IN THE COMMONWEALTH COURT OF PENNSYLVANIA

ALLEGHENY REPRODUCTIVE HEALTH CENTER, et al.,	:
Petitioners,	:
v.	:
PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES, et al.,	:
Respondents.	:

DECLARATION OF COURTNEY ANNE SCHREIBER

I, Courtney Anne Schreiber, MD, MPH, make this declaration:

1. I am a board-certified obstetrician/gynecologist (OB/GYN) with subspecialty training in family planning. As Division Chief and Medical Director, my career is focused on both direct patient care and programmatic oversight of the family planning programs at the Perelman School of Medicine, University of Pennsylvania.

2. It is medically necessary that all pregnant women receive medical care. If a woman is continuing her pregnancy, she needs care during the pre-natal period, care during delivery, and post-partum care. If the pregnancy ends in a fetal demise or miscarriage, a woman may need medical care to help complete the miscarriage in a timely and safe fashion. Similarly, if a woman decides she

needs to end the pregnancy, she needs medical care to complete an abortion. In my professional opinion, there is no medical or clinical reason to treat abortion as distinct from any other form of pregnancy-related care. Indeed, an abortion entails exactly the same surgical and medical procedures used to treat a miscarriage—there is no medical difference. Modern obstetrics has produced some of the most critical, life-saving interventions in all of medicine. About one-third of all pregnancies in the United States end as a miscarriage or abortion, and the safety of women who need care for an unwanted or abnormal pregnancy hinges primarily on timely access to care.[1]

3. The ability to control one's reproduction—including the ability to terminate a pregnancy rather than continue to term—is essential to a woman's overall health, her ability to contribute to society, and the health of her family. Pregnancy and childbirth have a profound effect on every woman's body, mind, and well-being for the nine months she is pregnant and beyond. Pregnancy is risky. Pregnancy alone can make a healthy woman sick. I know this based on my professional training and experience, but also based on my personal experience with being pregnant. This truth can be magnified for women who have chronic medical problems or are in less-than-optimal health at baseline. However, given

[1] National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* (2018), *available at* https://doi.org/10.17226/24950.

the impact that even an uncomplicated pregnancy can have on even the healthiest woman, a woman who decides to have an abortion is making a decision that protects her health and well-being.

4. Based on my education, scholarship, 19 years of clinical experience, and familiarity with the literature on the impact of pregnancy on a woman's health, and the safety of abortion and the important roles it plays in health maintenance, it is my professional opinion that abortion must be available as a necessary component of medical care during pregnancy. By excluding abortion from Pennsylvania Medical Assistance (except in extremely limited circumstances), the Commonwealth of Pennsylvania harms low-income women by preventing or delaying them from obtaining medically necessary health care, to the detriment of their health and safety.

I. BACKGROUND AND QUALIFICATIONS

5. In addition to being a board certified Obstetrician/Gynecologist, I am also an Associate Professor of Obstetrics and Gynecology at the Perelman School of Medicine, University of Pennsylvania. I am currently an Attending Physician in Obstetrics and Gynecology at the Hospital of the University of Pennsylvania, where I see patients as an obstetrician/gynecologist and family planning specialist in both inpatient and outpatient settings. I serve as Division Chief and Fellowship Program Director. I supervise fellows, residents, and

students in patient care. Over the past thirteen years, I have trained hundreds of medical students, residents, and fellows to be obstetrician/gynecologists and family planning specialists.

6. I received my medical degree in 1999 from New York University School of Medicine, completed my Obstetrician and Gynecologist residency at the Hospital of the University of Pennsylvania in 2003, and completed a fellowship in contraceptive research and family planning at the University of Pittsburgh in 2005. In addition, I received my Masters in Public Health, with a focus on epidemiology, from the University of Pittsburgh in 2005.

7. In 2008, I founded the Penn Family Planning and Pregnancy Loss Center, which changed its name to PEACE, the Pregnancy Early Access Center, in 2017 to better align its name with its mission of providing access to compassionate care for women and couples seeking family planning care and management of early pregnancy complications. I have served as the chief of this center since 2008.

