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The U.S. Senate Committee on Health, Education, Labor and Pensions
"Protecting Women: Exposing the Dangers of Chemical Abortion Drugs" Hearing
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Good morning Chair Cassidy, Ranking Member Sanders, and distinguished members of the Senate HELP Committee. My name is Dr. Nisha Verma, and I am a double board-certified, fellowship trained, obstetrician and gynecologist and fellow with Physicians for Reproductive Health. I provide full-spectrum ob/gyn care in Georgia and Massachusetts, meaning that I provide everything from pap smears and cancer screenings, to delivering babies and supporting patients postpartum, to providing contraception, abortion, and miscarriage care.

As a doctor, I know that abortion care can be complicated for many people. I sit with that complexity every day, as do so many of my patients and their families. Holding space for complexity is important—but discomfort with abortion care should not be used as an excuse to distort facts.

So, let's talk about the facts. The fact is: the science on mifepristone's safety and effectiveness is longstanding and settled. Over the past three decades, mifepristone has been rigorously researched and proven safe and effective in hundreds of high-quality, peer-reviewed studies for both medication abortion and miscarriage management in patients who do not pass the uterine contents on their own.[1] To date, mifepristone has been discussed in more than 780 medical reviews and used in more than 630 published clinical trials—of which more than 420 were randomized controlled studies, the gold standard in research design.[2] Over one hundred of those studies have specifically assessed safety. Serious adverse events with medication abortion—such as severe hemorrhage or infection—are very rare, consistently occurring in well under one percent of cases in both telehealth and in-person care.[3] In fact, one study of over 19,000 medication abortion patients taking mifepristone either at home or with a physician found that significant adverse events (including hospital admission and emergency department treatment) with medication abortion were as rare as 0.3%.[4] Mifepristone has a lower

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[1] John Hopkins School of Public Health, What Is Mifepristone, aka "The Abortion Pill"?, Oct. 8 2025, available at https://publichealth.jhu.edu/2025/what-is-mifepristone-aka-the-abortion-pill.
[2] American Medical Association. AMA to court: Don't overturn FDA approval of mifepristone. *American Medical Association*. https://www.ama-assn.org/health-care-advocacy/judicial-advocacy/ama-court-don-t-overturn-fda-approval-mifepristone. Published March 14, 2023.
[3] ANSIRH, Issue Brief, U.S. Studies on Medication Abortion Without In-Person Clinician Dispensing of Mifepristone, at 1 (Oct. 2021).
[4]Daniel Grossman & Kate Grindlay, Safety of Medical Abortion Provided Through Telemedicine Compared with in Person, 130 Obstetrics & Gynecology 778 (Oct. 2017).

complication rate than many other FDA approved drugs widely available by prescription and over the counter across the United States with fewer restrictions.[5]

Studies have also found that telemedicine is an equally safe option for medication abortion.[6] A 2022 study of medication abortion provided through online telehealth in the United States found that 96.4% of patients successfully ended their pregnancies without the need for intervention.[7] In 2015, a study of 13,373 patients whose medication abortion regimen consisted of taking mifepristone orally at a health center followed by misoprostol used at home concluded that the efficacy of the regimen was 97.7%.[8] Another study published in *Nature* in 2024 demonstrated that 99.8% of abortions provided through telehealth were not followed by serious adverse events.[9] Only 1.3% were followed by a known emergency department visit, out of which 38.3% of visits required no further treatment. Data indicate that provision of medication abortion via telehealth is increasingly prevalent and is a vital source of access for many people, including those living in maternity deserts now comprising 35% of the country.[10] Findings also suggest that telehealth abortion care does not delay and sometimes facilitates earlier detection and treatment of ectopic pregnancy.[11]

The combined mifepristone–misoprostol regimen is highly effective—when taken together following the medical best-practices, mifepristone and misoprostol are 93%–99% effective at completing medication abortion.[12] Medication abortion is currently the most common

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[5] See Jay Cohen et al., Comparison of FDA Reports of Patient Deaths Associated with Sildenafil and with Injectable Alprostadil, 35 Annals Pharmacotherapy 285, 287 (Mar. 2001); Anne Miles et al., Penicillin Anaphylaxis: A Review of Sensitization, Treatment, and Prevention, J. Ass'n Acad. Minor Physicians 50-56 (1992); see also ANSIRH, Issue Brief, Analysis of Medication Abortion Risk and the FDA Report "Mifepristone U.S. Post-Marketing Adverse Events Summary through 6/30/2021," at 3 (Nov. 2022) (noting that mifepristone has a lower mortality rate than other common medications like penicillin, which has a morality rate three times higher than mifepristone, and Viagra, which has a morality rate more than six times greater than mifepristone).

