2nd trimester ABORTION

An interview with W. Martin Haskell, MD

Last summer, *American Medical News* ran a story on abortion specialists. Included was W. Martin Haskell, MD, a Cincinnati physician who introduced the D & X procedure for second trimester abortions. The Academy received several calls requesting information about D & X. The following interview provides an overview.

Q: What motivated you to become an abortion specialist?

A: I stumbled into it by accident. I did an internship in anesthesia. I worked for a year in general practice in Alabama. I did two years in general surgery, then switched into family practice to get board certified. My intentions at that time were to go into emergency medicine. I enjoyed surgery, but I realized there was an abundance of really good surgeons here in Cincinnati. I didn't feel I'd make much of a contribution. I'd be just another good surgeon. While I was in family practice, I got a part-time job in the Women's Center. Over the course of several months, I recognized things there could be run a lot better, with a much more professional level of service—not necessarily in terms of medical care—in terms of counseling, the physical facility, patient flow, and in the quality of people who provided support services. The typical abortion patient spends less than ten minutes with the physician who performs the surgery. Yet, that patient might be in the facility for three hours. When I talked to other physicians whose patients were referred here, I saw problems that could be easily corrected. I realized there was an opportunity to improve overall quality of care, and make a contribution. I own the center now.

Q: Back in 1979 when you were making these decisions, did you consider yourself pro-choice?

A: I've never been an activist. I've always felt that no matter what the issue, you prove your convictions by your hard work—not by yelling and screaming.

Q: Have there been threats against you?

A: Not directly. Pro-life activist Randall Terry recently said to me that he was going to do everything within his power to have me tried like a Nazi war criminal.

Q: A recent American Medical News *article stated that the medical community hadn't really established a point of fetal viability. Why not?*

A: Probably because it can't be established with uniform certainty. Biological systems are highly variable. The generally accepted point of fetal viability is around 24-26 weeks. But you can't take a given point in fetal development and apply that 100 percent of the time. It just doesn't happen that way. If you look at premature deliveries and survival percentages at different weeks of gestation, you'll get 24-week fetuses with some survival rate. The fact that you get some survivors demonstrates the difficulty in defining a point.

Q: Most women who get abortions end pregnancies during the first trimester. Who is the typical second-trimester patient?

A: I don't know that there is a typical second-trimester abortion. But if you look at the spectrum of abortions (most women are between the ages of 19 and 29) they tend to be younger. Some are older. The typical thing that happens with older women is that they never realized they were pregnant because they were continuing to bleed during the pregnancy. The other thing we see with older women is fetal malformations or Down's Syndrome. These are being diagnosed much earlier now than they used to be. We're seeing a lot of genetic diagnoses with ultrasound and amniocentesis at 17-18 weeks instead of 22-24 weeks. With the teenagers, anybody who has ever worked with or had teenagers can appreciate how unpredictable they can be at times. They have adult bodies, but a lot of times they don't have adult minds. So their reaction to problems tends to be much more emotional than an adult's might be. It's a question of maturity. So even though they may have been educated about all kinds of issues in reproductive health, when a teenager becomes pregnant, depending upon her relationship with her family, the amount of peer support she has—every one is a highly-individual case—sometimes they delay until they can no longer contain their problem and it finally comes out. Sometimes it's money: It takes them a while to get the money. Sometimes it's just denial.

Q: Do you think more information on abstinence and contraceptives would decrease the number of teenage pregnancies?

A: I grew up in the sixties and nobody talked about contraception with teenagers in the sixties. But today, though it may be controversial in some areas, there's a lot being taught about reproductive health in the high school curricula. I think a lot more is being done, but the bottom line is we're all still just human—with human emotions, and particularly with teenagers, a sense of invulnerability; it can't happen to me. So education helps a lot, but it's not going to eliminate the problem. You can teach a person the skills, but you can't make them use them.

Q: Does it bother you that a second trimester fetus so closely resembles a baby?

A: I really don't think about it. I don't have a problem with believing the fetus is a fertilized egg. Sure it becomes more physically developed but it lacks emotional development. It doesn't have the mental capacity for self-awareness. It's never been an ethical dilemma for me. For people for whom that is an ethical dilemma, this certainly wouldn't be a field they'd want to go into. Many of our patients have ethical dilemmas about abortion. I don't feel it's my role as a physician to tell her she should not have an abortion because of her ethical feelings. As individuals grow and mature, learn more, feel more, experience more, their perspective about themselves and life, morality and ethics change. Facing the situation of abortion is a part of that passage through life for some women—how they resolve that is their decision. I can be their advisor much as a lawyer can be; he can tell you your options, but he can't make you file a suit or tell you not to file a suit. My role is to provide a service and, to a limited degree, help women understand themselves when they make their decision. I'm not to tell them what's right or wrong.

