

## **Testimony for Vermont H 57** **Ingrid Skop, M.D.**

Thank you for the opportunity to testify today. My name is Dr. Ingrid Skop, and I have been practicing obstetrics and gynecology for 27 years in San Antonio, Texas. I am the Chairman-elect of the American Association of Obstetricians and Gynecologists, and a member of the American College of Obstetricians and Gynecologists. I have previously published on the safety of abortion.<sup>1</sup> I speak in vehement opposition to Vermont HB 57.

You have heard heart-breaking stories from families who have lost children to severe fetal anomalies diagnosed in-utero. My heart goes out to these families. I cannot imagine the pain they have endured in the loss of their children. Yet, their stories are being used to advance draconian legislation that will lead to much pain for the women of Vermont. This legislation does not allow any restrictions on abortion for any reason at any time in a pregnancy. You will hear from biased pro-abortion organizations that will tell you that no restrictions are necessary because abortion is extremely safe-safer than taking a Tylenol or getting a shot of penicillin. They will imply that women have late term abortions for only truly compelling reasons, and that a physician will guide a woman through the decision-making process. They will misinform you, so that the state will neglect its duty to protect its citizens and allow the removal of laws that keep legal abortion from being misused.

There are many reasons that this legislation is unnecessary and dangerous for the women of Vermont. Abortions late in pregnancy are far more dangerous for a woman. Almost all late term abortions are done for elective reasons and women have ready access to abortion early in pregnancy. The second and third trimester fetus feels pain during an abortion. If a woman's life is in danger from her pregnancy, her obstetrician can deliver her regardless of the laws regarding abortion. After viability, a medically indicated delivery does not involve intentionally killing the fetus, as abortion does, but merely separating the fetus from his mother. There are other more humane ways to assist families who have received an in-utero diagnosis of life-threatening conditions to their child. Most Americans do not want late term abortions to remain legal and there are less than a handful of countries in the world that will allow abortions without restriction, as the state of Vermont is proposing. What good reasons are there to pass such extreme legislation?

Advocates for this legislation will tell you that legal abortion is extremely safe, and safer for a woman than carrying a pregnancy to term and giving birth. While first trimester abortions are usually safe, there is little evidence that this is true for those in the second trimester and beyond. Risks associated with abortion increase as pregnancy advances. The risk of death increases by 38% for each additional week past 8 weeks gestation, leading to a relative risk of mortality 15 times higher early in the second trimester, 30 times higher in the mid second trimester, and 76 times higher after viability.

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<sup>1</sup> Skop I. Abortion Safety: At Home and Abroad. *Issues in Law & Medicine*, Vol. 34, No.1, pp. 43-75 (Spring 2019)

This Vermont legislation will remove any oversight from a late term abortion provider's facilities or competency. The stigma of abortion insures that for many physicians, abortion provision is a practice of last resort. Many abortion providers are failed practitioners who have lost privileges or been disciplined in other states, are often not board certified, have frequently trained in foreign countries, or for various reasons are unable to obtain hospital privileges.<sup>2</sup> You have undoubtedly heard of Dr. Kermit Gosnell, a late term abortion provider imprisoned for causing the death of a patient, for performing infanticide on many infants who survived abortion, and for running a clinic described by the Philadelphia District Attorney as a "house of horrors". You may think he was an anomaly and believe it cannot happen in your state. If you refuse to supervise the practices of poor-quality physicians who have elected to become providers of death, you will undoubtedly see that it can happen here.

You can't trust the statistics you have been given about abortion complications. The numbers are incomplete, because in the U.S., abortion reporting is purely voluntary. In the most recent year, the CDC, which receives voluntary reporting by most states, reported 638,169 abortions were performed. Meanwhile, the Guttmacher Institute, an abortion advocacy group which gets their information directly from the abortion providers, reported 926,000. The statistics supposedly proving that abortion is extremely safe come primarily from studies of early abortion performed by Planned Parenthood of California. That organization performs an extraordinary amount of abortions (one of their studies included almost a quarter of a million patients),<sup>3</sup> but most abortions are performed by independent abortion providers who may not be as skilled. We don't really know how safe abortion is, because only half of the states mandate that abortion providers report their complications, and only a quarter mandate that other treating physicians report them. None of the states have significant enforcement mechanisms in place. We are allowing the abortion business to police itself.