8. I submit this declaration as an expert in obstetrics and gynecology, family planning and abortion care, and public health. As a clinical researcher, I have expertise in how science promotes health and the critical importance of following the tenets of evidence-based medicine in the clinical setting. As a Senior Fellow of the Leonard Davis Institute of Health Economics, I

have expertise in the medical, economic, and social issues that influence how health care is organized, financed, and delivered across the United States. My curriculum vitae, which sets forth my experience and credentials in greater detail and contains a full list of my publications and lectures, is attached as Exhibit A to this declaration. All of my opinions in this declaration are stated to a reasonable degree of professional and medical certainty.

II. PHYSIOLOGICAL EFFECTS OF PREGNANCY

9. Even for the healthiest women, pregnancy is a time of profound physiological changes. These changes can have a lasting effect on a woman's health and well-being, including her ability to have, and to parent, children in the future.

10. Pregnancy poses challenges to a woman's entire physiology. Almost all pregnant women experience conditions such as fatigue, headaches, backaches, difficulty sleeping, and difficulty with mobility. Their bladders must be emptied frequently. The hormonal changes in pregnancy induce changes in their bowels, causing gassiness, heartburn, chronic constipation, and hemorrhoids, and varicose veins may develop on their legs, vulvas, and vaginas. Even these "minor" conditions can cause discomfort, pain, and stress for the women involved, and can make work, child care, and other daily tasks extremely difficult. Some women are unable to perform usual tasks during pregnancy. If pregnancy renders

a woman unable to work, or work as often as she did prior to becoming pregnant, she may not be able to support her family.

11. Pregnancy stresses most major organs. For example, during pregnancy the heart rate increases in order to pump 30-50 percent more blood. By the second trimester, the heart is already doing 50 percent more work than usual, and that heightened rate continues throughout the rest of the pregnancy. This increased blood flow results in the enlarged kidneys and increased production of clotting factors by the liver to prevent the woman from bleeding to death. The increase in clotting factors poses health risks to pregnant women in that it increases the risks of blood clots or thrombosis.

12. Pregnancy also weakens the immune system and as a result makes pregnant women more vulnerable to infections, such as urinary tract infections. These infections can be more severe among pregnant women than among non-pregnant women, and lead to life-threatening complications such as sepsis much more frequently among pregnant women.

13. During pregnancy, a woman's lungs must also work harder to clear both the carbon dioxide produced by her own body and the carbon dioxide produced by the fetus. Yet her very ability to breathe in the first place is hampered by the fetus growing in the woman's abdomen, leaving most pregnant women feeling chronically short of breath. Every organ in the abdomen— e.g., intestines,

liver, spleen—is increasingly compressed throughout pregnancy by her expanding uterus.

14. Sometimes the nausea and vomiting commonly associated with "morning sickness" develops into a syndrome known as hyperemesis gravidarum (HG). HG is accompanied by vomiting so severe that it may result in dangerous weight loss, dehydration, acidosis from starvation, or hypokalemia, a potentially dangerous condition caused by a lack of potassium that can trigger psychosis, delirium, hallucinations, and abnormal heart rhythms, among other things. Women with this condition may require multiple hospital admissions throughout pregnancy.

15. Moreover, there is a 15 to 20 percent risk of miscarriage present associated with every pregnancy. Complications from miscarriage can lead to infection, hemorrhage, surgery, and even death.

16. Even a normal pregnancy can suddenly become life-threatening during labor and delivery, when 20 percent of the woman's blood flow is diverted to the uterus. This increased blood flow places a woman at risk of hemorrhage and, in turn, death; indeed, hemorrhage is the leading cause of maternal mortality worldwide. To try to protect against hemorrhage, the body again produces more clotting factors, which increases the risk of blood clots or thromboembolism. This

heightened risk extends past delivery into the post-partum period, and is another dominant cause of maternal mortality.