Q: Do your patients ever reconsider?

A: Between our two centers, that happens maybe once a week. There's a patient who changes her mind or becomes truly ambivalent and goes home to reconsider, then might come back a week or two later. I feel that's one of the strengths of how we approach things here. We try not to create pressure to have an abortion. Our view has always been that there are enough women who want abortions that we don't have to coerce anyone to have one. We've always been strongly against pressure on our patients to go ahead with an abortion.

Q: How expensive is a second trimester abortion?

A: Fees range from $1,200-1,600 depending on length of pregnancy. More insurance companies cover abortion than don't cover it. About 15 percent of our patients won't use insurance because they want to maintain privacy. About 10-20 percent use insurance. The rest pay out of pocket.

Q: What led you to develop D & X?

A: D & E's, the procedure typically used for later abortions, have always been somewhat problematic because of the toughness and development of the fetal tissues. Most physicians do terminations after 20 weeks by saline infusion or prosteglandin induction, which terminates the fetus and allows tissue to soften. Here in Cincinnati, I never really explored it, but I didn't think I had that option. There certainly weren't hospitals willing to allow inductions past 18 weeks—even Jewish, when they did abortions, their limit was 18 weeks. I don't know about University. What I saw here in my practice, because we did D & Es, was that we had patients who needed terminations at a later date. So we learned the skills. The later we did them, the more we saw patients who needed them still later. But I just kept doing D & Es because that was what I was comfortable with, up until 24 weeks. But they were very tough. Sometimes it was a 45-minute operation. I noticed that some of the later D & Es were very, very easy. So I asked myself why can't they all happen this way. You see the easy ones would have a foot length presentation, you'd reach up and grab the foot of the fetus, pull the fetus down and the head would hang up and then you would collapse the head and take it out. It was easy. At first, I would reach around trying to identify a lower extremity blindly with the tip of my instrument. I'd get it right about 30-50 percent of the time. Then I said, 'Well gee, if I just put the ultrasound up there I could see it all and I wouldn't have to feel around for it.' I did that and sure enough, I found it 99 percent of the time. Kind of serendipity.

Q: Does the fetus feel pain?

A: Neurological pain and perception of pain are not the same. Abortion stimulates fibers, but the perception of pain, the memory of pain that we fear and dread are not there. I'm not an expert, but my understanding is that fetal development is insufficient for consciousness. It's a lot like pets. We like to think they think like we do. We ascribe human-like feelings to them, but they are not capable of the same self-awareness we are. It's the same with fetuses. It's natural to project what we feel for babies to a 24-week old fetus.❑

The D & X Procedure—Dilation and Extraction (D & X), a method for second trimester abortion up to 26 weeks, was developed in 1992 by Cincinnati physician W. Martin Haskell, MD. It is a modification of Dismemberment and Extraction (D & E) which has been used in the US since the 1970s. Haskell has performed more than 700 D & X procedures in his office.

Step One—The patient's cervix is dilated to 9-11 mm. over a period of two days using Dilapan hydroscopic dilators. The patient remains at home during the dilation period.

Step Two—In the operating room, patients are given Valium, the Dilapan are removed and the cervix is scrubbed, anesthetized and grasped with a tenaculum. Membranes are ruptured.

Step Three—The surgical assistant scans the fetus with ultrasound, locating the lower extremities.

Step Four—Using a large forcep, the surgeon opens and closes its jaws to firmly grasp a lower extremity. The surgeon turns the fetus if necessary and pulls the extremity into the vagina.

Step Five—The surgeon uses his fingers to deliver the opposite lower extremity, then the torso, shoulders, and upper extremities

Step Six—The skull lodges at the internal cervical os. Usually there is not enough dilation for it to pass through. The fetus is spine up.

Step Seven—A right-handed surgeon slides the fingers of his left hand along the back of the fetus and hooks the shoulders of the fetus with the index and ring fingers (palm down). He slides the tip of his middle finger along the spine towards the skull while applying traction to the shoulder and lower extremities. The middle finger lifts and pushes the anterior cervical lip out of the way.

Step Eight—While maintaining this tension, the surgeon takes a pair of blunt curved scissors in the right hand. He advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger. The surgeon forces the scissors into the base of the skull and spreads the scissors to enlarge the opening.

Step Nine—The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents.

Step Ten—With the catheter still in place, he applies traction to the fetus, removing it completely from the patient, then removes the placenta