[6] Daniel Grossman & Kate Grindlay, Safety of Medical Abortion Provided Through Telemedicine Compared with in Person, 130 Obstetrics & Gynecology 778, 780-81 (Oct. 2017).

[7] Abigail Aiken et al., Safety and Effectiveness of Self-Managed Medication Abortion Provided Using Online Telemedicine in the United States, The Lancet Regional Health - Americas, Vol. 10, June 2022, at 1, 3, 4

[8] Mary Gatter et al., Efficacy and Safety of Medical Abortion Using Mifepristone and Buccal Misoprostol Through 63 Days, 91 Contraception 269, 270, 273 (Apr. 2015)

[9] Upadhyay UD, Koenig LR, Meckstroth K, Ko J, Valladares ES, Biggs MA. Effectiveness and safety of telehealth medication abortion in the USA. *Nature Medicine*. 2024;30(4):1191-1198. doi:10.1038/s41591-024-02834-w

[10] Stoneburner A, Lucas R, Fontenot J, Brigance C, Jones E, March of Dimes. *Nowhere to Go: Maternity Care Deserts Across the US*.; 2024. https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf.

[11] MA Biggs, S Kaller, D Grossman, J Ko, L Koenig, U Upadhyay, Experiences of Ectopic Pregnancy Among People Seeking Telehealth Abortion Care, Contraception, Volume 134, 110405, June 2024.

[12] Supra note 1.

method of abortion care in the United States, used by more than 7.5 million people since its FDA approval in 2000.[13]

Similarly, mifepristone and misoprostol are safe and effective for miscarriage management. Fifteen percent of all clinically recognized pregnancies end in miscarriage, and approximately 80% of all cases of pregnancy loss occur within the first trimester.[14] I often care for women and families experiencing the loss of a highly desired pregnancy who wish to treat their miscarriage with medication. For these patients, mifepristone, along with misoprostol, speeds along the process, reduces pain, and decreases the need for additional treatments. A 2018 study of the treatment of first-trimester pregnancy loss with mifepristone followed by misoprostol found this regimen had a higher likelihood of success than treatment with misoprostol alone.[15] Knowing their safety and efficacy, I took these medications myself a few months ago after my husband and I experienced a devastating pregnancy loss. Luckily, in Massachusetts, we were able to obtain the medications from our local pharmacy and complete this very difficult process safely, privately, and at home. Unfortunately, for many people, unnecessary restrictions on mifepristone make this evidence-based care unavailable, and force them to undergo additional hardship during already heartbreaking experiences.

When we look to the full body of high-quality evidence, it is clear that the safety and effectiveness of mifepristone and misoprostol is not a matter of opinion or debate; it is the clear consensus of the evidence-based medical community, both here in the U.S. and globally. Leading professional organizations—including the American College of Obstetricians and Gynecologists and the American Medical Association—affirm this fact, as does the National Academies of Sciences, Engineering, and Medicine. Globally, the World Health Organization classifies mifepristone and misoprostol as essential medicines—among the safest and most effective treatments that should always be available to patients.

The small number of studies that contradict this track record of safety are deeply flawed, to the extent that two have been retracted.[16] Most recently, the Ethics and Public Policy

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[13] Advancing New Standards in Reproductive Healt, *Analysis of Medication Abortion Risk and the FDA Report "Mifepristone US Post-Marketing Adverse Events Summary Through 12/31/2024."*; 2025. https://www.ansirh.org/sites/default/files/2025-05/Issue%20Brief%20MAB%20SAEs-May2025%20Final_0.pdf.

[14] Siobhan Quenby et al., Miscarriage Matters: The Epidemiological, Physical, Psychological, and Economic Costs of Early Pregnancy Loss, 397 Lancet 1658 (2021).

[15] See Courtney Schreiber et al., Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss, 378 N. Engl. J. Med. 2161, 2168-69 (June 2018) (additionally finding that pretreatment of mifepristone resulted in a higher likelihood of successful management of firsttrimester pregnancy loss).

