DeBOER: [00:54:16] OK. Thank you.

LATHROP: [00:54:23] Thank you. Good afternoon.

DEBORAH TURNER: [00:54:38] Good afternoon. My name is Deborah, D-e-b-o-r-a-h, Turner, T-u-r-n-e-r. I am the associate medical director for Planned Parenthood of the Heartland. I am here to testify in opposition to the additions to LB209 as it cuts across the core values of medicine: the physician-patient relationship and science. Briefly, my background is I completed my residency in obstetrics and gynecology at the University of Iowa, followed by a fellowship in gynecologic oncology at MD Anderson Cancer Institute. I am certified by the American Board of Obstetrics and Gynecology. I have served as assistant professor of gynecologic oncology at University of Nebraska Medical Center and the VA Hospital in Omaha, as associate medical director at University of Iowa and the Medical College of Wisconsin. I retired from the practice of gynecologic oncology as director of "medico" of-- at Mercy Medical Center in Des Moines, and I have spent over 35 years, including in basically growing and building my expertise in gynecology, gynecology, gyne oncology, and abortion care. I spend much-- most of my life dealing with women who are dealing with serious issues in their life and making serious decisions. There are several misconceptions about medical abortion and the so-called medical abortion reversal process that I will address here. Medical abortion is a healthcare service that is available to patients who have been pregnant for fewer than or equal to 70 days or 10 weeks. The patient is given two pills or two medications. The first is mifepristone and then a second is misoprostol. The misoprostol is administered either 6 to 48 hours later, depending on the avenue, be it vaginal, buccal, or oral. The patient is given the misoprostol because in order to empty the uterus after the Mifeprex has worked. And how Mifeprex works is it an antiprogesterone, basically, or it's a synthetic steroid, as we would call it. It essentially attaches to progesterone receptors and by doing so it stops the growth of the pregnancy. It softens

and starts the breakdown of the uterine lining. So that is the mechanism of it. Medical abortion is a safe procedure that has been studied and approved by the U.S. Food and Drug Administration, in contrast to the idea that the process can be reversed by administrating reversal doses of progesterone, which has not been studied, evaluated, or approved by the FDA. The literature purporting, as has been discussed earlier, proposing and promoting this procedure is uncontrolled, mostly case studies, and mostly by one individual. One of the biggest things about the LB209 that I have concerns about is that not only that the research regarding reversal so is inappropriate, or incomplete I should say, but the fact that the physician-patient relationship is critical. When we talk to patients about their options, whether it be for abortion or whatever the medical procedure is, we are required as physicians to give honest, factual, science-based information. If you talk to-- if we are telling physicians like I that we have to tell our patients information that has not been shown to be proven, is untrue, and could potentially give harm, we are destroying the patient-physician relationship and it would cost me simply to lie to my patients, so.

LATHROP: [00:58:24] Doctor, let's see if there's any questions for you. Senator DeBoer.

DeBOER: [00:58:31] Thank you for testifying today. Can you tell me what the standard of care is? This is my question.

DEBORAH TURNER: [00:58:37] OK.

DeBOER: [00:58:37] Still, still don't know the answer to. What is the standard of care for someone who's coming in to have a medica-- medication abortion about the efficacy of the procedure and about-- so the efficacy of the first half, if they don't take the second one? What do you tell them now?

DEBORAH TURNER: [00:58:55] Basically, what we tell them, first of all, we go through the process of what will be done. We talk to them. We give them all the options, ask them for sure. They have to do a decision regarding do they want an abortion. We talk to them about parenting. We talk to them about adoption. And then we talk about their abortion, if that's what we choose. Then we tell them about how the pill works. We explain to them that the first pill is the one that actually stops the pregnancy growth and they understand that that may not be 100 percent effective. And we usually give them percentages. We tell them that the second pill, which is some-- the misoprostol, is one that empties the uterus and causes to uterus to contract. So by the time they've gone through our first initial discussion with our ultrasonographer who goes over their background and that and then spends time with our educator who goes over all the facts, talks about the medication, talks about the process, talks about the side effects and makes sure that they have their decision to go through for the abortion is clear. And then they come to the provider, who is me in this case, in our clinic, and I sit down and I go through all the options again with them but I also discuss with them the possibility that it may not be effective and explain to them what our recommendations would be if it's not effective. They understand that if they take the one pill and they don't take the second pill there is a large possibility that they may not-- or about a 50 percent, I guess I should say, possibility that they might not abort the pregnancy. How many of those will continue on for a viable pregnancy you can't be absolutely sure about. Depends on what you read in the literature. It could be anywhere to 25 to 50 percent. And they understand that if they take the second pill were thereby we recommend that they continue with the completion of the pregnancy at that time and they usually come back, get an ultrasound, and then determine whether they want to go through with a surgical abortion, if there's still tissue left, or if they want to try a second dose of the misoprostol. So they have multiple chances to hear everything and they have multiple decisions, times to make the decision and make sure that this is what they want to do.

