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**Admitted Pro Hac Vice*

IN THE DISTRICT COURT OF THE NINTH JUDICIAL DISTRICT
IN AND FOR TETON COUNTY, WYOMING

DANIELLE JOHNSON; KATHLEEN DOW; GIOVANNINA ANTHONY, M.D.; RENE R. HINKLE, M.D.; CHELSEA'S FUND; and CIRCLE OF HOPE HEALTHCARE d/b/a Wellspring Health Access; Plaintiffs, v. STATE OF WYOMING; MARK GORDON, Governor of Wyoming; BRIDGET HILL, Attorney General for the State of Wyoming; MATTHEW CARR, Sheriff Teton County, Wyoming; and MICHELE WEBER, Chief of Police, Town of Jackson, Wyoming, Defendants.	)	Case No. _____

AFFIDAVIT OF INGRID SKOP, M.D.

Exhibit 1

I, Ingrid Skop, being of lawful age and upon my oath do depose and state as follows:

I. Professional background and experience:

1. I have been a board-certified obstetrician and gynecologist since 1998.

2. I received a Bachelor of Science in physiology from Oklahoma State University, and a Doctorate of Medicine from Washington University School of Medicine.

3. I completed a residency in obstetrics and gynecology at the University of Texas Health Science Center at San Antonio.

4. I was in an obstetrics and gynecology group practice in San Antonio from 1996 to 2022.

5. I continue to practice as an obstetric and gynecologic hospitalist in addition to my work as the Vice President of Medical Affairs at the Charlotte Lozier Institute.

6. In my clinical work as an obstetrician and gynecologist, I have delivered over five thousand babies, including many at the threshold of viability.

7. I have also evaluated and treated thousands of women who have had abortions, and many women who have carried unplanned pregnancies to term.

8. This clinical experience, as well as familiarity with the relevant research literature, informs my opinions herein regarding the physical and psychological effects of the experiences of abortion and of carrying unwanted or unintended pregnancies to term.

9. For a complete listing of my professional background, experience, research, responsibilities, and publications, please see my Curriculum Vitae, which is attached to this declaration as Exhibit A.

II. Basis for my opinions:

10. I have been asked by those filing an amicus brief in this case to offer my professional opinion regarding the medical implications of the Life Is a Human Right Act.

11. I have reviewed the Wyoming law and the affidavits by Plaintiffs Dr. Giovannina Anthony and Dr. Rene Hinkle.

12. The opinions I express herein are based upon my medical education, training, research, and over 30 years of clinical experience as an obstetrician and gynecologist, as well as my familiarity with the medical literature. These opinions are my own and do not represent those of the institutions with which I am affiliated.

III. Summary of opinions:

13. Wyoming Enrolled Act No. 88 "Life is a Human Right Act" prohibits abortion, with exceptions if the act is performed to "save the life or preserve the health of the unborn baby; remove a dead unborn baby caused by spontaneous abortion or intrauterine fetal demise; treat a woman for an ectopic pregnancy; or treat a woman for cancer or another disease that requires medical treatment which treatment may be fatal or harmful to the unborn baby".

14. Exceptions to this law occur when: (1) "A pre-viability separation procedure (is) necessary in the physician's reasonable medical judgment to prevent the death of the pregnant woman, a substantial risk of death for the pregnant woman because of a physical condition or the serious and permanent impairment of a life-sustaining organ of a pregnant woman, provided that no separation procedure shall be deemed necessary under this paragraph unless the physician makes all reasonable medical efforts under the circumstances to preserve both the life of the pregnant woman and the life of the unborn baby in a manner consistent with reasonable medical judgment", defined as "a medical judgment that would be made by a reasonably prudent

physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." (2) Abortion performed "when the pregnancy is the result of incest as defined by W.S. 6-4-402 or sexual assault as defined by W.S. 6-2-301. Prior to the performance of any abortion under this [exception, the woman or her guardian] shall report the act of incest or sexual assault to a law enforcement agency and a copy of the report shall be provided to the physician." (3) Abortion performed "when in the physician's reasonable medical judgment, there is a substantial likelihood that the unborn baby has a lethal fetal anomaly or the pregnancy is determined to be a molar pregnancy. "Lethal fetal anomaly" is defined as "a fetal condition diagnosed before birth and if the pregnancy results in a live birth there is a substantial likelihood of death of the child within hours of the child's birth."

15. The plaintiffs-Dr. Giovannina Anthony and Dr. Rene Hinkle-express some concerns that may be based on a misunderstanding of the law. In my opinion, this law will promote compassionate care for women and their unborn children in Wyoming, so I will address these concerns.

