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Speakers:

-Dr. Ann Schutt-Aine, Chief Medical Officer, Planned Parenthood Gulf Coast ("**PP**")

-Tram Nguyen, RN, VP Abortion Access, Planned Parenthood Gulf Coast ("**PP2**")

-CMP undercover reporter ("**Buyer**")

frame counts are approximate

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Buyer: Hey, Texas!

PP: Hi, how are you?

Buyer: Did we meet before, or?

PP: I'm not sure.

Buyer: [Name], I'm with BioMax, the fetal tissue collection agency.

PP: Oh okay, no we haven't. I'm Ann Schutt-Aine, I'm her Medical Director at Gulf Coast, at Center for Choice.

Buyer: Oh you are. The medical director for 2nd tris, I guess.

PP: Well, so, Paul Fine is the medical director for the entire affiliate, and I am over the abortion services.

Buyer: Oh, okay.

PP2: So I introduced her to [Name] last night, because she's one of my two providers that goes up to the state max. So if there's gonna be, like, if you know how I was telling you Thursday, Friday, Saturdays are our heavier D&E days? She's one of the providers.

Buyer: Yea. [Name] had said to me that you guys had a great conversation last night about, how, for him to go out there, and there was talk of the quality of specimens, and he was like, "You'll be so excited! They're really, really down, they want to do it!" And I was like well, that's what we found out when we went there, so.

PP: Yeah, no it's good. I mean we, yeah. We definitely have the volume, so.

Buyer: And the quality too. You know how to do some of the tricky--

PP: Yeah, we do our best. I mean, I mean, especially when it—you know, sometimes it's not possible. Sometimes—but you know, we had a patient, a couple months ago, who it was an anomalous fetus, a desired pregnancy, and she wanted footprints, and so I made sure that the resident didn't do that procedure, so that I was able to do it in such a way that we were able to, you know, get footprints and handprints for her.

Buyer: Yeah, yeah.

PP: So, it's not always possible, but we can, you know—

Buyer: No, so I mean, we're not looking for footprints and handprints though—

PP: No no no, I understand!

Buyer: We're looking for livers, and cardiac [heart], and—

PP: Those I can get you! Those I can get you without too much difficulty at all. Yeah.

Buyer: Good, good. Do you do the whole, convert-to-breech, beforehand?

PP: Um, it depends.

Buyer: Were you trained by Deb [Nucatola], or—

PP: No [laughter]. It depends. It really depends. But, you know, even without that, there's a, we have the capability to get good specimens.

Buyer: Mhm. And what, so what is it then? Is it just like, you're more careful, or how do you, because I know different people—

PP: I think a lot of it has to do with dilation. Really and truly, a lot of it has to do with dilation. Because when you have good dilation, a cervix that's either well-dilated and/or just softer, and more pliable, then as you bring the fetus down, you can get more of it out before disarticulation [dismemberment] occurs, and you can get bigger pieces out before disarticulation occurs. Whereas, if you don't have good dilation, then you're literally almost like, you know, you're picking. Because you get whatever's in your forceps, but if you have good dilation then more than that will come past. If you don't have good dilation, then all you're getting out is what's in your forceps—

Buyer: It just gets stuck right there—

PP: And so whatever's in your forceps and nothing more.

Buyer: And those forceps, they're made to grasp really, so—

PP: Correct.

Buyer: So if something's gonna give, the forceps aren't gonna give, it's the rest of the—

PP: Correct.

Buyer: Right, right.

PP: So, um, and you know, there are some centers who do a lot of same-day preparation, even for up to you know, 18, 20 weeks. And you just don't necessarily—not that you cannot do the procedure safely and effectively, but the dilation is not necessarily as good,

Buyer: Right, right, but you guys dilate Day 1, and then on Day 2 you do the procedure.

PP: Correct. And even for patients over 20 weeks, who need more dilation, we still do it essentially in 1 day, because we do Dilapan for 3 to 4 hours in the morning, take those out, put their second set of overnight dilators in, and then have them come back in the next day—

Buyer: So you guys are all Dilapan.