Statistics on abortion mortality are known to be even more erroneous. The CDC only studies those deaths reported on death certificates as due to abortion, but information about an abortion preceding death is often not recorded on a maternal death certificate. Inconsistent implementation of a pregnancy checkbox on death certificates, or search engine failure to provide ICD 10 codes specific to abortion-related deaths or complications may thwart this documentation. Even when an abortion initiated a cascade of events resulting in death, only the most proximate events may be listed on the death certificate due to space limitations. The certifying physician may be unaware of the abortion, as many abortion providers lack hospital admitting privileges, and care is often provided by other physicians. Or he may mistakenly believe that a miscarriage, and not an abortion, led to the complications. Further, ideological commitments may lead a certifier to omit this information. A study in Finland, where all deaths and medical events are accounted for

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<sup>2</sup> <https://journals.sagepub.com/doi/full/10.1177/2333392819841211>

<sup>3</sup> Cleland. Significant adverse events and outcomes after medical abortion. OBG. 2013. 121(1):166171.

due to very complete records, demonstrated that 94% of deaths related to abortion were not reported on death certificates.

Causes of severe injury and death in women undergoing abortion can include vaginal and intra-abdominal hemorrhage, infection (endometritis, septicemia, and other), embolic phenomena (thrombotic, amniotic, air), complications of anesthesia, and cardiac and cerebrovascular events.<sup>4</sup> The likelihood of complications in later abortions increases due to “inherently greater technical complexity of later abortions related to the anatomical and physiologic changes that occur as the pregnancy advances. The increased amount of fetal and placental tissue requires a greater degree of cervical dilation, the increased blood flow predisposes to hemorrhage, and the relaxed myometrium is more subject to mechanical perforation.”<sup>5</sup> A D&E abortion requires multiple blind passages of the surgeon’s instruments into the uterus, which could easily result in damage, even in experienced hands.<sup>6</sup> If an abortionist perforates a uterus and introduces a sharp instrument into the bowel, bacteremia will follow. If he traumatizes a uterine vessel, thrombotic emboli can be released that will travel to the lungs or brain. If catastrophic hemorrhage, disseminated intravascular coagulation or overwhelming sepsis results from these events, the woman’s cardiovascular system could collapse, leading to death.

Let me discuss how abortions are performed after the first trimester. In the early to mid-second trimester 95% are performed by non-intact dilation and evacuation, also called a “dismemberment abortion”. A cervical dilating agent is usually given for one to three days prior to the surgical procedure. When the cervix is sufficiently dilated, the abortionist introduces a suction catheter to remove the amniotic fluid and softer tissue such as the placenta. The size of the fetus and his calcified bones necessitate his extraction manually. The abortion provider will progressively disarticulate the fetus by pulling off his legs and arms and sections of his torso, prior to crushing and removing his skull.<sup>7</sup>

Abortions extremely late in pregnancy are usually performed by labor induction. An abortionist should perform feticide prior to the induction of a potentially viable baby, because these babies are often not killed by labor, and can be born alive. Recently the U.S. Senate has tried without success to advance legislation that would protect such infants. But late term abortion providers consistently oppose legislation requiring performance of feticide prior to a late term abortion. They state their objection arises from concern of risk to the mother. However, there are numerous peer reviewed studies that have documented the safety of various feticide procedure including intra-cardiac or umbilical cord potassium chloride, umbilical cord transection, intra-amniotic and intra-fetal digoxin, umbilical cord sufentanil and lidocaine or potassium chloride, laser and bipolar

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<sup>4</sup> S Lalitkumar, et al, “Mid-Trimester Induced Abortion: A Review” Human Reproduction Update, 13(1) (2007) 37-52.

<sup>5</sup> Mentula, et al, “Immediate Adverse Events After Second Trimester Medical Termination of Pregnancy: Results of a Nationwide Registry Study” Human Reproduction 26(4) (2011) 927-932.

<sup>6</sup> Niinimaki, “Immediate Complications After Medical Compared with Surgical Termination of Pregnancy” OBG. (2009) 114(4) 795-804.

