

STATEMENT

of

Warren M. Hern, M.D., M.P.H., Ph.D.

Director

Boulder Abortion Clinic

1130 Alpine

Boulder, Colorado 80304

Assistant Clinical Professor

Department of Obstetrics & Gynecology

University of Colorado Health Sciences Center

Denver, Colorado 80220

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of the

United States Senate

Concerning S. 939

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Thank you, Mr. Chairman, for the opportunity to submit a statement to this body concerning S. 939, the so-called "Partial Birth Abortion Ban Act" of 1995. I appreciate the invitation to prepare a statement that came to me from Senators Kennedy, Biden, and Specter as members of the Judiciary Committee. I also deeply appreciate the joint request by Senators Hank Brown and Ben Nighthorse Campbell of Colorado that I be given an opportunity to testify in person and that my remarks be inserted in the record. Since I was not permitted to testify in person, I request that this written statement be entered into the record as per the requests by Senators Brown and Campbell.

My name is Warren Martin Hern. I am a physician engaged in private medical practice in Boulder, Colorado, where I specialize in outpatient abortion services. My formal medical training includes graduation from the University of Colorado School of Medicine in 1965 followed by a one-year rotating internship at Gorgas Hospital in the Panama Canal Zone. I subsequently served for two years as a commissioned officer in the United States Public Health Service assigned as a Peace Corps physician in Brazil. Following that, I studied public health and epidemiology at the University of North Carolina School of Public Health in Chapel Hill, receiving my Master of Public Health degree in 1971. In March, 1970, I began service as Chief, Program Development and Evaluation Branch, Family Planning Division, Office of Health Affairs in the Office of Economic Opportunity, Executive Office of the President in Washington, D.C. I served in this capacity as a federal official until June, 1972.

Since 1973, I have provided abortion services in Boulder, Colorado. I have provided these services in my private practice, Boulder Abortion Clinic, since 1975.

In 1980, while continuing my medical practice, I resumed my graduate work in Chapel Hill, and in 1988, I received my Ph.D. in Epidemiology from the University of North Carolina School of

Public Health. My dissertation research studied the health effects of cultural change among the Shipibo Indians of the Peruvian Amazon.

My publications since 1975 include three books and some 40 professional papers concerning abortion and other aspects of fertility.¹ My medical textbook, *Abortion Practice*, was published by J.B. Lippincott Company of Philadelphia in 1984. It remains in print as the principal textbook concerning abortion and is used internationally.

In addition to my private medical practice, I hold several academic appointments. I am Assistant Clinical Professor of Obstetrics and Gynecology at the University of Colorado Health Sciences Center and Professor Adjunct in the Department of Anthropology, University of Colorado at Boulder. I also hold appointments in the USHSC Department of Preventive Medicine and Biometrics, Department of Family Medicine and at the University of Colorado at Denver, Department of Anthropology.

Senate Bill 939

The bill under consideration, S. 939, is called the "Partial Birth Abortion Ban Act," but there is no such thing as a "partial birth abortion." This is an operation which has never been described in the medical literature, and as far as I know, it does not exist. The bill's sponsors describe some procedures which have been performed for many generations in the case of obstetrical emergency. The operation mentioned in the Senate bill contains some elements of a procedure called an "Intact D & E," or "Intact Dilation and Evacuation" by some physicians during the course of scientific discussions of late abortions, but I have never heard the term, "partial birth abortion" in these discussions. As written, the bill describes aspects of an operation which is performed routinely by some physicians currently, but they are procedures with a long history and wide application by other physicians on a sporadic and unpredictable basis. The bill's language could be interpreted to refer to virtually any second trimester or later abortion. If made more specific, it has the potential to single out and discriminate against specific doctors, some of whose procedures may be alleged to be consistent with the language of the bill. Doctors are poor judges of these subtleties when presented with the exigencies of patient needs. These circumstances mean that the bill can produce a "witch hunt" atmosphere that chills medical practice and interferes with good patient care by conscientious doctors.

History of Intact D & E

Evidence from the ancient city of Pompeii indicates that an operation like this may have been performed by physicians and surgeons during that era, approximately 1,950 years or more before the present time. Breech extraction followed by perforation of the fetal skull by surgical instruments to allow delivery of the aftercoming head in an obstetrical emergency has been practiced by physicians and midwives for hundreds if not thousands of years. It has been practiced in the South American Amazon for a similar period. This is not a new idea.