PP: No no no no no, so typically we use Dilapan for one-day procedures, so usually between like 15 and 16 weeks they'll get Dilapan and do it in one day. And then over 20 weeks, we'll have them come in, we'll do Dilapan for about 4 hours, switch those out and do overnight laminaria. So they're still getting two-stage dilation, but it's not taking two days, or three days, rather, to get it done.

Buyer: Are you ever using Miso for dilation, or no?

PP: We typically use that under 15 weeks. But we're not, we don't usually, we haven't been using it a lot in combination.

Buyer: Okay.

PP: Sometimes, but not a lot, and we don't tend to use it at higher gestational ages alone.

Buyer: Right.

PP: So.

Buyer: Makes sense. Yeah yeah yeah. I mean, so do you agree with the move, like the switch to do things in one day, or where do you come down on that?

PP: I worry about future cervical patency

Buyer: About what?

PP: Future cervical patency

Buyer: Oh

PP: We do have some data that suggest that in terms of risk of future pre-term deliveries, women who have had laminaria, have overnight laminaria, have less risk than women who have other dilation methods. The, kind of the—and it makes sense from a biological plausibility standpoint, because you can imagine that slower dilation over time, overnight, puts less kind of force on the cervix and is perhaps less likely to cause, you know, microdamage, than if you are, you know, doing Misoprostol for a few hours and then doing mechanical dilation to do it in one day.

Buyer: Right, right.

PP: So we don't have great data on that. But there is some thought that the overnight dilation may actually be—and so that's what I, one, that, and then two, it's just—I mean, I understand that all, everything else being equal, women would rather have a procedure in one day. Especially in Texas when you have a requirement for coming 24 hours beforehand anyways, I realize from that standpoint it can be difficult. But, from a safety perspective, from a, you know, from a lot of—I mean we, Thursday, Friday, Saturdays are busy days for us, with D&E, it's not uncommon to have, you know, 4 to 6 2nd-tri[mester] procedures, along with, you know, 25, 30 1st-tri procedures on a Thursday, Friday, or Saturday, and so if my D&E are even taking, you know, 10 minutes longer each, by the end of the day it's an extra, that's an extra hour, you know, on my clinic day, you know, because I don't have as good dilation.

Buyer: Right. That's if you're trying to do one-day?

PP: Right, 'cause you just don't get as good dilation.

Buyer: Oh, so it ends up, in terms of the clinic flow and time for the clinic, you think it actually might not make that much of a difference because it's—

PP: No I think it's actually better to do overnight dilation

Buyer: Yeah, yeah

PP: Because you get better dilation and so your procedures—

Buyer: Are smoother.

PP: Right. Not that you can't do them safely and effectively, but there are certainly—you know, I would much rather do 3 or 4 passes [of forceps], than 15.

Buyer: Yeah, yeah. Right.

PP: Picking, picking, picking.

Buyer: Is that your average, like 3 or 4 passes to remove everything, or?

PP: I think so

Buyer: Tram's listening in, she's like—you take notes then, and keep track of—yeah. You probably do actually, yeah,

PP: It really, it depends, I mean—

PP2: There are some that are like, "I need to make one more pass, one more pass."

PP: To avoid PBA [partial-birth abortion].

PP2: Yeah. I was like, "Uh, a little bit—getting too close!"

Buyer: Oh, to avoid the ban, the federal law.

PP2: Too close, too close! Too close. I was like,

Buyer: Oh, so you're sitting there like coaching her, like watching how to—

PP: No no no, but I mean, we know, right? Like if I'm doing a procedure,

Buyer: And it's breech.

PP: and I'm seeing that I'm in fear that it's about to come to the umbilicus [navel], I might ask for a second set of forceps to hold the body at the cervix, and pull off a leg, or two, so it's not PBA.

Buyer: See, so that's where though, see so that's where, if you've got it coming out to the umbilicus, and that torso area is also intact, that's when I start to get excited because that's like it's all the organs in there that we need are right there.

PP: But I mean, I find that even if I can't get it out intact, I can still get you a good sample.

Buyer: Right. Now if you just do a disarticulation though, you know, while it's sitting there, so you just, you know, pop a leg off, or whatever,

PP: Right.

Buyer: Then you're free, right, like it counts?