17. Pregnant women can develop preeclampsia, a disease unique to pregnancy characterized by high blood pressure and a high level of protein in the urine, which can develop suddenly and with little warning and can cause significant damage to a woman's vision, kidneys, and liver, and cause a stroke. Preeclampsia can progress to eclampsia, where a woman has seizures or goes into a coma. Preeclampsia/eclampsia and their complications are associated with an increase in maternal mortality in the United States and are one of the leading causes of maternal mortality worldwide; they are responsible for approximately twenty percent of perinatal (fetal and newborn) deaths.[2]

18. Furthermore, one-third of pregnancies result in a caesarean section delivery.[3] A caesarian section delivery involves a significant abdominal surgery that carries risks of hemorrhage, infection and injury to internal organs. Vaginal delivery can also cause physical injury, such as injury to the pelvic floor. This can have long-term consequences, including fecal or urinary incontinence (inability to control the bowels or the bladder).

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[2] Lelia Duley, *The Global Impact of Pre-eclampsia and Eclampsia*, 33 Seminars in Perinatology 130 (2009).

[3] Centers for Disease Control and Prevention, *Births - Method of Delivery*, available at https://www.cdc.gov/nchs/fastats/delivery.htm.

19. In Pennsylvania in particular, according to Pennsylvania's Department of Health, almost 13 women die within 42 days of the end of pregnancy for every 100,000 live births in the state, a rate that has doubled since 1994. In cities like Philadelphia, that rate is much higher.[4]

20. Abortion, in contrast, is almost always safer for a woman than carrying a pregnancy to term. This is especially true for first trimester procedures, but this margin of safety extends even into the second trimester.[5] While the risks associated with abortion increase as the pregnancy progresses,[6] overall legal induced abortion is markedly safer than childbirth. The risk of death associated with childbirth is approximately 14 times higher than that with abortion, and the overall morbidity associated with childbirth exceeds that with abortion.[7]

21. In short, a policy that forces even healthy women to carry a pregnancy to term—and thereby risk these serious complications—rather than having a desired abortion puts women's health and life at risk above and beyond

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[4] Sean D. Hamill, *Why Has Pennsylvania's Maternal Death Rate Doubled in 20 Years? A New Committee Will Look at Past Cases*, Pitts. Post-Gazette, Jun. 18, 2018.

[5] Elizabeth G. Raymond & David A. Grimes, The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, *Obstet Gynecol*, 2012 Feb;119(2 Pt 1):215-9.

[6] Suzanne Zane, et al., Abortion-related mortality in the United States, 1998–2010, Obstetrics & Gynecology, 2015, 126(2):258–265.

[7] Elizabeth G. Raymond & David A. Grimes, The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, *Obstet Gynecol*, 2012 Feb;119(2 Pt 1):215-9.

the relatively minimal risk that having an abortion presents and is antagonistic to the promotion of health and well-bring.

III. Conditions That Are Exacerbated By Pregnancy and Delivery

22. Pregnancy can be especially dangerous for a woman with a baseline medical condition, or multiple co-existing conditions or diseases (known as comorbidities). Because pregnancy may exacerbate these conditions, it is important that a woman has the option to terminate the pregnancy before her health worsens, as the disease progression is often irreversible. These pre-existing conditions include: heart disease, lupus, cancer, diabetes, obesity, hypertension, renal disease, liver disease, epilepsy, sickle cell disease and numerous other conditions. Based on my training in the field of obstetrics and gynecology as well as my general knowledge of the research literature, below I have described the following more common conditions that are frequently exacerbated by pregnancy in greater detail below:

Diabetes

23. Diabetes is a complex disease that can be difficult to manage even at the best of times. It is more prevalent among women of lower socio-economic status, and poses particular challenges for poor and low-income women who lack easy or regular access to health care.

24. Pregnancy compounds the challenges of managing diabetes. For instance, vomiting caused by morning sickness can easily disrupt a careful regimen of insulin control and result in difficulties managing blood sugars. Some diabetic patients need to test their blood sugar levels 6 to 8 times per day during pregnancy, and make appropriate changes to the dosage on a weekly basis in order to maintain good control over the diabetes. In addition, some women become increasingly resistant to insulin as the pregnancy progresses, making it more difficult to properly regulate the diabetes.