16. Hereinafter I will respond to claims raised by the plaintiffs' affidavits, summarized below in bold print.

Plaintiffs' Claim: Women with desired pregnancies will be harmed by the law because it creates uncertainty regarding medical and surgical treatment of pregnant women. The law will force (doctors) to delay medical or surgical treatment to women until they are in a life-threatening situation. Hemorrhage and infection with sepsis are listed as examples of conditions the law does not allow (a doctor) to treat.

17. The plaintiffs suggest that this law prevents physicians from providing medical care when a patient's life is threatened. That is directly contradicted by the text of Enrolled Act No. 88, allowing "a pre-viability separation procedure (when) necessary in the physician's reasonable medical judgment to prevent the death of the pregnant woman, a substantial risk of death for the pregnant woman because of a physical condition or the serious and permanent

impairment of a life-sustaining organ of a pregnant woman, provided that no separation procedure shall be deemed necessary under this paragraph unless the physician makes all reasonable medical efforts under the circumstances to preserve both the life of the pregnant woman and the life of the unborn baby in a manner consistent with reasonable medical judgment", defined as "a medical judgment that would be made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." Notably, the law does not require the threat to be "immediate", only foreseeable. A physician does not need to wait until a woman is seriously ill before intervening.

18. Fortunately, the need for a physician to resort to an abortion when complications arise during pregnancy is rare, because these life-threatening events usually occur in the second half of pregnancy.

19. For nearly any serious pregnancy complication that arises after the point of viability (around 22 weeks gestation), a cesarean section or labor induction will be the most effective remedy.

20. If the pregnancy is causing a serious health concern for the mother, delivering the baby will address the underlying health issue, while also providing the baby with the best opportunity for survival.

21. Delivery is also far preferable to a dilation and evacuation abortion because it is faster and more widely available and shows respect for the unborn human life. Once a physician determines that separation of mother and baby is necessary, a cesarean section can usually be performed within 30 minutes. If the situation is less immediately urgent, labor induction is also an option. Both interventions can be performed in any hospital environment providing obstetric

care, as all obstetricians are trained to perform these procedures but few have technical experience in performing the dangerous dilation and evacuation procedure. Perinatal hospice services are also available in many hospital systems, whereby a multidisciplinary team comforts and supports the fragile child and his family, even if he is too young or sick to survive. Consistent evidence supports improved mental health outcomes for women and families following this more caring approach.[1]

22. Pre-viability medically indicated deliveries are rare. Deliveries between 20 and 26 weeks, either due to spontaneous labor or medical intervention for serious maternal complications are estimated to comprise only 0.5% of all births.[2] Moreover, often when life-threatening situations arise before the point of viability, temporary medical interventions, such as antihypertensive treatments, antibiotics, bedrest and other measures may allow delay of delivery until viability has been reached, and then delivery can occur through standard obstetric interventions as mentioned above.

23. There should not be confusion about when intervention is needed. The law allows a physician to use his "reasonable medical judgment" defined as an action taken by a "reasonably prudent physician" to determine when action is required. The American College of Obstetrics and Gynecology (ACOG) has created comprehensive guidance for management of many obstetric and gynecologic conditions, and I will discuss how this guidance may be applied in some life-threatening conditions below.

24. **Hypertension:** Some women experience severe hypertensive emergencies during pregnancy (preeclampsia/eclampsia), which can lead to severe maternal complications such as

[1] Controlled prospective study on the mental health of women following pregnancy loss. Am J Psychiatry 1996;153:226-230; Lawson HW, Frye A, Atrash HK, et al.
[2] ACOG Obstetric Care Consensus: Periviable Birth. Obstet Gynecol. 2017;130(4):e187-e199.

hematologic abnormalities, seizures, stroke, and liver rupture, although these events rarely occur before fetal viability (and by definition are not considered to be preeclampsia unless they occur after twenty weeks). This condition can usually be treated without abortion. As ACOG recognizes, "[d]elivery is recommended when gestational hypertension or preeclampsia with severe features is diagnosed at or beyond 34 0/7 weeks of gestation, after maternal stabilization or with labor or prelabor rupture of membranes… The expectant management of preeclampsia with severe features before 34 0/7 weeks of gestation is based on strict selection criteria of those appropriate candidates and is best accomplished in a setting with resources appropriate for maternal and neonatal care. Because expectant management is intended to provide neonatal benefit at the expense of maternal risk, expectant management is not advised when neonatal survival is not anticipated" (p. 252). In other words, ACOG supports maternal fetal separation (which can be done by abortion or labor induction) if this crisis occurs before the fetus can survive. After viability, ACOG agrees that delivery, not abortion is the appropriate treatment.[3]

25. **Periviable Premature Rupture of Membranes ("PPROM**"). Some women also experience PPROM, which occurs when the amniotic membrane ruptures in the absence of labor but before the fetus can survive if delivered. This is a severe complication, which can pose serious health risks to the mother and child. Again, however, it is very rare.