<sup>7</sup> Live Action, “Abortion Procedure: What you need to know” available at [abortionprocedures.com](http://abortionprocedures.com), last visited on August 21, 2017.

cord cautery, and fetal hyperosmolar urea injection. Abortionists resist performing feticide because they do not want to take the additional time and effort to kill the fetus first. They know that no one will be supervising the abortion clinic, and they can just kill the infant after birth if he inconveniently survives the labor process.<sup>8 9 10 11 12 13 14 15</sup>

Pain is defined as an “unpleasant sensory and emotional experience associated with actual or potential tissue damage”. During a dilation and evacuation abortion there is much tissue damage as a result of the dismemberment of the unborn human being. The fetal sensory neurons begin developing at 7 weeks gestation and connection is made to the midbrain between 14-20 weeks. Connections to the emotional centers in the cerebral cortex start at 17 weeks and are fully functional by 26 weeks, when the third trimester begins. In the second and third trimesters a fetus will recoil in response to a painful stimulus, with vigorous body and breathing movements, increased heart rate and blood flow to the brain, and release of stress hormones and endogenous opioids, much as we would expect from any other living human being.

Abortion advocates deny that this represents pain, because the pain system may not be fully connected to the emotional centers of the cerebral cortex, and they feel it does not count as pain unless the fetus can form an emotional response to the tissue damage that occurs during the late-term, dismemberment abortion. This argument is based upon an extreme interpretation of what constitutes pain. Some have taken this extreme definition a step further and asserted that it does not count as pain unless the fetus can look back on the experience and feel traumatized. Since he is destined for death, he cannot do this. It is chilling to realize that this extreme definition of pain has been applied to a living member of the human species.

There are many instances in our society in which we take extra precautions to prevent pain even though we do not know whether the recipient is capable of fully experiencing pain as we know it. It is the standard of care to provide anesthesia for intrauterine surgery at early gestational ages, and to give pain medication to prematurely born babies undergoing potentially painful procedures. Babies born at the edge of viability, around 22 weeks gestation, can be noted to have cries and facial expressions that we recognize as

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<sup>8</sup> AK Sfakianaki, et al, “Potassium Chloride Induced Fetal Demise” *Journal of Ultrasound Medicine*. (2014) 33(2):337-41.

<sup>9</sup> L Pasquini, et al, “Intracardiac Injection of Potassium Chloride as a Method of Feticide” *BJOG*. (2008) 115(4):528.

<sup>10</sup> MV Senat, “The Use of Lidocaine for Feticide in Late Termination of Pregnancy” *BJOG*. (2003) 110(3):296.

<sup>11</sup> MV Senat, “Funipuncture for Feticide in Late Termination of Pregnancy” *Prenatal Diagnostics*. (2002)22(5):354.

<sup>12</sup> A Bhide “Comparison of Feticide Carried Out by Cordocentesis versus Cardiac Puncture” *Ultrasound Obstetrics and Gynecology*. (2002) 20(3):230.

<sup>13</sup> P Gill “Induction of Fetal Demise in Advanced Pregnancy Terminations: Report of Funic Potassium Chloride Protocol: Fetal Diagnostics and Therapeutics. (1994) 9(4):278.

<sup>14</sup> L Lewi “Pregnancy and Infant Outcome of 80 Consecutive Cord Coagulations in complicated Monochorionic Multiple Pregnancies” *AJOG*. (2006) 194(3):782.

<sup>15</sup> AK Sfakianaki, et al, “Potassium Chloride Induced Fetal Demise” *Journal of Ultrasound Medicine*. (2014) 33(2):337-41.

resulting from pain. We administer anesthesia when we harvest organs from a person who has experienced brain death. When a convicted murderer is given the death penalty, there is a long list of safeguards to make sure that he dies as quickly and painlessly as possible. We treat lab rats and animals destined for slaughter with more care than we treat the fetus. Does Vermont really want to lead the way on the most extreme abortion provision in the country, ignoring the potential for severe pain to a living human being?