DeBOER: [01:01:03] So, OK, I have a number of questions.

DEBORAH TURNER: [01:01:05] Oh, OK, I'll try to answer them.

DeBOER: [01:01:08] So what are the-- so medication abortion in general, about what percentage of the time is it successful in terminating pregnancy?

DEBORAH TURNER: [01:01:18] If we do the medication abortion which we consider the Mifeprex and the misoprostol, if you are at under nine weeks of gestation, it's roughly around 98 percent. You'll see some studies that will tell you 95 percent, but it's closer to 98 percent. If you are 9 to 10 weeks, which is to 10 weeks is the upper limit, you are-- we will tell patients that they have about a 92 percent chance. So in other words, when we're talking to patients, I'll say 2 out of 100 women, if you're at seven weeks for example, may not be have a complete abortion, may need something further or-- and if you're at 10 weeks I'll say 8 out of 100 women may need further.

DeBOER: [01:01:58] OK. So you're-- so particularly with the 10 weeks,--

DEBORAH TURNER: [01:02:06] Uh-huh.

DeBOER: [01:02:06] -- you're telling them that they're-- this may not be effective. You may need additional.

DEBORAH TURNER: [01:02:10] Right. Yes. So they have a 92 percent chance of it being effective, but there are going to be 8 out of 100 women that may need something further. That

doesn't mean that it'll be ongoing pregnancy. It may mean that they don't completely expel all the products of conception.

DeBOER: [01:02:25] OK. So then is that the-- the process? I know that-- that some of the process that you described for informed consent is-- is part of our statute.

DEBORAH TURNER: [01:02:38] Uh-huh. Yes.

DeBOER: [01:02:40] But it-- it doesn't sound like all of what you describe to them is statutory. You also have other things you say to them. Or am I getting that wrong?

DEBORAH TURNER: [01:02:50] I guess I'm not understanding your question exactly. I'm sorry.

DeBOER: [01:02:54] Yeah, yeah, yeah. Do you just tell them what's required by statute or do you add additional instructions, information beyond what's just required by statute?

DEBORAH TURNER: [01:03:05] I can say that in our clinic the things that-- I guess I'd have to look at see exactly what we say. We tell everything that's in the statute. But you know we're going to give them further information that if you have this problem you can call us at this time, if you have this concern you can call us at this time. And you know we do things like ask them to make sure they're going to have somebody with them, do they feel comfortable, those kind of things that maybe I guess is what you're talking about?

DeBOER: [01:03:32] For example, like--

DEBORAH TURNER: [01:03:33] I'm curious.

DeBOER: [01:03:35] --the question about whether or not after taking the first pill they might still be pregnant. That it doesn't seem like is required statutorily or for I don't know why we're all here. So that doesn't seem like that's required. So where does that-- you said that that's something that you tell them. Is that a Planned Parenthood? You work--

DEBORAH TURNER: [01:03:58] Any-- I guess the quest-- I think the question you're trying to get at is that if they take the first pill and then decide not to take the second pill? Is that what--

DeBOER: [01:04:08] Yes.

DEBORAH TURNER: [01:04:08] --you're asking me?

DeBOER: [01:04:08] You said that there was some information that you give them about--

DEBORAH TURNER: [01:04:11] We explain to them that the first pill, what it does is it stops the pregnancy growth, and the second pill empty the uterus. We explain to them that if they do not take the second pill, you know, they may not potentially empty the uterus so they may not have a complete, completion of the-- of the abortion, if that's what you're asking me.

DeBOER: [01:04:32] Yeah.

DEBORAH TURNER: [01:04:33] Yeah.

DeBOER: [01:04:33] And where does that--

DEBORAH TURNER: [01:04:34] They-- they long-- basically, basically what we tell them along the way is that there are no absolute positive guarantees that any step of the way that it will all be completed.

DeBOER: [01:04:43] And where do-- so what makes you tell them that?

DEBORAH TURNER: [01:04:47] Because physicians speak honestly to their patients. Like if I tell someone they're going to have a hysterectomy, you know, chances are very good they're going to survive, but I tell them they could die.