25. The risks associated with diabetes during pregnancy include, at one end of the spectrum, the patient becoming *hypoglycemic* (caused by low blood sugar), which can lead to hypoglycemic shock, and, at the other end, the patient becoming *hyperglycemic* (caused by excessive blood sugar). If left untreated, a hyperglycemic patient may develop diabetic ketoacidosis (DKA), a life-threatening complication of diabetes that can lead to coma, cerebral edema, and death. Diabetes also affects many major organ systems including the heart, blood vessels, nerves, eyes, and kidneys, and can lead to irreversible damage to a major organ, such as coronary heart disease (a major cause of death for patients with diabetes), neuropathy (nerve damage, which can lead to toe, foot, or leg amputation), retinopathy (loss of vision or blindness), or nephropathy (kidney failure).

26. For some diabetics, often referred to as "brittle" patients, the disease can be especially difficult to manage; these patients might experience blood sugar levels that range from extremely low to extremely high in the course of a single day. Such wide swings are very difficult to control during pregnancy, when patients are already more prone to experiencing greater variation in their blood sugar levels. Women who suffer from Type I diabetes may become even more brittle in the first trimester, and therefore more prone to hypoglycemic and hyperglycemic episodes.

27. For diabetic women experiencing multiple co-morbidities, managing the diabetes is already difficult, and it becomes even more so during pregnancy. For instance, a diabetic patient with comorbid lupus or asthma may have been prescribed glucocorticoids—steroid medications with anti-inflammatory effects that help control these diseases. However, glucocorticoids can make it more difficult to control diabetes by increasing insulin resistance. Likewise, studies have shown that depression is more common in people suffering from diabetes than among the general population. If pregnancy causes a diabetic woman to go off her anti-depressants or change her prescription or dosage, she may stop eating, stop taking her diabetes medications, or other problems that can interfere with the management and control of her diabetes.

28. Diabetes also poses risks to the developing fetus, including neural tube defects such as spina bifida, cardiac anomalies, restricted fetal growth, respiratory distress syndrome, low birth weight (for Type 1 diabetes), high birth weight (macrosomia), and a higher risk of developing diabetes later in life (for Type 2 and gestational diabetes).

29. In fact, healthy women can actually *acquire* diabetes during pregnancy, called gestational diabetes, because pregnancy is accompanied by insulin resistance. Gestational diabetes mellitus (GDM) develops during pregnancy in women whose pancreatic function is insufficient to overcome the insulin resistance associated with the pregnant state. Women with gestational diabetes are at increased risk of preeclampsia and eclampsia, stillbirth, and excessively large fetuses (macrosomia) which can result in delivery complications and need for cesarean delivery. Risks associated with gestational diabetes extend beyond the pregnancy and neonatal period. Gestational diabetes may affect a child's risk of developing obesity, impaired glucose tolerance, or metabolic syndrome. GDM is also a strong marker for maternal development of type 2 diabetes, including diabetes-related vascular disease.[8]

[8] Marshall W. Carpenter, *Gestational Diabetes, Pregnancy Hypertension, and Late Vascular Disease*, 30 (Supp. 2) Diabetes Care S246 (2007).

Hypertension

30. Women with chronic hypertension may experience an exacerbation of their condition during pregnancy, which can in turn lead to stroke, cerebral hemorrhage, hypertensive encephalopathy (a condition where dangerously high blood pressure causes brain swelling), congestive heart failure, renal failure, and death. For the fetus, the risks include premature birth, placental abruptions (a condition where the placenta prematurely separates from the uterine wall), restricted fetal growth, low birth weight, and death. Even mild hypertension in pregnancy is associated with an elevated risk of adverse maternal, fetal and neonatal outcomes.

31. Pregnant women with hypertension are also at higher risk of developing preeclampsia, a unique condition characterized by high blood pressure and a high level of protein in the urine, referenced above, which can develop suddenly and with little warning and can cause significant damage to a woman's vision, kidneys, and liver, and lead to seizures and/or stroke. Women with hypertensive conditions also have an increased incidence of premature separation of the placenta (placental abruption), which can cause disseminated intravascular coagulopathy (and can result in uncontrolled bleeding of the uterus often requiring a hysterectomy), fetal hemorrhage and anemia requiring a blood transfusion, and fetal death.