The specific operation described by the bill's sponsors involves routine version of a 20-week or later fetus into a breech (feet first) position, followed by extraction of the fetus up to the neck, when the base of the fetal skull is perforated with surgical instruments. At that point, the contents of the fetal skull are removed by vacuum aspiration using a hollow cannula. Since the fetus is usually dead by this point, whether due to an induced abortion or miscarriage, and since the head

is under great pressure, the cerebral contents are often extruded without any intervention by the surgeon. The head collapses, permitting delivery of the more or less intact fetus.

A variation of this procedure, which is usually preceded by several days of treatment to open the uterus so as to permit passage of the fetus, is decompression of the fetal skull as it presents first in the sequence of expulsion or delivery of the fetus. Again, the fetus is usually dead at the point at which this occurs. I think fetal death is often brought about by infarction (death) of the placenta as the result of other kinds of treatment such as those that cause uterine irritability.

A common approach to abortion by some obstetricians who have discovered a severe fetal anomaly in an advanced pregnancy is to place prostaglandin suppositories in the vagina followed by induction of labor and expulsion of the fetus. It is my understanding that the maneuvers described by the sponsors of S. 939 are followed by attending physicians throughout the nation when the safety of the woman having the abortion is at issue.

Another approach, which I favor and which is followed by some other physicians, is to induce fetal death on the first or second day of treatment of the cervix. This requires an injection of a medication into the fetus under (usually) ultrasound guidance. This is the procedure which I and one or two other physicians follow. It is accompanied by other forms of treatment, but these vary according to the physician. In the case of a breech presentation of a dead fetus, the procedure described by sponsors of S. 939 is routinely followed.

Advantages of Intact D & E

The principal purpose of an abortion is to end a pregnancy which threatens a woman's life or which she wants terminated. The manner of ending the pregnancy must be determined by safety factors for the woman and acceptability of the methods used. The considerations for the fetus are secondary to the safety and welfare of the woman seeking the abortion.

The possible advantages of Intact D & E procedure include a reduction of the risk of perforation of the uterus. Since most women seeking abortions are young women who hope to reproduce in the future, having a safe abortion technique for late abortion is of paramount importance, aside from the prevention of complications. Another advantage of the Intact D & E is that it eliminates the risk of embolism of cerebral tissue into the woman's blood stream. This catastrophe can be almost immediately fatal.

I support the right of my medical colleagues to use whatever methods they deem appropriate to protect the woman's safety during this difficult procedure. It is simply not possible for others to second guess the surgeon's judgment in the operating room. That would be dangerous and unacceptable.

Fetal Considerations

According to biologist Clifford Grobstein and others, fetal neurological development well into the early part of the third trimester is insufficient for the fetus to experience what we regard as "pain." In Professor Grobstein's book, *Science and the Unborn* (1988, Basic Books, New York), "...an adequate neural substrate for experienced pain does not exist until about the seventh month of pregnancy (thirty weeks), well into the period when prematurely born fetuses are viable with

intensive life support." Like any other mammalian organism, fetuses have enough neurological development to permit certain reflexes, but this is not the same as pain. Interpretation of these reflexes as "pain" is highly misleading.

Duration of pregnancy and reasons for late abortion

While about 1% of all abortions are performed after about 20 weeks of pregnancy, only about .03%, or fewer than 500, are performed after 26 weeks. The majority of these are now performed by me or one of my medical colleagues. These abortions are almost always performed for the most tragic reasons of severe fetal anomaly, genetic disorder, or immediate risk to the woman's life. They are not performed for frivolous reasons, contrary to statements by those opposed to abortion.

For example, one woman was recently brought to me by air ambulance from Rapid City, South Dakota for an abortion because she was about to die from her pregnancy, which was desired. She was a diabetic and had developed hyperemesis gravidarum (uncontrollable vomiting from pregnancy). She was starving to death. Her doctors were having difficulty keeping her alive. Her blood chemical balance was severely altered to the point that her heart could stop at any time. She was profoundly dehydrated. She was critically ill and could barely speak. Since she and her husband wanted the pregnancy, they tried everything to get her through it, but she was finally advised that she must have the abortion. While being flown to Boulder so that I could see her, she almost died in the airplane. I began her treatment immediately and performed the abortion by one of the techniques I have described here two days later. She recovered completely and felt healthy again the next day. Without this operation, she would have died.