DeBOER: [01:04:57] Sure.

DEBORAH TURNER: [01:04:58] OK? So it's the kind of same thing, that the outcome may not be. And I tell them they might have injury to the bowel, bladder, or whatever. So the statute may not say that I need to say that when I get informed consent for a hysterectomy, it may or may not, but you try to give women as much information as they need to make the decision in a informed way, but also not giving them information that is incomplete or inaccurate.

DeBOER: [01:05:26] So it's part of just the standard of care that you would have as a doctor to offer--

DEBORAH TURNER: [01:05:32] Right, inform your patient, uh-huh.

DeBOER: [01:05:32] --as much information as possible, including this information about the effectiveness of each of the individual pills?

DEBORAH TURNER: [01:05:41] Yes, we talk about the effectiveness. Yes.

DeBOER: [01:05:43] OK. That's fine.

DEBORAH TURNER: [01:05:45] OK. I'm sorry I [INAUDIBLE].

DeBOER: [01:05:46] No, I [INAUDIBLE].

DEBORAH TURNER: [01:05:47] I was trying to figure out what you were asking me. I apologize.

DeBOER: [01:05:49] I'm trying to figure out what people know and when they know it and why they know it.

DEBORAH TURNER: [01:05:53] Sure. Uh-huh.

DeBOER: [01:05:53] So thank you for-- for that. I had another one for you. Let me look through. Oh, how many-- how would-- how would you study this? So the-- the progesterone issue, how would you study? You know that's--

DEBORAH TURNER: [01:06:17] That would be a very difficult, honestly, study to setup, OK? And there are, you know, I'm honestly not a researcher and I don't design all research studies, but

when you're looking at a research study, first you look at the question you want. Then you figure out how many people you would need to prove it one way or another. That's kind of where you would start. And the trick would be how many-- how you could get women. I doubt you're going to get a group of women that are going to a controlled study to say, yes, I will take it and see what happens as opposed to I take it and I want the abortion, particularly since most women who come in for abortion have already decided that's what they wanted. Very few of them change their mind. That's a very small number and there are plenty of studies out there that show that. So it would take you years and years and years probably to figure how to design a study and that would actually prove that this was the case, would be my guess. But I'd start out by looking at what it is you want to answer and then how many patients or women you would need to actually have the power enough to prove that. And two or three or four or five or six is not enough.

DeBOER: [01:07:27] And then my last question, I promise, what-- are there-- are there any risks of taking the progesterone at any level after taking the mifepristone?

DEBORAH TURNER: [01:07:40] As far as the risk of, you know, anytime you take a hormone, be it a small dose or a large dose, there are some concerns about the risk. So you would have to look at the dose that you're taking and you'd have to look at studies that show what progesterone does or does not do to a woman who is pregnant or nonpregnant. Because the-- the complications may be something other than related to the pregnancy. And you'd all-- we all know that taking hormones during pregnancy can have some effects on the fetus. And we just have to look at those [INAUDIBLE] and determine that. And there's data out there and there's studies out there that actually look at progesterone supposedly in the nonpregnant and pregnant woman.

DeBOER: [01:08:26] OK. So that data is available somewhere.

DEBORAH TURNER: [01:08:29] Uh-huh. Yes.

DeBOER: [01:08:30] OK. All right. Thank you.

DEBORAH TURNER: [01:08:31] Uh-huh.

LATHROP: [01:08:34] Did you have any questions? Senator Pansing Brooks.

PANSING BROOKS: [01:08:36] Thank you for coming,--

DEBORAH TURNER: [01:08:37] Uh-huh.

PANSING BROOKS: [01:08:38] --Ms. Turner-- or Dr. Turner. Yeah.

DEBORAH TURNER: [01:08:40] No, that's OK.

PANSING BROOKS: [01:08:41] I guess I was-- I'm just interested in the study that has been referenced and I think that you-- you also referenced that it would be very difficult to have-- have a group of people come in pregnant, take the first pill, and then-- and then not take the other, and then be able to prove that this works. So do you have anything else to say about the study from your understanding as a medical professional?