32. In addition, several types of drugs most commonly prescribed to control hypertension— ARBs, ACE inhibitors, and some beta-blockers —have been linked to adverse fetal and neonatal outcomes, especially when used in the latter part of pregnancy. Thus, pregnant women with hypertension are faced with the difficult choice between utilizing a less appropriate medication and risking harm to themselves, or utilizing a teratogenic medication and risking injury to their fetus.

33. Healthy women are in fact at risk of acquiring hypertension in pregnancy, called gestational hypertension.[9] Gestational hypertension and preeclampsia/eclampsia are hypertensive disorders *induced* by pregnancy. Gestational hypertension is the most common cause of hypertension in pregnant women, and is defined by the new onset of hypertension (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg) at ≥20 weeks of gestation in the absence of proteinuria or new signs of end-organ dysfunction. Once a woman develops proteinuria or organ damage, she is classified as having preeclampsia, a disease unique to pregnancy.

[9] American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 202 Summary: Gestational Hypertension and Preeclampsia*, 133 Obstetrics & Gynecology 211 (2019).

Asthma

34. Pregnancy can exacerbate pre-existing asthma, or asthma may develop for the first time during pregnancy. Like diabetes, asthma is more prevalent among women of lower socio-economic status.

35. Even mild asthma can become debilitating during pregnancy. According to the American College of Obstetricians and Gynecologists ("ACOG"), asthma "complicates approximately 4-8% of pregnancies" and "the prevalence of and morbidity from asthma are increasing, although asthma mortality rates have decreased in recent years."[10] Poorly controlled asthma during pregnancy is associated with both maternal and fetal complications, including preeclampsia, restricted fetal growth, complicated labor, preterm birth, and low birth weight.

Heart Disease

36. Heart disease is the most common non-obstetrical cause of maternal mortality. Because pregnancy puts an added strain on the heart muscle due to the dramatic increase in blood volume over the course of pregnancy, most women with preexisting heart conditions will experience an exacerbation of symptoms during pregnancy.

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[10] ACOG Practice Bulletin No. 90: Asthma in Pregnancy, February 2008.

37. Women with heart valve abnormalities or deformities and other forms of heart disease (also known as cardiomyopathy) face an increased risk of complications during pregnancy. In addition, they are more susceptible to developing endocarditis during pregnancy, a potentially life-threatening infection of the lining of the heart and heart valves. Indeed, with certain heart conditions, the risk of maternal mortality can run as high as approximately 10 percent and the risk of fetal mortality as high as 30-40 percent.

38. Women with congenital heart defects are also more likely to give birth to a baby with a heart defect, and are at higher risk for preterm birth. Moreover, medications that treat heart conditions often pose a risk to the fetus, thus presenting the pregnant woman with the same complicated, and often emotionally distressing, choice I have previously mentioned.

Autoimmune disorders

39. Autoimmune disorders, such as lupus, Grave's disease, and rheumatoid arthritis, are more common among women. For women with these and other autoimmune disorders, pregnancy can cause complications such as kidney damage, hypertension, or preeclampsia, as well as complications for the fetus, including restricted fetal growth, preterm birth, and low birth weight.

40. Many of the drugs used to treat these autoimmune disorders are contraindicated in pregnancy. If a woman taking one of these drugs continues her

pregnancy, she will be advised to alter her treatment regimen by, for example, taking a smaller dose or less effective medication, which makes it more likely that her health will deteriorate.

Renal disease

41. Pregnancy exposes women with renal disease to additional complications. Pregnant women with this kidney condition risk hypertension, which can lead to preeclampsia and eclampsia. In some cases, the pregnancy will exacerbate preexisting renal disease, forcing a woman into dialysis—a time-consuming and psychologically difficult treatment that involves filtering the patient's blood through a dialysis machine. In even more extreme cases, the pregnancy exacerbates the woman's condition to the point where she may require a kidney transplant.

IV. Indications for Abortion and Impact of Abortion on Health; Reasons for and Consequences of Care Delays

42. One out of four American women will have an abortion in her reproductive lifetime.[11] The main reasons women cite for seeking abortion care are interference with education, work or ability to care for their dependents, or the

[11] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 AJPH 1904 (2017).

inability to afford a baby at the time.[12] Interviews with women indicate that they rarely feel as though they have "a choice."