PP: Correct.

Buyer: And so then you can just bring the rest of it through, all in one

PP: Correct. If it hasn't got the umbilicus. Correct.

Buyer: However, all in one piece, because you've already done a disarticulation.

PP: Correct. And usually at that point—yeah. Yeah.

Buyer: And obviously, you probably do the whole intent statement thing, and all of that with the—

PP: Yes. Yeah.

Buyer: Do you think that's better than dig[oxin], or where do you? Because some people, that's another like, controversy

PP: I have zero experience with dig[oxin].

Buyer: Oh really

PP: I've just—I, yeah, I just don't have any experience with it, so I can't really speak to that.

Buyer: Yeah. It nukes the stem cells obviously, so we don't want anything that's been dig'ed.

PP: Right, right.

Buyer: I had a colleague who tried to do a cell isolation on a liver that was from a fetus that had been dig'ed, just for kicks and giggles to see—oh excuse me, sorry.

PP2: I'm just laughing at you.

Buyer: Oh. Just to see like if they could get anything out of it, nothing. It was all completely dead. Nothing.

PP2: Yeah.

Buyer: Yeah, of course, right?

PP: Right.

Buyer: So. It's a thing. It's a real thing.

PP: Yeah. So, I mean, like I said, even in the procedures where I'm not doing anything close to intact, I find that it's pretty easy to, you know, identify and isolate relatively intact abdominal contents.

PP2: See and I told you that the abdominal stuff is the easiest,

Buyer: Yeah.

PP2: Like hands down, but like, the thymus, I don't know about all that.

Buyer: Yeah.

PP: Yeah the thymus is gonna be a little bit trickier.

Buyer: Right. Because it's right up here, it's smaller, and that's the thing is, you know, even if they're all intact, if it's all spilled out of the body cavity, you know, by the time you've got it all there in the tray, you're spending like an hour playing like "Find the thymus!" like, poking around,

PP: Livers, kidneys, lungs,

PP2: Intestines

PP: Intestines

Buyer: Yeah we saw all that

PP2: It was like a 16-weeker, that Dr. [Anitra] B[easley] had did, but it was on a minor, and so it was one of those minors where like Dr. B had to like just hurry it up, and like—

Buyer: Oh, was it because the patient was not cooperative or—

PP2: Yeah.

Buyer: Okay.

PP2: So it was just like, not the smoothest. But when you have patients who like cooperate, and there's good dilation, it's just like one pass, and,

Buyer: And you get the whole thing?

PP2: Yeah.

PP: And the truth of the matter is that, you know, as, you know, kind of, medium-range planning, is getting a nurse anesthetist or somebody who can do deep sedation, like Propofol or something like that. Because one of the limiting factors in doing an intact procedure, so Beasley, the other one who does a lot of the bigger procedures, trained at Columbia, and she was trained to do intact procedures without dig, so what their practice was is they would deliver to just above the umbilicus, and then you can reach down and bring down the cord, sever the cord, wait for pulsations to stop from the cord, and then you can do an intact procedure. So, but, to do an intact procedure, you are doing more manipulation intra-uterine, and so you need patients to be more comfortable.

Buyer: Right, ‘cause if they, yeah—

PP: So, you know, the level of manipulation that’s often required to do an intact procedure, and the level of dilation, we just don’t have the sedation capabilities to do. So, you know, in a couple years, hopefully we will be able to have a nurse anesthetist or somebody who can do deep sedation and then we can do more intact procedures.

Buyer: Yeah. Interesting. There you go. Well, I think Missy [Melissa Farrell] is supposed to be sending us some stuff pretty soon, so,

PP2: Yeah, we, uh, her and I needed to meet with Legal.

Buyer: Oh.

PP2: Just to, just ‘cause we’re in Texas we just always want to be like, you know, so we’re just meeting with our legal counsel, and then, setting up something after that.

Buyer: Did you hear anything more about the stuff with [Planned Parenthood] Greater Texas, and what their like confusion is, or?

PP2: I have no idea.

Buyer: No idea

PP2: Trust me, ‘cause like, I would never would have had a conversation with you if I wasn’t already like, fairly confident that it was gonna be—you know, that our bases were covered and stuff like that, so.