26. PPROM can also be treated without abortion. Certainly, if PPROM occurs after the point of viability, delivery or expectant management to allow additional fetal maturation is the most reasonable response to protect the mother's life. And, even before viability, abortion is not the only option. There is no reason that, post-viability, an abortion is more appropriate than delivery. ACOG advises, "Women presenting with PROM before neonatal viability should be

[3] ACOG Practice Bulletin 222: Gestational Hypertension and Preeclampsia. Obstet Gynecol 2020;135(6):237-260; ACOG Practice Bulletin 203: Chronic Hypertension in Pregnancy. Obstet Gynecol 2019;133(1):26-50.

counseled regarding the risks and benefits of expectant management versus immediate delivery. Counseling should include a realistic appraisal of neonatal outcomes. Immediate delivery (termination of pregnancy by induction of labor or dilation and evacuation) and expectant management should be offered. Physicians should provide patients with the most current and accurate information possible" (p. 88).[4]

27. PPROM is a complicated situation. The prognosis for the fetus is poor: the risk of stillbirth is 36% and about 46% of liveborn babies will die within the first month.[5] Even if he reaches the point of viability, the lack of amniotic fluid may cause his lungs to fail to mature, leaving him unable to breathe when delivered. Additionally, the risk of infection (chorioamnionitis) for the mother is very high. Even if she does not show obvious evidence of infection, it is likely that a subclinical infection is already present, and may have been the event that caused the membranes to rupture. Microscopic examination documents evidence of infection in 94% of placentas in the setting of PPROM between 21-24 weeks gestation.[6] The risk to the mother of developing a more serious infection, if the pregnancy continues, is high (up to 71%), and may progress to sepsis (overwhelming blood infection) or even maternal death.[7]

28. To be clear, because the likelihood for progression to life-threatening sepsis for the mother is high, and the prognosis for continued extra-uterine life for the fetus is poor, the law allows an exception where an abortion is necessary to preserve the life of the mother. Offering immediate delivery by induction or by induced abortion is supported by medical guidance. In

[4] ACOG Practice Bulletin 217: Prelabor Rupture of Membranes. Obstet Gynecol 2020;135(3):80-97.
[5] Sim WH, et al. Maternal and neonatal outcomes following expectant management of of preterm prelabor rupture of membranes before viability. J Perinat Med. 2017;45(1):29-44; Kibel M, et al. Outcomes of pregnancies complicated by preterm premature rupture of membranes between 20 and 24 weeks gestation. Obstet Gynecol. 2016;128(2):313-320.
[6] Kim JC, et al. Acute chorioamnionitis and funisitis: definition, pathologic features, and clinical significance. Am J Obstet Gynecol. 2015;213(40):S29-S52.
[7] Margato MF, et al. Previable preterm rupture of membranes: gestational and neonatal outcomes. Arch Gynecol Obstet. 2012;285(6):1529-1534.

this rare situation, abortion is permissible by state law, as necessary to prevent the mother's death.

29. Occasionally women will choose expectant management—i.e., no intervention except watchful waiting and antibiotics—in hopes of reaching delivery at a viable age, and this option is also supported by ACOG guidance if clinical infection is not present. But, refusing to offer the option of intervention in this circumstance is not supported by this law, which would permit intervention because of the likelihood it that PPROM could become life-threatening for the mother. Physicians at Southwestern Medical School demonstrated this reality recently, when they misinterpreted Texas law and declined to offer 26 women with PPROM immediate intervention. The results were predictably poor: 57% of the women experienced serious morbidity and only one of the babies remains alive.[8]

30. **Maternal heart disease.** Some mothers experience complications from heart disease, which may vary from mild to life-threatening. ACOG documents what constitutes "Life-threatening Maternal Heart Disease", advising, "[p]Patients should be counseled to avoid pregnancy or consider induced abortion if they have severe heart disease, including an ejection fraction below 30% or class III/IV heart failure, severe valvular stenosis, Marfan Syndrome with aortic diameter more than 45 mm, bicuspid aortic valve with aortic diameter more than 50 mm, or pulmonary arterial hypertension". Consistent with this law, these patients may be offered immediate abortion when their pregnancy is diagnosed due to the high likelihood of death as the physiologic changes of pregnancy progress. In such rare cases, an abortion may be necessary to prevent the death of the pregnant woman, and thus would fall within this law's exception.[9]

[8] Nambiar A, et al. Maternal morbidity and fetal outcomes among pregnant women at 22 weeks gestation or less with complications in two Texas hospitals after legislation on abortion. Am J Obstet Gynecol. 2022; doi: https://doi.org/10.1016/j.ajog.2022.06.060.
[9] ACOG Practice Bulletin 212: Pregnancy and Heart Disease. Obstet Gynecol 2019;133(5):320-356.