Another woman with an advanced pregnancy was referred to me by a colleague in northern Colorado because her fetus had been found to have a severe genetic disorder. She and her husband both wanted the pregnancy to continue. The fetal disorder also caused a serious disease of the placenta, which, in turn, caused the woman's blood pressure to go up. When she arrived at my office, her blood pressure was starting to go up at an alarming rate. I put her in the hospital as I continued my treatment. Her urine output diminished. She became edematous. Her electrolytes (blood chemicals) were out of balance because she was not excreting urine. She developed pulmonary edema (water on the lungs) and began having difficulty breathing. Meanwhile, I was trying to prepare her for the abortion, which promised to be extremely dangerous because of a large placenta that obstructed the opening of the uterus and threatened to cause catastrophic bleeding. We crossmatched blood for her. At 2 AM on the second night, before her cervix was completely prepared for the abortion I needed to perform, I had to act. She was deteriorating rapidly and it was clear that she would die before morning if I did not perform the abortion. This operation took every bit of my skill and experience as a surgeon and everything I have learned in 22 years of performing abortions. Although she was ill for some days from the effects of the pregnancy, the patient recovered fully.

On another occasion, a woman had been referred to me from Michigan for a late abortion because the fetus had a severe anomaly. The pregnancy was complicated by polyhydramnios (too much amniotic fluid surrounding the fetus), which was the result of one of the fetal anomalies. She was resting in my recovery room in preparation for her abortion, accompanied by her husband, when suddenly, without warning, the woman developed signs of shock, and I made a

diagnosis of placental abruption. The placenta had torn away from the wall of the uterus and she was bleeding to death into the uterus. I carried her into my operating room without waiting for assistance, placed her on the operating table, and assembled my surgical team. My nurse held her fist on the patient's aorta to keep her from bleeding to death while I did the abortion. As I began the procedure, two units of blood (about a quart) spurting out of her uterus, and she lost another unit during the operation. Without our preparations and my skill and experience, that woman would have died within minutes.

Mr. Chairman, I did not have time with any of these cases to consult the United States Senate on the proper method of performing the abortions.

Comparative risk of abortion and term birth

Without medical treatment, the risk of death due to pregnancy and childbirth is in the range of 1%. This is measured by the maternal mortality ratio, which is the proportion of women dying from pregnancy or its effects to the number of live births. For example, in 1920, the maternal mortality ratio was 680 per 100,000 live births. 680 women died for each 100,000 live births. In the Peruvian Amazon, where I conduct medical research from time to time, the maternal mortality ratio is about 1000 deaths of women per 100,000 live births, or about 1%.

By 1960, the U.S. maternal mortality ratio had dropped to about 38 per 100,000 live births. It is now about 8 per 100,000 live births for term pregnancy.

By contrast, the death rate in abortion is about 2 or 3 per 1,000,000 procedures, or about .2-.3 per 100,000 abortions. For early abortion, the abortion mortality rate is less than 1 per million procedures.

This means that a woman is ten or more times likely to die if she carries a pregnancy to term than if she has an abortion. For women at high risk of pregnancy complications, the risk of death may be 100 times greater for carrying the pregnancy to term.

Late abortion is a more dangerous procedure than early abortion, but the evidence is that it is still much safer in terms of mortality risk than carrying a pregnancy to term. The risk of a major complication is about 25-30% with term pregnancy, but it is much lower in late abortion. In a recent medical article of mine published in the journal *Obstetrics and Gynecology* in February, 1993, I described the experience of 124 patients for whom I performed abortions in pregnancies complicated by severe fetal anomaly, diagnosed genetic disorder, or fetal death. The average length of pregnancy was 23 weeks with a few over 30 weeks. The major complication rate was less than 1% (one patient). In another comparative study of mine published one year ago in the *American Journal of Obstetrics and Gynecology*, 1001 patients whose pregnancies ranged from 13 to 25 weeks in duration experienced a major complication rate of 0.3%. Only 3 of these patients experienced a major complication.

