

Testimony of Dr. Allison Linton
Before the U.S. Senate Committee on Health, Education, Labor and Pensions
“The Assault on Women’s Freedoms: How Abortion Bans Have Created a Health
Care Nightmare Across America”

June 4, 2024

Chair Sanders, Senator Murray, Ranking Member Cassidy, Members of the Committee:

My name is Dr. Allison Linton. I am a board certified obstetrician and gynecologist as well as a board certified complex family planning specialist.

I completed my medical school training, a residency in obstetrics and gynecology, and Complex Family Planning fellowship and Masters of Public Health at Northwestern University in Chicago, Illinois. I subsequently moved to Milwaukee, Wisconsin, where I am an Assistant Professor of obstetrics in gynecology, as well as the Chief Medical Officer of Planned Parenthood of Wisconsin, and Fellow at Physicians for Reproductive Health.

I have had the opportunity to teach dozens of ob-gyn residents and hundreds of medical students over the past seven years. I have had the opportunity to work with community partners, expanding access to contraception and sexually transmitted infection testing and treatment in multiple Milwaukee health departments. I have given lectures and trainings across the Midwest in both academic and community settings.

But most of all, I have been honored to take care of patients. I see them annually for Pap tests and breast cancer screening exams, catching up on their new jobs, where their kids are going to college, or what vacation they have coming up. I see them as adolescents when they have questions about how their body is changing. I see them for STI testing, discussions of birth control, irregular periods, and chronic pain symptoms. I sit with them for hours on labor and delivery as they push to bring a new baby into the world. And I cry with them when something changes in their life or a new diagnosis is made and they are forced to make decisions they never thought they would have to.

Sometimes they come alone. Sometimes with a partner or a friend. But we are always with them. Their doctors, their nurses, their health care teams — we support them in every situation, giving them all the information we can, and trusting them to make the decision that is best for them.

Unfortunately, our ability to do our job changed two years ago. On June 24, 2022 at 9:10 a.m. Central Time, the *Dobbs v. Jackson Women’s Health Organization* ruling sent reproductive health care into a tailspin. For the past 711 days, my patients and my colleagues have been existing in a state of chaos, confusion and fear.

In my home state of Wisconsin, a statute from 1849 remained on our books, which seemed to ban abortion from the moment of conception. A law written before the Civil War and the abolition of slavery, before women had the right to vote, before the discovery of penicillin. While there were certainly questions about the enforceability of this law, due to the harsh penalties associated with violating it — \$10,000 fine and six years in prison — all abortions in the state were immediately ceased. There was only a narrow exception for an abortion that “is necessary, or is advised by 2 other physicians as necessary, to save the life of the mother.” No exceptions for rape or incest. No further language to help clarify. Just that one sentence.

For those who have no understanding of the complexities of the human body or the perils of pregnancy, this exception may seem self-explanatory. I have heard some say that physicians should know which cases meet this exception and which don't. That it is up to our best medical judgment and it's the physician's fault if a patient suffers from not receiving appropriate care.

As a practicing physician, I can tell you this is NOT self explanatory. Deciding whether something is or is not necessary to “save the life of the mother” is not clear. Phrases like “threat to maternal life” are not a medical diagnosis, and adding phrases like “imminent death” or “direct threat” do not help to clarify. Medicine is complex and rapidly changing. It is an art where physicians must take all the information presented and try to predict a prognosis or outcome. And we are not infallible. Our tools are not infallible. Telling a physician to “do our best” under threat of felony charges if someone doesn't agree with our best medical judgment is not fair and it is not appropriate.

As physicians, we are trained to make decisions based on the medical evidence in front of us. We are taught to minimize risk to our patients, discuss all medically appropriate options, including their relevant risks and benefits, and honor patient autonomy when they choose the treatment that is best for them. As of June 24, 2022 at 9:10 a.m. Central, we were no longer able to do this.

When would an abortion be necessary “to save the life of the mother”?

What about a patient who presents with heavy bleeding in the first trimester, but there is still fetal cardiac activity on ultrasound — can I remove the pregnancy to stop her bleeding? Do I have to wait for a certain amount of blood loss? Do I have to wait for her vital signs to change, or until she needs a blood transfusion, or until she bleeds so much that she can no longer clot her own blood?

What about a pregnancy affected by a lethal fetal diagnosis such as anencephaly where the top of the fetal head fails to develop or renal agenesis where the fetus's lungs cannot develop. Continuation of pregnancy will never lead to a live child, so is the risk of pregnancy without any potential benefit enough to justify an abortion?

What about when the bag of water breaks before the fetus can survive outside the womb? Or a pregnant patient with unresolved congestive heart failure from her last pregnancy that puts her at a higher risk of dying in this pregnancy – what percent chance of death does she need?

What about a patient with newly diagnosed breast cancer at eight weeks of pregnancy who cannot start chemotherapy or radiation while she is pregnant? Is delaying her treatment until after delivery a risk to her life?

What about a patient with a blood clotting disorder where pregnancy will further increase their risk of a pulmonary embolism or stroke? Is the risk of a blood clot enough, or do I have to wait until the actual stroke occurs?