31. ACOG continues, "[p]atients with moderate and high risk cardiovascular disease should be managed during the pregnancy, delivery and the postpartum period in medical centers with a multidisciplinary Pregnancy Heart Team that includes obstetric providers, maternal fetal medicine subspecialists, cardiologists, and an anesthesiologist at a minimum…A personalized approach estimating the maternal and fetal hazards related to the patient's specific cardiac disorder and the patient's pregnancy plans can provide anticipatory guidance to help support her decision making" (p. 346). In other words, in serious but not life-threatening cardiac conditions, careful multidisciplinary care should be provided, and the fetus can be delivered or aborted if the care team agrees that pregnancy has begun to pose a risk to a woman's life. And again, consistent with this law, the fetus can be aborted in this situation if necessary to save the woman's life. Still, it should be noted that medical or procedural treatments are available in many instances to improve cardiac function, allowing a woman to continue her pregnancy until childbirth.

32. **Placenta accreta spectrum.** Women may also experience Placenta Accreta Spectrum, when the placenta becomes abnormally invasive, extending into the uterine musculature, cervix, or surrounding organs. When this occurs and the woman desires to continue her pregnancy to birth, she is followed closely by high-risk obstetric specialists and delivery is arranged in a tertiary medical center where a multidisciplinary team and well-stocked blood bank are immediately available if catastrophic bleeding occurs. ACOG similarly provides guidance for dealing with Placenta Accreta Spectrum, "When the diagnosis of placenta accreta spectrum is made in the previable period, it is important to include counseling about the possibility of pregnancy termination for maternal indications given the significant risk of maternal morbidity and mortality. However, there are currently no data to support the magnitude

of risk reduction, if any. Further, pregnancy termination in the setting of placenta accreta spectrum also carries risk, and the complexities of counseling should be undertaken by health care providers who are experienced in these procedures" (p. 263-264). This extremely high-risk condition is associated with frequent hysterectomies if the fetus is carried to childbirth, but as ACOG notes, there is no data to support the magnitude of risk reduction afforded by abortion versus continuing the pregnancy. Introducing surgical instruments through a placenta previa (which covers the cervical opening) to perform a D&E abortion may itself cause immediate and catastrophic hemorrhage. Of course, if active catastrophic bleeding is occurring, a cesarean section delivery is the quickest and most effective way to immediately control the bleeding.[10]

33. **Critically ill patients.** There are sometimes situations when a mother will experience a serious illness during pregnancy that is not itself caused by the pregnancy but nonetheless threatens her life. This may require treatment in an Intensive Care Unit (ICU). But once again, this does not mean that abortion is the necessary treatment. Rather, the treatment options will vary depending on the illness and organ systems affected. Most of the time, care for the ill mother through circulatory, respiratory, renal dialysis or other organ system support will protect her life and allow recovery from the initiating illness without ever resorting to delivery, much less abortion. In these circumstances, ACOG advises: "[b]ecause the risk benefit considerations for continued pregnancy versus delivery are likely to change as the pregnancy and critical illness progress, the care plan must be reevaluated regularly. In situations when there is an acute deterioration in the patient's clinical condition, immediate reassessment of continuing the pregnancy versus delivery should be undertaken" (p 308). "When obstetric patients are transferred to the ICU, patient care decisions including mode, location and timing of delivery

[10] ACOG Obstetric Care Consensus 7. Placenta Accreta Spectrum. Obstet Gynecol 2018;132:259-275.

ideally should be made collaboratively between the intensivist, obstetrician-gynecologist, and neonatologist, and should involve the patient and her family when possible" (p. 314). Doctors can confidently rely on standard evaluations of medical necessity when such a risk arises to determine if an abortion is necessary in compliance with the law. But as noted, ACOG agrees that early delivery rather than abortion will often be a method of responding in such circumstances if separation becomes necessary, where the child and his mother are both given the best opportunity for survival.[11]

34. **Cancer treatment.** If maternal cancer is diagnosed during pregnancy, treatment considerations and concerns for maternal and fetal health can vary depending on the type of cancer, the degree of spread, the likelihood of recurrence, the proximity of the cancer to the uterus, the possibility of cancer promotion due to pregnancy hormones, and the toxicity of treatment options for the unborn child (which may include surgery, radiation and chemotherapy), so there is not a standard recommendation on how cancer treatment should be addressed in pregnancy. However, if a multidisciplinary team—which should be standard in such a situation—concludes that ending the pregnancy would be necessary to prevent the woman's death, this management would also fall under the statutory exemption for the life of the mother.[12]

Plaintiffs' Claim: Pregnancy may induce or exacerbate mental health conditions, and women who experience intimate partner violence may require abortion as a treatment.