Buyer: Uhuh. Yeah, right, right. No no no no. It’s, yeah, I mean, and I saw the provider who I know, Amna Dermish, I saw her wandering the hotel like a couple days ago and I haven’t seen her since, do you know Amna?

PP: No she, yeah, I met her, she had to go back to work so she left yesterday.

Buyer: Oh, that's too bad. I was hoping to, yeah—we met back at the SFP meeting back in October, and she was telling me about the IUD research she was doing and all kinds of stuff. It was cool.

PP2: But for some reason, so PPGT said it was illegal—correct me if I'm wrong, but pretty much like illegal to do this kind of, like—

Buyer: Yeah, they didn't—they said it was, like, not allowed, for whatever reason, and I said, well is it like a statute? Like, I was like I know there are researchers in Texas, publishing their research—

PP: That's right.

Buyer: Like, using aborted fetal tissue, like there's no way it can be completely illegal.

PP: Right.

Buyer: But apparently her CEO was very very uncomfortable with it

PP: Right, they stay away from that.

Buyer: So.

PP2: And we're, I'm all like, okay!

Buyer: And you guys have done it before,

PP2: Yeah, we did it before.

Buyer: And you've been doing it for a long time, so

PP: Right.

PP2: And so I was excited, I was like, you know, we've been wanting to do it

PP: And it's surprising, a lot of our patients actually ask, because I think in our standard kind of consent form it says, you know, sometimes they're researching, and sometimes I'll have patients ask, you know, is this going to be donated to research? Because I want something good for humanity to come out of it, so

Buyer: Yeah. Yeah. Yeah, I think that's really important. And it's just, it's one of those things, we were talking with actually, with one of the other procurement companies last night, about so, just some of the issues with, just with the whole stigma and stuff like

that, there's these areas that people are just not really comfortable talking about, even in our own community sometimes, and that, you know, that holds everybody back and it ends up coming back to bite us, you know, a little bit later on, because then, you know, so,

PP: I mean, I think a lot of the work that's going on in terms of de-stigmatizing, normalizing, I think, it's usually—were you at the lunch today?

Buyer: No.

PP: So, there's this young woman, fourth-year medical student, who got an award for her work. And she's, just, you know, she is full of ideas and enthusiastic and like ready to go and she's like, you know, we need to make this move, we need to partner with companies like Nike, and Dove, and Banana Republic, and [inaudible] and she was like and I don't know how you partner to make the clothing company to make—but we need to do it! And you know, I think she's a little idealistic, but I think her idea is, you know, her message is right. It's like, there needs to be, you know, a bunch of moms, wearing Gap jeans, instead of mom jeans, and be like, yeah, I'm a mom. Yeah, I had an abortion. You know, like? And I wear Gap.

Buyer: Yeah. And you were probably in the plenary earlier today, right?

PP: Yeah.

Buyer: I don't know if I was hearing that from the older ladies up on the stage—I mean a little bit, but I don't know, I don't know, what do you, you're the one—

PP: Well, no, I think they're very interested in reducing the stigma, but I do think that, some of the older people in the room, I think in particular, and I'll say this, I think particular from the Planned Parenthood side, are a little more conservative, right? And a little bit more, trying to be a little bit more measured in their responses. And while I can understand that, I think sometimes—you know, like, it's been 40 f***ing years. We can't be measured anymore.

Buyer: Yeah. Right, right. I mean, and the interesting thing—you know, I talked to Dr. [Vanessa] Cullins at the Medical Director Council, a couple of, I think it was like two months ago when we were there, and she said that stigma reduction is a major goal for PPFA Communications now, though

PP: Right. Yes.

Buyer: Which is kind of a big shift from even just a couple years ago—

PP: Well, and I think part of what happened was, you know she mentioned this morning, and she kind of got on Planned Parenthood rightfully, for the whole issue around the

Komen thing, right? You know like, where abortion is only 3% of what we do, 97% of what we—

Buyer: Yeah, yeah

PP: Which is true, but there's a way of saying that without throwing abortion under the bus.

Buyer: Without throwing it under the bus, yeah!