DEBORAH TURNER: [01:09:09] Well, other than the fact that, yes, it would be difficult, but when you design a study, you try to compare apples to apples, as oranges to oranges. So one of the

difficulties with the study that is out there, and there's a really great review and we can certainly get to the reference that was in the New England Journal of Medicine and I believe it was October of 2018 that review. Saw the information, It's an excellent article so we can get to the reference. I apologize I didn't bring that today. But so if you're going to study women who are going to take progesterone in this sense or whatever sense it may be, first of all you would have to look at the same gestation. You'd have to make sure they were taking the same dose. You would have to make sure they were taken in the same regimen. You would have to determine whether you were giving it, whether someone already has an ongoing viable pregnancy or someone has a pregnancy that's, oh, if the-- how you're going to determine if it's a viable pregnancy or not. Because there's good data that shows that if indeed you take the Mifeprex and you have an ongoing pregnancy at about-- a viable pregnancy after, I believe, it's 72 hours. And I'd look at that for sure but I think it's 72 hours. The chances of you going on to have-- continuing the pregnancy are probably at least 50 percent, which is basically kind of the same numbers that you're seeing in the studies. So it's like you really have to fine-tune it to very specific data and comparing apples to apples and oranges to oranges.

PANSING BROOKS: [01:10:45] OK. Thank you.

DEBORAH TURNER: [01:10:46] Uh-huh.

LATHROP: [01:10:47] I have a question. In the bill it says that-- that somebody that wants to have this done must be told 24 hours in advance and there's a series of things as you--

DEBORAH TURNER: [01:10:58] Uh-huh.

LATHROP: [01:10:58] --probably well know. This would add the following: that it may be possible to reverse the effects of a medication abortion if she changes her mind but that time is of the essence. Is that a true statement? If we made you say that to a patient would it be a true statement?

DEBORAH TURNER: [01:11:13] No, it would not. There's no data or information that would-- that I could tell a patient that that would be an honest statement. So if you told me I had to tell the patient that, medically or ethically, I would either have to say I can't tell them or I have to tell them, you know, basically this is not a proven or true statement that I'm going to tell you, if you're an honest physician.

LATHROP: [01:11:39] And we-- we talked to physicians about the efficacy of medications when we had medical marijuana here--

DEBORAH TURNER: [01:11:48] Uh-huh.

LATHROP: [01:11:48] --a month ago or so. And your opinion that you just gave is a function of the fact that there are no studies that would show the efficacy of the progesterone treatment that's been described. Is that my understanding?

DEBORAH TURNER: [01:12:03] Yes.

LATHROP: [01:12:05] And is it possible, I think maybe in answering pan-- Senator Pansing Brooks's question, it doesn't sound like it's possible to do such a study because you can't get a control group.

DEBORAH TURNER: [01:12:17] I didn't say it's not possible. I'm saying that in order to try and do it, you would really have to design a well-designed study, and that has not been done.

LATHROP: [01:12:30] OK. It's not-- that's something that's possible; it just hasn't been done. So from a scientific point of view, you don't have the information.

DEBORAH TURNER: [01:12:38] Right. And we try not to give patients information that is not scientific or proven. And it's very unethical to do that, and as physicians, we try to be as ethical as possible.

LATHROP: [01:12:52] OK. And I want to try to understand one more thing that you testified to, to make sure I understand what your testimony is. And you tell me if I got this wrong. If somebody takes the first medication of the two-medication regimen and they change their mind and stop, they have a 50 percent chance that the child will go-- the development will continue. The child will ultimately be born.

DEBORAH TURNER: [01:13:13] And in the-- if you look at the literature, there's anywhere from some studies will say 25 percent, some will say 50 percent. We say there's about a 50 percent efficacy with mifepristone alone without the misoprostol.

LATHROP: [01:13:27] OK. And the fact that some of those people who took the first one but not the second one went on to have a successful pregnancy suggests that some of the information that's been put out by some of the folks that have case studies, it may just be a function not of the progesterone but the fact that they're in the 25 to 50 percent of the people that would go on to have a

successful pregnancy just by virtue of not taking the second drug.

DEBORAH TURNER: [01:13:56] Yes.

LATHROP: [01:13:56] I think I get it.

DEBORAH TURNER: [01:13:58] OK.

LATHROP: [01:14:00] Senator Morfeld.

MORFELD: [01:14:03] Thank you for your testimony.

DEBORAH TURNER: [01:14:04] Uh-huh.

MORFELD: [01:14:04] [INAUDIBLE] a copy of your testimony?

DEBORAH TURNER: [01:14:07] Yes.

MORFELD: [01:14:08] That would be useful. Thank you.

LATHROP: [01:14:13] I do not see any other questions.

DEBORAH TURNER: [01:14:15] OK.

LATHROP: [01:14:15] Thank you for your testimony--