35. Fortunately, ending human life in order to treat mental health disorders is not now, nor has it ever been, a proven medical therapy. Many psychiatric medications and other treatment modalities can be used safely in pregnancy to aid women facing depression and suicidal ideation. In fact, comprehensive European record linkage studies found that in the year

[11] ACOG Practice Bulletin 211. Critical Care in Pregnancy. Obstet Gynecol 2019;133:303-319.
[12] New Drugs Raise Old Questions about Treating Cancer during Pregnancy, Nat'l Inst. Of Health (May 25, 2022), https://www.cancer.gov/news-events/cancer-currents-blog/2022/treating-cancer-pregnancy-new-drugs.

following an abortion, a woman was six times as likely to commit suicide, four times as likely to die from an accident, and fourteen times as likely to be murdered, compared with a woman who carried to term.[13] Offering a woman abortion in the circumstances of a pregnancy complicated by mental illness should be avoided as it may worsen her risk of suicide. Similarly, there are many better options for addressing domestic violence in an abusive relationship than offering to end a life.

36. The association between induced abortion and mental health consequences is controversial because women seeking abortion are often in complex social situations, but it is intuitive that the delivery of a baby should be protective of a mother's health, whereas a pregnancy loss would be expected to have a detrimental effect on her mental health.[14] A meta-analysis of 22 studies found a moderate to highly increased risk (81% overall) of mental health problems after abortion compared to childbirth. Specifically, it found 34% increased risk of anxiety, 37% increased depression, 110% increased alcohol abuse, 230% increased marijuana abuse, and 155% increased suicidal behavior.[15] The most comprehensive review of available literature studying mental health outcomes after abortion revealed that two thirds (49 out of 75) of the studies showed a positive correlation between abortion and adverse mental health

[13] Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland, 1987-94. Register linkage study. Br Med J 1996;313:1431-1434; Karalis E, Ulander V, Tapper A, Gissler M. Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy associated deaths in Finland 2001-2012. BJOG 2017;124:1115-1121; Gissler M, Berg C, Bouvier-Collie M, Buekens P. Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. Eur J Public Health 2005;15:459-463.

[14] Ney PG, et al. The effect of pregnancy loss on women's health. Soc Sci Med. 1994;38(9):1193-1200; Coleman PK. Post abortion mental health research: distilling quality evidence from a politicized professional literature. J of Am Phys and Surg. 2017;22(2):38-43.

[15] Coleman PK, Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009. British J of Psychiatry. 2011;199:180-186; Coleman PK. Deriving Sensible Conclusions From the Scientific Literature on Abortion and Women's Mental Health. Peace Psychology Perspectives on Abortion. 2016;74-93.

outcomes.[16] Anxiety and depression may lead to substance abuse and overdose, self-harm and suicide, domestic violence including homicide and high-risk taking behavior leading to accidents, all of which have been linked to maternal "deaths of despair," increasingly common causes of maternal mortality.[17]

37. There are many subgroups of women who have been documented to be at high risk for mental health complications following abortion. 40-50 percent of American post-abortive women have had multiple abortions. Some 20-60 percent of women obtaining abortions may desire their pregnancy but experience pressure or coercion to terminate. Some women terminate a desired pregnancy due to perceived health risks for themselves, or abnormalities in the baby. Minor women account for 15-30 percent of abortions and one study showed that these young women have a ten times higher suicide rate than their peers. An abortion may trigger or aggravate preexisting mental health conditions held by 20-50 percent of women who undergo the procedure. A late abortion is also a significant risk factor for psychological problems.

Plaintiffs' Claim: Women who seek but are denied abortion have poor mental health and economic outcomes.

38. In order to conclude that women do better mentally and economically following abortion, the plaintiffs referenced the biased studies derived from the "Turnaway cohort" of women seeking abortions, some of whom were denied an abortion due to an advanced gestational age. Pro-choice researchers from the abortion advocacy organization, Advancing New Standards in Reproductive Health, reported that they found worse mental health and

[16] Evidence Directing Pro-life Obstetricians & Gynecologists. (2019). Practice Bulletin 7: Abortion and Mental Health. American Association of Pro-Life Obstetricians & Gynecologists. Available at https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf. Accessed August 1, 2022.
[17] Texas Maternal Morbidity and Mortality Task Force. 2016. Available at https://www.dshs.texas.gov/mch/Maternal-Mortality-and-Morbidity-Review-Committee.aspx, accessed August 2, 2022.

economic outcomes in those denied abortion.[18] Yet, these studies are methodologically flawed due to an extremely poor participation rate and selection bias. Only 37% of eligible women agreed to participate, and an additional 44% dropped out before the study's completion (leaving a cohort of only 17% of those initially surveyed, a total of only 516 women, representing 0.32% of the total estimated abortions performed in the 29 participating facilities over the three-year recruitment period).[19] It is intuitive that a woman who anticipates she may suffer emotionally from her abortion would decline to participate in such a study, which may recall negative emotions. Even the study authors acknowledged that these women were self-selected to be those most confident in their decision. Other compounding factors, such as mental health history or history of other abortions, were not controlled for.[20]

39. The association between abortion and economic outcomes is complicated but appears to be more closely related to economic status before pregnancy and single-motherhood than to the pregnancy outcome itself. Even though a woman may have an immediate decrease in income while caring for a child, income improves over time so that eventually no long-term deficit is noted.[21] At any rate, making economic arguments for ending human life is distasteful and should be avoided.