PP: And I think PPFA heard that a lot from their abortion providers.

PP2: Yeah, yes.

PP: A year ago, there was a 2nd-tri providers' meeting that PPFA convened.

Buyer: Yeah.

PP: And you know, one of the things, they were like you know, at the end of the meeting they were like, what else do you need from us, what else do—and the providers were like, stop talking about it as only, you know, like—

Buyer: Yeah, as if you're ashamed of us, right?

PP: Exactly! We're not you're dirty little secret.

Buyer: Yeah.

PP: How 'bout—we take such good care of women, and men, and we do such a good job of getting them contraception, that we have, that abortion services are a smaller part of what we do, because we take such good care of everyone else. But it's still a necessary service and we're proud that we offer it.

Buyer: Yeah. Yep.

PP: Right? Like there's a different way to message it. And I think that they heard a lot

Buyer: They heard it.

PP: Internally, that we were pissed. That they kind of, that we felt like we were being thrown under the bus.

Buyer: Yeah,

PP2: So like after that, they did, abortion stigma, University of Michigan, and they actually like called us on the phone and was like, you know, what do you say, and like, when I was interviewed, it was like, I feel more stigma internally than I do externally.

Buyer: Wow. Wow.

PP2: That was like, my straight up, like,

PP: And we're lucky as an affiliate because we have a CEO who is very supportive of our abortion mission

Buyer: Yeah.

PP: And not everybody's CEO is.

PP2: Yeah.

PP: And so, I think that's part of the reason why they've—and they've latched onto this de-stigmatization movement that's going on, because they realize that their own providers are pissed at them for contributing potentially to that.

Buyer: Yeah. Yeah. Wow. That's inspiring, there was a little rebellion in the ranks that actually changed a little bit of the direction there.

PP: I think one thing you learn from this meeting, as opposed to some other family planning meetings, is how passionate abortion providers are about what we do, right? And we're not—we are careful about talking about what we do, because it can be dangerous, but we're not ashamed of what we do.

Buyer: Yeah.

PP: And don't you, nobody puts baby in a corner. Right? Don't you put us in the corner!

Buyer: Ah!

PP: That's what I say. Don't you put your baby in the corner! Right? 'Cause we're not having it. We're not having it.

Buyer: That's good. That's incredible. Well, it sounds like, I mean, just from an outside perspective, like the past like two or three years, I've seen the shift, like I've seen it, so it made a difference. I think it made a big impact.

PP: Right. And I think you know, it said a lot to abortion providers within PPFA when Cecile came out—

Buyer: Right.

PP: And talked about—

Buyer: I was very surprised, because I remember like reading, in like in the blogs, just a couple years ago, people complaining that, you know, Cecile Richards isn't saying anything, she won't talk about this one subject, and then I saw that headline and I was like—really?

PP: And I think it's great, every time I heard about another female legislator or somebody who comes out and is like, yes, I had an abortion—

Buyer: Yeah, contact theory, right?

PP: Well, I mean, you know, when you look at the statistics, you know, how many women in this room, given the statistics, had an abortion? A hell of a lot. A hell of a lot.

Buyer: Yeah. Yeah. A hell of a lot. Yeah. Right.

PP: You know? And those of us who haven't, it's probably more than luck than a lot of other things. Thank you! She's looking out for me, finding me shrimp.

Buyer: So how long have you been a provider?

PP: Um, since my fourth year of residency, when I was trained, which was in '04. And I've been providing at least part-time since then. So when I finished my residency, and for the first three years thereafter, I would do one to two Saturdays a month at Planned Parenthood in Pittsburgh, and then I did a year full-time as Associate Medical Director in California. And that's the only thing I did was, I did Planned Parenthood work including two to three abortion clinics a week, and for the past seven years I've been here, where I split my time between academic [Texas] Medical Center and Planned Parenthood, so.

Buyer: Okay. Which affiliate in California?

PP: Golden Gate, before it was dismembered and became something else.

Buyer: Where was that?

PP: San Francisco.

Buyer: Okay.

PP: And then it became NorCal, like Mar Monte and Shasta Pacific.

Buyer: Yeah, yeah, we're from southern California. Oh. Sorry.

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