43. More than half of all abortion patients in the United States in 2014 were in their 20s: patients aged 20–24 obtained 34% of all abortions, and patients aged 25–29 obtained 27%. Twelve percent of abortion patients in 2014 were adolescents: Those aged 18–19 accounted for 8% of all abortions, 15–17-year-olds for 3% and those younger than 15 for 0.2%. White patients accounted for 39% of abortion procedures in 2014, blacks for 28%, Hispanics for 25% and patients of other races and ethnicities for 9%. Seventeen percent of abortion patients in 2014 identified as mainline Protestant, 13% as evangelical Protestant and 24% as Catholic; 38% reported no religious affiliation and the remaining 8% reported some other affiliation. In 2014, some 46% of all abortion patients had never married and were not cohabiting. However, nearly half were living with a male partner in the month they became pregnant, including 14% who were married and 31% who were cohabiting. Fifty-nine percent of abortions in 2014 were obtained by patients who had had at least one prior birth. Clearly, the need for an abortion does not discriminate based upon race, parenthood status, or creed. What's more, fifty-one percent of abortion patients in 2014 were using a

[12] Lawrence R. Finer et al., Reasons U.S. women have abortions: quantitative and qualitative perspectives, 37 Persps. Sex. & Repro. Health 110 (2005).

contraceptive method in the month they became pregnant, most commonly condoms (24%) or a hormonal method (13%).[13]

44. Women who learn that their fetus has been diagnosed with a severe or lethal anomaly, such as anencephaly (a severe neural tube defect associated with lack of brain development), may experience significant stress, anguish and anxiety over the thought of carrying the pregnancy to term. For some women, the idea of continuing a pregnancy only to give birth to a fetus that will suffer and die is too much to bear. Women and couples who learn that their pregnancy is abnormal may decide that termination of the pregnancy is the most humane option in a terrible situation.

45. The Turnaway Study shows that many of the common claims about the detrimental effects on women's health of having an abortion are not supported by evidence. For example, women who have an abortion are not more likely than those denied the procedure to have depression, anxiety, or suicidal ideation. These data show that that 95% of women report that having the abortion was the right decision for them over five years after the procedure.[14]

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[13] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (2016), *available at* https://www.guttmacher.org/report/characteristicsus-abortion-patients-2014.

[14] Corinne H. Rocca, et al., Decision rightness and emotional responses to abortion in the United States: a longitudinal study, PLOS ONE (2015) Jul; 10(7):e0128832, *available at* https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128832.

46. The Turnaway Study does find serious consequences of being denied a wanted abortion on women's health and wellbeing. Women denied a wanted abortion who have to carry an unwanted pregnancy to term have four times greater odds of living below the Federal Poverty Level (FPL).[15] In addition, women denied abortion are: 1) more likely to experience serious complications from the end of pregnancy including eclampsia and death; 2) more likely to stay tethered to abusive partners; 3) more likely to suffer anxiety and loss of self-esteem in the short term after being denied abortion; and 4) less likely to have aspirational life plans for the coming year.[16]

47. The study also finds that being denied abortion has serious implications for the children born of unwanted pregnancy, as well as for the existing children in the family. Denying women a wanted abortion may have negative developmental and socioeconomic consequences for their existing children.[17]

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[15] Diana Greene Foster, et al., *Socioeconomic outcomes of women who receive and women who are denied wanted abortions*, 108 Am. J. Pub. Health 407 (2018).

[16] *See generally* ANSIRH, *Introduction to the Turnaway Study*, *available at* https://www.ansirh.org/sites/default/files/publications/files/turnaway-intro_1-3-2019.pdf.

[17] Diana Greene Foster, et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, J. Pediatrics (2018), *available at* https://doi.org/10.1016/j.jpeds.2018.09.026.