[16] Studnicki J, Harrison DJ, Longbons T, et al. RETRACTED: A longitudinal cohort study of emergency room utilization following MIFEpristone chemical and surgical abortions, 1999–2015. *Health Services Research and Managerial Epidemiology*. 2021;8:23333928211053965. doi:10.1177/23333928211053965

Center self-published a paper that has received attention and support from the anti-abortion movement. Secretary of Health and Human Services Robert F. Kennedy Jr. and FDA commissioner Marty Makary are using the findings of this paper to conduct a review of mifepristone's safety. This is deeply concerning given the substantial errors in the paper and the opacity of the database used to arrive at its conclusions, despite repeated requests for greater transparency about the data.[17] For example, the EPPC study makes egregious errors in its count of serious adverse events related to medication abortion. It misrepresents, for example, routine evaluation of expected symptoms of a medication abortion like bleeding and cramping as adverse events. This goes against the FDA's own guidance, which states: "Emergency room visits that do not result in admission to the hospital should be evaluated for one of the other serious outcomes (e.g., life-threatening; required intervention to prevent permanent impairment or damage; other serious medically important event)."[18] Additional errors include counting subsequent treatment to complete an abortion as an adverse event, conflating abortion care with miscarriage care and other uses of mifepristone, and counting longstanding health conditions such as chronic pulmonary issues as adverse events even if they are not related to the abortion.[19] The paper makes sweeping policy recommendations that are not at all supported by its findings.

In my practice, I regularly prescribe mifepristone and misoprostol for the same reasons I chose to take them myself when I needed them: because I know they are safe and allow patients to access the highest quality care. When I prescribe these medications, I counsel my patients, ensure they understand their options, review potential side effects and risks—just as I would with any treatment—and support them in making the decisions that are right for them.

Access to mifepristone and misoprostol keeps my patients safe and does not pose a threat to their wellbeing. However, my patients do face real, well-documented threats to their health, wellbeing, and lives. One real risk is the impact of losing access to these medications. The consequences of losing access to mifepristone will disproportionately impact my patients with low-incomes, patients of color, immigrant patients, and those who live in rural areas; the same communities already facing dangerous barriers to accessing any health care they need due to systemic barriers and denials of care.

My patients are also at risk because of restrictions on abortion care and cuts to Medicaid. In the last year, Medicaid funding restrictions forced clinics to close across the country, leaving many patients in remote or rural areas without a reproductive health care

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[17] Upadhyay U. *Review of Hall and Anderson Report on Abortion Safety*.; 2025. https://www.ansirh.org/sites/default/files/2025-09/Anderson%20and%20Hall%20Review_Final.pdf.
[18] Id.
[19] Id.

provider.[20] More than 16 million women of reproductive age are covered by the Medicaid program.[21] Because of decreased funding to clinics that provide preventive care and cancer screenings, patients are without many access points to lifesaving care. My patients are also at risk because of fears about whether they can safely go to the hospital based on their immigration status, and the ever-increasing crisis of maternal mortality. When it comes to maternal mortality, Black women are three times more likely to die from pregnancy related harm than White women.[22] Among all this, my patients must navigate widespread misinformation and a disregard of science and evidence. While we know conclusively based on science and evidence that mifepristone and misoprostol are safe, these are some of the actual threats patients are facing everyday.

Patients will further suffer if access to mifepristone is rolled back and the FDA restores regulatory burdens on access to mifepristone. This is unnecessary and harmful. Over time, the FDA expanded access to mifepristone by removing medically unnecessary restrictions.[23] In 2021, the FDA halted enforcement of the Risk Evaluation and Mitigation Strategies (REMS) for in-person dispensing requirements for mifepristone. In 2023, the FDA formally lifted the requirement, meaning patients no longer had to travel to a clinic to receive mifepristone and could continue to receive safe care via telehealth if that was more accessible for their life, family, and needs. These modifications reflect science and evidence-based best practices, reaffirming the safety and efficacy of mifepristone. This change also reflects the needs of my patients, who often have to travel significant distances just to access needed healthcare. If this barrier were restored, it would be unnecessary, burdensome, confusing, and contradictory to evidence and science.

As a doctor, I have the immense privilege of sitting with people and their families to learn about their lives. My patients remind me every day that abortion care, pregnancy, and medicine are not isolated political issues, and I chose to be here in this room today, as challenging as it is, to honor them. I hope moving forward this committee will focus on addressing the many real, documented dangers patients face, rather than restricting access to safe, evidence-based care.

Thank you for having me today. I look forward to your questions.

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[20]Gounder C. The quiet collapse of America's reproductive health safety net - KFF Health News. KFF Health News. https://kffhealthnews.org/news/article/title-x-family-planning-hhs-opa-trump-cuts-reproductive-health-maine/. Published October 30, 2025.

[21] Medicaid. ACOG. https://www.acog.org/advocacy/policy-priorities/medicaid.

[22] Hill L, Rao A, Artiga S, Ranji U. Racial disparities in maternal and infant health: current status and key issues. KFF. https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-key-issues/. Published December 3, 2025.

[23] ACOG, Understanding the practical implications of the FDA's December 2021 and January 2023 MiFePristone REMS decisions, https://www.acog.org/news/news-articles/2022/03/understanding-the-practical-implications-of-the-fdas-december-2021-mifepristone-rems-decision. Published December 4, 2023.