to that at a 4-state Planned Parenthood affiliate in the southeast.

PPNNE is the largest reproductive health care and sexuality education provider and advocate in northern New England. We serve more than 43,000 patients each year at 21 locations across Vermont, New Hampshire, and southern Maine. In Vermont, there are 12 Planned Parenthood health centers and we provide health services to serve approximately 19,000 patients annually.

Our mission is to provide, promote, and protect access to reproductive health care and sexuality education so that all people can make voluntary choices about their reproductive and sexual health. We provide a broad range of care to Vermonters, including contraception, pregnancy tests, cancer screening, STD testing, depression and substance use screening, as well as abortion.

To help you understand some of the subtleties of abortion care as it exists right now in Vermont, I'd like to walk you through what abortion is like for our patients, the complexity of the care and the safety of the care. In Vermont, six percent of PPNNE patients seek abortion care. Out of 19,000 patients, we provide abortion care to 1,100 of them. About a third of these are surgical abortions (or "in-clinic abortions" as we describe them to patients) and 2/3 are abortions by pill, also called medication abortions. The percentage of medication abortions that we do has been increasing for many years, likely due to early pregnancy diagnosis or discovery and easier access for the patient because she's more likely to get an appt for this service in a health center

close to home. In addition, you should know that most abortion, whether by pill or in-clinic, happen very early in a pregnancy, within 6-8 weeks of conception.

When a woman finds out she is pregnant unexpectantly, she has to decide whether to continue the pregnancy or end it. Sometimes a woman is very clear very quickly in her decision, and others need more time to decide. They consider the opinions of their partner and loved ones, fear of the procedure itself, financial resources, and their own physical and mental well-being, and much, much more. Every person is different, and every pregnancy is different. There are a few things that remain consistent though: for every patient, abortion is a deeply personal medical decision, and it is a decision they make after careful thought.

Once she has decided to end a pregnancy, a woman must consider how to end it. If her decision is made before ten weeks, she chooses between abortion by pill and in-clinic abortion, commonly. In all cases, the pregnancy must be dated in some manner to best understand the safest methods for her. This may be done by understanding a patient's last menstrual period or dates of sexual encounters, or by ultrasound. Pregnancy dating is a great example of how legislative restrictions can be problematic for patient care. Many states are legislating how ultrasounds must be done before abortions; meanwhile, there is a mounting body of scientific evidence that ultrasounds are unnecessary prior to some abortions. A good medical history can often suffice. In my experience, science, as slow as it can be, usually changes faster than legislation, policy and procedure. Examples like this abound in abortion care.

If a patient chooses medication abortion, she must make that appointment in a specific time frame (indeed, this is true of all types of abortion), and this time frame is also one that changes with scientific evidence. At her visit, a thorough history is taken and lab tests are done, as well as an ultrasound when needed, allowing us to understand whether she has medical conditions that would make the process unsafe for her or her future pregnancies. She is thoroughly counselled on the process of abortion by pill and given plenty of opportunities for questions. When ready to proceed, our compassionate provider administers, dispenses or prescribes the set of medications she will need to complete the abortion successfully. She is given a follow-up appointment to assure that everything has gone well, and phone numbers to reach our on-call staff should she have difficulties. Only about 1% of patients have complications that require additional care with this procedure, usually in the form of additional medications or an in-clinic abortion procedure.

If a patient chooses an in-clinic abortion (also called suction curettage or formerly called “D&C” for dilation and curettage), she goes through the exact same medical screening to assure her safety. If she is choosing to be sedated, there is additional screening for this portion of the process. She is counselled just as thoroughly and referred to an outside provider if she falls outside our scope of practice because of her medical conditions. She is given medications to help her through the procedure in various ways and an antibiotic to prevent infection that could be caused by the procedure. An experienced provider completes the suction curettage in a standard manner in a setting appropriate for such care with staff ready to support where needed in provision of sedation medications and monitoring of the patient during recovery, which usually lasts only 15 minutes. In fact, the care is so routine and smooth that many patients comment to us “that was all?” And our safety figures, similar to those across all abortion providers, show complication rates around 1%, most often dealt with using medication or watchful waiting.

If a patient is beyond the first trimester, her options change depending on the gestational age. Medication abortion is no longer an option because of the risk of bleeding outside a hospital setting. At PPNNE, we use 2 procedures, very similar to the suction curettage method, that are also very safe and have similar rates of complications. If you look at a very large number of patients receiving these procedures, the complication rate goes up by gestational age, but never reaches that of carrying a pregnancy to term. Our safety processes are similar to those in the first trimester, and we are more likely to refer to our hospital-based colleagues for care because there is more often need for closer monitoring during the procedure.

So, I’m proud to report to you that the safety of abortion care in Vermont is excellent, and that part of that is because of the lack of restrictions. Patients are able to access care early and safely.

I’d also like to say a word about abortion at gestational ages that are later than what we offer at PPNNE. I’m grateful that these options are available to patients because of the varied reasons a woman may need to access them: serious risks to her health, severe fetal abnormalities, and a host of additional factors that affect the decision a woman makes with her provider, usually involving her family, and often involving counsellors and religious leaders. These are the kinds of situations where a woman and her doctor need every medical option available.

Finally, I ask that you keep our legislation free of restrictions on minors' ability to access abortion care. The teens to whom I have provided care usually involve one of their parents or a trusted adult in their decision and these people often accompany them to their appointments. Less commonly, these teens have chosen not to involve the parents because of fear the parents might hurt them. In NH, and in several states in which I served as medical director in the South, parental notification or consent laws left minors in a position of having to go through a judicial bypass process further delaying their ability to have an abortion and thus increasing the risk of the procedure unnecessarily. It's important that we maintain access to abortion without restriction for ALL patients, including minors.

In summary, as a physician, I applaud the introduction of "H.57, an Act Relating to Preserving the Right to Abortion." On behalf of my patients, we must keep abortion legal, safe, and free from restrictions.

I want to thank Vermont's House leadership, especially House Human Service Committee Chair, Representative Ann Pugh, for being the lead sponsor of the bill. I respectfully ask the Vermont House of Representatives to pass H.57 to ensure that reproductive rights are protected in Vermont. I remain available to you as needed for questions you may have through this process.

Thank you.