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[18] ANSIRH Find research. Available at www.ansirh.org/research, accessed August 1, 2022; Rocca C. Women's emotions one week after receiving or being denied an abortion in the U.S. Persp on Sexual and Reproductive Health. Aug 2013; Foster D, et al. A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. Psychol. Med. 2015;45(10):2073-2082; Biggs MA, et al. Does abortion increase women's risk for post-traumatic stress? Findings from a prospective longitudinal cohort study. BMJ Open. 2016;6:e009698.

[19] Dobkin L, et al. Implementing a prospective study of women seeking abortion in the U.S.: Understanding and overcoming barriers to recruitment. Women's Health Issues. 2014;24(1):e115-123.

[20] Reardon, DC. The Embrace of the Pro-Abortion Turnaway Study. Wishful Thinking? or Willful Deceptions? Linacre Quarterly. 2018;85(3):204-212.

[21] Available at https://lozierinstitute.org/does-abortion-improve-economic-outcomes-for-women-a-review-of-the-evidence/, accessed March 21, 2023.

Plaintiffs' Claim: Abortion is 12 times safer than childbirth.

40. It is well established that the CDC has incomplete statistics regarding abortion-related maternal mortality because most of their data is obtained from maternal death certificates, and maternal death certificates frequently do not document preceding pregnancies, especially early pregnancy events such as abortion or miscarriage.[22] Even if related to childbirth, at least 50% of maternal deaths are not reported as pregnancy-related on death certificates.[23] Mortality from events in the first half of pregnancy, which are unable to be linked to a birth certificate, are even more difficult to detect, but high-quality records-linkage studies from Finland document that 73% of all maternal deaths and 94% of abortion-related deaths are not documented as such on the maternal death certificate.[24] Relying primarily on death certificate data as the CDC does will inevitably undercount maternal deaths.

41. Thus, the plaintiffs' assertion that legal abortion is far safer than childbirth is based on conjecture by researchers associated with the abortion industry. A close analogy would be if the U.S. had allowed the tobacco industry to control the studies and narrative regarding the safety of smoking. The data regarding abortion-related complications and maternal mortality is similarly compromised. The authors of one misleading study claiming that deaths from childbirth occur fourteen times as often as deaths following abortion are vocal abortion advocates who are

[22] Studnicki, et al. Improving the Metrics and Data Reporting for Maternal Mortality: A Challenge to Public Health Surveillance and Effective Prevention. Online Journal of Public Health Informatics. 2019;11(2):e17; Marmion P, Skop I. Induced abortion and the increased risk of maternal mortality. The Linacre Quarterly. 2020;87(3):302-310; Jatlaoui TC, Boutot ME, Mandel MG, et al. Abortion Surveillance-United States 2015. Surveillance Summaries. 2018;67(13);1–45, accessed August 1, 2022.

[23] Horon IL. Underreporting of Maternal Deaths on Death Certificates and the Magnitude of the Problem of Maternal Mortality. AJ of Public Health. 2005;95:478-82; Deneux-Tharaux C, Berg C, Bouvier-Colle MH, et al. Underreporting of pregnancy related mortality in the U.S. and Europe. Obstet Gynecol. 2005;106(4):684-692.

[24] Gissler M, Berg C, Bouvier-Colle MH, Buekens F. Methods for identifying pregnancy associated deaths: Population based data from Finland 1987-2000. Pediatric and Perinatal Epidemiology. 2004;18:448-455. DOI:10.1111/j.1365-3016.2004.00591.x; Gissler M, Berg C, et al, Pregnancy Associated Mortality After Birth, Spontaneous Abortion or Induced Abortion in Finland. 1987-2000. AJOG 2004;190:422-427.

well aware of the limitations of the data the CDC used. The study used four disparate and difficult to calculate numbers with non-comparable denominators: abortion-related deaths were compared to the number of legal abortions, maternal deaths were compared to the number of live births.[25] Comparing a maternal mortality ratio to an abortion mortality rate is a meaningless exercise, even if all deaths following all pregnancy events were accurately recorded, which abundant data demonstrates is not the case.[26] Confident assertions about mortality from the various pregnancy outcomes just cannot be made with certainty in the U.S.[27]