What about a 13 year old who is the victim of incest? Is the psychological and physical trauma of carrying a child in her barely pubescent body enough to justify ending the pregnancy?

What about a mother of three who cannot emotionally or financially support another child? She is making a loving decision for the children she already has. She should have just as much control over her body and future as any other person who needs an abortion, for any reason.

These are not rhetorical questions. They are real patients that my colleagues and I have encountered and tried to care for in Wisconsin.

In reality, any law that tries to delineate when an abortion is or is not permitted will never be able to fully account for the complexities of our patients' health and their lives. Each patient's situation is unique, and regardless of their reason for needing an abortion, they deserve health care. These decisions are deeply personal, and my job is to make sure my patients have all the information they need to make the best decision for themselves, their families, and their futures.

Under the 1849 law, instead of being able to follow the medicine – offering patients all their options and letting them choose – we would call additional colleagues asking their opinions, we would discuss cases with our hospital's lawyers. And far too often, we would have to look our patients in the eye and tell them that despite having the medical training to help them and knowing that an abortion was a safe and medically appropriate option, we couldn't help them in their home state due to a law written over 170 years ago by legislators who likely had no medical training and certainly had no understanding of modern medicine.

The consequences of this confusion and fear went beyond what many would typically consider abortion-related. I received calls from colleagues asking if they could provide care for a patient who had experienced a miscarriage. I received calls from colleagues in Illinois and Minnesota who were seeing patients with ectopic pregnancies who had been told they could not receive care in Wisconsin.

Of course my first thought was frustration and concern for patients that were not receiving the standard of care due to fear and misunderstanding. But you must remember we are physicians

— not lawyers. These physicians were afraid, trying to interpret an archaic, non-medical law through a modern medical lens. They feared a threat of prosecution, loss of their medical license, loss of their livelihood and career. You cannot blame physicians for being afraid when you have forced them to go against the core tenants of their medical training.

Shortly after the *Dobbs* decision, my partners and I discussed our concerns of covering labor and delivery due to fear of what clinical scenarios may present. We feared being forced to go against our medical training of providing the standard of care OR providing the standard of care and putting ourselves at risk of criminal prosecution. I had similar discussions with my colleagues in the Emergency Department and institutions across the state. We all felt we were left with an impossible choice — risk of malpractice and harming a patient or risk of criminal prosecution?

Since June 24, 2022, pregnancy in the United States is far more dangerous. For patients with medical complications, yes, but also for people with abusive partners. For people who may not understand what is happening to their bodies. For Black women, who die from pregnancy and childbirth three times as often as white women.

And it will only get more dangerous: The fear of not being able to adequately care for patients has led some practitioners to choose to move out of their home states or to stop caring for pregnant patients. It has also made it more difficult to recruit new providers to move into states where they may face criminal prosecution for providing the standard of care. In many areas of the country with maternity care deserts, including Wisconsin, this difficulty retaining and recruiting providers will only worsen our maternal health crisis. There is less sexual and reproductive health care where it is most desperately needed.

In the wake of *Dobbs*, I learned of several residents and medical students inquiring about transferring to another state for the remainder of their training. Speaking to one student, they voiced concerns not just about not being able to receive adequate training to provide comprehensive care to their patients after graduation, but given that they too were of reproductive age, they worried about their health if they or their partner were to experience a medical complication during pregnancy.

Unfortunately, confusion and fear was not isolated to physicians and health care providers. While Wisconsin's 1849 law only threatened prosecution of the person who performed an abortion and not the patient themselves, patients were still afraid. I met with patients who told me they were afraid to come to the emergency room when they were experiencing medical complications in early pregnancy, concerned they would be denied care or accused of doing something to themselves to harm the pregnancy. I spoke with a patient who told me she thought she wasn't allowed to discuss her thoughts about terminating her pregnancy with her own family, being under the impression that they could be charged with a crime if they knew what she was considering. Despite trying our best as a medical community to reassure patients that they could trust their health care team and should feel safe seeking help, I have no doubt that

many patients did not receive the care they deserved due to confusion and fear stopping them from disclosing information to their providers.

After a ruling from a state judge on our 1849 law, we started providing abortion again in Wisconsin in late 2023. Now, the lower court's ruling is making its way through the appeals process. Because we don't have any affirmative state-wide protection, there is uncertainty about the future of abortion access in Wisconsin. And we still work under medically unnecessary restrictions. These restrictions, including a mandatory 24-hour waiting period, with a same-provider requirement for medication abortion, and a ban on telemedicine abortion, do nothing but make it harder for patients to get the care they need — especially those who live in rural areas of the state.

I'm glad to see the Senate taking action, from Senator Baldwin's legislation to help restore the federal right to abortion, to moving to pass the Right to Contraception Act and ensuring the right to IVF. All of this will not fix what has been broken by the *Dobbs* decision, but it is a step in the right direction.

Abortion bans mean there is no longer a standard of care for pregnant patients — they're getting care based on the state they live in. In the wealthiest country in the world, this is what we're subjecting pregnant people to: chaos, confusion, and fear.

My patients deserve so much better.