48. A recent report by the National Academies of Science and Engineering showed that abortions that are provided in the United States are safe and effective. About 90 percent of all abortions happen in the first 12 weeks of pregnancy, which is good, because abortion is safer when it is performed earlier in gestation. Delays in care are what decrease safety. Complications for all abortions are rare, but abortion-specific regulations in many states create barriers to safe and effective care. "Delays put the patient at greater risk of an adverse event," the report says.[18]

V. Effect of Medicaid Ban on Women

49. As part of my practice caring for women with many medical issues, I care for women and couples who need to end their pregnancies for all the reasons mentioned above. There are a huge range of indications, and some are tragic circumstances: many of these patients must terminate a wanted pregnancy because the fetus has been diagnosed with an abnormality, or because a baseline medical condition has worsened and makes carrying the pregnancy unsafe, or because her partner has left her or is abusive and carrying this pregnancy to term would connect the woman to her abuser for the rest of her life. I have patients request an abortion so that they can finish their nursing degree, or so that they can

[18] National Academies, *supra* note 1, at 12.

continue to work two jobs to put food on the table for their children at home, or care for an ailing parent. I have had patients seek abortion care while their young child is hospitalized with a chronic illness just so that they can be more available to care for that ill child. All of these women are making hard decisions for good reasons, and they all need care. In my experience working as a provider in Pennsylvania, I have personal experience with Pennsylvania Medical Assistance eligible patients and their struggles to pay for the care they need, the delays this creates, and, in some cases, a resultant forced parenthood. Somewhat ironically, the same woman who may seek an abortion because she cannot afford another child may have difficulty paying for the abortion because her insurance does not cover the procedure. I have listened to my patient care coordinator ask women the dehumanizing question "What can you sell?" so that they can raise the money for the reproductive healthcare they need. This process affects women uniquely.

50. Abortion is one of the safest procedures in modern medicine, and safer than carrying a pregnancy to term. Indeed, abortion is about 14 times safer than continuing a pregnancy to term. However, despite abortion being safer than childbirth, both the risks from and cost of the procedure increase as pregnancy advances. Women may need to delay procedures to raise the money to cover the costs – this delay puts them at risk of abortion complications, and also increases the fees associated with the procedure. A second trimester procedure may require

more appointments, and as a result will cause the patient to need more time off of work and/or will require the patient to obtain more childcare for existing children than a first trimester procedure.

51. Furthermore, the very limited exception to Pennsylvania Medical Assistance for abortions in the event of rape, incest or to save the life of the pregnant woman is completely inadequate to protect the health and well-being of the women of our State.

52. First, the very narrow life exception excludes the vast majority of women who are not facing a condition that imminently threatens their life, but for whom continuing a pregnancy is seriously detrimental to their health. In addition, a woman's medical condition may not be life-threatening at the time that she presents to her doctor for abortion care, but could become so in the future. As a physician, I believe it is dangerous and unethical to force a woman to wait until her health deteriorates to the point that her life is in danger in order to be able to pay for the health care that she needs – abortion is preventive care. This also requires that physicians balance payment issues and regulations with their health care decision-making in a unique and unethical manner. A physician's role is to improve health and well-being, not to determine if a woman is sick enough and close enough to death to warrant the state to pay for the abortion to "save her life"—especially when, as started previously, all women are uniquely at risk of

death due to pregnancy and delivery. This is a health burden that women uniquely have to bear in the context of reproductive healthcare.

53. Second, these exceptions do nothing for those patients who make the often difficult decision to terminate a wanted pregnancy after learning that the fetus has been diagnosed with an abnormality. Many of these anomalies are lethal and cannot be detected—let alone diagnosed—until later in pregnancy when abortion is even more expensive or even prohibited by law because the pregnancy has progressed beyond Pennsylvania's gestational limit for abortion.

VI. CONCLUSION

54. I have dedicated my career to improving the health of women. There is no clinical justification for forcing any woman to undergo a prolonged, physically taxing and, indeed, dangerous experience such as pregnancy against her will. For those pregnant women who need to end their pregnancies, abortion is medically necessary and appropriate care that protects their life and health, including their ability to have children some day in the future if they decide to do so.

I make this declaration subject to the penalties of 18 Pa. C. S. § 4904 (unsworn falsification to authorities).

Dated this 11 of January, 2019.

Courtney Anne Schreiber, MD, MPH.