Implications of S. 939 for medical practice

Late abortion as currently practiced in the United States is a safe procedure that saves women's lives. The medical community has not determined the very best way to perform these procedures,

and that cannot be determined by any legislature. That is a matter for scientific study and medical judgment.

If S. 939 is passed into law, any physician performing any second trimester or later abortion could be prosecuted by an aggressive public prosecutor. It would cause each physician to have to make a legal and political judgment with each patient as to whether prosecution would follow the exercise of the physician's judgment. It is an unwarranted and unacceptable intrusion into the practice of medicine.

The women who seek late abortion always do so for serious reasons. My experience has been that the women who seek my services are experiencing great pain and anguish, along with their family members, as the result of a very difficult decision. Even those who have all the information in a particular case have difficulty in determining the best thing to do. As a practicing physician, I do not see how any governmental body can effectively or rationally control these decisions.

S. 939 is an irretrievably bad piece of legislation that cannot be made acceptable by any means, and I urge the Senate to defeat it at the first opportunity.

References

1. Hern, W.M.: Laminaria in abortion: use in 1368 patients in first trimester. Rocky Mountain Medical Journal 72:390-395, 1975.

Hern, W.M. and A. Oakes: Multiple laminaria treatment in early midtrimester outpatient suction abortion. Advances in Planned Parenthood 12:93-97, 1977.

Hern, W.M.: The concept of quality care in abortion services. Advances in Planned Parenthood 13:63-74, 1978.

Hern, W.M., W.A. Miller, L. Paine, and K.D. Moorhead: Correlation of sonographic cephalometry with clinical assessment of fetal age following early midtrimester D & E abortion. Advances in Planned Parenthood 13:14-20, 1978.

Hern, W.M. and B. Corrigan: What about us? Staff reactions to D & E. Advances in Planned Parenthood 15:3-8, 1980.

Hern, W.M.: Outpatient second-trimester D & E abortion through 24 menstrual weeks' gestation. Advances in Planned Parenthood 16:7-13, 1981.

Hern, W.M.: Correlation of fetal age and measurements between 10 and 26 weeks of gestation. Obstetrics and Gynecology 63:26-32, 1984.

Hern, W.M.: Serial multiple laminaria and adjunctive urea in late out patient dilatation and evacuation abortion. Obstetrics and Gynecology 63:543-549, 1984.

Hern, W.M.: *Abortion Practice*. J.B. Lippincott Company, Philadelphia, 1984. Reviewed in *Family Planning Perspectives*, *New England Journal of Medicine*, *Journal of the American Medical Association*.

Hern, W.M.: Evolution of second trimester abortion techniques. In *Prevention and Treatment of Contraceptive Failure*, U. Landy and S.S. Ratnam, eds. New York: Plenum Press, 1986.

Hern, W.M.: Use of prostaglandins as abortifacients. In *Gynecology and Obstetrics*, Chapter 58, J.W. Sciarra, Ed., Philadelphia, J.B. Lippincott Co, 1982. Published in 1988.

Hern, W.M.: [Abortion Practice](#). Softcover reprint. Alpenglo Graphics, 1990, 368 pages, 59 illustrations, 3 color plates, 16 tables. Available from Alpenglo Graphics, 1130 Alpine, Boulder, CO 80304.

Hern, W.M., C. Zen, K.A. Ferguson, V. Hart, and M.V. Haseman: Outpatient abortion for fetal anomaly and fetal death from 15-34 menstrual weeks' gestation: Techniques and clinical management. *Obstetrics and Gynecology* 81:301-306, 1993.

Hern, W.M.: Cervical treatment with Dilapan™ prior to second trimester dilation and evacuation abortion: A pilot study of 64 patients. *American Journal of Gynecologic Health* 7(1):15-18, 1993.

Hern, W.M.: Laminaria versus Dilapan osmotic cervical dilators for outpatient dilation and evacuation abortion: Randomized cohort comparison of 1001 patients. *American Journal of Obstetrics and Gynecology* 171:1324-1328, 1994.

Hern, W.M.: [Abortion: Medical and Social Aspects](#). In *Encyclopedia of Marriage and the Family*, David Levinson, Ed. New York: Simon & Schuster MacMillan, 1995. pp 1-7.