42. The definition of maternal mortality encompasses all deaths that occur up to a year from the end of the pregnancy. While catastrophic complications directly related to the pregnancy separation event are more likely to be detected, mental health complications remote from the event are likely not to be detected or attributed to the method in which the pregnancy was resolved. Yet, one finding in the investigation of recent increases in U.S. maternal mortality is the increase in "deaths of despair"—substance abuse and overdose, suicides, homicides, and excessive risk-taking behavior. Mental health issues may contribute to drug overdoses, suicides, homicides, or even accidents due to risk-taking behavior, but current systems of data collection are not capable of linking these events to induced abortion.[28]

[25] Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. Obstet Gynecol 2012;119:215–9; David A Grimes. https://www.huffpost.com/author/david-a-grimes accessed December 9, 2022.
[26] Studnicki, et al. Improving the Metrics and Data Reporting for Maternal Mortality: A Challenge to Public Health Surveillance and Effective Prevention. Online Journal of Public Health Informatics. 2019;11(2):e17; Marmion P, Skop I. Induced abortion and the increased risk of maternal mortality. The Linacre Quarterly. 2020;87(3):302-310; Jatlaoui TC, Boutot ME, Mandel MG, et al. Abortion Surveillance-United States 2015. Surveillance Summaries. 2018;67(13);1–45, accessed August 1, 2022.
[27] Reardon D, Strahan T, and Thorp J. Deaths Associated with Abortion Compared to Childbirth-A Review of New and Old Data and the Medical and Legal Implications. J. Contemp. Health Law & Policy. 2004;20(2):1-51.
[28] MacDorman MF, et al. Recent Increases in the U.S. Maternal Mortality Rate Disentangling Trends From Measurement Issues. Obstet Gynecol 2016;128:447–55.

43. Better quality data than the CDC reports can be obtained from records-linkage studies, where all deaths in reproductive aged women are linked to records on all pregnancy outcomes. When this analysis is applied to this question, a far different result is obtained: deaths are more frequent in the year following abortion than childbirth.[29]

44. An eight-year retrospective California study showed that women who aborted had significantly higher age-adjusted risks of death from all causes (162%) and suicide (254 %) compared to those who delivered a baby.[30] Comprehensive record linkage studies from Finland found that following an abortion, a woman was two to four times as likely to die within a year.[31] Similar results have been documented in Danish studies, with a 39% increased risk of death after first- trimester abortions and a 341% increased risk after later abortions.[32] The state of Wyoming can justify limiting abortions in the interest of protecting a woman's mental health and protecting her from a death of despair.

Plaintiffs' Claim: Women are burdened by being forced to carry a 'non-viable' pregnancy to term.

45. The plaintiffs express concern about options for fetal abnormalities. While the diagnosis of an unborn child with abnormalities is undoubtedly a tragedy, further discussion is

[29] Reardon D, Strahan T, and Thorp J. Deaths Associated with Abortion Compared to Childbirth-A Review of New and Old Data and the Medical and Legal Implications. J. Contemp. Health Law & Policy. 2004;20(2):1-51.
[30] Reardon DC, Ney PG, Scheuren F, Cougle J, Coleman PK, Strahan TW. Deaths associated with pregnancy outcome: a record linkage study of low-income women. South Med J 2002;95:834-841.
[31] Gissler M, Hemminki E, Lonnqvist J. Suicides after pregnancy in Finland, 1987-94. Register linkage study. Br Med J 1996;313:1431-1434; Karalis E, Ulander V, Tapper A, Gissler M. Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy associated deaths in Finland 2001-2012. BJOG 2017;124:1115-1121; Gissler M, Berg C, Bouvier-Collie M, Buekens P. Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. Eur J Public Health 2005;15:459-463; Gissler M, Kaupilla R, Merilainen J, Toukomaa H, Hemminki E. Pregnancy-associated deaths in Finland, 1987–1994—definition problems and benefits of record linkage. Acta Obstet Gynecol Scand 1997;76:651-657.
[32] Reardon DC, Coleman PK. Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980-2004. Med Sci Monit 2012;18(9):71–76; Coleman PK, Reardon DC, Calhoun B. Reproductive History Patterns and Long-term Mortality Rates: A Danish population-based record linkage study. Eur J of Public Health.

warranted about whether abortion is the only or best solution. Enrolled Act No. 88 contains an exclusion allowing termination "when in the physician's reasonable medical judgment, there is a substantial likelihood that the unborn baby has a lethal fetal anomaly", defined as "a fetal condition diagnosed before birth and if the pregnancy results in a live birth there is a substantial likelihood of death of the child within hours of the child's birth". Although termination is frequently advised as the only reasonable option when a severe abnormality is diagnosed, there are other options that should be presented. Sometimes the diagnosis is wrong, and the disability is not as severe as anticipated.[33] Studies indicate that grief may be as severe or more severe for a woman who loses an anomalous fetus to termination than to stillbirth or neonatal loss if she continues her pregnancy.[34]

46. Severe fetal abnormalities are often not diagnosed until late in pregnancy, and later abortions are far more dangerous. The CDC documents that the risk of maternal death following abortion in the late second trimester is 76-times higher than if she had an early abortion.[35] The multi-disciplinary option of perinatal hospice, involving a care team of specialists such as the primary physician, social worker, nurse with training in bereavement issues, neonatologist, anesthesiologist, psychiatrist, psychologist, chaplain, local priest/pastor, bereavement counselor, and additional labor and neonatal nurses, to provide support to a

[33] Lee TS. False Positives for Genetic Disorders in Prenatal Testing Unacceptably High. The Daily Signal. Jan 12, 2022.