The people of Vermont probably generously assume that a woman would turn to a late-term abortion in only the most difficult situations. They may feel it is appropriate to leave the decision to the discretion of “a woman and her doctor”, assuming the doctor will offer the woman guidance, and the procedure will be performed for only truly compelling reasons. Most would be surprised to learn that only seven to fourteen percent of obstetricians and gynecologists will perform an abortion when requested by their patients. Almost all abortions in this country are performed as a result of a financial transaction whereby a woman hires the technical skills of an abortion provider. There is usually no medical judgment involved, and very little counseling about other options. To be clear, pregnancy is a normal physiologic function, not a disease state. Interrupting this normal process is not health care. It is a surgical solution to a societal problem.

10% of U.S. abortions are performed after the first trimester, and 1.3% after viability when the infant can survive separated from his mother. Only 1-3% of abortions occur due to rape, incest, severe fetal anomalies and to protect the life of the mother. The rest are obtained for social and financial reasons. Women have late-term abortions for the same reasons they have abortions earlier in pregnancy. Reasons frequently given for late term abortions are: “not knowing about the pregnancy”, “trouble deciding about the abortion”, and “disagreeing about the abortion with the man involved”. Although it is possible not to know about a pregnancy, my experience as an obstetrician has been that most women know or suspect but may be reluctant to admit the pregnancy to their parents or unsupportive partners. I suspect that women are often coerced into a late-term abortion when the pregnancy becomes obvious, even though this may not have been their “choice”. Vermont may feel it is helping women by passing this legislation that will allow a small trickle of women with severe fetal anomalies to receive late term abortions in the state. However, by opening this door, you will allow a tsunami of elective late terms abortions to follow, many of which will be obtained by coercion of the pregnant women. You will aid and abet human traffickers who will bring their victims here to cover their crimes. You will become a destination for “late term abortion tourism”. You will become a state where people go to be killed. Is this really what you want to do?

In the rare event that a severe fetal anomaly is diagnosed prenatally, leading to the likelihood that the baby’s life will be limited, we should all be aware that perinatal hospice is a life affirming option for this baby and family. If any other family member received a terminal diagnosis, would we advocate killing him at that moment? Of course not. Why should we do the same for a desired child? There have been many occasions in my career when, instead of sending such a patient to an abortionist for

fetal dismemberment, I have instead delivered the baby in my hospital, where the staff and chaplains can offer support, the baby can be held and comforted until his life ends, and the family can express their love to him. How much better for a woman's mental health, to say good-bye to her child in that way than in the office of an abortionist, surrounded by healthy women terminating healthy babies for reasons of convenience?

We are frequently told that a late term abortion may be necessary to save a woman's life, but this occasion is actually very rare. It is clearly the standard of care for any physician to intervene in a pregnancy that presents a risk to the mother's life. The law does not limit intervention in these circumstances. It should be noted, however, that the goal of an abortion is a dead baby. "Premature parturition" occurs when the mother's life requires separation from the baby. The purpose of delivery is to save the life of the mother and the life of the fetus, or to save the life of at least one of them. This can be done in such a way, induction or C-section by her own obstetrician, that the baby can be saved if possible, and many babies survive when born prematurely as early as 22 weeks gestation. If a woman were truly sick enough to need emergent delivery, it should not be delayed and she should be delivered in a hospital, not an abortionist's office.

Finally, it should be noted that most Americans are vehemently opposed to abortion on demand throughout an entire pregnancy. Although about half of Americans identify as "pro-choice", when polled 2/3 would like to see elective abortion prohibited after the first trimester, and 4/5 feel it should be prohibited after viability. With the widespread availability of ultrasound pictures in physician's offices and on social media, most Americans have seen what I see daily in my work as an obstetrician: a fetus beyond the first trimester is a fully formed human being. Every organ is present and only needs to mature. The heart has been beating and brain waves have been detectable for at least six weeks. Even fingerprints have formed. This fetal human being deserves the most basic of human rights: the right to life.

Worldwide, only 6% of countries allow elective abortion after the first trimester, and only 3% allow it after viability. By having such permissive laws, you will find ourselves in the company of nefarious human rights violating countries like China and North Korea. If Vermont passes HB 57, your state will have the dubious distinction of having the most extreme abortion laws in the entire world. Please reconsider your support of this legislation.