[34] Zeanah CH, Dailey JV, Rosenblatt MJ, Saller DN. Do women grieve after terminating pregnancies because of fetal anomalies? A controlled investigation. Obstet Gynecol 1993;82(2):270-275; Korenromp MJ, Christiaens ML, van den Bout J, Mulder EJH, Hunfeld JAM, Bilardo CM, Offermans JPM, Visser GHA. Long-term psychological consequences of pregnancy termination for fetal abnormality: a cross-sectional analysis. Prenat Diagn 2005;25:253-260; Korenromp MJ, Page-Christiaens gCML, Van den Bout J, Mulder EJH, Visser GHA. Adjustment to termination of pregnancy for fetal anomaly: a longitudinal study in women in women at 4, 8, & 16 months. Am J Obstet Gynecol 2009;201:160.e1-78. Janssen HJ, Cuisinier MC, Hoogduin KA, de Graauw KP. Controlled prospective study on the mental health of women following pregnancy loss. Am J Psychiatry 1996;153:226-230; Lawson HW, Frye A, Atrash HK, et al.

[35]

grieving women and family, is a caring alternative to a late abortion and should be encouraged. A woman and her family can grieve an intact fetus who may be born alive (instead of dismembered body from D&E), allowing holding, photographing, burial and autopsy for future counseling. Just as medical professionals would not recommend immediate death for a family member diagnosed with a terminal illness, continuing pregnancy for as long as possible in the situation of a severe or lethal abnormality allows the family to bond with the child whose life will be regrettably shortened, allow for a healthier grief response, and will improve their emotional outcomes.

Plaintiffs' Claim: Law traumatizes an incest or rape survivor by requiring her to file a police report on the attack.

47. By requiring a police report, this law ensures women are protected from abusive circumstances. The plaintiffs' opposition to this requirement to allow a rape or incest exception is surprising. For a woman who becomes pregnant as a result of incest or in the situation of domestic violence, regardless of whether she obtains an abortion, it is necessary that she receive other social service interventions. Providing an abortion and returning the woman to the abusive situation does her a grave disservice. A police report is the first step toward providing needed interventions, as well as administering justice to her abuser. She may need removal from an abusive home or ongoing child protective services supervision. She certainly will also require comprehensive trauma-informed counseling. Counseling is necessary, especially in the event of pregnancy from incest, to determine whether an abortion is in her best interests, including her mental health.

48. Even in these difficult situations, abortion is not a panacea. One study found that eighty percent of those who aborted a pregnancy conceived in sexual assault reported that it had been the wrong solution, and they felt it contributed to the trauma they experienced, while none

of the women who gave birth to a child conceived in rape experienced regret or wished they had aborted instead.[36]

Plaintiffs' Claim: Law will worsen critical shortage of physicians.

49. This concern can easily be dispelled. If Wyoming residents face a critical shortage of reproductive health care providers, including obstetrician-gynecologists, this problem is unrelated to these legislative limitations on abortion. 87-93% of obstetrician/gynecologists do not perform elective abortions. The solution to a shortage of health care providers is not to end the lives of patients needing care. It is to prioritize training and incentivizing providers to locate to rural areas and areas of need. Wyoming has the opportunity to redistribute resources from life-ending care to life-enhancing care, and perhaps lead the nation in prioritizing the lives of all its citizens, from youngest to oldest.

End of Affidavit.

[36] Reardon, Makimaa & Sobie, Victims and Victors, Speaking Out About Their Pregnancies, Abortions and Children Resulting from Sexual Assault. Springfield, IL: Acorn Books, 2000. P 19-22.

Dated this 22 day of March 2023.

Ingrid Skop M.D.
2800 Shirlington Road, Suite 1200
Arlington, VA 22206

STATE OF TEXAS)
COUNTY OF BEXAR)
)

The foregoing affidavit was sworn to or affirmed as true by Ingrid Skop M.D. before me on this 22 day of March 2023.

WITNESS my hand and official seal.

3/22/2023
Date

Notary Public

(SEAL)
My commission expires:

EDWARD CAMACHO REYNA
Notary Public, State of Texas
My Comm. Exp. 05-24-2026
ID No. 13377956-1

05-24-2026